



**THE USE OF MASEKITLANA AS A THERAPEUTIC  
TECHNIQUE FOR CHILDREN AFFECTED BY HIV/AIDS**

by

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**PRETORIA**

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**THIS THESIS IS DEDICATED TO**

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who unstintingly gave encouragement throughout  
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and who sacrificed their own pleasures and comfort  
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## DECLARATION OF ORIGINALITY

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I, S.A. John (student number 29593477), declare that:

*“The use of Masekitlana as a therapeutic technique  
for children affected by HIV/AIDS”*

is my original work and that all the sources that were consulted and quoted have been acknowledged in the reference list.

**S.A. JOHN**

**March 2012**

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## SUMMARY

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This study is an investigation into the use of an African indigenous narrative game, Masekitlana, which I used as a therapeutic medium for four children, aged eight to 12 years. The participants are of Zulu origin and culture and were affected and orphaned as a result of HIV/AIDS. The game involved the participants in activities, such as hitting stones together or arranging them at will, that they felt familiar with and that enabled freer verbal expression from them. I employed a single-system research design that consisted of mixed methods approaches in the form of a qualitative thematic analysis and a quantitative graphic presentation of the results. The research design was a time series design that involved using, at four different times along the process of therapy, the measure of the Roberts-2 test (ethnic version). Therapy consisted of three sessions of standard of care therapy (therapy that was routinely being used in the psychology clinic) and three intervention therapy sessions of Masekitlana. I found the mixed-methods approach to be a practice-friendly form of research as it helped to describe the concerns of the participants in depth and enabled a concrete, quantitative conclusion about the efficacy of Masekitlana as an intervention. Syncretism of both approaches meant that qualitative data helped to clarify and confirm the findings of quantitative data and vice versa.

Qualitative analysis showed how Masekitlana helped participants to express their traditional African beliefs, such as belief in the guidance of their ancestors, in the influence of bewitchment in their lives, and in the animation of the natural world. Thematic analysis also revealed the anger that participants felt resulting from the sense of disempowerment they experienced in Children's Homes and from their separation from their biological families, and their need to sublimate this anger into future careers in the police force or alternatively to resort to crime. Thematic analysis also revealed the strategies employed by participants for coping with peer conflict in the Children's Homes, and the challenges they face with schooling difficulties. Quantitative analysis revealed how participants progressed to complex forms of adaptive functioning and explanation of situations in their lives as a result of Masekitlana therapy.

Recommendations arising out of this study are that psychologists strive to use forms of therapy that are familiar to the cultural backgrounds of indigenous children, and that training

psychologists learn about the cultural beliefs of their patients and be exposed to the rituals used in traditional environments in order to understand indigenous clients. Psychologists should also be aware of the fact that, with the effects of television on children, and with present globalization and ease of international travel, children of African origin and culture are a mixture of traditional African and modern Western values. Therefore an integration of Western and indigenous forms of psychology might be considered.

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## KEYWORDS

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|                             |                                 |
|-----------------------------|---------------------------------|
| Masekitlana                 | African belief systems          |
| Ancestors                   | Bewitchment                     |
| Therapeutic interventions   | Developmental adaptive function |
| Projective identification   | Story-telling                   |
| Traditional African healers | Indigenization                  |

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## GLOSSARY OF ZULU WORDS

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|                                       |   |
|---------------------------------------|---|
| <i>Balungisiwe</i> .....              | balanced or in good order   |
| <i>-buyisa (uku-)</i> .....           | cause to return, restore, call back spirit of deceased as at departure ceremonies   |
| <i>Diketo (Sotho)</i> .....           | traditional Sotho stone game  |
| <i>-dlozi (i- ama-)</i> .....         | spirit of departed person, guardian spirit, snake supposed to be spirit of departed, living dead  |
| <i>-gebengu (isi- izi-)</i> .....     | criminals, gangsters  |
| <i>-gogo (u- o-)</i> .....            | grandmother   |
| <i>-hlonipha</i> .....                | act respectfully, honour, empathy, avoid certain sounds by women ( <i>hlonipha</i> custom)  |
| <i>Igqira</i> .....                   | Xhosa healer  |
| <i>kusempondo zankomo</i> .....       | ‘it is the horns of the cattle’, metaphor for ‘the dawn is rising’  |
| <i>-ma / mama (u- o-)</i> .....       | my/our mother   |
| <i>-makoti (u- o-)</i> .....          | bride, newly married woman  |
| <i>mhondoro (Sotho)</i> .....         | ancestor spirit   |
| <i>Ngamatshe / umagenda</i> .....     | traditional Zulu stone game   |
| <i>-ndaba (i- izi-)/ imbizo</i> ..... | community gathering   |
| <i>-nyama (um-)</i> .....             | literally ‘darkness’ but refers here to ‘pollution’, ill omen   |
| <i>-nyanga (i- izi-)</i> .....        | herbalist/herbal healers.   |
| <i>-sandulela (i-) ngculaza</i> ..... | HIV   |
| <i>-thakathi (ubu-)</i> .....         | witchcraft  |
| <i>-thandazeli (um- aba-)</i> .....   | prayer/faith healer (sometimes spelt <i>abathandazi</i> )   |
| <i>-thi (umu- imi-)</i> .....         | medicine  |
| <i>Ubulawu</i> .....                  | refers to ‘red’ followed by ‘white’ form of Zulu medicine, pleas for protection from ancestors, bodily weakness as a result of witchcraft |
| <i>Ubuntu</i> .....                   | African humanness/humanity  |





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|--|--|
| <i>ukugcina isiZulu</i> .....            | take care the Zulu way, Zulu way of doing things, honouring Zulu customs                                       |
| <i>ukunxulumana</i> .....                | loosely translated as ‘to stand beside one another’ or ‘side-by-sideness’                                      |
| <i>Umagenda</i> .....                    | traditional Zulu stone game  |
| <i>Umlabalaba</i> .....                  | traditional Zulu stone game, similar to ‘noughts and crosses’  |
| <i>isangoma/izangoma</i> .....           | traditional diviner/s, healers, sometimes called ‘witch-doctor/s’ (sometimes written <i>umngoma/abangoma</i> ) |
| <i>ukuhlambuluka/ukuhlambulula</i> ..... | self-cleanse, cause to become clear, rinse in water, improve in appearance                                     |
| <i>-vivane (isi- izi-)</i> .....         | cairn, pile of stones  |
| <i>-vumisa/-vuma</i> .....               | method of ritual and dialoguing, falling down, singing   |
| <i>-zila (uku-)</i> .....                | mourn, abstain from food or withdraw from society  |

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## **CHAPTER 7 CONCLUSIONS AND RECOMMENDATIONS**

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## CHAPTER 1 IDENTIFYING THE STUDY

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### 1.1 INTRODUCTION TO THE STUDY

Much has been written by theorists and psychologists in South Africa and throughout the world on the need to contextualize and indigenize psychology (Naidoo, 1996), to preserve indigenous knowledge systems (Ngulube & Lwoga, 2007), to pursue culturally relevant research (Allwood & Berry, 2006; Allan & Dana, 2004; Adair, 1999; Adair & Diaz-Loving, 1999; Kim, Park & Park in Adair & Diaz-Loving, 1999; Misra & Gergen, 1993), and to use culturally appropriate and locally normed methods of assessment (Kekae-Moletsane, 2008; Singh, Sunpath, John, Eastham & Goundan, 2008; Foxcroft, 2002; Lu & Bigler, 2002). Traditional healing methods for people from African cultures in general have been covered in South African literature (Maiello, 2008; Sandlana & Mtetwa, 2008; Mufamadi, 2001; Holland, 2001; Tyrrell, 1971; Mutwa, 1998; Buhrmann, 1984; Krige, 1950).

Despite the significant body of literature that describes the need for forms of indigenous psychology, psychologists who are trained in South African universities have traditionally been encouraged to study the theories and counselling practices of American and European theorists and practitioners. These practices are not always relevant for the client or patient of African origin and culture (John & Kekae-Moletsane, 2011). In particular, the assessment techniques taught in South African universities often use complex instruments that have been standardized on American and European cohorts. The relevance of these instruments is thought to be particularly problematic in connection with indigenous African children, who are bound by cultural practices and living environments that are very different to those children upon whom the standards of the tests were developed.

There appears to be a need, therefore, for forms of assessment and therapy that not only can be proven to be valid for these children but can also offer them something familiar to their cultural and environmental experiences. Specifically, the question arises on how to create forms of assessment and therapy that are relevant for the present circumstances of the Human Immunodeficiency Virus (HIV) epidemic and widespread poverty, as well as being

complementary to the African sense of community and living alongside one's fellow human beings (John & Kekae-Moletsane, 2011).

South African practitioners in the past 25 years have been confronted with the epidemic of HIV/AIDS. One of the results of this epidemic is that many young mothers, and to a smaller extent fathers, have lost their lives to Acquired Immune Deficiency Syndrome (AIDS), leaving their children parentless and in many cases suffering from Human Immunodeficiency Virus (HIV) themselves. Research has highlighted how the "health, development and psychological well-being of orphans living with HIV, or affected by HIV/AIDS, are at risk long before either parent dies" (Juma, 2001, in Mbugua, 2004:307). The psychological trauma these orphans might undergo includes "tending to a dying parent and, at the same time or after the death of their parents, taking care of siblings" (Mbugua, 2004:307). The result is that these children often suffer from depression, anxiety or anger, which could lead to learning and behavioural problems (Cluver & Gardner, 2006).

Furthermore, children who formerly lived with their parents find themselves living in sibling families without adults, in the homes of relatives and neighbours, or in Children's Homes and shelters. Living in the latter forms of "residential care settings may be associated with various challenges and stressors that have the potential to increase the vulnerability and risk for children" (Mohangi, 2009:119). Some of the more unfortunate of the orphans are choosing to face a life on the streets. It has, therefore, become the challenge of health care workers of all types to facilitate the transition of these orphans into new modes and abodes of living.

Regarding indigenous forms of therapy with children, I had read about methods of psychological sand therapy with aboriginal children in Australia (Raphael, Delaney & Bonner, 2007) and narrative story-telling therapies to help children in Uganda recover from involvement in war (Lamwaka, 2004). There appeared to be a gap, however, in the literature when it came to methods of psychological therapy for South African children of ethnic cultures. A matter of concern for my working environment was that I had found very little written on methods of therapy relevant to children of Zulu origin and culture. The research indicated that although people of Zulu origin historically negotiated with each other or related stories to each other using natural products as enabling symbols or props (Krige, 1950; Hayes, 2000), there was little written on therapeutic methods presently used with children in South Africa that involve natural products.

Hence, I thought that play therapy involving story-telling and the manipulation of natural products familiar to the African child might offer a form of cathartic therapy for the traumatized HIV orphan or child affected by HIV. The current research, therefore, has aimed to investigate whether an indigenous narrative seSotho game called Masekitlana<sup>1</sup> could be used effectively as a form of therapy with Zulu-speaking children in the context of HIV/AIDS. The study has also aimed to cast light on the theoretical underpinnings of Masekitlana and how it informs indigenous psychology.

## 1.2 BACKGROUND AND RATIONALE OF THE STUDY

I work in the psychology department of McCord Hospital, which is attached to the Sinikithemba ('We Give Hope') HIV clinic of McCord Hospital, a hospital not for profit (HNP) serving a predominantly urban population from the greater Durban area of KwaZulu-Natal<sup>2</sup>. McCord Hospital has historically been a mission-based hospital, and was originally called McCord Zulu Hospital. It was the first hospital in KwaZulu-Natal to train Zulu nurses. As a result of this history, its ethos, embedded in its mission statement, was originally to serve the underprivileged population of Durban. Sinikithemba clinic, located within the hospital grounds, has tested and treated 1090 HIV-positive children between the ages of 0 and 14 years since July 2004 (604 of these children are still under the care of the clinic). Children who attend this clinic are referred to the psychology department of the hospital where I am supervisor to intern training psychologists of various categories, including post-Master's counselling psychologists and post-Honours psychological counsellors. It has been our task to conduct therapy and assessment on these children and we identified the need to offer forms of therapy and assessment that were relevant to their indigenous culture, their value systems and the environments that they were living in.

There were specific challenges that the training psychologists and I had experienced with children of Zulu culture in the psychology clinic of McCord Hospital. We noticed that children who were referred to us were often uncommunicative in therapy and with their parents or caregivers. They appeared to find it hard to describe their life experiences readily to the psychologists in order to reveal their hardships. When asked to draw a person, they were

---

<sup>1</sup> Masekitlana is a monologue form of play and projective therapy involving a child hitting two stones together while describing concerns in his day or life to one other person or a group of people who listen and offer encouragement and contributions.

<sup>2</sup> KwaZulu-Natal is one of the nine provinces of South Africa.

often reluctant to do so or drew a very small person. Knowing the backgrounds of these children who attended this clinic, we presumed that this indicated insecurity, withdrawal and possible depression (Koppitz, 1968). To enable expression of these states of mind, I therefore decided to introduce the medium of natural potter's clay into the therapeutic process. I found that the children were immediately interested and stimulated to manipulate the clay. I found that if the children did not have to look me in the eye or sit opposite me, they more readily chatted to me and answered my questions about their lives. Hence, I wondered if therapeutic media of a more natural type and closer to the upbringing or culture of Zulu-speaking children would be more effective in therapy.

I accordingly researched literary sources on Zulu customs and ways of healing relational and family conflict, current and historical (Krige, 1950; Mutwa, 1998; Johnson-Hill, 1998; Hayes, 2000). I was interested to find that various forms of healing and conflict resolution in families involved natural products such as banana leaves and clay beads (Krige, 1950; Hayes, 2000). I also knew, from living in a rural part of KwaZulu-Natal for twelve years that stones held great symbolic value in the form of remembrance. Large piles of stones called *isivivane* could be seen alongside roads in the rural KwaZulu-Natal countryside. The accepted explanation for these was that if travellers picked up their own stone and added it to the collection on the pile, they would return to pass through the area (Mutwa, 1998). Stones were also used to cover graves dug alongside the *umuzi* or homestead of the deceased person. If people added their own stone to this pile, it meant that they would return to this homestead to pay their respects to the deceased person.

After I became aware that work had been done in therapy and assessment using an ancient Sotho game with stones (Kekae-Moletsane, 2008; Odendaal, 2010), I began to question children in our clinic about the games they played using stones. I found that they particularly enjoyed a game requiring skill and speed in throwing up a single stone and moving a number of other stones on the ground simultaneously. It involved children taking turns as the person throwing the stones fell short of the speed and accuracy required to complete the game. Girls appeared more skilled than the boys but the latter were keen to improve their skills and take part in the game with the girls. I also found that this game of throwing up stones and catching them had a variety of names in different languages, such as *Ngamatshe* or *Umagenda* (Zulu) and *Diketo* (Sotho).

On my monthly trip with the Red Cross Air Mercy Service to a children's home in the rural town of Matatiele, I began to take a bag of stones with me to ascertain what the reaction of the children there would be. I was interested to find that the children at play eagerly took the stones and began to dig holes in the ground. I also placed a pile of stones on the therapy table when I worked with teenage children. I noticed that, almost subconsciously, they fiddled with the stones, trying to fit them together or bang them together while they talked to me. It therefore appeared to me that the manipulation of the stones enabled freer expression from this age group of children.

I therefore approached psychologist Professor Mokgadi Kekae-Moletsane, who published the first article on the narrative stone game, Masekitlana. I thought that Masekitlana presented a window of opportunity, possibility and hope for therapists such as me working with traumatized black South African children. I assumed that these children would be able to teach psychologists something immensely valuable through the use of their own authentic African game. Professor Kekae-Moletsane agreed to supervise my research into this form of therapy through the University of Pretoria where she worked.

### **1.3 STATEMENT OF THE PROBLEM**

The intern psychologists of the psychology department of McCord Hospital work on a daily basis with troubled and traumatized children within the hospital wards, the Sinikithemba HIV clinic and in outreach programmes in communities. The ravages of poverty and disease on the children is most evident to us in the work we do in Children's Homes and hospital clinics in the rural areas of Nkandla in northern Kwazulu-Natal and Matatiele in the Eastern Cape, to which we are flown by the Red Cross Air Mercy Service. The urgent and immediate challenge is to provide community and individual support to these children in a culturally relevant and multi-disciplinary way.

The children who are referred to McCord hospital are mostly Zulu-speaking. In the Matatiele area, the children are Xhosa-speaking. In most cases, I believe the challenge for the psychology staff is to overcome differences in worldviews between them and the children, and a need to develop more of an understanding of the children's cultural heritage, values and beliefs. In certain cases the lack of a common language shared by the psychologists and children has contributed to the difficulty in understanding the children.

The psychologists are called on to conduct assessments with children in order to report back to schools or government institutions that sanction grants for the children. The assessment instruments and the methods whereby the psychologists approach these children are dictated by Eurocentric and American theories, values and ideologies (Foxcroft, 2002; Allan & Dana, 2004; Kekae-Moletsane, 2008). The quantitative assessment instruments that are used are normed and standardized on Western children. Consequently these methods are often ill-suited, and there is a need for a science or practice that is culture and context specific. I thought that methods that are holistic, qualitative, and phenomenological (Adair, 1999) would be more appropriate to and compatible with these children and their indigenous cultures.

In my observations and reflection on the issues and feelings the clinic children brought to us, I had wondered to what extent the issues were an expression of the children's own cultural contexts as opposed to what the Western world was expecting them to be like or to be saying. I had often reflected on the fact that the children who came to the psychology clinic fell into the gap between a traditional society rich in its own rituals and beliefs in the strong role of ancestral spirits and bewitchment, and a Westernized, or international Christian society that prescribes universal values, norms and behaviours.

My reading into literature advocating alternative paradigms and methods of psychology to the predominant Western or Eurocentric forms, appeared to point towards finding solutions in the fields of indigenous knowledge systems and culturally-orientated, context-specific indigenous research and psychology. Indigenous research advocates for an understanding of people from a 'bottom-up' perspective rather than imposing the dominant cultural view of the practitioner and his or her academic and theoretical learning (Allwood & Berry, 2006).

The situation therefore appeared to call for a greater awareness by psychologists and therapists of indigenous knowledge and indigenous forms of psychology. I felt that children of African origin and culture would be able to teach psychologists something immensely valuable through the use of their own authentic African games, healing rituals and other traditional solutions to their problems. Masekitlana appeared to be a combination of an indigenous African game, a narrative therapy and a traditional healing ritual.

#### **1.4 PURPOSE OF THE RESEARCH**

The purpose of this research was to investigate whether the narrative and projective technique, Masekitlana, could be of use in therapy with children living with and affected by HIV/AIDS. In particular, four children between the ages of eight and twelve years and who lived in Children's Homes were selected as participants. Working in the Sinikithemba HIV clinic, the intern psychologists and I had counselled many children living in Children's Homes in and around Durban. As we had for a long time been working with the challenges faced by children in children homes, and I had been wondering about the future of the many orphans in South Africa, I felt that I would like to conduct my research on this cohort of children.

I was particularly keen to use the indigenous game, Masekitlana, as it had been proven to be culturally and environmentally familiar to children of seSotho origin and culture, and is an ancient part of seSotho indigenous knowledge (Kekae-Moletsane, 2004, 2008; Odendaal, 2010). My purpose in the current study was to ascertain whether Masekitlana would enable children of Zulu culture and origin to express and explore the experiences of their lives against the background of their traditional belief systems.

I hoped that a relaxed atmosphere would be created by using a simple, non-directive narrative game utilizing stones, which are natural earthy materials familiar to African children's neighbourhood play environments (Kekae-Moletsane, 2008). The objective of this was that participants of this research would be able to explore all the facets of their modern and traditional lives, which would thereby help them to overcome their mental health concerns. Conceptual categories and emergent themes were analyzed, and improvement or otherwise in their emotions and coping abilities was measured at intervals during the intervention therapy, and finally two months after therapy ended. I hoped that the findings of the research study would add to the existing body of indigenous knowledge and would inform the field of indigenous psychology and therapeutic methods.

#### **1.5 RESEARCH QUESTIONS**

In accordance with the purpose of the research stated above, the current study was guided by the following primary research question:

*How can insight into the use of Masekitlana in therapy with children living with and affected<sup>3</sup> by HIV/AIDS, inform new knowledge on therapeutic techniques?*

To make the above question relevant to the cohort of participants of the current study, the following sub-questions were asked:

- How do children living with and affected by HIV/AIDS respond to Masekitlana in therapy?
- What meaning do children living with and affected by HIV/AIDS construct from their experiences when playing Masekitlana?

The answers to the above questions then led to the following third sub-question:

- How might the new knowledge on the use of Masekitlana in therapy inform literature and research on the relevance, irrelevance or partial relevance of indigenous knowledge in therapy?

## **1.6 RESEARCH METHODOLOGY AND DESIGN**

This research made use of the single-system design whereby single subjects are studied on a repetitive basis (Barker, 1997, Glicken, 2003, Mark, 1996, Mitchell & Jolly, 2001, in Strydom, 2005c). In the current study, the single subjects were four individual participants from two Children's Homes; hence, it was a multiple case study. Both the Homes<sup>4</sup> and the participants were selected using purposive and convenient sampling methods. Two of the participants were patients in the Sinikithemba Paediatric HIV clinic. All four participants resided in Children's Homes. The single-system design incorporated the measurement of therapeutic progress (or otherwise) during standard of care therapy and then the intervention therapy, Masekitlana. It involved three phases: Phase A: Baseline A – Pre-test; Phase B: Intervention; and Phase C: Baseline A – Post-test 1 and Post-test 2. Background information was obtained from the social workers in the Children's Homes before therapy began. Therapy was audio-visually recorded and field notes were taken. The metatheoretical paradigm was interpretive, with qualitative and quantitative approaches.

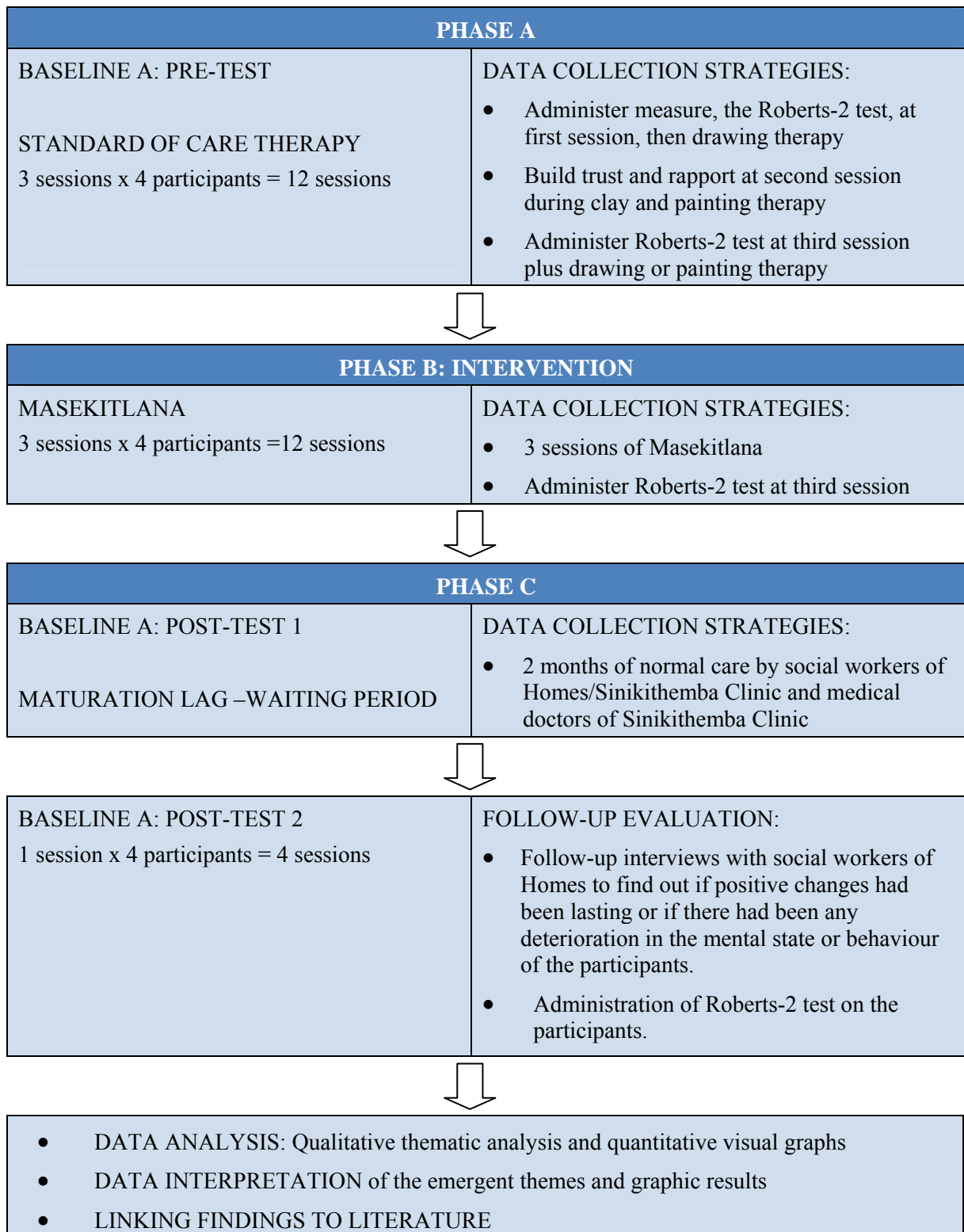
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<sup>3</sup> A person living with HIV is the presently acceptable term to describe a person infected with the HI virus. A person affected by HIV is a person who is not necessarily infected with the HI virus but has been affected by the epidemic of HIV in that 1) his parent/s /caregiver/s/sibling/s have died as a result of HIV, or 2) he is living in a household where other inhabitants are infected with HIV, or 3) he has had his livelihood or environmental circumstances changed by the effects of HIV.

<sup>4</sup> Children's Homes will be referred to as 'Homes' in the text of the current study.



The following is a diagrammatic representation of the research design and process.



**Figure 1: The research design**

The following section will explain the above schematic presentation.

### **1.6.1 PARADIGM**

The metatheoretical paradigm within which I worked was interpretive and the methodological paradigm was the single-system research design. I used a mixed methodology of qualitative and quantitative approaches within these paradigms.

#### **1.6.1.1 Metatheoretical paradigm: Interpretive**

An interpretive approach in the classical sense of the word is one that is concerned with the understanding of the ‘subjective’ meaning of participants, rather than a supposedly value-free positivist description of ‘objective’ behaviours of actors (Johnson-Hill, 1998; Kiguwa, 2004). In the current study, I felt that I needed to be taught by the participants and how they constructed and generated meaning in their lives, rather than judge the adequacy of that meaning and understanding (Kiguwa, 2004; Isasi-Diaz, 1993, in Johnson-Hill, 1998). Trying to understand how participants constructed meaning in dialogue with the therapist involved my being sensitive to and transcending my own historical circumstances, including my prejudices and biases (Schwandt, 2000, in Denzin & Lincoln, 2000). By not using a scientifically standardized, prediction-and-control form of intervention, I hoped to encourage participants to give shape and form to their own experiences, thereby discovering new insights and encouraging transformation.

#### **1.6.1.2 Methodological paradigm: Single-system research design involving intervention**

The umbrella design that I utilized in the current study is an ‘interrupted time-series design’ in that different forms of therapy were performed on the participants and measured at intervals over a time period. From this comes the term ‘single-system design,’ which is a “genus/generic description denoting the study of a single subject on a repetitive basis” (Strydom, 2005d:145).

Participants were subjected to normal standard of care therapy<sup>5</sup> in the form of drawing and clay, followed by the intervention therapy of Masekitlana. In this way the research mimicked

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<sup>5</sup> Normal standard of care therapy in this context is child therapy that is normally conducted by registered and intern psychologists in the psychology clinic of McCord Hospital. It includes narrative and play therapy with the use of toys, sand, clay, drawing and painting.

the conditions of my clinical workplace but was an elaboration thereon. Normal standard of care therapy became the control comparison for the intervention therapy of Masekitlana, and so each participant became his own form of control. This eliminated extraneous and confounding factors as well as the ethical issue confronting researchers when using separate participants as a control group. This “built-in strategy for comparing pre-tests and post-tests, the fact that no statistically calculated measurements were produced, and the fact that participants were not randomly selected”, meant that this design could be referred to as a “quasi-experimental/associative form of design” (Fouche & de Vos, 2005:138).

Phase A of the research (consisting of pre-test, baseline A) was standard of care therapy, phase B was the intervention of Masekitlana, and phase C consisted of baseline A including post-test 1 and post-test 2 (also termed baseline A as it was a return to normal standard of care). Post-test 1 comprised of a time lag of two months and post-test 2 involved the final measurement of the Roberts-2 test. The latter assessment measure was also administered before and after the pre-test phase, so was administered a total of four times during the period of therapy.

Qualitative emergent themes were categorized from the narrative during both forms of therapy, and quantitative indications of changes were made by comparing the scores on the different occasions of the Roberts-2 test measurement. Hence, I utilized a mixed-methods approach to the analysis of data.

### **1.6.1.3 Qualitative approach**

Through the process of crystallization in the qualitative focus of this research, I looked at the participants and their contexts from many angles, in many lights, and using various techniques and methods, and so I was able “fully and rigorously” to “capture the nuance (s) and complexity of the social situation under study” (Flick, 1998; Janesick, 2000:381). I did not have a “step-by-step plan or fixed recipe” (Fouche, 2005:269) to my investigation but attempted to apply divergent thinking and observation, that is, a moving away from a central point and looking outwards (Reber, 1985). This was in contrast to convergent thinking, which is a form of inward looking focused on or around a specific, central point, such as preconceived ideas of specific themes I might have had in mind before the research had even begun.

Qualitative research is a lot more open to personal opinion and judgment; hence, in order not to draw conclusions too prematurely from the data as it unfolded, I remained open-minded, flexible and immersed in the narrative, and attempted to understand the meanings the participants enunciated without trying to explain them. Participants' perceptions of the situations of their lives and their feelings over them became the qualitative focus for this research rather than the positivist concept of reality existing out there separated from participants' perceptions of it (Guba, 1990, in Denzin & Lincoln, 2000).

Finally, a qualitative approach to research prefers participant observation in as naturalistic a setting as possible or as close to the everyday living environment of the participants as possible. Hence, I conducted the research in the environment of the Children's Homes where participants spent most of their days. The limitation to this was that it excluded the environment of their families of origin and the communities in which they lived.

#### **1.6.1.4 Quantitative approach**

A quantitative aspect to the current study was able to complement the qualitative approach by providing more concrete evidence of what the qualitative data appeared to be indicating, and by more clearly representing differences between and changes brought about by the two forms of therapy.

I used two forms of quantitative scoring in the current research. The first was scoring according to the scoring manual of the Roberts-2 test (2005) although I had to simplify and adjust the scoring procedure as participants did not respond to all 14 cards at each test administration. The second was a scoring method inspired by a research project using Dynamic Assessment by Matthews and Boucher (2009). This involved adding up certain responses to therapist prompts such as the number of prompts, choice of words, number of hesitations, number of repetitions and number of statements. The second scoring procedure was only applied to one of the participant's narratives, the most voluble of the participants, in order to validate for me the scoring results of the Roberts-2 test.

Both sets of scores were represented in graphic analysis. I confirmed with Professor H. Strydom (telephonic communication, August 2009), who wrote a chapter on single-system research design in de Vos et al. (2005), that graphic presentation without complex statistical analysis would be acceptable in the use of single-system design in this particular research.

### **1.6.2 SELECTION OF PARTICIPANTS**

I chose a convenient and purposive sample of participants without random assignment to groups or random choice of participants. The sample was termed ‘convenient’ in that participants were attending the clinic or were available for therapy during the time period of this research, their number was small enough to complete therapy on them within the time I had available to complete the research, and I had practical logistical access to them as the Children’s Homes were situated within a ten-kilometer radius of my workplace. The sample was a purposive sample in that I purposively or purposely chose the participants as they fulfilled the inclusion criteria of being children living with HIV, affected by HIV, whose parent/s might have died from HIV/AIDS, and who lived in Children’s Homes at the time of this research. I also purposely chose the age group eight to 12 years as these children are not at the developmental language stage where they have words to describe accurately how they are feeling, or are able to use abstractions and hypothetical reasoning when talking about their lives (Cherry, 2011). Hence they were considered an appropriate cohort of children to be potentially assisted in expressiveness by the use of stones. For reasons of anonymity, I gave participants pseudonyms.

### **1.6.3 DATA COLLECTION**

Data collection techniques allow researchers to systematically collect information about participants. I used a mixed methodology in data collecting, as qualitative data collection searched for rich and deep meanings while quantitative data collection involved more explicit observations, and more concrete and structured gathering of data.

Qualitative data collection involved gathering background information using open-ended, semi-structured, “in-depth” (Greef, 2005) interviews with social workers of the Children’s Homes and Sinikithemba Clinic. These interviews were roughly guided by an interview schedule and I wrote the responses in longhand. Narratives of participants were recorded with an audio recorder placed in front of them and a video camera that I operated. Feedback interviews with the social workers were conducted at the end of phase C, that is, after the maturation lag period and post-test 2 were complete.

Quantitative data collection involved offering participants 14 picture cards of the Roberts-2 test to look at, to allow them to choose the ones they wanted to talk about and then to record

and video their responses. Participants' descriptions or stories about the picture cards were categorized under different appropriate headings according to the scoring manual of the Roberts-2 test. Results were then filled in to scoring sheets, a different scoring sheet for each participant for each assessment administered. Hence, there were 16 scoring sheets in all.

I made field notes during and after therapy sessions, which included observations of a practical nature on factors such as environmental influences, as well as self-reflections, such as my ambivalent feelings about the effect that the participant narratives were having on me. Although the video recorded participants' facial and bodily expressions and movements, it was useful to note these down in the field journal so I could link them to the translated narratives at a later stage.

### **1.6.3.1 Research team**

The research team consisted of a Zulu-speaking social worker from Sinikithemba HIV clinic and me. She was experienced and trained in therapy with children, and so I referred to her as the therapist in the current study. I explained to her the conceptual background of Masekitlana therapy, and trained her on the Roberts-2 test and how to use prompts to encourage more expression from participants.

### **1.6.3.2 Therapeutic and assessment methods**

The first three sessions of therapy conducted in the current study comprised of drawing, painting and clay work. This was the usual form of therapy that would be conducted in the Sinikithemba HIV paediatric clinic and the psychology clinic of McCord Hospital with children living with or affected by HIV/AIDS. These sessions of therapy became the control or pre-test phase for Masekitlana therapy. The therapeutic intervention that was used in the fourth to sixth sessions of therapy for each child was the indigenous narrative Sotho game called Masekitlana. How to play or make use of the game was suggested to participants as follows:

Each child is given two or more stones or is asked to find his own stones. He<sup>6</sup> then sits on the floor or at a table and bangs the stones together or throws them down, picks them up again or

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<sup>6</sup> I have used the gender terminology 'he' or 'his' for simplification purposes and for ease of readability. I also chose to use male gender referencing as opposed to female gender referencing as three of the participants were

pushes them around the floor or table. While he does this, he describes any situation he chooses to in his past, present or future life. He might bang the stones together in anger or he might rub them softly together if describing something pleasurable. The therapist responds with sounds or words of encouragement or sympathy. In narrative therapy, the therapist aims to focus on the positive aspects articulated by the participant in order to create a change of thinking patterns and therefore transformation.

The Roberts-2 test (Roberts, 2009) provided a quantifiable way to measure the progress of therapy and allowed me to make more valid and explicit comparison observations between the two models of therapy used. It would have been difficult to make clear observations on the progress of therapy through the thematic analysis. The Roberts-2 test was performed on the participants at the end of the first, third, sixth and seventh sessions of therapy. Participants were shown pictures of interpersonal interactions and they were asked to comment on them. According to the Dynamic Assessment technique (Matthews & Bouwer, 2009), they were prompted by statements such as, “I would like to hear more about your story” and “Thank you, you can carry on telling me more about that person”. The Roberts-2 test measures 1) developmental adaptive function, which documents changes as children grow older and become more socially experienced, and 2) clinical function, which documents more unusual or atypical responses from children who are experiencing social and emotional problems (Roberts, 2009:3). The allowed population is 6 to 15 years old, the time allowed for conducting the test is unlimited and the ‘ethnic version’ pictures reflected children with more African than European features.

### **1.6.3.3 Language and translation**

Therapy sessions were conducted in Zulu and were directly transcribed and translated into English by two Zulu-speaking postgraduate students with prior experience in translating for research projects. They signed declarations of responsibility for confidentiality of information. As a cross-check to the translations, I compared them to the video footage, which I watched simultaneous to reading the transcripts. As I understood the Zulu narrative during the sessions, I found it unnecessary to have the English translations back-translated into Zulu.

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male as opposed to one female participant. This proportion was done for criteria satisfaction and convenience purposes.

#### **1.6.4 DATA ANALYSIS AND INTERPRETATION**

Data was analyzed using mixed methods of qualitative and quantitative approaches.

##### **1.6.4.1 Qualitative analysis and interpretation of narratives**

I analyzed the qualitative data from a macro to micro perspective. The macro perspective involved noting down how participants manipulated the stones, their bodily and facial expressions, and any visible changes in demeanour and general attitude as therapy progressed. The micro perspective involved searching for themes, sub-themes and sub-categories or “meaning units” (Giorgi, 1995, John, 2001) in participant narratives. A coding system was employed to distinguish the different themes. I reduced the number of main themes to four, which was a “manageable number for maintaining order in analysis and interpretation, and for generating the results required” (Boyatziz, 1998, in Knight, 2002:189). Analysis and interpretation involved a “complex, non-linear, non-consistent course with a continuous sense making, to-ing and fro-ing between the data, the categories, the emerging stories or theories and the literature” (Knight, 2002:186).

I was guided in my interpretation by the assumptions and theoretical concepts of indigenous psychology methods that I set out with and as informed by literature. Although this served as the framework for this research, I needed to be guided by the “allegiance effect, which is the desire on the part of researchers to prove their theories to be correct, effective and appropriate” (Menzies & Lees, 2004). An important part of the interpretation process was the validation of my findings through discussions with colleagues, as well as ongoing self-reflection, which was recorded in a field journal.

##### **1.6.4.2 Mixed qualitative and quantitative analysis and interpretation of Roberts-2 test**

I analyzed the participants’ narratives in response to the Roberts-2 test using four different methods:

- Qualitative thematic analysis as described above in section 1.6.4.1.
- Quantitative analysis according to scoring instructions pertaining to the seven scales and then the conversion of responses into percentages in graphic form.
- Qualitative content analysis of participants’ narratives according to criteria typically used for the Thematic Apperception Test (Murray, 1971).



- Quantitative structural analysis of the participants' narratives according to Matthew and Bower (2009) and represented in graphic form.

I used the latter two forms (to be found in Appendix R) in order to validate and enrich my qualitative thematic analysis as well as the analysis according to the scoring instructions of the Roberts-2 test.

### **1.6.5 QUALITY CRITERIA**

#### **1.6.5.1 Quality criteria of qualitative research**

The basic premises of trustworthiness of this study were that the readers or colleagues in the psychological field found the findings to be worth paying attention to, and to be credible and reliable enough to act on and use in their own work, and that they found the research to be of a high quality (Babbie & Mouton, 2001; Maree, 2007; Schwandt, 2007). The following strategies were employed in order to establish trustworthiness:

- Plausibility, through depicting the results as accurately as possible;
- credibility, through ensuring that data and findings were congruent or appropriate to research questions, study concepts, theoretical framework (Gay & Airasian, 2003), cultural sensitivities (Paniagua, 1998) and intentionality of participants;
- transferability, through establishing whether this research could be duplicated transferred or generalized to other settings (Gay & Airasian, 2003);
- dependability, through a logical and traceable process of research that had been documented with integrity (Schwandt, 2007); and
- confirmability, through ensuring that the findings were the product of the focus of inquiry (Babbie & Mouton, 2001) and not of my own biases.

#### **1.6.5.2 Quality criteria of quantitative research**

These pertained to the quantified results of the Roberts-2 test and were ensured through:

- face validity, in that the graphs showed that the intervention resulted in improvements in adaptive functioning (through expression of cultural beliefs) as indicated in graphic analysis;
- construct validity, in that the concepts of personality and adaptive functioning that were being measured and scored were clearly described;

- concurrent validity, in that the Roberts-2 test scores indicated results from the intervention that were “concurrent or consistent with findings in other settings” (Knight, 2002:137);
- predictive validity, in that the Roberts-2 test scores demonstrated that the “predicted effect of the intervention was proven to actually occur” during the current study (Knight, 2002:138); and
- reliability, in that the Roberts-2 test and the intervention could be consistently administered and performed on the different occasions, in the two different venues and with the four different participants, and consistently produced similar results.

#### **1.6.6 ASSUMPTIONS OF THE STUDY**

My knowledge of the traditional Zulu person informed my assumptions. The first assumption was that participants, being of Zulu origin and culture, would be immersed enough in traditional African belief systems and a background of story-telling to appreciate an African form of narrative play. I assumed that participants would have an inherent or essential African affinity for the organically natural stone and would have prior experience with stone games. I assumed that stones would be the symbolic and metaphorical catalysts to enable participants to express the difficulties in their lives. Because participants were in the concrete operational stage of development (Piaget, 1981, in Cherry, 2011), I assumed that they would find it hard to talk in an abstract and hypothetical way, and therefore that narrative play would be more appropriate than simply sitting and talking to the therapist.

My knowledge of literature on indigenous and cultural psychology also informed my assumptions. If psychologists are to understand people in their indigenous contexts it is assumed that they need a basic understanding of the belief systems of their indigenous clients. Psychological methods need to be contextualized to the indigenous environment and need to feel familiar to the indigenous client. The assumption, therefore, in conducting this study was that a form of therapy such as Masekitlana that originated within an African cultural group would prove useful for the participants of this study. In this way I intended to contribute to an “autochthonous form of discipline development” (Adair, 1999) whereby a bottom-up, inductive, “emic” focus on therapy, rather than a top-down, deductive “etic” way of conducting psychology, would prove more effective for the participants of this study.

Furthermore, I thought that a form of therapy that encourages creativity from participants, rather than a more structured therapist-directed assessment, might enable participants to reveal more about their lives. In this way, the therapist conducting the therapy sessions during the current study would be a “co-participant in the joint construction of reality, rather than an authority to control and predict the future of a person” (Misra & Gergen, 1993:237).

As participants lived in Children’s Homes in the outer suburbs of the city, I presumed that the intervention of Masekitlana would not only allow for expression of traditional African beliefs but would additionally enable dialogue and narrative around the facets of participants’ lives that reflected Western cultural trends. As participants had one foot in traditional African life and one foot in globalized, in particular American, ways of living through exposure to American television programmes, I assumed that this “cultural in-betweenity” (Mkhize, 2004; Pederson, 2009) would be revealed in therapy sessions.

Finally, I assumed that because I was a researcher from a different culture to that of the participants of the current study, the taken-for-granted assumption in approaching the subject of indigenous psychology was that I would be aware of the strengths and weakness of my own culture before trying to understand those of the culture I was about to investigate (Keteyi, 1998). Thereafter, I expected to be challenged by participants’ narratives and to have an open-minded and optimistic stance towards the ‘other’ culture (Keteyi, 1998) so I could understand the issues participants brought into therapy. At all times the caution was for me not to impose my own understanding in the form of “conquest mentality” (Gobodo-Madikezela, 2006).

#### **1.6.7 ETHICAL CONSIDERATIONS**

I adhered to the code of Ethical Guidelines of the Faculty of Educational Psychology, University of Pretoria.

Letters of explanation, and consent and assent forms explained the purpose and process of the study, participant involvement and participant benefits. They were assured that they would not be deceived as to the purpose of the research and that they would be protected from harm or distress during the research process of after (Cohen, Manion & Morrison, 2007; Maree, 2007). Participants were informed that should they wish to terminate therapy during the research process, their treatment programme within Sinikithemba HIV clinic would in no way be affected. Furthermore, they were offered further therapy within the psychology clinic of

McCord Hospital should they have felt the need for it after the therapy sessions of the current study were complete. I attempted at all times to ensure that the dignity and self-respect of the participants was not undermined in any way by the research process.

Anonymity of the participants was ensured through the use of pseudonyms in the translated and interpreted data. Confidentiality of data was ensured as I securely stored all recorded, videoed and transcribed data at my home. In order to use video footage of the data for conference purposes, I filmed the participants from the shoulders down.

After completion of the research all forms of data will be stored for 15 years by the University of Pretoria, to avoid confusion in the event that there are any queries or disputes arising from the research.

## **1.7 THEORETICAL AND CONCEPTUAL FRAMEWORK**

The purpose of the theoretical and conceptual framework of the current study was to research and present ideas, opinions, findings and theories from the existing body of research and literature to serve as the basic structure and starting point from which the information collected in the current study was interpreted. The purpose of the conceptual framework was also to “pinpoint a yardstick that [would] be a basis for interpreting the information collected in the study” (Nwanna, 2006:12).

### **1.7.1 EMPIRICAL WORK IN INDIGENOUS CONTEXTS**

The current study was grounded on indigenous knowledge as well as theories of indigenous psychology. In order to know and work with South African children and the populations in which they live, it is necessary to have an understanding of the indigenous knowledge systems within their cultures. Literature on indigenous knowledge provides the basic framework from which to understand cultures. Furthermore, indigenous psychology is created out of the empirical analysis, through questionnaires for instance, of how philosophical and indigenous ideas or knowledge affect the values and beliefs of different cultures. Mere descriptions of indigenous and cultural phenomena alone are insufficient for research. A form of systematic methodology, analysis and comparison of cultural phenomena needs to be presented in order to make legitimate claims to inform indigenous psychology. The aim of the present study was to prove empirically the usefulness of the cultural game of Masekitlana in order for it to

inform the field of indigenous psychology. Hence, Masekitlana was not just described in this study but was embedded in a systematic methodological framework or paradigm.

### **1.7.2 HEGEMONY OF WESTERN PSYCHOLOGY**

There has been much written in the literature about the challenges of working with Western forms of psychology in a non-Western or developing world. My research considered the theories and concepts written about this issue. Western (predominantly Euro-American) psychology has for a long time dominated world psychological trends and methods (Naidoo, 1996). The rationale behind this so-called Western hegemony was that psychology is an objective science and constructs established from studying populations in one nation should have universal application throughout the world (Allwood & Berry, 2006). My research took a critical look at the universal constructs that were normally applied to traumatized children in South Africa, such as question-and-answer talking and drawing, with a view to identifying what was more useful for this study. I hypothesized that a more contextual and culturally idiosyncratic way of viewing people and their behaviours and values would be more useful when applied to therapy with South African children. As such, I felt that a subjective, qualitative, phenomenological way of conducting research with South African participants was more fitting for the environment of my research than a causal, linear, quantitative form of research (Adair, 1999; Kim, Park & Park, 1999; Moghaddam, 2006, in Allwood & Berry, 2006).

### **1.7.3 CROSS-CULTURAL RESEARCH AND PAN-HUMAN PSYCHOLOGY**

The debate as to the difference between cross-cultural research and indigenous psychology also informed my research. To compare the cultural findings of one country with those of another country is the basis of cultural research (Berry, 2006, in Allwood & Berry, 2006). Although an awareness and a knowledge of relative forms of values and behaviours between and across countries, including Uganda, India, Japan, Australia, Canada and the USA, were of necessity part of my reading, my research was more narrowly focused around pioneering a culturally relevant form of psychology for children, in particular those of Zulu culture and origin, in the South African environment. The combination of a large body of different indigenous psychologies from different developing countries forming a new universal psychology, or ‘pan-human’ psychology, presented an alternative to dominant Western

psychology (Allwood & Berry, 2006). However, this was also beyond the scope of this research.

#### **1.7.4 SYMBOLISM AND METAPHOR IN INDIGENOUS THERAPY**

The debate as to what constitutes therapy relevant to indigenous cultures formed part of the framework of this study. Theories around different forms of indigenous therapeutic media for indigenous contexts are tied up with the relative importance of cultural theories and traditions in the life of the child undergoing therapy. In therapy with adults (and children) in the indigenous context, the person's individual characteristics in individualistic models of therapy become less important than the different meanings he or she attaches to values, collective ways of problem solving, using community resources and achieving different goals (Naidoo, 1996; Mufamadi, 2001; Kim & Park, 2003). Furthermore, children in cultural contexts express their meanings in culturally symbolic ways, such as talking about snakes as metaphors for illness, fear and ancestral guidance. This thinking, imagining and talking in metaphor dictates how they perceive incidents and behave in their worlds (Kim & Park, 2003). It was this concept of symbolic perception and representation in the narratives of children, rather than concentrating on more Western models of childhood development, that served as a framework for investigating Masekitlana in the current study and led to my realization of its importance as a building block for a new form of indigenous therapy. It also served as a framework for me to understand and explore concepts around symbolic aspects of play (Byers, 1998), such as African stone games, and the contribution this would make to how participants responded to Masekitlana.

#### **1.7.5 NARRATIVE AND ORALITY IN THE AFRICAN CONTEXT**

The African cultural mannerisms of gesture, action and reaction (demonstrated for instance by hitting stones together using rap rhythm in the current study) whilst manipulating language (Comaroff & Comaroff, 1991, in Maluleke, 2000) was a foundation for exploring indigenous narrative therapy in the current study. In particular, concepts and theories discussing the effectiveness and applicability of narrative and orality in making sense of life (Denis, 2000, 2003) and creating identity (Buhrmann, 1984; Andersen, 1992; Mkhize, 2004), and story-telling in the African context (Lamwaka, 2005) formed the structure of this research. Mkhize's (2004) theory of how African children use the contradictory and confirming narratives and behaviour patterns of significant others in their lives, how they incorporate

them into their own identity through a process of ‘dialogism’ and how they reflect this in their ‘different voices’ through a process of ‘polyphony’ also informed the current study.

#### **1.7.6 INDIGENOUS THINKING, INDIGENOUS KNOWLEDGE SYSTEMS AND THE PHILOSOPHY OF *UBUNTU***

An understanding of indigenous knowledge that is, knowing how indigenous people think and behave, and knowing their preferences in spiritual, emotional and their everyday functional lives has helped practitioners to develop food, health, economic and social programmes within developing countries (Gorjestani, 2000). Enhancing the human resources of countries and building on their historical ways of doing things enable development programmes to be successful (Gorjestani, 2000). My research took cognizance of systems of indigenous thought such as ancestral callings and dependence, and how they affect the meanings adults and children ascribe to events such as death and illness (Krige, 1950; Ngubane, 1977; Buhrman, 1984; Mutwa, 1998; Holland, 2001; Kagee, 2008; Edwards, 2011). The collective conscience and community ‘self’ in African societies, otherwise termed *ubuntu*, is a concept that needs to be incorporated into any form of therapy aiming to create resilience in African children (Schutte, 2001).

#### **1.7.7 AFRICAN CHILDREN IN TRANSFORMATION**

Theorists in indigenous psychology realize that they need to understand the history, the present and the future aspirations of cultures. In particular they need to understand how cultures transform themselves. The past history of one generation is not necessarily the past history of the next generation (Kim, 2001, in Kim, Yang & Hwang, 2003). Cultural traditions change from one generation to the next and undergo ongoing processes of modification throughout a person’s life. “Personhood” in African scholarship can only be defined in terms of “becoming” (Ramose, 1999, Sow, 1980, Zahane, 1979, in Mkhize, 2004). Rituals of transformation occur throughout life in participation with a community of others, and the status of a full person is only taken on in old age, almost with a quality of ancestry (Sow, 1980, in Mkhize, 2004). In this study, I realized the need to inform myself on various historical African cultural traditions such as age-related rituals, including ritualistic stone games, healing and conflict-solving traditions, and the changing relationship between children and elders in order to understand the dynamic and culturally bound character of indigenous psychology. How the South African child’s interests and attitudes are changing through

urbanization, institutionalization (especially in Children's Homes) and globalization, and how the field of HIV is evolving and the effect this has on children's HIV identity, also helped to structure my investigation.

### **1.7.8 ASSESSMENT IN INDIGENOUS CONTEXTS**

In the South African context, Western forms of assessment have been challenged as being reductionist and quantitative (Bulhan, 1985, in Naidoo, 1996), as well as having a predominantly pathogenic focus (Guthrie, 1970, in Naidoo, 1996). In answer to this, various instruments of assessment on children and adults have been adjusted to fit local African and South African settings. Examples of these are *The Shona Symptom Questionnaire* in Zimbabwe (Patel, Gwanzura, Simunyu, Lewis & Mann, 1997), the adjustment of the Rorschach Comprehensive System (RCS) administration procedure for a cohort of South African learners (Kekae-Moletsane, 2004), and the adjustment of the norms of a brief screening test for dementia using a hospital cohort of patients with low CD4<sup>7</sup> counts (Singh, Sunpath, John, Eastham & Goundan, 2008). In the case of South African children, the methods we use to enable our patients to express themselves, such as the Goodenough Draw a Person Test or the Goodenough Harris Drawing Test (Goodenough, 1926), the Kinetic Family Drawing Test (Burns & Kaufman, 1970), the Children's Apperception Test (Bellack & Bellack, 1949), or even Show and Tell in the educational setting, need to be examined for their cultural relevance. We should even ask ourselves if the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) diagnosis of post-traumatic stress is contextually relevant to African children. The need to adjust these tests formed part of the conceptual background for this research, and processes whereby instruments, tests and methods are changed formed part of the literature review of this research.

### **1.7.9 INTERFACE BETWEEN RESEARCHER AND PARTICIPANT, AND RESEARCHER SELF-REFLEXIVITY**

In addition to a focus on the development and origins of indigenous psychology, the relationship between researchers and participants formed part of the framework of this study. The interface between researcher and participants inferred, by application, the relationship

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<sup>7</sup> The immune system contains specialized cells such as CD4 or T-cells that help protect the body from infection. HIV attacks these types of cells and uses them to make more copies of HIV. If the number of CD4 cells per microlitre (or cubic millimetre, mm<sup>3</sup>) of blood, that is the CD4 count, falls below 200, the person is classified as having AIDS and his or her body's immune system is considered no longer strong enough to prevent illness and infection.



between clinician and clients in the practical setting. It was hypothesized that the “positioned status” of the researcher or clinician would have an effect on the participant or client (Ropers-Huilman & Grane, 1999). The question of whether the difference between my cultural perceptions, rituals, languages, behavioural norms and values and those of the participants enhanced or even disrupted the process of research, was also examined. My self-reflecting abilities, and my conclusions and findings on examining this self-reflection, also structured this study.

## **1.8 KEY CONSTRUCTS**

There are many different definitions, terminologies and descriptions in use in the fields of HIV orphans and trauma, of culture and indigenous psychology, and of narrative therapy, in particular Masekitlana. I define them below as they were appropriate for the purposes of this research study.

### **1.8.1 VULNERABLE CHILDREN, INCLUDING ORPHANS AND CHILDREN LIVING WITH HIV OR AFFECTED BY HIV/AIDS**

For the purpose of this research, vulnerable children, including orphans and children living with HIV and affected by HIV/AIDS, were defined as children under 15 years (UNAIDS, 2003; WHO, 2003; UNICEF, 2006) who have lost a mother or both parents to HIV or who “are deprived of some protection or advantage, who are alone, solitary, abandoned, cast off, forsaken, lost, disregarded, ignored, neglected or slighted” (Allen, Fowler & Fowler, 1990).

### **1.8.2 INDIGENOUS KNOWLEDGE**

The term ‘indigenous’ has two meanings: one refers to Fourth World peoples, and the other to all peoples residing in a particular society (Allwood & Berry, 2006). Indigenous knowledge has been defined as local knowledge in countries, and the basis for community-level decision making in areas pertaining to food security, human and animal health, education, natural resource management and other vital economic and social activities. “Epistemologically, the production of African knowledge systems is more concerned with local knowledge as opposed to universal knowledge” (Higgs, 2006:1).

### 1.8.3 MASEKITLANA

This is a traditional seSotho game that is mostly played by South African children in townships and rural areas. It is a projection and expression medium whereby children use two or more stones that they bang together while they are narrating their story to other children around them. It is a game, involving monologue, where the children talk in the third person so as to distance themselves from the story. The children are given the opportunity to use their imaginations almost in the form of fantasy play. When the children relate a story that pleases them, they brush the stones together softly. When they are demonstrating negative experiences of their lives, they hit the stones together aggressively. The listeners make comments, show sympathy and encourage the children to continue talking when they have finished their story. “The narrator or listeners may even cry over the story or the narrator may not be able to finish the story because of his or her strong emotions” (Kekae-Moletsane, 2008:368). Masekitlana’s function for the players appears to be an informal mode of story-telling and catharsis. In this research, it was proposed that Masekitlana could be adapted to become a more formal method of psychotherapy.



**Figure 2: Therapist conducting Masekitlana therapy session with participant, Hlonipho**

### 1.8.4 THERAPY AND PSYCHOTHERAPY

Psychotherapy is the “treatment of mental disorders by psychological methods and is deliberately planned and guided by certain theoretical preconceptions” (Carson & Butcher,

1992:627). Psychotherapy is based on the assumption that, even in cases where physical pathology is present, an individual's perceptions, evaluations, expectations, and coping strategies also play a role in the development of the disorder and will probably need to be changed if maximum benefit is to be realized. The therapeutic technique of a child projecting his perceptions and feelings through the manipulation of stones was used in the context of this research.

### **1.8.5 TRAUMA**

Trauma has sometimes been described as an overwhelming experience that can result in a continuum of post-traumatic adaptations and/or specific symptoms (Irving, Weiner, Freedheim & Goldstein, 2003). It has also been defined by psychologists as a qualitative degree of suffering within the child as a result of an incident/s. Relevant DSM-IV-TR diagnoses related to childhood trauma, and which are particularly relevant to HIV/AIDS orphans, include, but are not limited to, post-traumatic stress disorder, acute stress disorder, and adjustment disorder with anxious or depressed features (DSM-IV-TR, 2000).

## **1.9 LIMITATIONS AND STRENGTHS OF THE STUDY**

The limitations and strengths of the study are discussed in more detail in Chapter 7 of this thesis. The following summary will introduce the weaknesses and benefits of the study that I was aware of from the inception of the research process.

A criticism of case study research is that the findings are not necessarily transferable to larger populations. Generalizing from this research to the larger population of similar cases in South Africa cannot be taken as a given due to the small sample of four participants in this research. My defence against case study criticism is that, in the current study, each case was studied in great depth so as to prevent a superficial argument for my hypotheses. Furthermore, I felt that 28 sessions of therapy in all presented rich enough data from which to draw substantial conclusions. Enough detail was provided and I was able to describe the data "as it is" (Yin, 1989). In this way I and the readers of the study could feel that we were immersing ourselves in the participants' lives in as real a way as possible.

Crystallization of research implies that "many facets of the cases under observation are revealed", the cases are studied from many angles, with a variety of methods, and the "choice

of what to describe is not routinized” (Yin, 1989) but is open to the creativity of the researcher. I felt that conducting an intervention after standard of care therapy, and subjecting the data to various forms of qualitative and quantitative analysis, increased the validity of the research.

The fact that I was a researcher from a different cultural and language group from the participants may have had an influence on my analysis. I needed to be aware of the potential role that my subjectivity and bias, although inevitable, might have been playing.

Another cautionary note was that the four study participants were drawn from the middle to lower socio-economic groups in society. As the clinic site that serviced the participants in this research was only partially government subsidized and therefore charged a fee, participants from environments of extreme poverty were excluded. Upper economic groups were also more likely to have attended private practitioners rather than this particular clinic. The participants drawn from this clinic were also more than likely to have come from urban and peri-urban environments, as children from more rural areas further afield were referred to outlying clinics in Durban. These facts might have had an impact on the attitude to Masekitlana and might have had an effect on reactions to this form of therapy. The possibility at the outset of the current study was that Masekitlana would be proven to be more of a rural child’s game and would not fall into the play and narrative repertoire of urban and peri-urban children.

This research was interested in exploring whether Masekitlana might be equally effective for Zulu children as it has been proven to be for Sotho children. The results of this particular study therefore were only applicable to and valid for children of Zulu origin and culture.

The findings of the study increased our knowledge on the relevance of indigenous forms of therapy in the lives of children living with HIV or affected by HIV/AIDS. On a design level, the strengths of the study were in-depth insights, quantitative comparisons between different forms of therapy with high face, constructive and prediction validity, and closeness of relating and warm rapport with the participants.

## **1.10 OUTLINE OF CHAPTERS**

### **CHAPTER 1: INTRODUCTION**

This chapter covered the background to this research, and the rationale for and the purpose of conducting the current study. It also covered my paradigmatic perspectives, ethical and quality considerations, and the theoretical framework.

### **CHAPTER 2: LITERATURE REVIEW**

In this chapter, I described the existing body of published research regarding the topic of my research.

### **CHAPTER 3: METHODOLOGY**

This chapter delineated the methodology I used.

### **CHAPTER 4: QUALITATIVE ANALYSIS**

In this chapter, I described the qualitative findings of my research, which included themes, categories and sub-categories of meaning. Included in this chapter were quotations for each theme and an explanation of each theme and its sub-headings.

### **CHAPTER 5: QUANTITATIVE ANALYSIS**

In this chapter, I presented the quantitative analysis of my findings, which consisted of graphs indicating the scores of each participant on the Roberts-2 test. Also in this chapter are graphs comparing the difference in participant results between standard of care therapy and Masekitlana intervention therapy.

### **CHAPTER 6: DISCUSSION AND LINKING FINDINGS TO LITERATURE**

In this chapter, I presented a synthesis and interpretation of the analyzed data. I also discussed my findings in connection with the existing body of published research.

### **CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS**

This chapter presented my conclusions on the contributions of this research and my recommendations for the field of indigenous therapy based on my findings of the usefulness of Masekitlana in the current study. I also commented on the strengths and weaknesses of the study, the quality criteria, and my self-reflexivity as the researcher.

## 1.11 CONCLUSION

This chapter described the background, reasons for, rationale and purposes of the current study of an African form of psychological therapy. It described the interpretive, qualitative and quantitative research paradigms, and the methodology of the single-system research design. It explained where the research was conducted and on whom. Ethical considerations were also delineated. Theoretical and conceptual frameworks of indigenous knowledge systems and indigenous forms of psychology and assessment were discussed. I emphasized the hope that this research would contribute towards preserving an ancient African asset (Kekae-Moletsane, 2008) and making it into a practical and contemporary psychological tool for indigenous populations, in particular children of Zulu origin and culture. I explained that the aim of the current study was to offer new knowledge to the field of indigenous psychology so that psychologists might be challenged to use Masekitlana in other indigenous settings or might empirically research and develop new forms of therapy for indigenous populations.

The next chapter will describe opinions and trends in literature related to culturally focused paradigms, indigenous knowledge systems and indigenous psychology.

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## CHAPTER TWO EXPLORING THE LITERATURE

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*“Using a concept from an alien culture does not fit congenially into the Whole and results in a patchwork psychology with little or no meaning and much confusion. It is somewhat like searching in the darkness and either confusing one thing for another or concluding that the ‘given thing’ is absent. In both cases we are bound to draw erroneous conclusions and miss the local reality. It is thus lamentable that, as Marriot (1990) has argued, in the present day only Western-type ethnosocial science is used. Its application is fraught with the risk of imposing an alien ontology and an alien epistemology”*

(Misra & Gergen, 1993:235).

### 2.1 INTRODUCTION

Discussions in literature over indigenous psychology, indigenous knowledge, and indigenous assessment and methodology appear to focus around three main questions. Firstly, to what extent can dominant Western forms of psychology be considered universal and able to be generalized and applied with validity in non-Western cultures? Secondly, should developing or non-Western countries create their own culturally and contextually specific psychologies, by what processes and methodologies should they do this and might these indigenous psychologies and concepts be generalized to other nations, therefore becoming universal psychologies in their own right? And thirdly, does psychological science need to have an intercultural dialogue between indigenous and Western, the local and international (Gergen, Gergen, Lock & Misra, 1996, in Mkhize, 2004), and by what processes can these different psychologies be integrated?

The current literature review encompasses theorists’ views within the field of indigenous psychology, which by definition includes theories on culture, indigenous knowledge, and indigenous psychological assessment and therapy. The focus in each of these sections begins from a global base and then narrows down to African, in particular South African, challenges in the field of indigenous psychology. Each section covers the topics of universality and context within the field of psychology.

This chapter is divided into four sections. The first section reviews literature on psychology from a cultural perspective in general, on the difference between the Western outlook on psychology and the development of psychology from within developing countries, and on how psychologists work in cultural settings. The second section concentrates on literature around indigenous knowledge systems and their relevance to psychological methods and processes, particularly in Africa. The third section concentrates on particular aspects of indigenous assessment and indigenous therapeutic applications of psychology, and on literary contributions to this subject. This includes a focus on narrative and projective play therapy, and its application in the context of children of African origin. I explain how general theoretical ideas in literature can be linked with the more specific application of Masekitlana as a form of indigenous play using narrative modes of expression. The analysis and interpretation of the data, and resultant findings from the Masekitlana model of indigenous narrative play therapy, are discussed in the context of what constitutes indigenous research and methodology in literature.

Therefore this chapter begins with a general conceptualization of indigenous theories as they apply to the psychological field, and culminates in findings from literature on the specific therapy of Masekitlana and its relevance to indigenous psychology, which is the focus of the current study.

In addition to concepts from the field of psychology, I incorporated concepts from other disciplines into this study, such as social anthropology and education. In particular, I found literary texts from the theological field to be particularly useful for the purposes of this study, as South African theologians of European and American origin realized from an early time in the history of Christian theology in Africa that they would have to incorporate indigenous knowledge systems and traditional African beliefs into their teaching and sermons in order for Christianity to be more acceptable to the local context.

## **2.2 CULTURAL PSYCHOLOGY**

Literature on indigenous psychology encompasses discussions and ideas on understanding psychology in cultural and cross-cultural contexts. In general, different theoretical viewpoints range from seeing psychological constructs in a universal way, that is, a particular theory applying to all cultures, to the viewpoint that psychological theories must develop out of a



specific culture's beliefs, to a form of integrationist psychology that encompasses specific cultural concepts as well as more universally proven methods.

As “issues of cultural variation have played but a peripheral role in the psychological sciences, logical enquiry into and proper understanding of culture could transform the perception of psychological science itself and might encourage a genuine dialogue among different cultures” (Misra & Gergen, 1993:226). A more difficult question though, one that the current study hopes to explore, is how the psychological manifestations of people in different cultures are to be explained and how their value systems and patterns of behaviour are to be assessed and measured. Integrating behavioural methodological principles into a culturally sensitive science (Diaz-Loving, 1999) might be considered the basis of indigenous psychologies.

### **2.2.1 ISSUES OF UNIVERSALISM VERSUS STUDYING UNIQUE ASPECTS OF CULTURES: ‘ETIC’ VERSUS ‘EMIC’ FOCI**

The Western form of laboratory science and linear cause-and-effect thinking that was applied in psychology when it was first established as a ‘science,’ is considered by some to be “wholly inappropriate and superficial” for studying cultures, as culture is made up of “complex webs of interdependence, lodged within mixtures of interwoven traditions, and sustained by a dynamic multiplicity of intelligibilities at the psychological level” (Misra & Gergen, 1993:230). Despite this caution on cultural complexity and traditionalism, a universal or international form of psychology was considered expedient for all nations and races (Adair, 1999). The difficulty arises in identifying what the term, ‘universal’, entails as what was generally considered universal psychology was the ‘predominant’, often ‘quantitative’, ‘hypothesis-testing’ research approach, mostly originating from the United States of America (USA), which does not suit all population groups of all countries and is, in particular, an ill-fitting method by researchers in developing countries (Adair, 1999).

An example of generalization of methods and assumptions on behaviour not suiting every context is the standardized assessment instrument measuring ‘solidarity’ and ‘partriarchy,’ which indicates one dimension of the American family but not the complex intricacies of relating and its array of interdependencies (Misra & Gergen, 1993). If such variation exists across one country, how great are the variations of behaviour between different cultures of different countries?

In describing the angle or focus of psychological science in different contexts, the concepts labelled ‘etic’ and ‘emic’ have been used. Observing, recording and analyzing psychological practices within cultures involves, of necessity, “a form of coding that is embedded within a culture’s system of meaning”, that is, a ‘bottom-up’ or an ‘emic’ form of psychological application (Misra & Gergen, 1993; Poortinga, 1999; Allwood, 2006, Cheung, 2006, in Allwood & Berry, 2006;). Consensus on this point appears to have been reached; however, the debate is centred on taking *specific* form of behaviours from one culture, extrapolating norms for this behaviour and then expecting to be able to examine and measure similar manifestations of these specific forms of behaviour within another culture in another country using the same norms. This is an ‘etic’ focus, which appears to address the issue of *universality*. Although it is a matter for debate whether it is valid to take the culturally embedded concepts and apply them empirically to other cultures, or to cross-cultural data, in a form of ‘top down’ understanding, some believe that behavioural repertoires in particular cultures *can* be understood against the background of a broader frame of commonness (Poortinga, 1999). Relativistic psychology points towards the existence of certain common emotions such as anger, anxiety and sadness at an abstract level, even though they manifest in different ways in different cultures or nations, and this is borne out by factor analysis which points to broad universality in human functioning (Poortinga, 1999). The idea of universalism and ‘etic’ thinking appears to favour a form of deduction or inference. The question then arises as to whether this neglects the ‘emic’, inductive approach of examining specific manifestations of behaviour that might be unique to a culture and found nowhere else in the world, but are deserving of psychological consideration and attention.

In the South African context, a study into African people’s, in particular Zulu people’s conception of intelligence as compared to other parts of the world confirmed how the findings from one culture are not always found to be applicable to other cultures (Furnham, Ndlovu & Mkhize, 2009). Five hypotheses from studies worldwide were generated and not one hypothesis was found to apply to the African participants. The final result of this study indicated the uniqueness of African concepts of intelligence and the authors hence advocated for a questionnaire based on ‘emic’ rather than ‘etic’ concepts when recording Zulu-speaking people’s perceptions on intelligence.

The debate around universalism appeared to have taken on a political profile in that the so-called ‘universalistic image’ of psychology was considered to be primarily a colonial,

imperialist, Euro-American product, which believed psychology to be value-free (culture-free) and therefore easily transferable and applicable to non-Western cultures (Misra & Gergen, 1993; Gilbert, 2006; Yang & Sinha, 2006, in Allwood & Berry, 2006). In South Africa, white supremacy encouraged divisions between different cultures and discouraged cross-cultural research (Swartz, 1996, in Maiello, 2008) and “after the end of the apartheid regime, an excessively universalistic view of social phenomena tended to develop as a reaction to the previous policy of social segregation” (Maiello, 2008:242). Addressing this problem, Ratele (2003) appears to talk for the majority of cultural theorists when he calls for a “cultural revitalisation to redress the effects of oppressive practices which, in past South African times”, he claims, “dislocated, disrupted and even destroyed the indigenous social structure, family systems and integrated social identities”.

On the other hand, Apartheid might have encouraged certain indigenous groups in South Africa to hold on to their traditional beliefs and values as a form of defence against the disempowering affects of the predominantly white people’s Apartheid policies. Apartheid, however, also clouded certain people’s perceptions of indigenous people, and researchers tended to study and portray indigenous people in South Africa as if they were primitive oddities with idiosyncrasies not found in the so-called ‘civilized’ Western world (Furnham, Ndlovu & Mkhize, 2009).

Mufamadi (2001:6) goes so far as to say that “every effort (was) made to bring the African person to admit the inferiority of his/her culture which had been transformed into instinctive patterns of behaviour, to recognise the unreality of his nation and the confused and imperfect characteristic of his own biological structure”. There are many African cultural practices that people are ignorant of because they have been led to believe that African culture is not valid and lacks civilization (Mufamadi, 2001). This might also have been a globally historical phenomenon as Nsamenang (2006, in Allwood & Berry, 2006:258) describes how psychology became an “outreach discipline of Europe’s civilising mission rather than a universal science of human behaviour” and that psychology was a field of study that “located Europe as the locus of enunciation and other civilisations of the planet as the locus of the enunciated”.

## 2.2.2 DIFFERENCES BETWEEN WESTERN AND AFRICAN/NON-WESTERN CULTURAL FUNCTIONING

The call of ‘cultural’ psychologists has risen from a ‘reactive’ stance to Western psychology (Allwood et al., 2006) and has been to try to move away from Western concepts of personal functioning and to look for a more contextualized form of understanding people. The focus of this study is African indigenous psychology, and so the differences between Western culture and African culture imply different roles for psychology in the African context.

The main differences appear to concentrate on how individuals relate with each other and in communities. A Western person is accredited with living an individualistic form of existence, where self-achievement, self-fulfilment, “liberal freedom of choice, a personalized nature of control and interest in consumerism and materialism” are important features of living (Misra & Gergen, 1993:231). The African person, on the other hand, is bound by strong responsibilities to his or her family and community, with an emphasis on self-discipline and respect for all things animate and inanimate, physical and metaphysical, and these are linked to a moral code (Allwood & Berry, 2006). Nakamura (1964, in Pederson, 2009:148) describes how “collectivism and social relationships are emphasized in indigenous cultures rather than individualism, and how indigenous knowledge revolves around these ideas”. In the South African context, ‘collectivism’ (Nakamura, 1964, in Pederson, 2009:148) plays out in the idea of *ubuntu*, which is a unique indigenous form of being in community with others (Schutte, 2001; Mkhize, 2004). Collectivism is reflected in the African person’s concept of intelligence, which takes more of an inter- and intra-relationship form than an individualistic, inherited, self-achievement type of intelligence typical of the Western world; African cultures tend to value mature reflection, social skills and world wisdom as being important components of intelligence, not just problem-solving and knowledge accumulation (Furnham, Ndlovu, & Mkhize, 2009). In this way, non-Western forms of thinking appear to challenge Western psychology’s traditional self-image of being neutral and objective (Allwood & Berry, 2006).

Differences in organizing principles are that the Western viewpoint regards “knowledge as amoral (value-free) and secular” (Misra & Gergen, 1993:231), whereas the African person trusts ‘inherited wisdom’ and views knowledge as moral and sacred. Because African wisdom, knowledge, beliefs and communal values are so often passed down in verbal form in families and community gatherings, a qualitative, oral focus of psychological investigation might therefore be more suitable for the African context, while a quantitative form of

recording behaviour has been popularly employed in Western contexts. The aforementioned difference and divisions cannot be decisively laid down and there are certain commonalities, such as spirituality. Christianity is synonymous with both cultures (Holland, 2001) although Africans tend to have a strong, working spiritual link with their ancestors, whom they believe link them to God (Mutwa, 1998), while generally Westerners tend to recognize the influence of their ancestors as simply passed down through generations. Despite commonalities, Western psychology might be considered an indigenous psychology which has legitimacy in its own right but might not always be applicable to other cultures. Differences in traditional knowledge and Western science are demonstrated in Figure 3.



**Figure 3: Qualities associated with traditional knowledge and Western Science (Barnhardt & Kawagley, 2005)**

### 2.2.3 BUILDING FORMS OF CULTURAL PSYCHOLOGY: RESEARCH IN CULTURAL SETTINGS

Knowing the difference between Western and African outlooks on behaviour does not always translate into knowing how to create psychological methods and paradigms in specific cultures such as those in parts of Africa. Various ideas have been offered in reaction to the Western positivistic, linear mode of enquiry, where cause as of necessity leads to effect and culture has been regarded as an error source in research. An interpretive mode of knowing a culture has been advocated, which I followed in this study, and which entails a subjective understanding of a person's context and reality as interpreted by the person himself or herself, rather than objectified by outside professionals (Misra & Gergen, 1993). The researcher must be a "co-participant in the joint construction of reality, rather than an authority to control and predict the future of a person" (Misra & Gergen, 1993:237).

Creatively pursuing culturally and contextually relevant research has been called 'autochthonous discipline development' (Adair, 1999), which appears to have a very different ontology from the 'importation' and 'transplantation' of Western ideas, which disregards local norms and beliefs (Azuma, 1984; Naidoo, 1996). The process of autochthonous discipline development is not simply comprised of disjointed anecdotal descriptions of culturally-specific forms of behaviour to be researched and examined, through 'cosmetic indigenization' or a 'building block' approach, but is an attempt to understand the interconnected Whole or *Gestalt* within each culture (Azuma, 1984; Misra & Gergen, 1993; Adair, 1999; Moghaddam & Taylor, 1986, in Allwood & Berry, 2006;). It seems to me that this holistic, phenomenological way of looking at cultures allows for mindsets, intuitive states and idiosyncratic ways of being in indigenous cultures to be freely expressed, and out of this a more originally authentic form of indigenous psychology can be created. In this way, cultural psychology and research might empower indigenous cultures to explore their own realities and propose their own forms of psychological tools rather than controlling and predicting the future of the person (Misra & Gergen, 1993). Moving away from the Western detachment in researching other cultures to a more robust interaction with the subjective realities of indigenous cultures is aptly described as follows:

The shift toward multiple psychologies, each embedded within its cultural traditions, may also have a strong liberalizing effect. Through such an approach the realities of 'others', 'primitives', and 'savages', who were formerly objects of study, would become as authentic as ours (Fabian, 1983; Pandian, 1985, Rosaldo, 1980; Wolf, 1982). 'Acquiring empathic sensitivity to other cultures' requires what Kukla

(1998:151) envisages as “ethnophenomenology”, in which knowing another culture means ‘immersing oneself in that culture’s worldview in order to observe in oneself the effect of such an immersion” (Misra & Gergen, 1993:238).

#### **2.2.4 CULTURAL IN-BETWEENITY: AN INTEGRATIVE APPROACH**

The aforementioned discussion on universality versus contextuality in psychology appears to centre on the idea that people are either of Western culture *or* non-Western culture. People in certain societies, however, often exist somewhere in between typically Western and non-Western/indigenous states of being, demonstrating a “cultural in-betweenity” in which ‘new’ and ‘old’, ‘modern’ and ‘indigenous’ coalesce, one modifying the other and each losing in consequence its original character” (Ratele & Duncan, 2003:125). In South Africa, more now than ever before, youth are emulating the ‘Coca-Cola Afro-American’ culture where individualistic aspirations and “looking out for number one” (yourself) are important but may lead to “identity confusion and conflict with old values” (Ratele & Duncan, 2003:143).

The state of in-betweenity, which is not actually acculturation as such, appears to call for psychologist discretion as to which forms of psychological method to employ: traditional, Euro-American, something more amorphously universalistic, or an integration of all? Integration of old and new appears to be possible under a form of ‘both/and’ thinking originating in quantum physics, whereby the “importance of opposites has been proven and where something can be right and wrong, good and bad, true and false at the same time” (Pederson, 2009:145). Thus through an integrative approach, ‘etic’ and ‘emic’ foci do not seem poles apart but have meeting points. A worthy analysis would be to investigate to what extent indigenous psychologies developed independently in their own cultural environments and to what extent they were influenced by general principles from the international academic arena.

Integrationist policies or the comparative approach to viewing psychology is demonstrated by two examples, one from an ‘etic’ perspective and the other from an ‘emic’ perspective. Firstly, the concept of ‘authoritarianism’ appears, according to Keteyi (1998), to manifest itself in different cultural contexts but in different forms. From an ‘etic’ perspective, taking the construct of ‘authoritarianism’ then into different countries to ascertain if it is to be found in developing countries is not a form of “bland universalism in search of a home but rather concrete universalism that actually finds a home or already has a home in all cultures, albeit in

different forms created by the actual traditional needs of those cultures” (Keteyi, 1998:51). However, even this form of ‘bland universalism’ has its critics in that the conceptualization of the scale to measure ‘authoritarianism’ was found to have ethnocentric bias and additional scales had to be introduced that were synonymous with ways of relating to authority in different cultures (Diaz-Loving, 1999).

The second example demonstrates how researchers identify the indigenous construct, *amae* or ‘indulgent dependence’ in its country of origin, Japan, and take it to other countries and cultures where they identified the same concept but under different names and in altered forms (Chung, 2001, in Allwood & Berry, 2006). Allwood and Berry (2006:246-7) synthesize the two processes by stating that, “*universal* constructs may be manifested differently in different cultural contexts and *indigenous* constructs may be different ways of cutting the same psychological reality in different cultural contexts”. Diaz-Loving (1999) appears to agree with Allwood and Berry’s (2006) explanation by adding that at an abstract level of analysis dimensions such as ‘authoritarianism’ and ‘self-concept’ are general categories that are universal across several cultures; however, it does not mean that the ecologically valid definitions and behaviours that represent each dimension will be similar.

Teasing out the difference appears to become more and more difficult but what appears to differ between the above two examples is the starting point of researching a construct or how researchers define a construct in the first place. What is also evident is that examining psychological constructs in different societies and cultures suggests that there are more similarities between cultures than differences, and that “hybrid concepts and theories can be used with a synthesis of universal and idiosyncratic perspectives” (Poortinga, 1999). Allwood and Berry (2006) state that by *comparing* indigenous psychologies from different societies (the ‘cross-indigenous method’), psychologists might observe an ‘overall pattern’ of human behavioural development and expression. Furthermore, what seems a healthy goal of indigenous psychologies is the discovery of universal facts, principles and laws that could explain human *diversity* (Kim, Park & Park, 1999). This train of thought though is initially annihilated by Diaz-Loving (1999), who states that any comparison of behaviours that emanates from different behaviour settings is essentially a false enterprise that entails comparing incomparables. This could be an indication of degrees of defensiveness of culturally unique properties and reactivity to imposed methods of assessment versus tolerance and awareness of shared commonalities, shared possibilities and multimethodologies. This



attitude of Diaz-Loving (1999) was later ameliorated when the same author described how Mexican ethnopsychology had built a new psychological understanding of human behaviour based on its own findings *and* those mainstreaming an attempt at synthesis of universal *and* idiosyncratic perspectives (Diaz-Loving & Diaz-Guerrero, 1992, in Diaz-Loving, 1999). It appears from this that psychological exclusiveness within cultures is more of an ideal than a reality.

The establishment of Christianity, originally of European origin, in an African context and its integration with traditional African ancestral beliefs confirm that it is no longer possible to speak as though different cultures are to be found neatly bestowed in different places. South African youth of all cultures are exposed to a global world and globalization, where overseas travel is considered part of growing into early adulthood and, therefore, the integration of Western and non-Western ideas and identities will inevitably occur and should be accepted within traditional cultures. Table 1 indicates the different foci mentioned above.

**Table 1: Indigenous psychology: differences between psychological approaches**

|                       | EMIC FOCUS   | INTEGRATION   | ETIC FOCUS   |
|-----------------------|--|---|--|
| CULTURAL PSYCHOLOGY   | Specific, culturally embedded forms of behaviour   | Applying facets of generally accepted psychological forms alongside culturally specific forms of understanding psychology   | One, universal form of psychology applies to all cultures  |
| INDIGENOUS KNOWLEDGE  | One culture's beliefs norms, values, behavioural styles  | Specific <i>and</i> general forms of knowledge are examined   | Western knowledge can be transported anywhere in world and applied to specific cultures  |
| INDIGENOUS PSYCHOLOGY | Forms of therapy, assessment and psychological perceptions that originate from a specific indigenous group | Using tests, assessments and therapy models from the Western world and reassessing them for their relevance in indigenous populations; integrating indigenous and Western forms of therapy or renorming Western tests on indigenous populations | Assessments and therapeutic styles conducted and normed mostly in the Western world and then transported and transplanted into psychological practices of indigenous populations |

The main challenge in integrating cultural practices is that of dialogue across cultural boundaries, an optimistic stance towards the 'other' culture, an attitude of seeing the good in

it and being challenged by it (Keteyi, 1998). If a community sees its culture in absolute terms, it is rendered less capable of having a dialogue with other cultures and “runs the risk of becoming monological” as a “truly dialogical account of knowledge needs to take into account the Other’s worldviews and perspectives” (Mkhize, 2004:82-3). Dialogue is only possible between cultures if a culture knows its strengths and weaknesses and if it is prepared to augment where it is found lacking (Keteyi, 1998). It can be deduced from this that Western methods of psychology taken into developing countries might need to be augmented by indigenous ways; similarly, developing populations undergoing globalization might need to augment their methods of practice with Western ideas.

In the section above, I have established that psychological methods can be devised by examining the values, ways of thinking and acting within indigenous cultures, by importing and applying supposedly universal, pro-Western concepts and methodologies into cultures or an integration of both foci. When many different indigenous psychologies become available, a pan-human psychology might become possible whereby what is truly common or universal might be discerned (Allwood & Berry, 2006). Instead of being devised from the “imposed etic” of Western psychology, the ‘emic’ influence of indigenous psychologies would be the “building blocks” for a “derived etic” in psychology (Allwood & Berry, 2006:265), a more general psychology which will be comprised of general principles of human behaviour. I see this as a truly universal psychology as opposed to a pseudo-universal one originating in Europe and America and foisted on developing populations by supposed intellectual experts on human behaviour monitoring and assessment.

What is clear from the literature is that what was occurring in the cultures at the time researchers were creating indigenous forms of psychology was important, for instance, religious influences in India (as enunciated by Saraswati, 2006 & Sinha, 2006, in Allwood & Berry, 2006) and political influences in Iran in response to movements internationally (Moghaddam, 2006, in Allwood & Berry, 2006). In this study, the political effects of Apartheid on psychological processes of indigenous people will be addressed. Another observation is that different approaches to indigenous and cultural psychology can occur within one country. Similarly, homogenous forms of ‘Black psychology’ can develop in many so-called Black cultures worldwide, as can Chinese forms of psychology permeate the whole Eastern world despite the myriad different cultures to be found there.

Furthermore, the formation of a cultural psychology appears to arise from the discipline of ethnopsychology, which “demonstrates the effects of culture on the development and form of attitudes, norms, values, personality coping style, and social behaviour in general” (Diaz-Loving, 1999:445). The role of ethnopsychology as well as ecosystemic psychologies should not be ignored in the formation of indigenous psychologies within cultures, as they link psychological phenomena, theories and models to social, political and economic variables.

As this study is about indigenous psychological methods for a particular indigenous population of Zulu origin and culture, I favour a psychological approach that takes into consideration intrinsic values and beliefs unique to this culture. In order to devise methods of therapy and assessment appropriate and valid for particular indigenous contexts, psychologists need to have a comprehensive understanding of the indigenous knowledge and symbolic meaning systems of the culture under investigation.

### **2.3 INDIGENOUS KNOWLEDGE**

Indigenous knowledge is defined as the basis for community-level decision-making in areas pertaining to food security, human and animal health, education, natural resource management and other vital economic and social activities (Gorjestani, 2000). As “indigenous knowledge is an integral part of the culture and history of a local community, we need to learn from local communities to enrich the development process” (Wolfensohn, 2000, in Gorjestani, 2000:1). As this study is concerned with children suffering trauma and health issues, I will describe two examples of how local communities in Africa, using local indigenous knowledge, coped with these issues and contributed towards the development of social services in a way unique to their indigenous populations.

In Uganda, formerly high maternal mortality rates have been reduced through a system known and trusted by Ugandan women, that is, the use of the traditional birth attendants (TBA) (Musoke, 1999, in Gorjestani, 2000). The government health system became aware of this form of indigenous practice and they promoted the prompt referral by TBAs of troubled births to public health services. The result was a constructive and life-saving co-operation between modern and traditional forms of birthing. In Tanzania, an indigenous knowledge programme helped support exchanges between traditional healers and staff of hospitals dealing with HIV patients (Scheinman, 2000, in Gorjestani, 2000). The result is that a regional hospital has dedicated a hospital ward to these healers to treat and counsel patients.

Of relevance particularly for the present HIV health concerns in African, including South Africa contexts, are African divinities, diviners, and healers, whose beliefs include “symbolic representations of tribal realities, illness resulting from hot/cold imbalance, dislocation of internal organs, impure blood, unclean air, moral transgression, interpersonal struggle and conflict with the spirit world” (Airhihenbuwa, 1995, in Pederson, 2009:149). This is in addition to African cosmological belief that health depends on a balance both within the individual and between the individual and the environment or cosmos (Gobodo-Madikizela, 2006; Keteyi, 1998). In their arrogance and ignorance of indigenous knowledge systems, Western practitioners might not even know that there is already in place an indigenous framework whereby their patients can make sense of their own problems and trauma (Keteyi, 1998; Gobodo-Madikizela, 2006). Understanding the African world-view of “self, separation and connection with others, the predominance of inter-relationships and networks, extended kinship ties and obligations, and ongoing generational connections with ancestors” is the key to effective counselling in the African context (Holland, 2001; Gilbert, 2006). Having the knowledge that counselling on a one-on-one basis is alien to certain South African cultures and does not even have an equivalent word in Lesotho<sup>8</sup>, will help to caution practitioners not to impose their dominant, imperialistic views of therapy on these cultures (Gilbert, 2006).

### **2.3.1 CONTEXTUALITY AND UNIVERSALISM OF INDIGENOUS KNOWLEDGE SYSTEMS**

Having established an understanding of indigenous knowledge systems in an African context, to what extent can universally accepted psychological concepts be superimposed upon or integrated effectively within local indigenous meaning systems and interpretations of behaviour? The corollary is to ask how psychologists should understand local knowledge and what makes certain knowledge local as opposed to knowledge that can be considered to be universal (Higgs, 2006). Following on from this, can African knowledge systems be generalized to other parts of the world and therefore be understood as universal knowledge?

The dominant way of thinking is that universal knowledge is based on the assumption that “reality itself is universal and that universal knowledge is objective knowledge” (Higgs, 2006:3). Under this assumption, “human involvement in the production of knowledge is therefore ignored, perpetuating the idea that knowledge simply ‘is’ and that truth simply ‘is’” (Higgs, 2006:3). This is hard to believe in the light of the indigenous knowledge systems

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<sup>8</sup> Lesotho, officially the Kingdom of Lesotho, is a landlocked country and enclave, completely surrounded by its only neighbouring country, the Republic of South Africa. Its capital and largest city is Maseru.

described above, where indigenous communities are so obviously involved in their production. Alternatively, upholding African indigenous reality as universal knowledge risks creating a hegemony of African indigenous knowledge which “might then become a subject of argument and criticism”, as did the hegemony of Western knowledge systems that were upheld as being universal (Higgs, 2006:4).

An integrative way to comprehend universal knowledge in relation to indigenous knowledge is through a ‘social construction of knowledge’. According to this paradigm, the universal is nothing but an expression of the way in which power is distributed at a certain moment in time and hence the universal is in fact a specific manifestation of the local (Berger & Luckmann, 1967, Kuhn, 1962, Mannheim, 1991, Foucault, 1967, 1970, 1972, 1989; all in Higgs, 2006). To interpret the above statement more concretely, Western knowledge, often claimed as being universal, is actually derived from many locally generated knowledge systems, and denies its locality as it projects itself as universal (Semali & Kincheloe, 1999, in Nandozi, 2009).

### **2.3.2 PROTECTION AND DISSEMINATION OF INDIGENOUS KNOWLEDGE SYSTEMS**

Issues arise in relation to the protection and dissemination of indigenous knowledge. If local communities are taught to value their indigenous knowledge, they would more readily embrace it as part of their identity and not let it be erased, diluted by other influences or expropriated for international usage. Under present consideration is whether to extend international property rights to include indigenous knowledge or whether to treat it as a public good (Jones & Hunter, 2004). This dilemma is presently being experienced in connection with herbal remedies discovered, grown and used by traditional healers in South Africa, who are questioning the legality of the international appropriation of herbs and of the herbal knowledge that has been generated by communities in South Africa (Dugmore & van Wyk, 2008).

South African children could be taught indigenous knowledge in schools. However, the integration of indigenous knowledge in formal school learning has been largely done at a rhetorical level and no actual implementation seems to be taking place (Nel, 2005, Mosimege, 2005, in Nandozi, 2009). One way for education, in particular learning about the conservation of biodiversity and natural resources, to become effective in African societies is to include indigenous knowledge in the science curricula of schools (Zinyeka, 2011). By “infusing

indigenous knowledge into mainstream science in a legitimate way” and by training teachers to do so, “science education would be connected to issues of sustainable development in African countries” (Zinyeka, 2011:15). Educators need to understand indigenous knowledge and have the ability to integrate it properly (Grange, 2007, in Nandozi, 2009), as failure to integrate indigenous knowledge might be a result of their focus on ideological rather than pedagogical implications (Semali, 1999, in Nandozi, 2009).

Snivley and Corsogilia (2000, in Anderson, 2008) appear to substantiate ideological differences in their views on Western modern science and indigenous knowledge. They claim that Western modern science has in most cases around the globe been taught at the expense of traditional ecological knowledge, even though indigenous cultures have made significant contributions to Western science in that indigenous science is rich in time-tested approaches that foster sustainability and environmental integrity. This appears to be tied to issues of legitimacy in that Western science has contended that indigenous knowledge is not legitimate as it cannot be tested against set criteria for assessing validity, whereas indigenous cultures contend that Western science is not legitimate as it does not encompass spirituality (Durie, 2004, in Anderson, 2008) practicality and social relevance (Protacio-De Castro, in Allwood & Berry, 2006). This polarity further entrenches defensive attitudes rather than encouraging new insights (Durie, 2004, in Anderson, 2008).

Therefore, there seems to be a call in the literature for indigenous knowledge to be taken into account when devising methods of psychological therapy and research, and for it either to be directly applied as a culture’s unique resource or to be integrated with existing or ‘imported’ Western systems. The question of whether and how African knowledge systems can be useful when applied to other cultures does not seem to have been answered. Some valuable ways of conceptualizing psychology from indigenous forms of knowledge could be disappearing due to the present era of high technological advance, which considers indigenous knowledge to be primitive, rural, of ancient relevance and still developing in its applicability to a wider world.

## **2.4 INDIGENOUS PSYCHOLOGY**

As opposed to general principles of perceiving psychology in cultural contexts and/or its universal applications, this section on indigenous psychology will explore the manifestation of different forms of indigenous psychology and how it has developed and is applied to indigenous settings. As Diaz-Loving (1999) emphasizes, although culture with all its

idiosyncratic ways, norms and beliefs is at the forefront of any psychological interpretation, there needs to be an empirical effort directed towards specifying its characteristics in a measurable form. I described how making the discipline ‘autochthonous’ means developing a psychology of a country that is “independent of its imported origins and which stands on its own in addressing local problems (by) providing its own local training and textbooks” (Adair, 1999:415). In this section, I will cover literary concepts on specific forms of indigenous psychology and how it is created in indigenous contexts.

The process of development and evolution of indigenous psychology through various stages has been termed ‘indigenization’ (Azuma, 1984, Atal, 1981, Sinha, D., 1986; Sinha, J.B.P., 1984; all in Allwood & Berry, 2006). There are various aspects to this formation process and I regard the process of taking an indigenous game such as Masekitlana and using it in a therapeutic context to be an example of this indigenization process. Various authors try to make sense of the process of indigenization by focusing on various aspects of its formation.

Indigenization involves shifting and developing the approach towards indigenous psychology from seeing it as an authentic and essentially local cultural knowledge to developing an integrative and comparative framework for its application. A “purist endogenous trend” presents the “philosophical roots of a nation or culture’s wisdom and the psychological processes found in ancient texts”, and offers these as a form of “wellness” and indigenous psychology (Bhawuk, 1999; Sinha, 2006, in Allwood & Berry, 2006). However, a historico-religious way of developing a country’s indigenous psychology through examining texts does not constitute an empirical indigenous psychology; what is required is a ‘content’ analysis of psychological methods (Adair, 1999).

‘Content’ variables are comprised of methods of psychology such as test stimuli and instruments used as well as the theoretical concepts and topics selected for investigation (Berry, Poortinga, Segall & Dasen, 1992, in Allwood & Berry, 2006). The emphasis for the current study is on examining the relevance of these instruments and concepts in indigenous populations. Culturally idiosyncratic premises discovered for a given community must relate meaningfully and significantly to independent measures of cognitive, personality and moral development, and vocational interests, and these dimensions must, in turn, bear meaningful relationships to psychological and social constructs in a given culture (Diaz-Loving, 1999).

In South Africa various authors appear to be addressing these ‘content’ variables. Kekae-Moletsane (2004) describes the adjusted procedures that were developed in a study that focused on administering the Rorschach Comprehensive System for South African learners. John and Kekae-Moletsane (2011) make a plea for more culturally valid assessment instruments to facilitate grant application processes for rural school learners. Singh, Sunpath, John, Eastham and Goundan (2008) describe the norming of two cognitive assessment instruments on a Zulu-speaking population in an urban semi-private hospital, with the purpose of using them to more accurately detect cognitive deficits in patients living with HIV. Ward, Flisher, Zissis, Muller and Lombard (2003) assessed the reliability of the Beck Depression Inventory (BDI) and the Self-Rating Anxiety Scale for epidemiological investigations of adolescents’ symptoms. Their conclusions were that these instruments may be reliable in developing contexts but they recommend that larger studies should be conducted in order to explore item bias in different race and gender groups. It can be seen, therefore, that adjusting ‘content’ variables within assessment instruments and conceptualizing ‘content’ variables of indigenous populations is an important part of the indigenization process and the development of valid forms of indigenous psychology.

In order to address ‘content’ variables, ‘structural’ variables need to be considered. ‘Structural’ variables are comprised of the universities and numbers of academics available to teach students and encourage research and access to textbooks and journals based on local theories and research (Diaz-Loving, 1999). Structural recommendations for the South African context have been advocated in the form of more mental health posts in the state sector, for improving psychology’s location and role in the school setting, for training more effective psychologists cost-effectively and for providing acceptable and accessible services (Naidoo, 1996). An ‘ethnopsychology’, that is, a psychology of the people taking into account the behaviour patterns and worldviews of local people, requires the *integration* of structural *and* content advances (Adair, 1996, in Diaz-Loving, 1999).

Besides examining the content and structural variables of psychological systems, a form of ‘endogenous indigenization’ develops out of the ‘purist endogenous’ trend in that religious practices are built on ancient texts and ancient wisdom until they permeate the daily life of populations through beliefs, practices, and ethnotheories that continue to influence behaviour in a substantial way up to present times (Saraswathi, 2006, in Allwood & Berry, 2006).



The above discussion presents an inward-looking focus into forms of psychology in indigenous populations. In addition, a relative and integrative focus examines the psychological space of people in developing countries to ascertain whether and how imported and transplanted forms of Western therapy are being indigenised and are making a contribution within quite a different society and culture (Azuma, 1984). This trend leans towards ‘an exogenous indigenization’, a process described as one country or culture assimilating what it finds beneficial from the psychological methods of another culture. One step further removed is the ‘purist exogenous’ trend that simply uses Western psychological concepts to study other cultures’ forms of thinking and behaving (Sinha, 2006, in Allwood & Berry, 2006). As mentioned in the section on cultural psychology, ‘cross-cultural’ or ‘cultural psychology’ compares the perceptions and behaviour patterns of one culture with another (Allwood & Berry, 2006).

It can be seen in this section on the indigenization of psychology that development has commenced from an ‘emic’ perspective to an ‘etic’ perspective with a form of connection or integration between the two. The process of indigenization could equally have been described under the cultural psychology and indigenous knowledge sections of this literature review, as it is a process that occurs within both these realms. Masekitlana takes an ancient form of storytelling that is still in use today and integrates it with what has been found universally true concerning narrative therapy. In this way, Masekitlana itself has undergone an indigenization process.

#### **2.4.1 POSITION OF THE PSYCHOLOGIST IN INDIGENOUS PSYCHOLOGY PRACTICE**

Literature has highlighted the opinion that psychologists must be aware of the cultural elements that contribute to a patient’s ways of communication and expressing distress, and how this might differ from their own response or professional approach in a similar situation (Maiello et al., 2008). They might have to contend with multiple conflicting roles when helping clients in a cultural setting and must expect to experience in their own minds a certain amount of ‘cultural dissonance’ and feelings of not quite understanding the client’s values compared to their own cultural values (Sue, Ivy & Pederson, 1996). If psychologists from a Western background are perceived by their clients to be protecting the status quo of the “powerful conqueror and protector” and to be treating “their wards’ as inferior due to a mindset that assumes cultural deficiency and a previously disadvantaged status”, they might be distrusted by the client (Pederson, 2009:143). Of particular relevance for the South African

context is the more serious step on the part of the psychologist which involves “racial microaggressions defined as brief and commonplace daily verbal, behavioural or environmental indignities, whether intentional or unintentional, that communicate hostile derogatory, or negative racial slights and insults toward people of colour” (Sue et al., 2007:271). A bias toward a predominantly pathogenic focus when studying the behaviour of ‘Black’<sup>9</sup> South Africans has been noted in certain studies (Guthrie, 1970, in Naidoo, 1996).

Alternatively, it has been suggested that psychologists conducting therapy in indigenous environments could look for positive solutions to these challenges such as including ‘cultural teachers’ from the client’s life such as family members, teachers, doctors, spiritual leaders and other significant figures who may be brought into the therapeutic situation. This creates an atmosphere of “inclusive cultural empathy” and enables the psychologist or therapist to be “sensitive to differences and similarities between his or her own perceptions and those of the client” (Pederson, 2009:146). Therapists might look out for the ‘within-group’ differences and the ‘between-group’ differences when working with clients from indigenous contexts; this inclusive accommodation of similarities and differences will allow for the devising and using of psychological methods that take this into account (Pederson, 2009). This could encourage ‘yes’ assertions in the practicing narratives of psychologists, one of which is to “tolerate vague or ambiguous conditions and to suspend one’s decisions for as long as possible in dealing with conceptual, theoretical and methodological problems until something indigenous emerges in his or her phenomenological field” (Yang, 1997, in Pederson, 2009:145).

To become an ‘African expert’ but coming from the outside of the ‘Black’ experience (as is the case with many psychologists in South Africa), it is necessary to be sensitive to the dignity of African participants and their aspirations (Buthelezi, 1972 in Keteyi, 1998). To “propose that people should go back to their traditional customs will only serve to enslave their minds more, suggesting that they are not yet psychologically redeemed” (Keteyi, 1998). Equally “futile is for indigenous ways of behaving to be transcended”, such as “avoiding meaningful conversations” about ‘Afrikanerdom’ or ‘Africanness’ due to political sensitivity in the aftermath of Apartheid (De Gruchy, 1995; Villa-Vicencio, 1992, in Keteyi, 1998).

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<sup>9</sup> I have included the terms ‘Black’ as this is the term used in the literary works that I have described. The term ‘Black’ has traditionally and politically been used in South African to refer to the population group of people who speak an African language and who are of African origin and culture. Elsewhere in the current study I have felt it more sensitive to refer to the population group under study as ‘people of African/Zulu culture and origin’. The term ‘Whites’ is also referred to in this chapter and denotes people of European origin and culture.

Therefore, what is being advocated in literature is that the practice of indigenous psychology should take into account traditional beliefs, not only as anecdotal descriptions but in how they affect people in their everyday lives and in how they can be integrated into lifestyle influences and psychological processes from other parts of the world. Literature suggests that psychologists from another culture to the indigenous environment in which they are working will be challenged to be aware of similarities and differences between themselves and their clients, and should be encouraged to immerse themselves in the indigenous culture of the client.

#### **2.4.2 CONCEPTUALIZING TRAUMA, TRAUMA THERAPY AND INTERVENTION IN INDIGENOUS CONTEXTS**

As the current study explores an African indigenous form of therapy and its usefulness for children living with HIV and affected by HIV/AIDS, and who are considered to be suffering some form of trauma, I examined forms of therapy for traumatized children and adults in a variety of national and cultural settings, and then narrowed my focus to include forms of trauma therapy in indigenous settings in South Africa.

##### **2.4.2.1 Literature from non-African countries**

It appears that certain generalizations have been made about the effects of trauma in adults' and children's lives and the type of therapy they accordingly need. What is generally emphasized is that childhood experiences increasingly contribute to the trajectory of vulnerabilities in adult life, setting up cycles of traumatisation, victimization, further traumatic events and perpetuation of trauma in generations thereafter (Danieli, 2007; Raphael, Delaney & Bonner, 2007). The conspiracy of silence that most often follows trauma due to the society's, the family's and the individual's inability to integrate the trauma into their lives leads to subjects finding it difficult to narrate the trauma story and create meaningful dialogue around it (Danieli, 2007). This avoidance of discussing the traumatic experience may negatively affect physical health and may have a greater deleterious effect than a lack of social support (Danieli, 2007). Children whose primary caregiver, in particular the mother, had been taken away as a child, are twice as likely to suffer high levels of clinically significant emotional and behavioural problems, learning disorders, and alcohol and drug problems than children with primary caregivers in their lives (Raphael, Delaney & Bonner, 2007; Ardington & Leibbrandt, 2010).

Humans have an inherent need to make sense of their experience, especially when this involves suffering and illness (Smith, Lin & Mendoza, 1993, in Wilson & So-kum Tang, 2007). However, helping people in distress involves verbal therapies that have limitations for patients in indigenous settings; hence, integrating traditional healing practices into therapeutic models might play a vital role in determining whether a particular explanation and associated treatment plan makes sense to a patient (Moodley & West, 2005; Smith, Lin & Mendoza, 1993, in Wilson & So-kum Tang, 2007). Westerners often wade into crisis situations assuming that their diagnoses such as post-traumatic stress disorder (PTSD) and other cognitive forms of psychotherapy are recommended, whereas cultural practices might be more effective, less disruptive and more affordable (Shah, 2007, in Wilson & So-kum Tang, 2007). As mentioned before, there is not even a term for depression in some cultures, and in Lesotho for example, individual counselling is considered an alien concept (Gilbert, 2006). Somatic symptoms after trauma can be regarded as a more acceptable way of expressing stress as some non-Western societies do not ascribe to the dualism of body versus mind and the medical model of Western societies (Renner, Saleml & Ottomeyer, 2007, in Wilson & So-kum Tang, 2007).

What is evident and of relevance for this study is that culture influences or defines youths' characteristic reactions, methods of expressing reaction, and therapeutic needs following traumatic experiences (Nader, 2003, in Wilson & So-kum Tang, 2007). This fact has not always been borne in mind when assessing youth in cultural settings in that the impact of trauma and acculturative stress on 'core adaptation systems' such as safety/security, attachment/bonds/relationships, identity/role, existential meaning, and justice, are not delineated by Western societies (Silove, 1999; Dana, 2007, in Wilson & So-kum Tang, 2007).

To encourage a more proactive discernment when taking Western psychological methods into non-Western, indigenous populations, it has been pointed out that the preservation of culturally embedded and alternative healing practices would facilitate resilience, personal growth and "self-transcendence" in the wake of trauma (Wilson & So-kum Tang, 2007). An emphasis has also been placed on combining the modern, such as psychotherapy, with traditional ceremonies, in order to integrate rupture, discontinuity and disorientation by recognizing the role of family values, traditions, memories and early attachments (in particular with mothers and where mothers, who are the messengers of family values, have died). Therefore, it is important to study the sources of resilience and vitality not only within

the traumatized individual but within his or her community (Ebersöhn & Eloff, 2006; Ebersöhn & Maree, 2006; Danieli, 2007). In other words, it is the strength of the indigenous people themselves that will be essential for healing (Raphael, Delaney & Bonner, 2007, in Wilson & So-kum Tang, 2007), This would prevent dependency and victim situations amongst the people the practitioners are attempting to help (Shah, 2007, in Wilson & So-kum Tang, 2007).

It can be seen from the opinions expressed above that trauma therapy in indigenous settings emphasizes the recognition of intrinsic qualities within the child, such as resilience, as well as a recognition of culturally embedded strengths, such as traditional healing beliefs. Different ways of viewing trauma between non-Western and Western societies were described, and the integration of traditional and modern therapies was also called for.

#### **2.4.2.2 Literature in the South African context**

Literature on trauma in the South African context reflects the above concerns but encompasses certain features unique to South Africa. The literature appears to indicate that indigenous populations in South Africa suffer an inordinate amount of trauma, in particular from violence, poverty and marginalization, and that there are distinct cultural and contextual differences in trauma symptoms.

The studies mentioned in this section show the importance of contextual realities in reactions to trauma. They also indicate how different contextual factors have different effects on different population groups. Black South African children from particularly high-violence areas showed more distress than White<sup>10</sup> suburban children, although many White South African children also appeared stressed (Rudenberg, 1995). Black rural primary school children consistently achieved the highest anxiety scores, followed by Coloureds, Indians and Whites (Snyman, 1998). Mother ratings of their six-year-old children residing in Black communities confirmed community dangers such as poverty and violence as risk factors for anxiety, depression, aggression and low affability in children (Barbarin & Richter, 2001). These results, however, were contested by Jansen van Rensburg (2001), who found that Black children from informal, poverty-stricken areas were most exposed to violence but that these children reported the lowest depression levels of all the race groups in South Africa compared to White children,

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<sup>10</sup> 'White' South African is a term that refers to people from South Africa who are of European descent and who do not regard themselves, or are not regarded as being part of another racial group, for example, as Coloured.

who reported the lowest exposure rate to violence but presented with the highest depression levels. However, another study found that Coloured and Black youths displayed higher scores than other population groups on a measure (SCARED<sup>11</sup>) investigating fear and anxiety symptoms in South African youths (Muris, Loxton, Neumann, du Plessis, King & Ollendick, 2006). Similarly, cultural contextual differences appear to affect responses to trauma, such as fear-producing stimuli, perceived parental rearing behaviours, inhibition and obedience, which served to increase levels of fear (Akande, 2000). Although post-traumatic stress disorder might be a Western diagnosis, it has been identified as being prevalent in South Africa, especially amongst Black adolescents, as a result of social conditions in communities disadvantaged by South Africa's post-Apartheid communal existence (Cowley, 1995).

In a sample of Black school children from the Natal Midlands, it was found that sexual abuse had resulted in self-rejection, low self-esteem and interpersonal relationships characterized by a sense of betrayal and withdrawal (Segoati, 1997). A study on Black youths, in the five-to-fifteen-year age range, in a hospital outpatient department, found that the most common symptoms were poor school performance and enuresis, and the most common stressors were family-related: parent conflict, substance abuse by the father, and physical or sexual abuse (Pillay & Moosa, 2000). Another in-hospital study on childhood-onset psychiatric disorders and the use of outpatient services by depressed and anxious children, found that Blacks were less likely than Whites to obtain treatment; the conclusion was that childhood depression in African children is underreported (Goldstein, Olfson, Wickramaratne & Wolk, 2006). Ethnicity was identified in one study as a factor in low resilience scores, with adolescents of Black ethnicity demonstrating significantly lower scores as compared to their White and Coloured counterparts (Jorgensen & Seedat, 2008).

This multifactor complexity of context and ethnicity in South Africa, as demonstrated by the aforementioned studies, indicates the discernment necessary when therapy is conducted on different population groups. Since therapeutic resources appear to be limited or absent in many of the environments of these studies, it seems essential to develop projects tailored to the needs of these traumatized communities (Cowley, 1995). Although some recommendations were made from the above studies as to at what level of society, such as government health departments and school environments, interventions should be aimed at, they appeared not to offer guidelines as to what forms of therapy were indicated to ameliorate the situations

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<sup>11</sup> Screen for Child Anxiety Related Emotional Disorders (SCARED), consisting of a 41-item self-report questionnaire.

described. What these studies appeared to emphasize, though, was that different cultural groups manifest with different psychological symptoms and, therefore, call for different contextually relevant interventions.

#### **2.4.2.3 HIV/AIDS and trauma in South Africa**

Although little has been written about indigenous psychological methods and HIV/AIDS, the resultant traumatic effects of the HIV/AIDS epidemic on South African children have been covered in literature. Studies indicate that children orphaned by AIDS are a particularly vulnerable group emotionally and behaviourally, although there are variable reports on exactly how children affected by HIV/AIDS respond and behave.

Studies on urban township children showed that children orphaned by AIDS are more likely to report symptoms of depression, peer relationship problems, post-traumatic stress, suicidal ideation, internalizing problems, delinquency and conduct problems than children orphaned by other causes, non-orphaned children and compared to Western norms (Cluver & Gardner, 2007). Another study on a similar cohort of children found that 73% of orphans scored above the cutoff for post-traumatic stress disorder, and participant orphans in general were more likely to view themselves as having no good friends, to have marked concentration difficulties, to report frequent somatic symptoms, and to have constant nightmares, but were less likely to display anger through loss of temper (Cluver & Gardner, 2006). In another study on maternal HIV infection in women of African origin and the affect on their children, children whose mothers were living with HIV did not indicate more psychosocial stressors than children with mothers who did not have HIV (Palin, 2007). It might appear from this, therefore, that the trauma experienced by children occurs after a mother living with HIV dies rather than when she is still with her children, but does not suggest that children of mothers living with HIV are *not* affected by their mother's diagnosis (Palin, 2007). South African children in general are exposed to many risks beyond maternal HIV infection, such as economic instability, maternal depression, lack of family social support, variable parent-child relationship, and conflict in the mother-co-caregiver relationship, and these variables need to be addressed by individual and family-level interventions (Cluver & Gardner, 2006, 2007; Palin, 2007; Ardington & Leibbrandt, 2010).

Many literary sources conceptualize healing for trauma and describe what appear to be universally-used forms of therapy that might be appropriate for South African children who are

traumatized and affected by HIV/AIDS. Herman (1992:133) describes recovery as the ‘empowerment of the survivor’. Herman (1992: 133) maintains that ‘advice, support, assistance, affection, and care’ may assist the survivor but taking control away from him/her prevents the individual from being the ‘arbiter of (his)/her own recovery’. Lewis (1999) describes how allowing children to talk, listening to children, labeling their feelings or allowing children to label their feelings enables a form of catharsis of their feelings in the aftermath of trauma. Lamwaker (2004) describes the power of storytelling in healing children orphaned and traumatized by war in northern Uganda. Botha and Dunn (2009) explain how Gestalt play therapy using a board game builds trust between the therapist and the child. Clay therapy, art therapy, eye movement desensitization reprocessing (EMDR), stress inoculation training within cognitive-behavioural therapy (Carson & Butcher, 1992) and hypnosis appear to be approaches to help children to overcome traumatic experience and post-traumatic stress syndrome.

In the African or South African context, perceptions concerning impurity, contamination, colours of medicines, ancestral involvement in illness and traditional ways of curing illness using herbs have been covered in literature (Ngubane, 1977; Buhrmann, 1984; Mutwa, 1998). Knowledge of these perceptions is available to psychological practitioners, but traditional methods of counselling and understanding individuals and families are often inaccessible to psychological practitioners from other cultures, or even to those from the same culture but who are not trained in these traditional ways. Furthermore, in comparison to the amount of literature describing how children are differentially traumatized according to population group and context in South Africa, there appears to be a gap describing the development and provision of indigenous forms of psychological healing interventions for children suffering the effects of HIV/AIDS in South Africa. Therefore, I have identified three studies that have appeared in more recent literature that have addressed psychological intervention methods for indigenous populations in South Africa, and that would be useful for children affected by HIV/AIDS.

### **2.4.3 METHODS OF PSYCHOLOGICAL ASSESSMENT AND THERAPY FOR SOUTH AFRICAN INDIGENOUS POPULATIONS**

As mentioned in the discussion of cultural psychology in Section 2.2, a one-dimensional, linear, cause-and-effect form of assessment, or an uncritical assumption and acceptance of the mind-body duality, does not appear to address or record all the intricacies of human involvement in families and societies. Foxcroft (2002:6) observes that “very few multicultural



tests have been developed in the African continent” and that “the majority of tests that are in use have been developed in a mono-cultural context, either in Africa but more likely in the United States, United Kingdom, or Europe”. In conducting assessments, researchers and psychologists have found that there are differences in the way that cultures understand and use rating scales (Furnham, Ndlovu & Mkhize, 2009). A form of “yeah saying” from African participants and a tendency to agree rather than disagree with statements has the potential to result in “artificial results” (Furnham, Ndlovu & Mkhize, 2009). Certain South African researchers have therefore proposed more suitable forms of psychological approaches for South African indigenous contexts.

#### **2.4.3.1 Story-telling and Dynamic Assessment (DA)**

Story-telling has been a form of history transmission over the ages in Africa (Mutwa, 1998; Hayes, 2000). The creative ways in which children give “narrative form to their lives rather than formal discussion of their wishes or intrapsychic conflicts” has been noted (Matthews & Bouwer, 2009:231). Through story-telling, children’s “perception of their reality finds more complete representation than direct statement” (Sunderland, 2004, in Matthews & Bouwer 2009:231). Child soldiers traumatized by war in Uganda created a new meaning out of their trauma through telling stories, thereby healing themselves (Lamwaka, 2004).

Capitalizing on story-telling as a culturally embedded form of expression by people of African origin and culture, and in answer to psychologists’ dissatisfaction with self-report pen-and-paper questionnaires on psychological functioning (Cramer, 2004, in Matthews & Bouwer, 2009), a different form of assessment called Dynamic Assessment has been used as a way to engage participants and induce participants to reveal their authentic realities. Dynamic Assessment involves a process called ‘mediation’, which entails further questioning and prompting on what participants are saying beyond what standardized tests normally indicate (Matthews & Bouwer, 2009). A study using Dynamic Assessment principles in adapting the Rorschach Comprehensive System to an indigenous cohort of children found that deviation from more conventional methods of questioning revealed more authentic data, and deeper and richer culturally relevant data (Moletsane, 2004). Dynamic Assessment facilitates more valid results as it raises possibilities for unlocking the projective potential residing within young clients (potential that may remain untapped if the clients are assessed in a conventional manner). Probing deeper into the stories and descriptions that are offered by the client in response to picture cards used in projective tests enables psychologists to be sensitive to the

socio-cultural background influences on the test responses (Murphy & Maree, 2006, in Matthews & Bouwer, 2009).

Success with the Dynamic Assessment model is part of a movement to develop more culturally sensitive forms of assessment and therapy that appear to be becoming institutionalized in the field of psychology. The South African professional board of psychology, the Health Professions Council of South Africa (HPCSA), is urging psychologists to “address the development and adaptation of culturally appropriate measures as a matter of great urgency” as policy makers are questioning the limited empirical certainty about validity and cultural appropriateness of tests used in South Africa and the lack of empirical research into test bias (HPCSA, 2005, in Matthews & Bouwer, 2009).

With these challenges and goals in mind, two South African studies by Kekae-Moletsane (2008) and Odendaal (2010) appear to be pertinent in the literature on indigenous psychology, and of particular importance to the current study, where the prime focus is on indigenous therapy for traumatized children of African origin and culture.

#### **2.4.3.2 Masekitlana, an indigenous form of narrative therapy**

Kekae-Moletsane (2008) proved that although narrative therapy is a universal form of therapy for children (Wilson & So-kum Tang, 2007), she could adopt the ‘emic’ approach of taking an ancient but still existing indigenous game involving narrative and use it to create a form of indigenous therapy for traumatized children of African origin. In a journal article based on her study, she explored and described the effectiveness of this indigenous form of psychology, Masekitlana, as a therapeutic tool of healing for a three-year-old Sotho child who had witnessed the killing of his mother. This form of therapy with children, whereby they express themselves through the medium of stone therapy, may appear anecdotal and might be interpreted as simply taking them back to their African roots, but the intention of researching it is to ascertain whether it makes a difference in people’s lives, thereby developing a culturally relevant and ultimately a standardized form of therapy (Kekae-Moletsane, 2008).

Literature on child play presents some pertinent points of relevance for play therapy. Play touches a special part within the child as it is “characterized by the presence of joy and the absence of purpose” (McCune, 1998). However, its purposelessness might be disputed in that “at every age some needs of the child are fulfilled through play” (Vygotsky, 1978, in

McCune, 1998:601). Play begins with a sense of mastery over the earliest motor activities of the very young child and continues to provide some form of psychological function throughout life (Piaget, 1962, in McCune, 1998). In the South African context, most children in African townships and rural areas from disadvantaged families have grown up without toys and so have improvised with materials such as sticks and stones, clay and sand; Masekitlana has been identified as one of these games (Kekae-Moletsane, 2008).

In the context of trauma, play performs an important function in children's lives. "Children have an unconscious internal knowledge of the necessary direction for healing" (Norton & Norton, 1997, in Kekae-Moletsane, 2008:371) and "when children are afraid to express their emotions, the safest way to protect their emotions is through play" (Kekae-Moletsane, 2008:371). Paradoxically though, in the face of a crisis in the family, a child is often deprived of the opportunity to play. This appears to be counterproductive, as "a child at play, in particular a traumatized child can communicate his or her emotional needs, which can then be intuitively received by an astute therapist" (Kekae-Moletsane, 2008:371). The value of play in the face of trauma was confirmed by a study on play with Black hospitalized children; the results demonstrated how the group of children who were exposed to play sessions tended to express fewer symptoms of anxiety on discharge than the group of children not given an opportunity to play (Poulter & Linge, 1991). Play clearly symbolizes aspects of the child's life and emotions and is of developmental value in that it assists small motor co-ordination, enables mastery of various skills and empowers the child in team contexts (Piaget, 1962, Vygotsky, 1978, in McCune, 1998). In the current study, the value of the symbolic aspect of Masekitlana, and its particular relevance for traditional African settings, will be explored.

In Kekae-Moletsane's (2008) study, a child related what was worrying him while he banged two stones together with a firmness or rhythmic intensity matching his emotional expression. "Through a feeling of familiarity with Masekitlana stone play therapy, he was able to gain a different perspective on the events of the past by re-experiencing them under less painful circumstances, and thereby resolving his emotional trauma" (Kekae-Moletsane, 2008:375). Healing took place over a period of successive sessions. In this way, Kekae-Moletsane (2008) had taken an African form of indigenous knowledge and therapy and had proven its potential affectivity for traumatized children of African origin and culture. As Kekae-Moletsane's (2008:375) states, "Masekitlana is an African asset that has been in existence for decades and needs to be preserved".

Kekae-Moletsane's (2008) work encouraged Odendaal (2010) to pursue further research into indigenous assessment methods using the tool of Masekitlana. Odendaal's research participant was a seven-year-old female Sotho child in an informal settlement in Mamelodi <sup>12</sup>. Odendaal's conclusions after completing the study were as follows:

“Masekitlana certainly has potential value in terms of psychological assessment. It is ideal for children from African origin and culture, because it has the potential to put them at ease and let them feel comfortable because it is a medium that is familiar to them and they can relate to it. Furthermore the value of Masekitlana lies in the authentic image that a psychologist can obtain when he or she conducts an assessment with a child from African origin and culture. It elicits rich and detailed responses which might in many instances not be the case if Western media were administered. Studies have found pretend play and coping to be positively related” (Christiano & Russ, 1996; Russ et al., 1999; Goldstein & Russ, 2000–2001, in Pearson, Russ & Spannagel, 2008). “Masekitlana can be viewed as pretend play because the participant is pretending that the stones are different people and/or objects which interact. By playing Masekitlana the participant manages to cope apart from poverty, hardship and a lack of basic needs. Therefore Masekitlana as a projection medium is valuable in terms of the participant's coping style. Through Masekitlana the participant is able to verbalise and play out her feelings and thoughts” (Odendaal, 2010:74).

Both of the above studies therefore contributed to the body of literary knowledge that advocates the development of an *empirical* form of indigenous psychology to be developed out of indigenous knowledge systems, cultural traditions, codes of behaviour and beliefs. Kekae-Moletsane (2008) and Odendaal (2010) have identified and begun to fill a gap in psychological practice and literature that I propose could be further addressed by taking Masekitlana into the context of traumatized children of Zulu culture and origin affected by HIV/AIDS.

## 2.5 CONCLUSION

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<sup>12</sup> Mamelodi, part of the City of Tshwane Metropolitan Municipality, is a township set up by the former apartheid government northeast of Pretoria, Gauteng, South Africa. Since 2001, Mamelodi has had a large AIDS outreach programme helping several thousand orphans in the community.

Researchers and practitioners in the field of psychology have over the years realized the necessity to recognize indigenous knowledge when examining perceptions, behavioural styles and ways of relating in indigenous cultures. Literature has confirmed how it became obvious that forms of psychology created in Western societies were not entirely relevant when applied to non-Western cultures. There seems to be general agreement on this statement. What is more difficult to quantify or describe are the ways in which psychologists can develop therapeutic approaches and practices suitable for indigenous cultures. Indigenization in psychology (that is, the creation of psychological forms out of indigenous knowledge and beliefs) is a process that has been occurring worldwide. However, there appear to be many opinions on how this should be done. Approaches have ranged from focusing first on how the indigenous population under examination thinks, behaves, believes and conducts forms of psychological acts, to how universal forms of psychology might be applied to the indigenous population, with various levels of integration in between. The question is whether researchers can ever be categorical when adopting different foci, as few people are confined solely by the norms and mores of their culture. In most parts of the world, people might have their origin in one culture but grow up in a mixture of various cultures. This is particularly prevalent in the present global world, where international travel is commonplace and there occurs a natural infusion of ideas and values between different cultures and countries. It is debatable whether this has been caused by globalization or by the fact that even though human beings as a whole may speak different languages and look different, they are simply not that dissimilar, and show more intra-cultural differences than inter-cultural differences.

This chapter has examined various references in the literature concerning the relevance of and creation of indigenous psychological methods and perceptions. It introduced previous research on Masekitlana as a form of indigenous knowledge that might contribute to the field of indigenous knowledge, therapy and assessment. The next chapter describes the methodological process of researching the effects of this form of therapy on children affected by HIV/AIDS.

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## CHAPTER 3

### THE RESEARCH PROCESS: DESIGN AND METHODOLOGY

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#### 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  |
|---|---|
| <b>Control group evaluation</b>   |   |
| <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> | <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> |



### Convenience and Usefulness of Design in Everyday Practice and Evaluation

- 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.
- 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.

### 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:

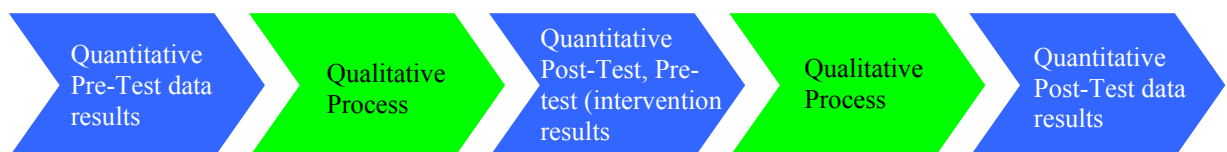
- The qualitative focus enabled the use of *induction*. I was able to search for patterns or trends arising out of participant narratives.
- The quantitative focus enabled *deduction and hypothesis testing*. From the quantitative results I was able to deduce intervention consequences on participants, 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.

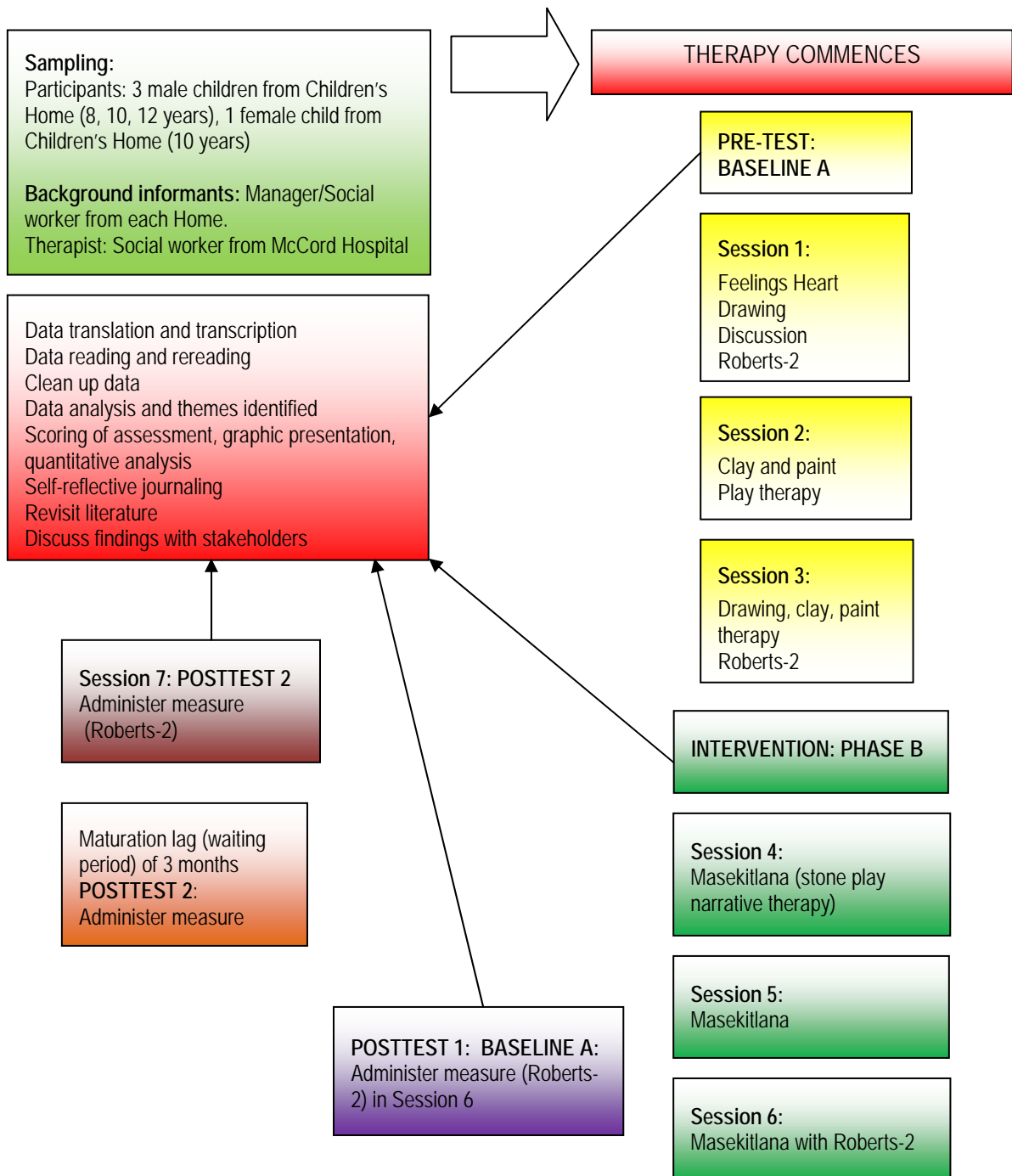
Crystallization also incorporates the use of other disciplines to inform the research process. In addition to consulting the theoretical principles and research findings of educationalists, psychologists, sociologists, and social anthropologists, I was particularly interested in the

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, measureable 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**

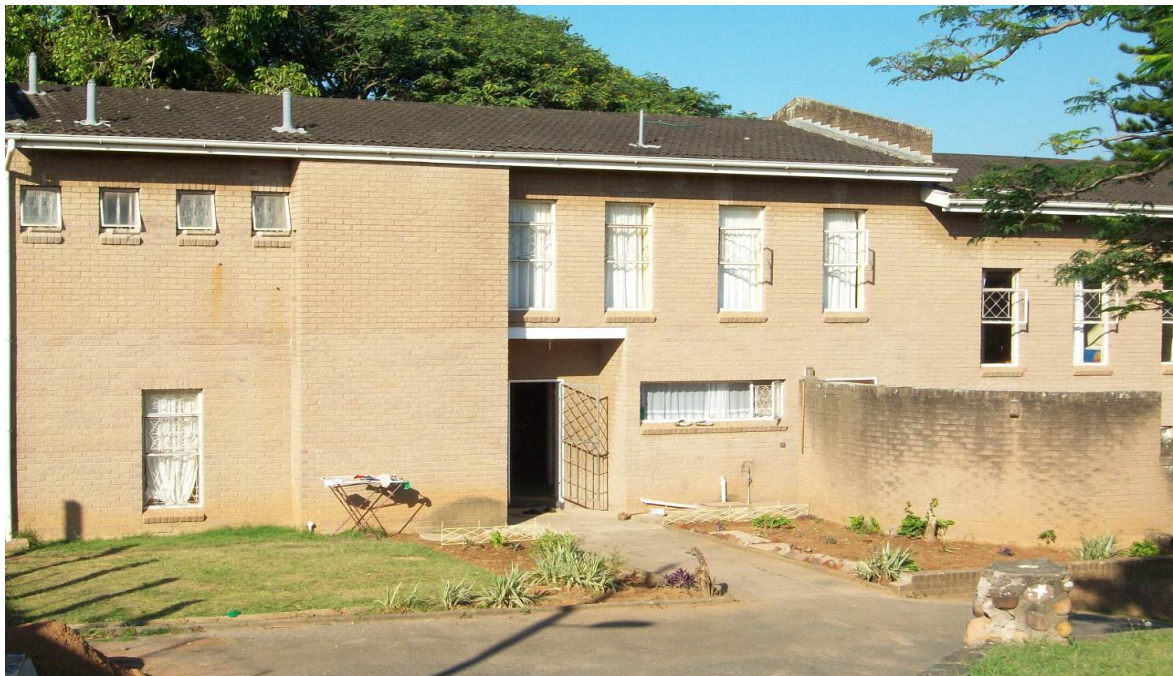
### 3.5 RESEARCH SITES

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 Coloured<sup>13</sup> 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.

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<sup>13</sup> 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: Hlonipho<sup>14</sup>**

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

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<sup>14</sup> 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 Lasich<sup>15</sup>, 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.

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<sup>15</sup> 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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## CHAPTER 4

### QUALITATIVE DATA ANALYSIS

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#### 4.1 INTRODUCTION

In this chapter, I describe the qualitative analysis of the data, including the practical steps involved in the analysis. A quantitative analysis of the data follows in Chapter 5. In the qualitative phase, I analyzed the data into generative themes, which will be described individually. I describe how the themes overlap. I link the findings to the literary body of indigenous psychology in Chapter 6. Evaluating whether and how the data illuminated and answered the research sub-questions will be considered in Chapter 7, where the primary question of this study will also be answered.

#### 4.2 INTERPRETIVE PARADIGM

Analysis of the data of the current study was guided by an interpretive paradigm by means of which I aimed to view the narrative against the context in which it was set and the subjective viewpoints of the participants. Participants of research have ‘working theories’ of their conduct and experiences which are based on ‘local knowledge’, which form part of the oral and written cultural texts of the group that they form part of, and which matter to them and give meaning to their problematic experiences (Geertz, 1983; Denzin, 1989:109). In exploring these local theories of interpretation, the conceptual structures that inform participants’ actions (and narratives) will be uncovered (Denzin, 1989:110). As the theoretical framework was indigenous psychology, I found an interpretive framework appropriate for the current study as it enabled me to explore participants’ perceptions in the context of their indigenous/cultural environments and through the lens of their cultural beliefs and values. I attempted to be sensitive to what *they* felt and said was important to them, to *their* ‘working theories’ and to *their* attributions of meanings. In analyzing and interpreting the text, I also strove to be aware of my own cultural biases, ‘local knowledge’ and conceptual structures. Continual self-reflection and reflexivity on the analytical process and the obligation to observe my own processes helped me in the illumination and reformulation of data (Patton, 2002, in de Vos et al., 2005). Self-reflection was aided by writing in a personal journal after each session and reflecting on the process with the therapist and social workers of the Homes. My concerns that arose out of my own reflection processes are described in Chapter 6.

### 4.3 DATA ANALYSIS PROCESS

In analyzing the data, part of the process implied my understanding how I was actually to make sense of the data. This entailed a form of ‘engagement’ with the data, which meant risking my everyday stance, attitudes or knowledge in order to acknowledge the ‘liminal’ experience of living between familiarity and strangeness (Kerdeman, 1998, in Denzin & Lincoln, 2000). As such my feelings ranged between a feeling of familiarity with the participants’ attributions of meaning in their lives and a feeling that I could not identify personally with what they could be feeling or describing. Knowing that I would encounter this ‘liminal’ experience encouraged me to explore the data with a sense of flexibility and open-mindedness, improvisation and creativity as well as planning and adherence to steps and rules (Janesick, 1998, in Denzin & Lincoln, 2000).

Analysis transforms data into findings by bringing order, structure and meaning to the mass of collected data (Patton, 2002, in de Vos et al., 2005). The analytical process “does not proceed tidily or in a linear fashion but is more of a spiral process; it entails reducing the volume of the information, sorting out significant from irrelevant facts, identifying patterns and trends, and constructing a framework for communicating the essence of what was revealed by the data” (de Vos et al., 2005:333).

There is an “inseparable relationship between data collection and data analysis, and this is one of the major features that distinguish qualitative research from traditional research” (de Vos et al., 2005:335). Accordingly, as the data was being transcribed and translated, I found myself identifying patterns of expressions that alerted me to be aware of similar or divergent themes as more data unfolded. Furthermore, “data analysis does not in itself provide answers to research questions as these are found by way of interpretation of the analyzed data” (Kruger, de Vos, Fouché & Venter, 2005:218). Interpretation involves explaining and making sense of the data (de Vos, 2005; Denzin, 1989). This again involves an ongoing engagement with the process, in that interpretation and analysis are closely intertwined as the researcher automatically interprets as he or she analyzes (Kruger et al., 2005). Hence, it was from this combined process of data collection and analysis that a “plausible and coherent” interpretation developed (de Vos, 2005:335).

#### 4.3.1 GENERATING THEMES: PARTICULARITIES, GENERALIZATIONS AND CONDENSATION

I read carefully through the transcripts to try to gain an overall understanding of each session. The importance of this stage lies in “immerse (in gone) self in the details, trying to get a sense of the interview as a whole before breaking it into parts” (Agar, 1980, in de Vos, 2005:337). In the data I identified trends or recurring patterns that reflected what the participants “felt most strongly about and what expressed the strongest emotional content which moved them and was typical of their common life” (Isazi-Diaz, 1993, in Johnson-Hill, 1998:33). Identifying “salient themes, recurring ideas or language, and patterns of belief that link the participants” is the “most intellectually challenging phase of data analysis and one that can integrate the entire endeavour” (de Vos, 2005:338). As therapy sessions progressed, I clustered recurring patterns and commonalities repeated by participants into generative themes.

A tension arises between preserving and representing each participant’s particular form of expression, whilst, at the same time, deriving broader meanings, interpretations and significances in the form of general themes common to all participants (Falmagne, 2006). This is because “the outcome of research cannot merely be a collection of *particularized* case histories” such as might be presented in discrete themes or discrete participant characteristics (Falmagne, 2006:171). Instead, Falmagne (2006:172) advocates “a notion of *generalization* that preserves the richly particularized, socially constituted nature of concrete individuals while enabling social interpretations that transcend the particular case”. This statement justifies the interpretive paradigm of the current study as far as theme generation is concerned and guided the interpretation process.

Generating themes with an awareness of participant *particularities* and *generalizations*, I found that the meaning expressed by one participant helped me to understand and make sense of what came next from another participant. This justified one of the goals of analysis, which is to “produce meaningful *condensations* that make it possible to gain from one participant an understanding that can enhance one’s understands of another participant as well” (Falmagne, 2006:181). Conversely, theme analysis also involved noticing how one participant’s expressions fitted into a chosen theme, while another might have indicated a divergence from the theme.

Individual theme content did not remain static throughout the therapeutic process. As therapy sessions progressed, I discussed the themes with the therapist, which gave her directives for encouraging change in participants' lives. The result was that the same patterns of expression generated in successive sessions often indicated a more positive slant as therapy progressed. This will be reflected in the quantitative data of Chapter 5.

To create order out of the different patterns and commonalities of participant expressions, I used a process of coding.

### **4.3.2 CODING OF THEMES**

I numbered each 'turn unit' of the transcribed participant narratives, that is, each change of narrative between the therapist and the participant. This enabled clearer presentation of data when the themes were described and supported by quotations in the final written thesis. I then followed the theme analysis process as described by Neuman (2000, in Nwanna, 2006) and Henning et al. (2004, in Nwanna, 2006).

#### **4.3.2.1 Open coding**

The first stage was *open coding*, which entailed reading and rereading the data in order to have an idea of how patterns could be clustered and coded. Open coding involves naming the identified patterns or categories of expression, breaking them down into discreet parts, closely examining them, comparing them for similarities and differences, and questioning the phenomena that are reflected in them (de Vos, 2005). In this study, I highlighted the clustered patterns or themes in yellow and then named each theme depending on its focus or subject matter and marked the name down in red in the text above the highlighted narrative. This naming process is called "conceptualizing the data" whereby the name stands for or represents a phenomenon (Strauss & Corbin, 1990, in de Vos et al., 2005). This is done by comparing utterances as the researcher goes along so that similar phenomena can be given the same name. Otherwise researchers would wind up with too many names that could result in confusion. The name given to each theme or category is the one that seems most logically related to the data it represents and is catchy enough to draw the researcher's or reader's attention to it (Strauss & Corbin, 1990, in de Vos et al., 2005).

#### **4.3.2.2 Axial coding**

Axial coding was then undertaken, which involved looking for links and connections between the themes so that related themes could be merged into clusters. De Vos (2005) calls this classifying or looking for categories of meaning and it involve searching for categories of meaning that have internal convergence and external divergence. De Vos (2005) qualifies this by explaining that the categories or themes should be internally consistent, but distinct from one another. In accordance to this, I clustered the highlighted themes in the different participants' narratives that were similar, and moved them to a new document.

Diverging instances of the identified patterns, trends and themes were noted from the narratives of the participants and they gave new meanings to my understandings of the text. They encouraged me to critically evaluate the “very patterns that seemed so apparent” (de Vos, 2005:339) and search for other, plausible and alternative explanations for the data.

#### **4.3.2.3 Selective coding**

Selective coding was the final process whereby all themes, from the document of the combined participant's themes, were divided into a selected number that comprised the final presentation. This involved “winnowing the data, and reducing it to a small, manageable set of themes to write into the final narrative” (de Vos, 2005:338). In the process, ‘families’ of themes were created with the sub-themes and categories being the ‘children’ and ‘grandchildren’ (de Vos, 2005).

As I conducted the above three processes I realized that the lines or boundaries between one type of coding and the next could be artificial (Corbin, 1990, in de Vos et al., 2005) and tended to be blurred at times as I constantly moved between the three methods. Furthermore, the different types of coding did not necessarily take place in sequence.

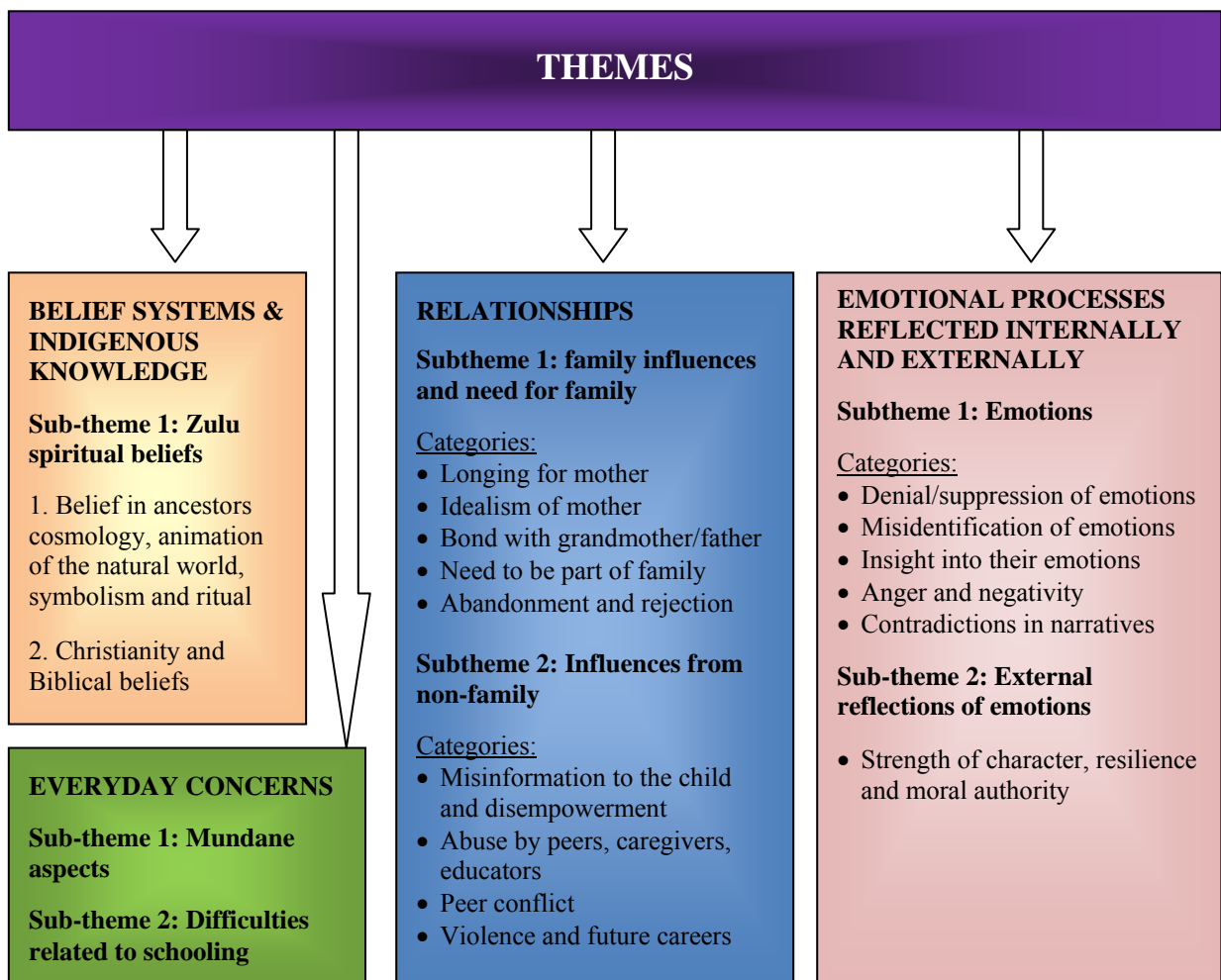
### **4.4 THEMES**

Four themes emerged from participant narratives:

- Participants' traditional beliefs
- Expressions of how the participants felt about and related to others in their lives
- The everyday concerns intrinsic to each participant
- Internal processes within participants' minds.



Themes will first be tabulated and then will be described. Within the tables I have indicated when a quotation was drawn from a Masekitlana session, as it can be seen how Masekitlana therapy encouraged talk on African belief systems as well as allowing for expression on other issues. It is not always possible to separate out themes, so in certain instances a description of one theme will make reference to the contents of another theme. Participants' lives could not be neatly demarcated into boxes, as I found that each facet of the participants' lives had an effect on other facets in a form of mutual influence and outcome. This overlapping of themes will also be explored.



**Figure 10: Themes and sub-themes**

#### **4.4.1 THEME 1: BELIEFS**

##### **4.4.1.1 Sub-theme 1: Cosmological, spiritual and ancestral beliefs, and symbolism**

**Inclusion criteria:**

Indigenous African beliefs of a spiritual nature

**Exclusion criteria:**

Beliefs of a universal Christian nature

The participants, in particular Hlonipho and Nana, expressed concepts in their narratives that reflected traditional African spiritual and cultural beliefs. Hlonipho, when playing Masekitlana, expressed an understanding of his mother's death that demonstrated a typically African form of belief in ancestor-influence on the living relatives. It also demonstrated the African way of interpreting signs from nature as being messages from the ancestors. The conversations between the therapist and Hlonipho over his mother's death indicated how dual levels of understanding of one situation could arise between Western thinking on the one hand and African thinking on the other. The therapist labelled the phenomenon of Hlonipho's mother seeing animals before she died as 'schizophrenia', whereas Hlonipho had an alternative understanding arising from his cultural and historically transmitted traditions. This illustrates that the researcher should be alert for cues that indicate "taken-for-granted meaning patterns of African peoples and how what they say relates to these patterns ... in order to try to catch something of the spirit of the people" (Geertz, 1973, in Johnson-Hill, 1998:34).

It is relevant for the purpose of this research that Hlonipho only related the full snake story during a Masekitlana session. He might have felt familiar with the typically African form of manipulating stones and it may have resonated with traditional African beliefs in the personalization of animals, the animation of natural objects, and the power these have to reveal ancestral spirits. Hence, he felt enabled at that session to reveal the snake story. Nana also related a story of bodily attack by a snake, demonstrating the symbolic significance of the snake in African culture. The ritual and symbolism of the stone play of Masekitlana might also have resonated with traditional African recitative rituals, and this, therefore, encouraged the participants to express themselves in traditionally African ways.

**Table 3: Excerpts on traditional Zulu beliefs**

| Unit/page/speaker/session                  | Quotation   |
|--|---|
| 358/18/Hlonipho/2                          | “She used to see things we couldn’t see....animals”.  |
| 658-672/34-35/Hlonipho/4 – Masekitlana     | “She used to say there was a snake that used to come in and sit on her bed ... I think it was alerting her that she needs to go back home ... It opened its mouth and it talked. I heard it on my ears ... I think it was alerting us that my mother needs to go quickly but we didn’t pay attention and my mother died”.   |
| 631/33/ Hlonipho/ 4 – Masekitlana          | “My mother was sick and she used to see animals. And I don’t know if that is what made her die”.  |
| 658/34/Hlonipho/4 – Masekitlana            | “My dad told us to leave it because maybe the ancestors were telling my mother that she needs to do Zulu rituals”.  |
| 5167/62/Nana/7 – Masekitlana               | “She had a bad dream. She dreamt about the snake, a big snake which has eight heads. The snake was eating her. The snake ate her and it only left the head. Then, another snake showed up and that snake had 50 heads. The snake swallowed her whole head in its mouth. This is the end of the story”.  |
| 3690-3693/8-9/ Nana/ 1                     | “Your neighbours can <i>thakathi</i> (bewitch) you ... They put some <i>muthi</i> on their food and then there was some horrible smell ... Another aunty she ate that food and then she asked for some more and then the person put another <i>muthi</i> again in that plate ... Then she says it is nice and the next day, she died ... My friend was also sick and they took her to the hospital and at the end of the day she died”. |
| 4179/33/Nana/4 – Masekitlana and Roberts-2 | “I am going with my stone. I want to suck it. When I go to bed ... the ghost comes this side and it also comes to the bed to sleep. Then my ghost goes to sleep. My ghost is very big. When it is not sleeping, it gets sent to go and hit that other person at night. When I say <i>ha</i> , it’s nice to sleep, it comes back. But if don’t say it, my ghost goes to sleep”.  |

#### 4.4.1.2 Sub-theme 2: Biblical beliefs

**Inclusion criteria:**

Beliefs of a Christian nature based on Biblical traditions

**Exclusion criteria:**

African non-Christian beliefs and beliefs in other religions

Hlonipho demonstrated how the African person can believe in the influence of the spirits of the ancestors whilst at the same time having a strong faith in Christianity and its effect on everyday life. In the first session of Masekitlana, Hlonipho appeared to have a form of

acceptance of the fact that a snake, embodying the spirits of his mother’s ancestors, had called her to her family home to die. In the second session of Masekitlana he narrated beliefs in God and his dislike of the Biblical serpent. He did not appear to notice the contradiction in this (Refer ‘contradictions in narratives’ Section 4.4.4.1, Table 19). In her first session of Masekitlana, Nana picked up the stones and started a theatrical form of Christian dialogue. It was in a ‘rap’ form of talking, as if she was an actor in front of an audience. At another session, she described her friendly or protective spirit in her life. She had also related an incident in her life of African bewitchment. Senzo appeared to have faith in a helping and rescuing God.

**Table 4: Excerpts on Biblical beliefs**

| Unit/page/speaker/session                          | Quotation  |
|--|--|
| <b>777 &amp; 779/41/Hlonipho/ 5 – Masekitlana</b>  | “I hate snakes”.<br>“Because it’s controlled by Satan. Like when it happened with Jesus Christ. The snake told Jesus to jump higher”.  |
| <b>798/42/Hlonipho/5 – Masekitlana</b>             | “So why can’t God stop Satan from causing people to do bad things?”  |
| <b>4753/49/Nana/6 – Masekitlana</b>                | “The girl asked the question that, ‘who was the creator of Jesus Christ?’ In response to that, he said, ‘It’s Maria’. Then she said, ‘Okay good’. Then she asked the question, ‘How were the people created?’ He said, ‘With soil’. Then, they clapped hands for him”.   |
| <b>4082/28/Nana/4 – Masekitlana and Roberts-2</b>  | “You know when you are quiet you are talking in your heart. It’s God who says speak with your heart. When you speak louder, it’s God who says talk. It’s God who tells me to speak this and this. Everybody on earth whether he us shouting loud, you don’t do it out of your own conscience. You say it because God tells you”. |
| <b>3060/77/Senzo/7 – Masekitlana and Roberts-2</b> | “Then you get sick, and then the Lord comes and says do you want to rest? You get sick then you walk down with the Lord. As you are walking the car smashes you then you die”.   |
| <b>3049/76/Senzo/7 – Masekitlana and Roberts-2</b> | “I say that I am cold then He picks me up”.  |
| <b>537/27/Hlonipho/3</b>                           | “It’s God’s spirit (who tells you to stop stealing)”.  |

#### 4.4.2 THEME 2: RELATIONSHIPS WITH OTHERS

##### 4.4.2.1 Sub-theme 1: Need for family

**Inclusion criteria:**

Relationships with family members and foster caregivers

**Exclusion criteria:**

Relationships with peers in Homes and schools and with caregivers in Homes

Throughout the participants' narratives, there were indications that the participants either placed a high value on their existing families or were longing for the love of a family. In particular, the participants talked a lot about their deceased or absent mothers, as not one of the participants was living with his mother.

- **Concerns around mother (sometimes father) and longing for mother**

The participants in the Children's Homes expressed the wish to experience the love of their mothers or they expressed regret that they had not experienced their mother's love. Hlonipho, in particular, mentioned his mother often and initially expressed anger over not being able to have her in his life (refer theme 'anger'). He was not able to be with his mother when she died, nor did he attend her funeral and the rituals surrounding that event. Often a participant would start talking about his absent or deceased mother or father and then would deny any sadness around this issue (refer theme of 'denial of emotions'). Senzo's mother had abandoned him to the care of his father's mother. Yet he still expressed a need to communicate to his mother his love for her. Mandla related how his mother was picked up by car by his grandmother to spend the weekend with the family but during Saturday night, she disappeared again. Nana was negative in her descriptions of a mother, as indicated in her picture stories. However, an expressed "negative contrast experience" might be a demonstration of the fact that she was aware that matters could be different and more ideal (Johnson-Hill, 1998). I felt that she was indirectly communicating that she would prefer a more nurturing mother. In effect what the participants were dealing with was the "trauma of the family unit dissolving" and in Hlonipho and Senzo's cases, "the stigma of AIDS associated to parental death" (Foster, Makufa, Drew & Kravolec, 1997). The death or disappearance of the participants' parent or parents had resulted in a "severe decrease in the

family’s economic power” (Foster et al., 1997) or ability to keep the participants safe, so they were placed in Children’s Homes.

**Table 5: Excerpts on concerns around and longing for mother and father**

| Unit/page/speaker/session                                    | Quotation   |
|--|---|
| 80 & 82/6/Hlonipho/1   | “He is writing he is angry. I think he is writing about his mother”.  |
| 237/13/Hlonipho/2  | “My mother loved me”.   |
| 572 & 574/30/Hlonipho/3                                      | “This one is dreaming bad things. He is dreaming about his mother”.   |
| 3024,3026, 3030 & 3034/80/Senzo/7— Masekitlana and Roberts-2 | “ (I would say) that I love her ... She would say that I love you too ... She didn’t say it ... Nobody (else says I love you)”. |
| 5178/64/Nana/7 – Masekitlana and Roberts-2                   | “Her mother was always scolding at the child even if the child has not done anything”.  |

- **Idealism of mother (sometimes father)**

The social worker of the children’s home where the three male participants stayed informed me that the boys would not countenance negative comments from her regarding their mothers as they held onto “utopian stories” (Balcomb, 2000) around the ‘perfect mother’. She was of the opinion that, although their beliefs were inaccurate at times, it enabled a form of wish fulfilment and a fantasy world ideology that gave the participants some form of psychological sustenance. I questioned whether it was not linked to the huge reverence that African people hold for the mother figure. Participants also resisted describing how their mothers looked or behaved when they were sick. Hlonipho mostly expressed positive, albeit sparse, aspects about his relationship with his mother, although she left him in a hospital when he was sick and returned to her family home. He remained in the hospital for a year, during which time his mother died. Nana only once described how her mother had dumped her in the rain at her grandmother’s door and had run away from the family. She expressed no further regret in connection with her mother. Senzo’s description of a mother being “health-filled” was the closest he would come to admitting that his mother had died (refer ‘denial of feelings’ theme). Mandla’s mother threw him away into a bush but the most he would say against her was that he felt “bad” about it; otherwise he remained neutral towards her presence in his life.

**Table 6: Excerpts on idealism of mother**

| Unit/page/speaker/session                     | Quotation   |
|---|---|
| 238/13/Hlonipho/2                             | “I don’t remember (if there were things that his mother used to do to show him she loved him)”.                                     |
| 933/49/Hlonipho/6 – Masekitlana and Roberts-2 | “It is my mother (who is the most important person in his life even though she was no longer around).”                              |
| 1669/5/Senzo/ 2                               | “His mother is health-filled” (in response to picture of mother hugging boy).   |
| 5508 & 5510/15/Senzo/5 – Masekitlana          | “She calls my phone on her cell phone that’s all (she does for him)”.<br>“No” (there is nothing he wants to change about his life). |

- **Abandonment and rejection**

The above section explained how participants appeared to idealize their mothers. However, at other times (refer ‘contradictions in narratives’) they expressed feelings of being rejected by their parents, families and foster caregivers, which led them to feel let down by the adult world. Hlonipho appeared to reject his father as a method of coping with how his father had apparently rejected him. Furthermore, he was not emotionally prepared for the death of his mother and experienced it as a form of abandonment. Similarly Senzo, Mandla and Nana all related incidents of being rejected by their mothers.

**Table 7: Excerpts on abandonment and rejection**

| Unit/page/speaker/session                            | Quotation  |
|--|--|
| 210/12/Hlonipho/2                                    | “I don’t know where he (the priest who took him in) went. The last time he said he is coming to fetch me but he didn’t arrive”.  |
| 421 & 423/22/Hlonipho/3                              | “They (priest and wife) didn’t come to fetch me ... It hurt me”.   |
| 945 & 947/50/Hlonipho/ 6 – Masekitlana and Roberts-2 | “No” (his father does not fit in anywhere because) ... He didn’t give birth to me”.  |
| 72 & 74/51/Hlonipho/6 – Masekitlana and Roberts-2    | (He was expecting his mother to pass away) “ <i>after</i> I passed away.....She wasn’t supposed to get sick”.  |
| 614/32/Hlonipho/4 – Masekitlana                      | “... my father told me that my mother is gone. Then he asked me to go to the priest because my mother was gone. I went there; when I came back my father was not there.” |
| 5466 & 5468/13/Mandla/5 – Masekitlana                | “I feel sad ... Because my mother threw me in the bush. Then someone picked me up”.  |

|                                 |  |
|---------------------------------|--|
| <b>3656 &amp; 3658/6/Nana/1</b> | “My mother put me out of the door of granny in the rain and my granny was there and I was crying and granny just picked me up ... Mother did not like me.” |
| <b>85 &amp; 87/24/Mandla/3</b>  | “Long time ago ... yes, years ago” (in answer to when he last saw his father).   |

Often, because of rejection by their parents, the participants expressed feeling a closer bond to their grandparents, especially their grandmothers.

- **Bond with grandmother or grandfather as substitution for parents**

Due to participants not having their immediate parents in their lives, the grandparents, especially the grandmothers, had taken over the roles of parental nurture, love and guidance. Hlonipho, at the time of the current study, had no contact with any family members yet he wanted to write a letter to his grandmother firstly (and secondly to his deceased mother). Both Senzo and Nana had replaced their mothers with their grandmothers as their primary caregivers. Senzo visited his grandmother’s sister, in the school holidays, although he referred to her as his “gogo/grandmother” and at times, his “ma/mother”. This was perhaps a way of saying that he felt he had now accepted that the mother figure in life was this “grandmother”.

**Table 8: Excerpts on bonding with grandmother**

| <b>Unit/page/speaker/session</b>                             | <b>Quotation</b>  |
|--|---|
| <b>5015 &amp; 5019/56/Nana/6 – Masekitlana and Roberts-2</b> | “I want to work for my granny ... I want to do everything that she wants”.  |
| <b>376 &amp; 3764/Nana/1 – Roberts-2</b>                     | “I miss home ... I miss my grandmother”.  |
| <b>3116/Senzo/3 – Roberts-2</b>                              | “So you say hello granny, how are you then that’s it ... Then I tell her I love her”.   |
| <b>1833/13/Senzo/2</b>                                       | “I will buy a house that my grandmother and I can stay in”  |
| <b>1714-18/7/Senzo/2</b>                                     | “She was a mother and she wasn’t a grandmother then she grew up and she became a grandmother ... Yes (when asked if he knows his mother) ... It’s my grandmother. She is now my grandmother ... Yes (when asked if she looks after him well) ... No (when asked if his mother looks after him well)”. |
| <b>1087/60/Hlonipho/4 – Masekitlana and Roberts-2</b>        | “I can write to my grandmother”.  |
| <b>5389 &amp; 5391/10/Senzo/5 – Masekitlana</b>              | “My granny and my other granny (in answer to who he loves most) ... my mother does not love me”.  |



- **Need to be part of their families out of the children’s home**

All four participants wished to leave the environment of the children’s home and return to their family homes or to the home of a foster parent.

**Table 9: Excerpts on the need to be part of own family out of the home**

| Unit/page/speaker/session                                    | Quotation  |
|--|--|
| <b>2701, 2703 &amp; 2705/60/Senzo/5 – Masekitlana</b>        | “Yes, I want to go ... Home ... I don’t like it (here at the children’s home) ... Yes, and not come back ... And stay at home”.  |
| <b>4812 &amp; 4814/51/Nana/6 – Masekitlana and Roberts-2</b> | “It’s been 2008, 2009, 2010 and 2012. Oh my God, there is no way. I am tired of this place. I don’t want to stay here anymore. It’s boring me ... They don’t treat me right. They are offending me”. |
| <b>1903/16/Senzo/3</b>                                       | “I was crying and I didn’t want to come back (to the Home). My foster parents gave me twenty Rand and they said I must stop crying”.   |

#### 4.4.2.2 Sub-theme 2: Influence of non-family members on participants in Children’s Homes and home environments

**Inclusion criteria:**

Influences from peers, caregivers, social workers and managers in Homes, influences from effects of participants’ home/family environments

**Exclusion criteria:**

Influences from family members and school authorities

Participants had been removed from their original homes and so were subjected to influences out of their homes that they would not otherwise have had to suffer.

- **Misinformation to participants leading to disempowerment of participants**

Participants often expressed a lack of knowledge about their past and what had led up to their being admitted into the Children’s Homes. Furthermore, children’s home authorities appeared not to tell them exactly when they were going home and when their school holidays were to begin and end. The most serious lack of information experienced by a participant was Hlonipho, who was not told how and when his mother and father had died. This lack of

information tended to lead to a sense of helplessness, hopelessness and confusion in participants as to their future and to their own ability to make decisions about their lives. It also resulted in Hlonipho still pondering, at the time of the current study, about the deaths of his parents, a few years prior to that, and not being able to reach any form of closure. He expressed a great amount of anger, which could be reflective of having no family member in his life that he could visit or who enquired about him. From his narrative, I gave Hlonipho the description of being ‘a child without a past’.

At one stage of the research and therapy process, I was not able to visit Hlonipho for three weeks due to the therapist’s family problems. The Home authorities did not inform Hlonipho of this and the result was that he appeared surly and uncooperative at the subsequent session. Similarly, Senzo and Mandla often appeared restless as they did not know if and when they were going home. They also appeared downhearted in sessions after the holidays as they had not been prepared or told in their family homes when they were going to be fetched to return to the children’s home. They had also developed their own ideas as to why they were originally admitted into the Children’s Homes. The social worker’s explanation to me for participants’ coming to the Home appeared different from the stories told by the participants. In Mandla’s case, his mother had abandoned him yet he believed that he came to the Home because he was “naughty”.

**Table 10: Excerpts on lack of information leading to disempowerment**

| Unit/page/speaker/session       | Quotation  |
|---------------------------------|--|
| 352, 363/19/Hlonipho/2          | “I don’t know, she (mother) didn’t tell us (where her family home was) ... There is nobody from my mother’s family that I know ... I don’t know anyone (relative) ... I only heard after she (mother) was buried”. |
| 615/33-4/Hlonipho/3             | “Then I went to the priest ... because my mother was gone ... when I came back my father was not there”.   |
| 100/7/Hlonipho/1                | “When I came out of hospital looking for my father, they told me my father died”.  |
| 2006, 2054 & 2068/21,23/Senzo/3 | “I was playing, playing and playing then the car (to fetch him back to the Home) came then I went ... I don’t know (why he had to come back to the Home) ... The social worker said I must go”.                    |
| 420, 422, 430/23/Hlonipho/3     | “They didn’t tell me when I am coming back ... I am not sure if they will come and fetch me ... They didn’t come to fetch me ... It hurt me ... He (caregiver) didn’t tell me (why they did not fetch him)”.       |

|                                       |   |
|---------------------------------------|---|
| <b>2739/62/Senzo/5 – Masekitlana</b>  | “I was young, I don’t know (why he came to the Home)”.                |
| <b>5452/13/Mandla/5 – Masekitlana</b> | “Because I am naughty (in answer to why he had to come to the Home)”. |

- **Abuse, peer conflict and fighting**

Participants had been removed from environments that were considered to be unsafe. However, in their alternate environments, that is, foster care, Children’s Homes and schools, they appeared to experience further forms of violence in the form of abuse by foster caregivers or physical and psychological hurts at the hands of their peers and teachers. Hlonipho was taken away from the care of his father as he was sexually molested in that environment. He was then put in the care of a priest, where not only were Hlonipho’s physical hygiene and nutritional needs neglected, but the priest’s wife reportedly hit Hlonipho for supposedly “wandering the streets of the location”.

A lot of participants’ expressed anger was in relation to conflict and physical fighting incidents. Participants bemoaned the fact that they often did not start the fighting between them and their peers but felt they were blamed for it. By the end of Masekitlana therapy, Hlonipho described how he prevented his friends from fighting. Although Mandla appeared not to like the fighting in the Home, he explained that he came from an area where he had witnessed many knife fights. Hence, he explained how he enjoyed fighting with knives. Nana had been raped in the environment of her grandmother’s home. During the course of the research, Nana was called out of a therapy session by another child in the Home on the pretext that Nana was to collect her laundry off the line. While Nana was out of the room, the girls hit her on her back. She returned crying. That evening, Nana ran away from the Home and was helped by a lady in the street to return by taxi to her grandmother’s house. Hence, each participant had been exposed to some form of violence.

**Table 11: Excerpts on abuse and fighting in the Homes**

| Unit/page/speaker/session              | Quotation  |
|--|--|
| <b>106, 108 &amp; 110/7/Hlonipho/1</b> | “He (the priest) used to ill treat me ... He liked hitting me ... With a stick ... He said I went around the location even if I didn’t”. |
| <b>63/4/Hlonipho/1</b>                 | “People get hurt when they are fighting then it becomes me who has done something wrong”.  |

|  |  |
|--|--|
| <b>101-3/55/Hlonipho/6 – Masekitlana and Roberts-2</b> | “They (the other boys in the Home) hit me then I stabbed them ... With a comb”.              |
| <b>5520/16/Senzo/5 – Masekitlana</b>                   | “My friends hit me. Then I get angry then I start fighting back. Then I get hurt”.           |
| <b>5734, 5736/25/Senzo/6 – Masekitlana</b>             | “Because he started on me ... then I started hitting him”.                                   |
| <b>5822/29/Senzo/8 – Masekitlana and Roberts-2</b>     | “When a person starts at me, swearing. Then I will kick”.                                    |
| <b>2953/21/Nana/3</b>                                  | “Then they hit me ... Then I ran away ... I told her (lady in street) they were hitting me”. |

- **Participants’ experiencing of violence and how it affected their ideas on future careers and community involvement**

Two of the participants, Senzo and Mandla, expressed violent ways to deal with situations. By this, they were reflecting their social context, that is, they had observed situations in their communities and had incorporated this into their attitudes towards managing conflict. Mkhize (2004) calls these internalized values or voices, reflective of social environment, the “dialogical selves” of the participants. This indicates how children’s minds are made up of different voices reflecting what Mkhize (2004) refers to as their different dialogical selves. Mkhize describes how children’s voices reflect socially constructed identities. What children hear being said around them and their observations of rituals and occurrences in their everyday lives, then become part of their identities. It is these identities that are expressed in their narratives.

Each of the three male participants wanted to be either a policeman or a soldier when he grew up and pursued a career. The need to be a policeman could have been a reaction to and a result of the participants’ sense of powerlessness in their lives at the time of the study (refer ‘disinformation and disempowerment’ theme). Concerning a career, the different voices of Senzo, his different dialogical selves, expressed themselves in contradictory ways (refer ‘different voices and contradictions in narrative’ theme): on the one hand, he wanted to help old people who could not help themselves to cross roads, and on the other hand, he expressed exceptionally punitive ways to deal with people. Mandla also expressed violent ways of how he would be a policeman and, despite wanting to be a policeman, he appeared to display enjoyment over the prospect of a criminal’s way of life and said that he would not be afraid to go to jail. It appeared that he was inured to violence and proud of his tolerance for violence.

The therapist commented to me that this was probably due to the environment from which he came, an environment of violence, and he was only expressing what he observed there. Nana recalled experiences of violence from her home environment. Participants often associated Roberts-2 picture cards with crimes such as shooting, killing and house-breaking. This could also have been a reflection of the society that participants found themselves in when they returned home to their communities.

**Table 12: Excerpts on perceptions of violence and association with future careers**

| Unit/page/speaker/session   | Quotation  |
|---|--|
| <b>1836 &amp; 1838/1844 – 6/14/Senzo/2</b>                                  | “I shoot people ... I want to take them out of jail ... I do what other police do, I hit them ... I will be a policeman ... I will come here (to the Home) and tell those who are naughty to go to the police station ... Then I will hit them ... I will make them sit in jail ... I will leave them there for one week”. |
| <b>1787 &amp; 1789/11/Senzo/2</b>   | “He woke up ... He sees a person who tries to open the door ... The thug opened the door then he (boy in bed) got frightened ... He thinks he is going to die ... Because they will shoot him”.  |
| <b>5535,5537,5539,5541,5543,5545,5547,5548/ 16-7/Mandla/5 – Masekitlana</b> | “I want to be a soldier ... I want to carry a gun ... If someone hits me then I kill them ... I changed my mind ... I want to be a boxer ... You fight for money ... I’ll go rob ... I will have lots of guns with my partners ... I will carry one until I am dead”.  |
| <b>5042, 5053, 5055/57/Nana/6 – Masekitlana and Roberts-2</b>               | “The other day they (her grandfather and friends) came into the house when I was still young ... They burnt the house ... We started building another house ... It was big ... He burnt the house again”.  |
| <b>3710 &amp; 3714/10/Nana/1</b>  | “(I had) a bad one (dream) ... Maybe there is someone who got shot ... And these people are armed ... They said to him come here and they had a gun in their hand”.  |
| <b>4082/28/Nana/4 – Masekitlana and Roberts-2</b>                           | “The sister is a child; she wanted to make the baby quiet. Then the mother arrived. She said I don’t like people who don’t handle my child properly. Leave my child or I will cut your neck”.  |
| <b>4187/33/Nana/4 – Masekitlana and Roberts-2</b>                           | “The other one says I will hit you ... The mother (holding the baby) said you know I will hit you (girl/daughter standing next to her) ... Then she hit her because she was being rude to all these children ... Then she hit her again and again ... The she hit her and hit her (hitting the stones)”.                   |

#### 4.4.3 THEME 3: EVERYDAY SITUATIONS

##### 4.4.3.1 Sub-theme 1: The ‘mundane’

**Inclusion criteria:**

Interests that are in common with most children of that age and not typical to children’s home children or children living with HIV

**Exclusion criteria:**

Interest in future careers, concerns with their HIV status

I noted not only the themes of interest to the focus of the current study but also the everyday, mundane themes that participants expressed. The latter, in accordance with an interpretive paradigm, were also important parts of participants’ lives as they reflected their unique needs within their social contexts. Research must be careful not to only “construct life narratives spiked with the hot spots” (Fine et al., 2000:118). The areas of participants’ lives where ordinary things happen are important as themes in that they not only accentuate the commonalities between researcher and participants but also demonstrate that participants live an ordinary life in spite of their trauma. Participants at times reflected the harsh realities of their lives but at other times they reflected more mundane desires, such as Mandla who, from wanting to be a policeman or a robber, changed his ‘plans’ to being a ‘transporter’ or driver of children (refer ‘contradictions in narratives’, ‘different dialogical selves’).

Participants in the current study followed daily routines and also had a need for comfortable homes, cars and entertainment. There were times when the therapist and I were hoping for richer content in participant narratives; however, they related situations typical to the everyday child of that age group. I also noted where participants’ lives did not typically reflect life in a children’s home but resembled the lives of the everyday child living in a suburban nuclear family environment.

**Table 13 Excerpts on everyday concerns: the ‘mundane’**

| Unit/page/speaker/session            | Quotation   |
|--------------------------------------|---|
| 2858 & 2862/67/Senzo/6 – Masekitlana | “My teacher is Miss Polo and the second one is Mr. Eckersley ... I do my homework ... I go and play outside ... we bath ... we watch Isidingo ... Dragon Ball ... We go to eat ... We drink our medicine ... We sit down a little bit then we go to sleep”. |

|  |  |
|--|--|
| 1634/13/Senzo/2                                | “I will have a lot of money ... I will buy a house that my grandmother and I can stay in”.   |
| 1859/15/Senzo/3                                | “Yes and my sister washes the dishes and sometimes I wash them”.   |
| 3020/79/Senzo/7 – Masekitlana and Roberts-2    | “Then I play with my two puppies ... When I want to go sleep, I put them back in their small house where my granny puts the dogs”. |
| 2890/69/ Senzo/6 – Masekitlana                 | “We go to parties”.  |
| 5565 & 5570/18/Mandla/6 – Masekitlana          | “I can drive it anywhere ... Mini Cooper”.   |
| 5634/21/Mandla/6 – Masekitlana                 | “I want to take the children to school ... My uncle has a taxi”.   |
| 3844 & 3854 & 3858/16 & 17/Nana/2              | “We are always eating jam, jam, jam ... Peanut butter is also boring ... Kentucky won’t bore me”.                                  |
| 1691-1701/6/Senzo/2                            | “I am expecting a Polly ... My grandmother will buy it for me ... He will play with me”.   |
| 5015/56/Nana/6 – Masekitlana and Roberts-2     | “I want to be a housewife”.  |
| 5108/60/Nana/7 – Masekitlana and Roberts-2     | “She bought me the shoes, dresses and a T-shirt and the skirts”.   |
| 1179/65/Hlonipho/7 – Masekitlana and Roberts-2 | “We were picking mangoes from the trees”.  |

#### 4.4.3.2 Sub-theme 2: Schooling problems

##### **Inclusion criteria:**

Participants’ educational concerns, including lack of school equipment and misunderstandings with educators.

Learning concerns

##### **Exclusion criteria:**

Conflict with peers in school

All four participants expressed difficulties with their schoolwork or with authorities in their schools. South African children who have experienced parental loss are vulnerable to poorer educational outcomes, and the death of the mother, in particular, has an impact on children’s schooling (Ardington & Leibbrandt, 2010). This appeared to be the case with participants of the current study. I noted that participants did not appear to have much interest in any of their subjects nor did they express any rapport with teachers. Senzo in particular had a fear of his

educational authorities and three participants described teachers as being punitive; they did not feel that they obtained the required support they needed at school.

**Table 14: Excerpts on schooling problems**

| Unit/page/speaker/session                                     | Quotation   |
|---|---|
| 854 & 858/48/Hlonipho/6 – Masekitlana and Roberts-2           | “It’s because I am not studying well I get a headache”.   |
| 896 & 894/49/Hlonipho/6 – Masekitlana and Roberts-2           | “I didn’t pass very well ... its spelling”.   |
| 2398/45/Senzo/4   | “I see a boy taking a chair and hitting it on the floor ... Then he cries and does not do his homework and does not listen to the teacher”.   |
| 2332/40/Senzo/4   | “Because he is not happy ... He failed so he is crying ... She will punish him and hit him”.  |
| 4053, 4058, 4060 & 4062/27/Nana/4 – Masekitlana and Roberts-2 | “I am going to fail ... Because my teacher always tells me that I will fail, though I am not sick but I am not part of the class ... Because in the class they make a noise ... all of us, one person starts singing, and then the rest of the class sings and if one person talks then the rest of the class talks ... Even good ones in the class, they also make a noise”. |
| 4114 & 4117/30/Nana/Masekitlana and Roberts-2                 | “It’s that today I got hit ... It’s unfair that they hit us with a pipe ... (she would prefer to be hit) with a stick ... You can just see the pipe ... It even broke on me”.   |

#### 4.4.4 THEME 4: PARTICIPANT EMOTIONS AS EXPRESSED INTERNALLY AND REFLECTED EXTERNALLY

The researcher noticed that the participants were thinking and expressing themselves in particular ways that reflected certain internal emotional and cognitive processes. However, as the participants were living in Children’s Homes where there was not the opportunity to express emotions and resolve their inner conflicts, they often denied their emotions and blocked any expression of them during the sessions. Especially when therapy commenced, it appeared that the participants had eliminated or suppressed the bad memories of their past lives in order to survive in their present lives. Expression of emotions became more overt as therapy, especially Masekitlana therapy, continued. By the end of the research, the scores on the Roberts-2 assessment instrument indicated considerably greater emotional expression than before therapy began (refer to graphic data indicating this in chapter 5).



#### 4.4.4.1 Sub-theme 1: Emotions

**Inclusion criteria:**

How participants felt, how they understood their emotions and how they expressed their emotions

**Exclusion criteria:**

Active expression of emotions in the form of anger and fighting with peers

Participants expressed their emotions in different ways during the course of therapy, with a denial or blocking of emotions at initial stages of therapy and a more open form of expressivity after the intervention of Masekitlana.

- **Denial or blocking of emotions**

I noticed that participants were not used to expressing their feelings at the commencement of therapy sessions. This could have been a socialized form of silence or a moratorium on expressing emotions that had been imposed on participants in their home environments as a result of the family's reaction to the behaviour of the participants' mothers – two of the mothers had abandoned their children – or as a result of their mothers having or dying from a stigmatized illness, HIV. A social and self-imposed silence reinforces orphans' feelings of grief, loss and failure since it prevents the children from preparing for the inevitable death of a loved one (UNAIDS Report, 1999). When probed by the therapist for some emotional expression, participants generally displayed, especially at the beginning stages of therapy, flattened, deadened emotions. I felt that this was an example of how participants had learnt to contain their emotions as a defence against feeling them acutely. This might have resulted in ongoing emotional pain, especially as they appeared to lack counselling support.

There is a difference between the ways in which “memory operates in safe and in conflict-ridden environments; traumatized people either repress their bad memories or are obsessed by them” (Denis, 2003:212). Denis (2003) believes that people are afraid to be confronted by their own pain and that therefore it takes time and courage to confront the past. Similarly, in the current study, I felt that it was only after a few sessions of therapy that participants felt comfortable, safe and contained enough to express their pain. Hlonipho's narrative around his mother appeared obsessive in that he related most of the Roberts-2 picture cards to a mother and he felt that any form of emotion he was feeling was because she was no longer in his life.

**Table 15: Excerpts on blocking of emotions**

| Unit/page/speaker/session                                      | Quotation   |
|--|---|
| <b>131, 141, 143, 47 &amp; 49/4 &amp; 9/Hlonipho/1</b>         | “I don’t remember... I don’t remember anything ... I don’t know (when asked if his mother ever felt sad or if his father ever read to him) ... He doesn’t want to talk that much about it ... I don’t understand”.  |
| <b>159, 161, 163, 165/10/Hlonipho/2</b>                        | “No ... no ... no ... There was nothing much” (when asked if anything troubled him, upset him, made him happy or if anything happened that day).  |
| <b>230, 234, 237 &amp; 242/14/Hlonipho/2</b>                   | “Nothing ... nothing ... I don’t remember ... I don’t know ... I don’t know” (when asked what he remembered about his family, what was nice about those times, how his mother used to show him her love, about his father’s love and about the people in his home). |
| <b>1063 &amp; 1067/58-9/Hlonipho/Masekitlana and Roberts-2</b> | “I don’t want to keep on thinking about it ... I just leave it ... I don’t want to tell anyone ... I keep quiet ... I don’t talk to anyone”.  |
| <b>2402/46/Senzo/4</b>   | ...And sleep and not think about what happened ... I try to not let it into my mind ... When I start sleeping I don’t think of anything”.   |
| <b>10, 12 &amp; 15/15/Senzo/5 – Masekitlana</b>                | “No ... (about anything he wants to change in his life) ... Yes ... (everything is fine) ... No (about if he has issues)”.  |

- **Misidentification or uncertainty in identifying emotions**

In their observed suppression of emotions, I questioned whether participants were unable to identify their emotions rather than simply suppressing them. I wondered if this indicated a lack of vocabulary, in general, or a cultural lack of emotional vocabulary, to express them. It could also have indicated a cultural difference between the researcher’s conception of certain emotions and that of the participants. I have often found in my work that Zulu-speaking African people describe depression with the words, “thinking and thinking”. In other instances during therapy, participants demonstrated unusual insight into their emotions.

**Table 16: Excerpts on misidentification of emotions**

| Turn unit/page/speaker/session                       | Quotation  |
|--|--|
| <b>1046/55/Hlonipho/4/ Masekitlana and Roberts-2</b> | “No (he does not know the difference between being angry and feeling sad) ... He is thinking too much (if he is feeling sad)”. |

|                   |   |
|-------------------|---|
| 2/1/Hlonipho/1    | “A person who is upset is the same as a person who is angry”. |
| 536/28/Hlonipho/3 | “What is a conscience?”                                       |

- **Insight into emotional responses**

Despite the apparent uncertainties quoted above, participants appeared to have, at times, insight into their emotions that appeared beyond their years in maturity. Hlonipho, in particular, demonstrated unusual insight into his motives and behaviour. Both Hlonipho and Senzo, in their narrative, appeared to understand the concept of suppression of anger and then ‘acting out’ in the form of bad behaviour at a later stage.

**Table 17: Excerpts on insight into emotions**

| Turn unit/page/speaker/session                | Quotation  |
|---|--|
| 565/30/Hlonipho/3                             | “Why don’t you listen to both your conscience and your mind before you do something? ... First you listen to the one who says the right thing then you listen to the one who says the wrong thing lastly”.   |
| 3026/75/Senzo/7 – Masekitlana and Roberts-2   | “Let’s say I dropped my money on the floor and the other boy says he also dropped his money on the floor ... Then they fight and fight ... Then they go home and do the wrong thing (in anger/acting out) ... They take paint and paint the wall”. |
| 555/29/Hlonipho/3                             | “There was something that was bothering him ... He kept it in his mind until he got too angry”.  |
| 850/47/Hlonipho/6 – Masekitlana and Roberts-2 | “It’s to find people who will love me” (when asked what would make him happy).   |

- **Predominance of negative emotional states especially anger**

Participants often expressed an unusual amount of anger over situations in their lives. This anger appeared to be linked to their feelings of rejection by their families and their placement in the Homes. It was also often linked to parental loss, neglect by their parents and being misunderstood by school and Home authorities. Hlonipho had a calm, gentle exterior yet often projected feelings of anger onto the picture cards. Of the four participants, he appeared particularly angry that his mother was no longer in his life, although he only expressed this as a form of explanation in response to the picture cards. In the Feelings Heart Test, one of the four faces that Hlonipho placed in his heart was an angry face. He then made the comment

that the drawing of the angry boy was copying him, an interesting way of expressing that he identified with the sad face. Participants also preferred to talk about particular picture cards that elicited negative feelings in them. This could have been an indication that they were aware of their need to express sad or angry emotions. Senzo, Nana and Mandla demonstrated more active ways of ‘acting out’ their anger (banging stones together very hard, talking about using knives, wanting to hit little children) than Hlonipho’s general negative malaise when describing the picture cards.

**Table 18: Excerpts on negative emotions and anger**

| Unit/page/speaker/session                      | Quotation   |
|--|---|
| 80 & 82/6/Hlonipho/1                           | “He is writing ... He is angry ... I think he is writing about his mother”.                         |
| 572 & 574/31/Hlonipho/3                        | “This one is dreaming bad things ... He is dreaming about his mother”.                              |
| 1042/57/Hlonipho/4 – Masekitlana and Roberts-2 | “I am always angry”.  |
| 2408/46/Senzo/4                                | (In answer to what he did when he was angry?) ... “I will hit a person then they start hitting me”. |
| 588/32/Hlonipho/4 – Masekitlana and Roberts-2  | (In answer to which picture card he wanted to begin with) ... “That which made me feel bad”.        |

- **Contradictions in narrative and contrariness of participants**

Often a participant’s way of thinking in one session would be contradicted by how he was thinking and expressing himself in another session. Even in the course of one conversation, participants contradicted themselves, indicating how their dialogical selves manifested their many facets. On one day a participant would be prepared to relate something about his past and on another day, he would deny any memory of the same incident. An example of this is when Hlonipho described the period of his life when he was hit by the wife of the priest who took him into his home. At another session, he stated that the priest hit him. Yet when questioned at another stage, he denied any memory of it. In another session, he denied feeling unhappy or sad; yet he contradicted himself by claiming that he was always angry. Similarly, Senzo would make one statement and then would immediately contradict himself, as if he feared being chastised for his first statement, or perhaps he did not have enough confidence in

his opinions to stand firm on his first statement. In all participants' narratives, contradictions seemed to characterize a certain amount of contrariness or resistance to therapy.

**Table 19: Excerpts on contradictions in narrative**

| Unit/page/speaker/session  | Quotation  |
|--|--|
| 98, 104, 106, 108, 110 & 131/7 & 8/Hlonipho/1                                      | "I don't remember (about his time with the priest, yet at previous sessions ...) ... The priest found me sick and took me to hospital ... I didn't like it there (when he returned to stay with the priest) ... He used to ill treat me ... He liked hitting me ... With a stick". |
| 74 & 76/50/Senzo/4   | "I am not happy (in answer to why he is so happy) ... I am" (in answer to why he is not happy).  |
| 2592, 2598 & 2600/56/Senzo/5 – Masekitlana   | "It's easy (in answer to what a road looks like) ... I don't know how to (when requested to draw it) ... No, I will draw whatever I want ... I don't know" (when asked what he wants to draw).   |
| 2693 & 2695/60/Senzo/5 – Masekitlana   | "Inside (when asked if his house is ugly outside or inside) ... Outside" (when asked why it is ugly inside).   |
| 3225 & 3226/86/Senzo/8 – Masekitlana and Roberts-2                                 | "Because he is angry (when asked why someone in a picture card was doing something angry) ... He is happy (when asked what made him angry) ... He is angry, he is happy" (when asked why he says he is happy).   |
| 41, 43, 258, 921 & 947/9, 15, 51 & 52/Hlonipho/1, 2 & 6 (Masekitlana and Roberts-2 | "I don't remember anything ... I don't know ... I don't have anything to talk about (when asked about his father, yet at subsequent sessions ...) ... My father loved horses ... When I came back my father was not there ... He didn't give birth to me".                         |

#### 4.4.4.2 Sub-theme 2: External reflections of emotions

##### **Inclusion criteria:**

Positive effects of participant suffering and trauma and how the emotions were managed in positive ways and in ways to ensure survival on an everyday basis

##### **Exclusion criteria:**

Descriptions of anger and fear as expressed through conflict with peers and in the school environment

Despite the above forms of managing emotions, participants had developed some positive and surprising ways of surmounting their past and present challenges.

- **Strength of character, resilience and moral authority**

Life in the Homes did not appear to be easy for participants. After participants experienced altercations with peers or Home and school authorities, they were not always offered immediate comfort and protection such as parents would give a child. They therefore had to be their own sources of strength. Participants expressed a need for guidance from others as to the correct ways to behave and felt the lack of structure and discipline that is normally communicated in families. Despite this, and perhaps as a result of their setbacks in life, they showed remarkable strength of character and resilience in their lives, and expressed a form of self-control and moral authority over their lives and the behaviour of others.

*Examples of resilience were demonstrated by all participants.*

Hlonipho appeared to have established his own form of moral authority, which manifested as self-control to restrain him from retaliating in fights with peers. Furthermore, he took on the role of peacemaker in the fights. Through this form of moral authority, Hlonipho was able to express “negative contrast experiences” (Johnson-Hill, 1998), which entailed awareness that there was another way of being or of dealing with situations. This could have been the foundation of participants’ resilience in that “reflective resistance, the impetus to resist the source of one’s discontents contains the seeds for change and exploration of alternatives to present suffering”. Hlonipho had identified within himself the seeds of transformation and change.

Senzo and Nana also appeared to know right from wrong. Senzo expressed a desire to help others and Nana demonstrated a quality of forgiveness in an incident involving her peers during the course of one therapy session. Her peers called her out of a session under the pretext that she needed to collect her laundry. Instead they hit her and she returned tearful to therapy (which had to be discontinued until the next day). On the evening of the incident she ran away from the Home to her grandmother, who returned her the next morning. Nana met with her peers, who apologized to her, and by the time she appeared at therapy that afternoon, she was cheerful and happy that she had reconciled with her peers.

Mandla, however, appeared to favour and respect violent forms of behaviour (refer theme ‘violence and future careers’). This embracing of violence as a solution to problems might be another form of resilience in participants, although not one usually considered socially acceptable. Malinda and Theron (2010:319) corroborate this in their study of street youth

when they state that “at-risk youth often use what society labels as ‘problematic’ as pathways to resilience” and that “although these coping mechanisms may be labelled socially ‘unacceptable’ or ‘maladaptive’, they cannot be written off, as resilience can be hidden in alternative, marginal, and often destructive behaviours” (Bottrell, 2007, Donald & Swart-Kruger, 1994, Kombarakaran, 2004, McAdam-Crisp, Apteker & Kironyo, 2005 & Ungar, 2004, 2006 in Malinda & Theron, 2010:319). Fighting in the Homes might have served an adaptive function and “a different approach to life’s challenges” for participants living in Homes (Hardoy, Sierra, Tammarazio, Ledesma, Ledesma & Garcia, 2010:371).

As expressed in the theme, ‘Idealization of mother’, the idea of a former loving mother appeared to be a strong source of resilience for participants and it demonstrated the need for the therapist in the current study to probe for loving memories. Hlonipho’s memory of a loving mother and of a father who had horses appeared to make him feel happy. I was uncertain whether it was an accurate memory or not.

**Table 20: Excerpts on strength of character, resilience and moral authority**

| Unit/page/speaker/session  | Quotation   |
|--|---|
| <b>4014, 4010 &amp; 4020/24 &amp; 25/Nana/4 – Masekitlana and Roberts-2</b>          | “I said they are abusing me where I stay ... I said ok I forgive you (for hitting her which led to her running away from the Home) ... We have forgiven each other”.  |
| <b>234, 236 &amp; 238/14/Hlonipho/2</b>  | “Nothing (could he remember about his mother, yet he knew that ...) ... My mother loved me ... I don’t remember” (how she showed her love for him).   |
| <b>262/15/Hlonipho/1</b>   | “At home ... My father used to have horses ... He loved horses”.  |
| <b>44/3/Hlonipho/1</b>   | “We must learn from adults and do what adults want us to do”.   |
| <b>559 &amp; 563/30/Hlonipho/3</b>   | “If it happens that I get angry, I would be able to stop it” ... If it happens that I feel like breaking a chair, I can just stop it and put it down again ... Your mind can tell you to stop”.   |
| <b>503,504,507/26/Hlonipho/3</b>   | “He is telling him rules at home ... That we must respect older people and that we must not fight”.   |
| <b>515 &amp; 517/27/Hlonipho/3<br/>995/55/Hlonipho/3 – Masekitlana and Roberts-2</b> | “I think this person is trying to stop these people because they are arguing ... He realizes that if he just lets them fight, one person will get hurt so he decided to come and stop the fight ... I would be the one who tries and stop the fight”. |
| <b>4071/27/Nana/4 – Masekitlana and Roberts-2</b>                                    | “Then the father said we are talking about respect and manners. You have a right to have parents. You have a right to have a bed. You also have a right to have a home”.  |

2530-2/53/Senzo/4

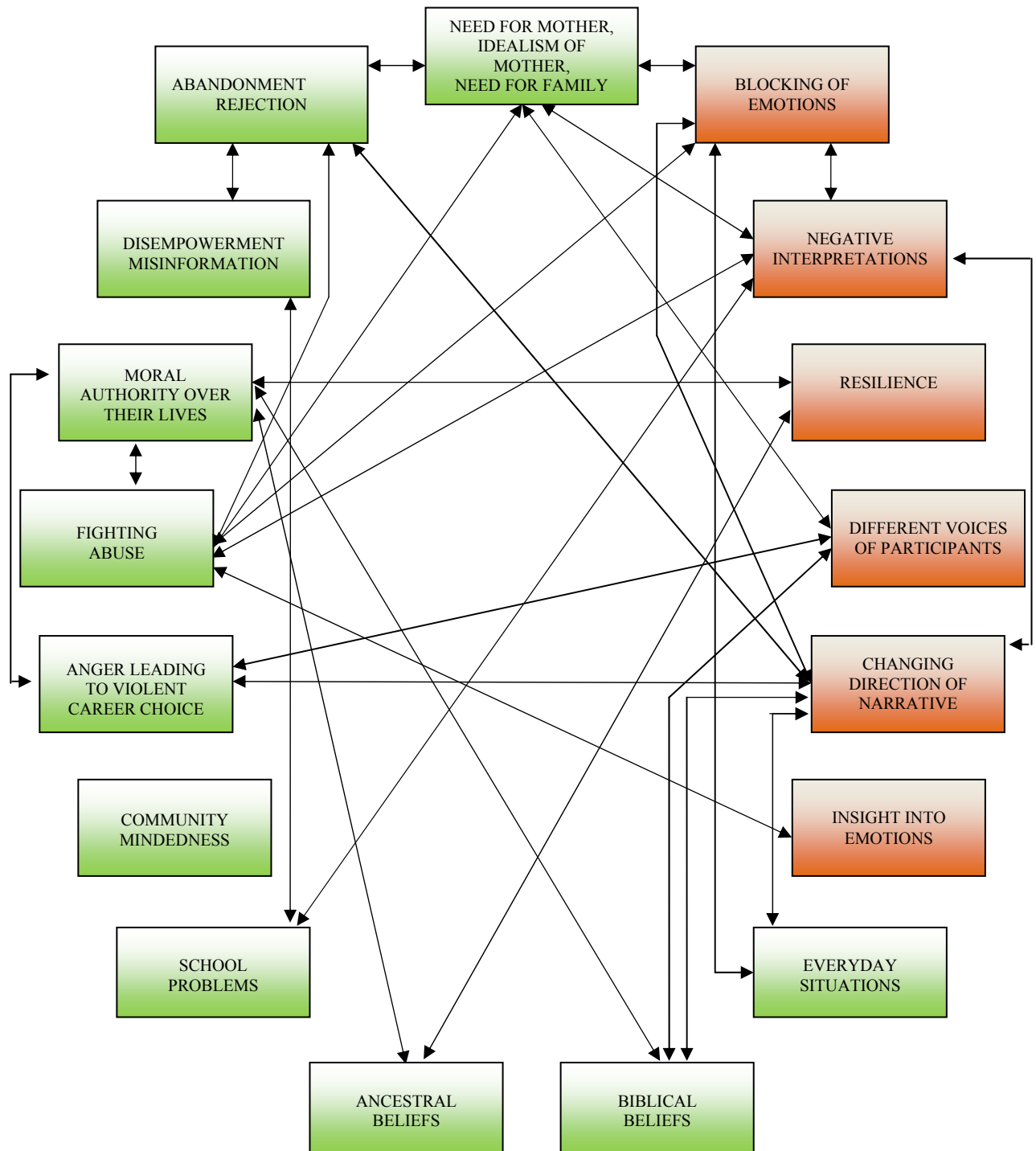
“I would help people ... I will help those who are elderly and those who have broken legs ... When they are walking slowly then there will be a car that goes fast and I will help them”.

#### 4.5 OVERLAPPING OF THEMES

In the current study, it was a challenge to keep different themes discrete, as the content of one theme either contradicted the content of another, was reflective of parts of another theme, or the result or cause of another theme. The participants’ need for their mothers and for their families was felt to be one of the underlying reasons for the anger they expressed towards their peers. Their suppression of emotions over the hurts they had received by being abandoned and neglected was probably released on the playgrounds of their schools and in the Homes, where they described the frequent situations involving fighting and bullying. Feelings of disempowerment and a lack of information in relation to their past, present and future lives resulted in negative perceptions of everyday situations. At the same time, having to defend themselves against their peers probably developed a form of resilience and adaptation to Home culture. Their community-mindedness also perhaps helped them to cope with the Home environment, and their ancestral and Biblical beliefs enabled them to accept their past lives and have faith that their future lives would unfold according to the plans of their ancestors and God.

The diagram below demonstrates how entwined the different themes are, how complex participants’ lives and personalities were and the challenge it was in the current study to ‘tease out’ and differentiate participants’ lives into distinct categories.





**Figure 11: Overlapping of themes**

#### 4.6 OBSERVATIONS

*How* the participants responded when using Masekitlana, the first sub-question of the current study, was partially answered by examining the above themes and will be revisited in Chapter 6, “Discussion”. Answering this question also involved an observational inspection of the

videoed data in conjunction with the meta-narrative from the participants around their experience of this method of therapy.

I noticed that participants were able to talk more freely when they played or ‘fiddled’ with the stones. Senzo enjoyed talking while he rolled a stone up and down his legs. I had noticed how he fiddled nervously with his hands when the Roberts-2 was performed on him before the intervention of Masekitlana was conducted, but this ended when he was allowed to manipulate the stones while talking. Nana found banging the stones very hard together – to the point of leaving a thin ‘carpet’ of stone chips around her – enabled her to release anger that she felt over her peers hitting her, and sorrow at having to leave her family home due to her being sexually molested. Hlonipho only narrated his traditional African beliefs in talking animals embodying ancestral spirits while he was playing Masekitlana. Three of the participants enjoyed playing other African forms of stone games after they had finished talking with Masekitlana. The following narrative units demonstrated the participants’ responses to Masekitlana therapy. However, it was the videoed material that indicated the participants’ bodily movements and manipulation of the stones in conjunction with the verbal expression.

**Table 21: Excerpts on participants’ narrative responses to Masiketlana**

| Turn unit/page/speaker/session                 | Quotation   |
|--|---|
| <b>93-2/34/Hlonipho/3 – Masekitlana</b>        | <i>Therapist:</i> “Maybe you can take the stones you like and tell us about that situation that made you feel sad ... Why are you choosing those stones, they look quite small”.<br><i>Participant:</i> “I don’t like that I am the only child from my mother and I don’t have brothers”.                 |
| <b>5697-8/23/Senzo/6 – Masekitlana</b>         | <i>Therapist:</i> “Tell us about your stones, who do they represent?”<br><i>Participant:</i> “People in my life”.   |
| <b>5706-7/24/Senzo/6 – Masekitlana</b>         | <i>Therapist:</i> “Tell us about yourself today. These are stones right, can you tell us about them? Tell us who N..... is, what does he do everyday, even on weekends?”.<br><i>Participant:</i> “There is a game that is being played ...”   |
| <b>4163,4165-8/32-3/Mandla/4 – Masekitlana</b> | <i>Therapist:</i> “Ok, you’ve hit the stones too many times”.<br><i>Participant:</i> “Yes, my stone is getting broken. These stones are so stupid”.<br><i>Therapist:</i> “Well, play with them in another way. Rub them together”.<br><i>Participant:</i> “This is a game they play at school. I’d rather |

|   |  |
|---|--|
|   | <p>not play it. Now I used to have a stone that looked like a cake. I like this one. No, I am going with this stone. I want to suck it. When I go to bed, the ghost will go away ... The ghost comes this side and it also comes to the bed to sleep on the other side and finishes the cake ... Then my ghost goes to sleep ... My ghost is very big ... When it is not sleeping, it gets sent to go and hit that other person at night ... When I say ha, it's nice to sleep ... It comes back ... But if don't say it, my ghost goes to sleep".</p> |
| <p><b>4438-40/40/Nana/5 – Masekitlana</b></p> | <p><i>Therapist:</i> “You said you like those stones?”</p> <p><i>Participant:</i> “Yes”.</p> <p><i>Therapist:</i> “You make a cross with your stones and tell us something nice about your life”.</p>  |

The themes as they stand alone and the actions involved in playing Masekitlana constitute a ‘thin’ description of the meaning that participants created out of Masekitlana. The interpretation of the themes at a deeper, more symbolic level and the relevance of Masekitlana therapy are covered in Chapter 6. Denzin (1989) confirms that interpretation is always symbolic in that an utterance can only be grasped and understood by considering gestures and facial expressions around it *and* by contextualizing it; what an act means on the surface is perhaps not what it means at a deeper, more symbolic level. How Masekitlana enabled participants to construct meaning at a deeper, more symbolic level is what lent credence to the intervention of Masekitlana.

#### 4.7 CONCLUSION

Generative themes in this chapter indicated that participants responded to Masekitlana by expressing:

- their traditional and Christian beliefs;
- their sadness over the loss of their parents or the disintegration of their original nuclear families;
- their everyday concerns and occurrences in the Homes, including conflict with peers and difficulties with schooling; and
- suppression of emotions but, at later sessions of Masekitlana, a more open revelation of inner feelings of sadness and anger, with indications of resilience and moral authority in their lives.

Themes that emerged from the data, along with sub-themes and categories, have all been discussed with supporting quotes from the recorded therapy and assessment sessions. It can be noticed from the quotation tables that there was a predominance of quotations located in the sessions where Masekitlana was conducted with the participants. This indicated how this narrative game enabled the participants to express themselves in meaningful ways.

I found it difficult to tease out and delineate different sub-themes from each other, as one facet of a participant's life tended to be part of, to be caused by or to be the effect of another situation in his life. I indicated this complexity of participant experiences in life in the section and diagram on overlapping of themes. I also noticed how certain features of each participant repeated themselves throughout the themes. For instance, across various themes, Mandla appeared angry, Hlonipho expressed the need for his mother, Senzo yearned for a domestic life with his family and Nana expressed issues with her peers. Furthermore, each participant's narrative reflected in distinct ways the social context against which he experienced and spoke about his life in the study. In generating themes, I also noticed trends of expressions and emotions similar to all participants, that is, 'condensations' and 'generalizations' that can be identified and analyzed without discarding the particular life circumstances or unique social context of each participant (Falmagne, 2006).

I found myself interpreting the thematic data as I was compiling different themes. In this way I began a simultaneous process of analysis and interpretation, although for clarification reasons I answered the sub-questions and main question of the current study in Chapter 6, "Discussion".

In the next chapter, I will describe and demonstrate through graphic analysis how the participants progressed during the standard of care sessions and during the intervention sessions. I will also show how quantitative graphic analysis was more precise and definitive than the qualitative analysis in indicating differences between the two types of therapy, and in indicating more clearly the effect of the intervention phase that involved Masekitlana. The quantitative data of the next chapter will also indicate more precisely how the participants' adaptive functioning and how they thought about their lives changed as the intervention of Masekitlana proceeded.

## CHAPTER 5

# QUANTITATIVE DATA ANALYSIS AND INTERPRETATION

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### 5.1 INTRODUCTION

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

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

### 5.2 QUANTITATIVE MEASUREMENT

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

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

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

### 5.2.1 SINGLE-SYSTEM DESIGN AND REPETITIVE QUANTITATIVE MEASUREMENT

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

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

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

### 5.2.2 RELIABILITY AND VALIDITY OF ROBERTS-2 MEASUREMENT

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

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

As the picture cards of the Roberts-2 test were of ethnic adults and children relating to each other, I felt that they would be suitable for the cohort of children of this study. Masekitlana is a narrative form of therapy, so describing picture cards fitted in well with Masekitlana therapy. The scenes in the picture cards were also reminiscent of the lives of the participants of this study. The Roberts-2 test had been piloted by students of the University of Pretoria psychology clinic on a group of children at the Kgolo Mmogo project in Kalafong Hospital<sup>16</sup> in 2008 to assess anxiety, depression, aggression and stigma (rejection) levels as well as their social adaptation.

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

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

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

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

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



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

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

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

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

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

As explained above, each participant’s responses to:

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

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

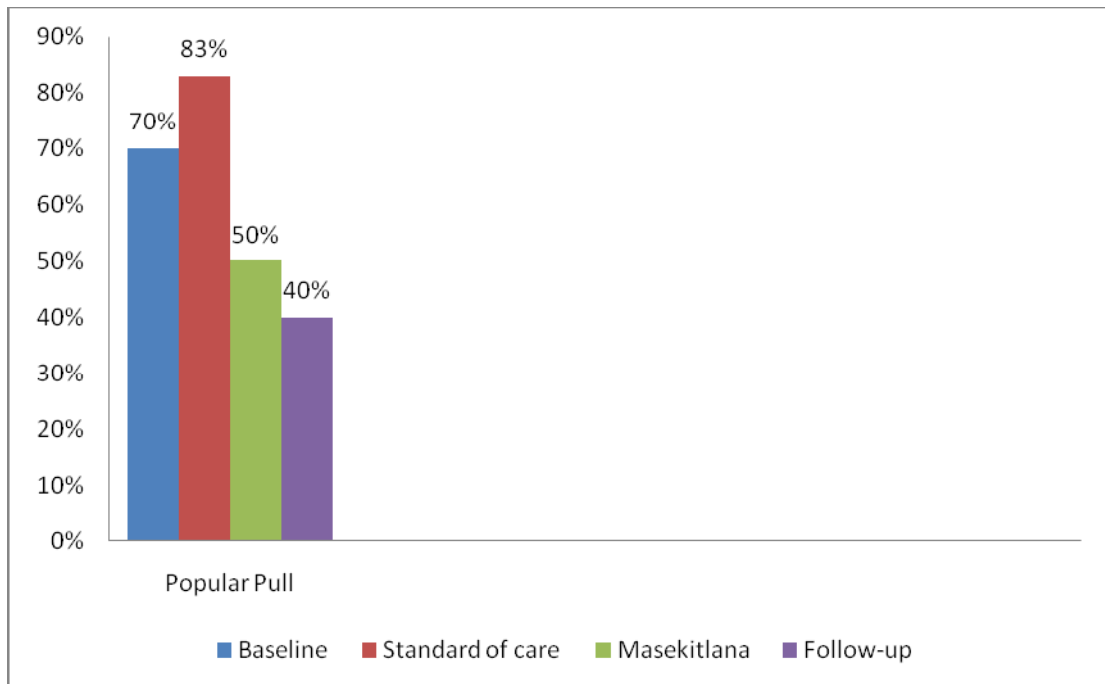
- **The blue** column represents Roberts-2 scores at baseline before therapy commenced.
- **The red** column indicates scores after standard of care therapy.
- **The green** column represents scores after the intervention of Masekitlana therapy.
- **The purple** column represents scores at the follow-up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

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

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

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

### 5.3.1.1 Hlonipho: Popular Pull

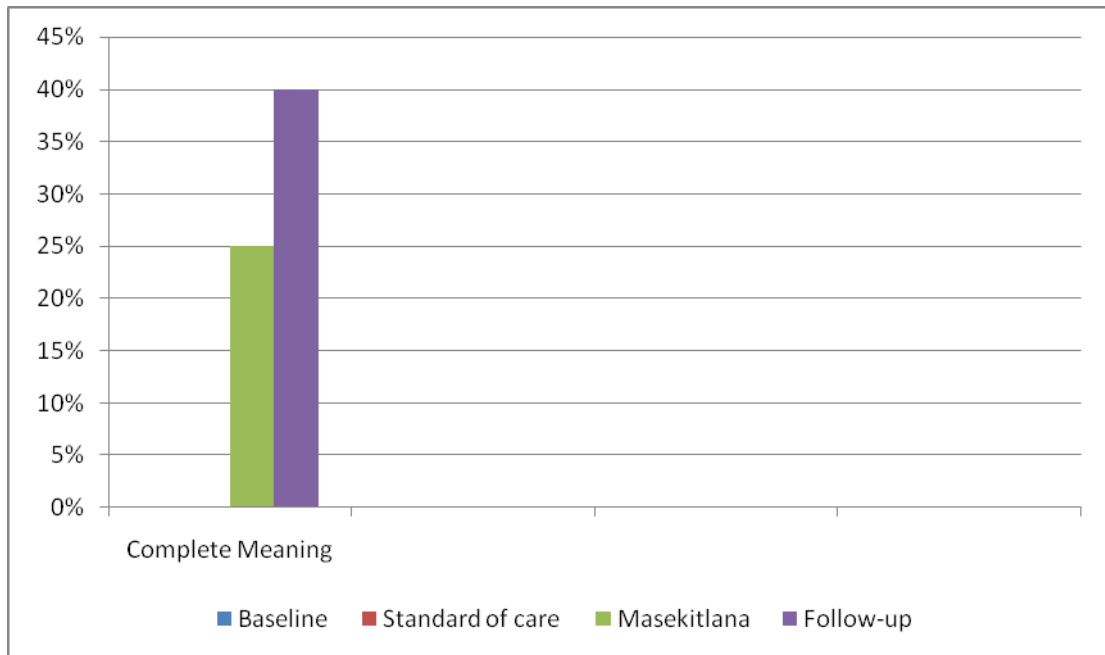


**Figure 12: Hlonipho: Popular Pull<sup>17</sup>**

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

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

### 5.3.1.2 Hlonipho: Complete Meaning

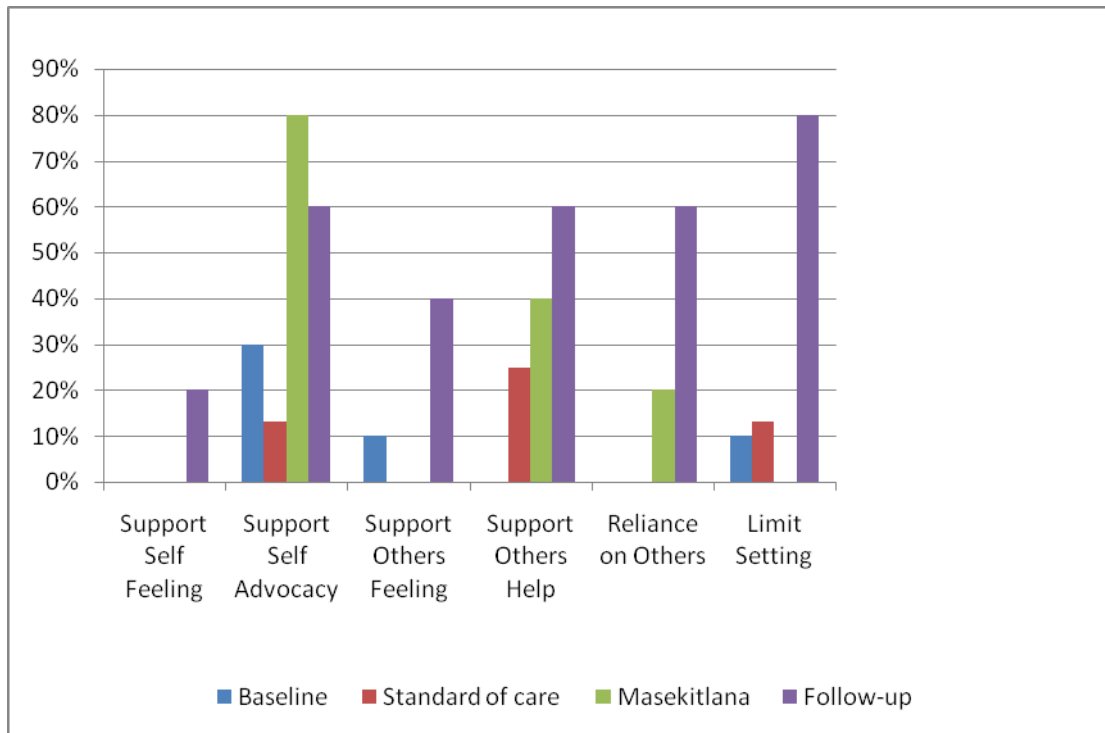


**Figure 13: Hlonipho: Complete Meaning<sup>18</sup>**

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

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

### 5.3.1.3 Hlonipho: Available Resources Scales



**Figure 14: Hlonipho: Available Resources Scales<sup>19</sup>**

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

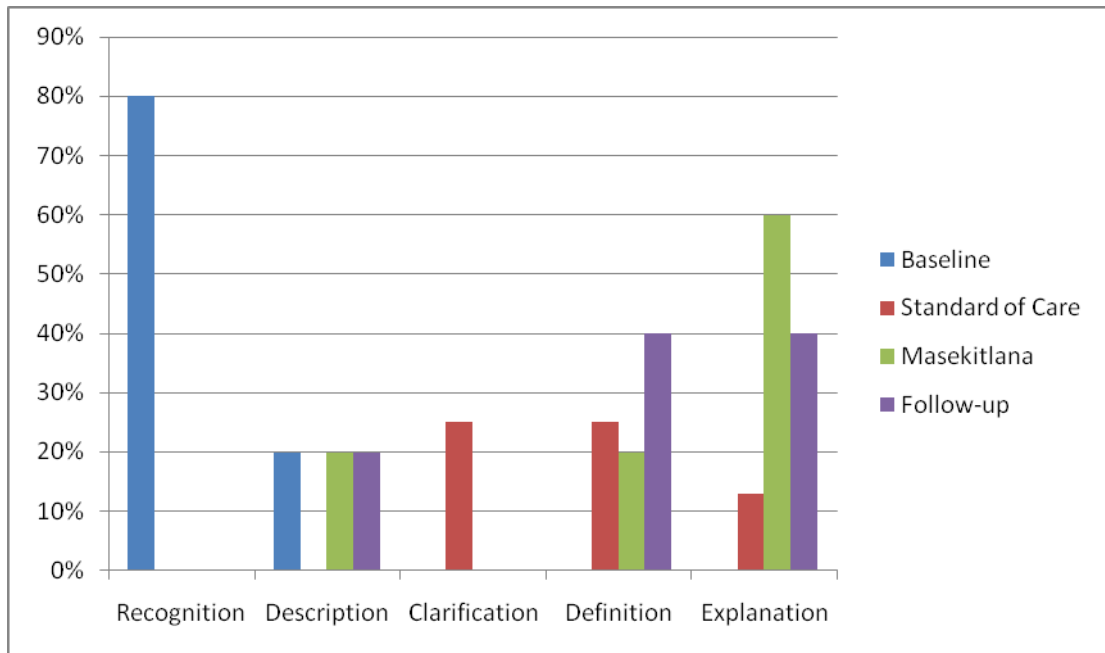
- **Support Self – Feelings:** Lack of responses to this category (nil scores except for at the follow-up measurement) could have been a reflection of Hlonipho’s general anhedonia (flat affect) and melancholic state of mind, which he presented with throughout therapy. There was, however, a slight increase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

<sup>19</sup> “Available Resources Scales” indicate how a participant uses other people or resources in his environment to support him.

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

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

### 5.3.1.4 Hlonipho: Problem Identification Scale



**Figure 15: Hlonipho: Problem Identification Scale<sup>20</sup>**

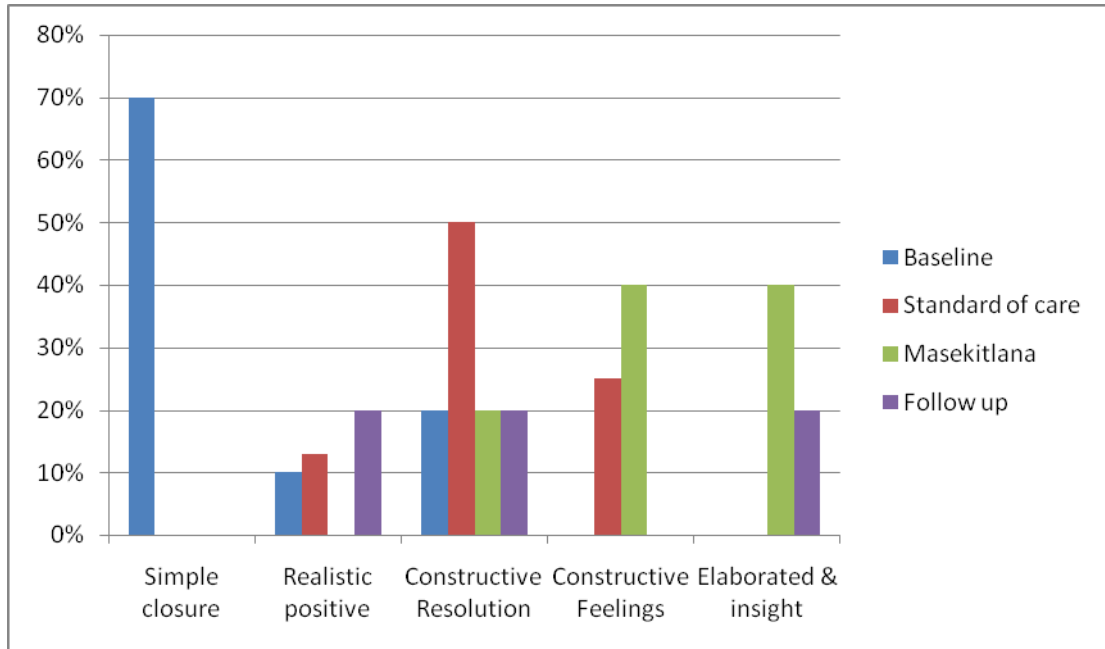
There is a hierarchy between Recognition and Explanation, with Recognition being simple and vague problem solving, and Explanation relating to the most elaborated and differentiated breakdown of a problem.

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

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

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

### 5.3.1.5 Hlonipho: Resolution Scales



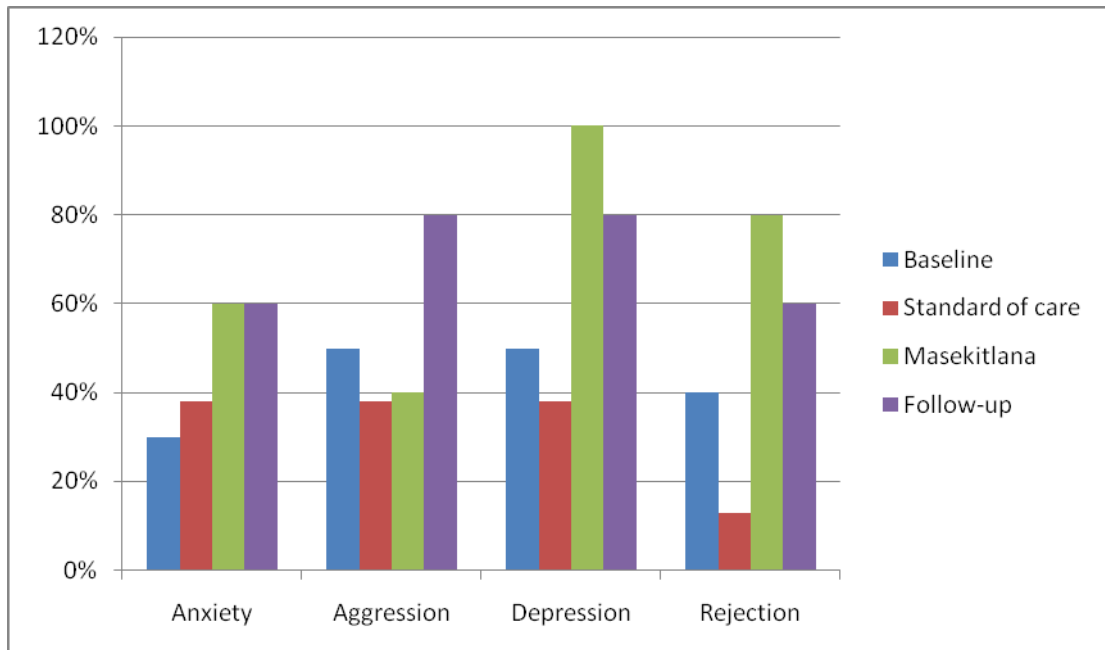
**Figure 16: Hlonipho: Resolution Scales<sup>21</sup>**

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

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



### 5.3.1.6 Hlonipho: Emotion Scales



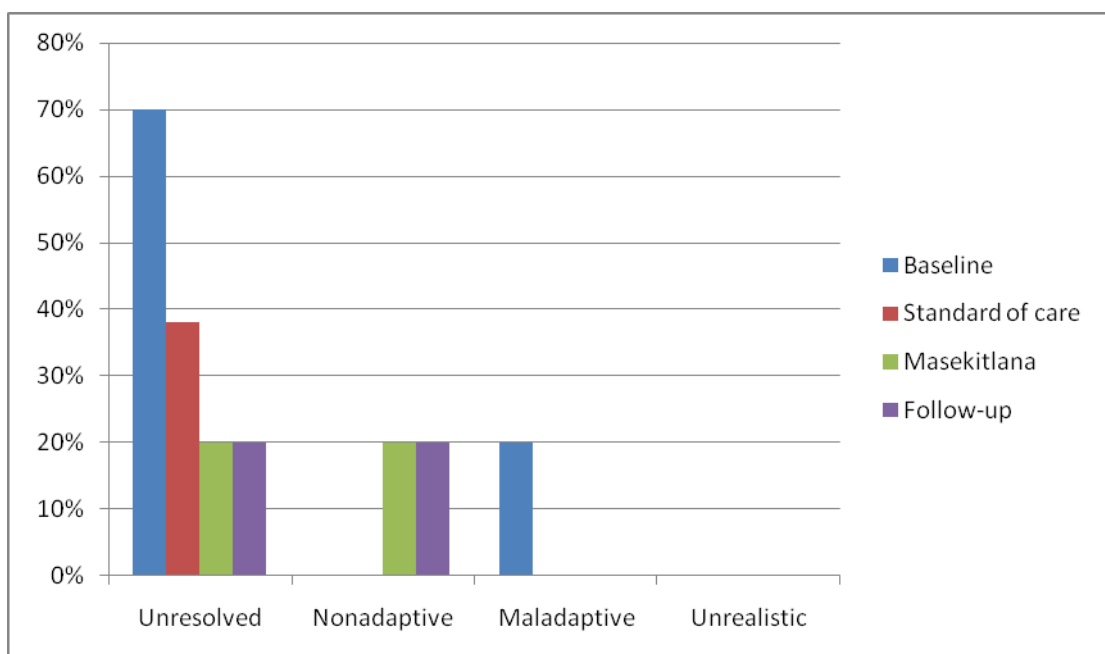
**Figure 17: Hlonipho: Emotion Scales<sup>22</sup>**

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

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

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

### 5.3.1.7 Hlonipho: Outcome Scales



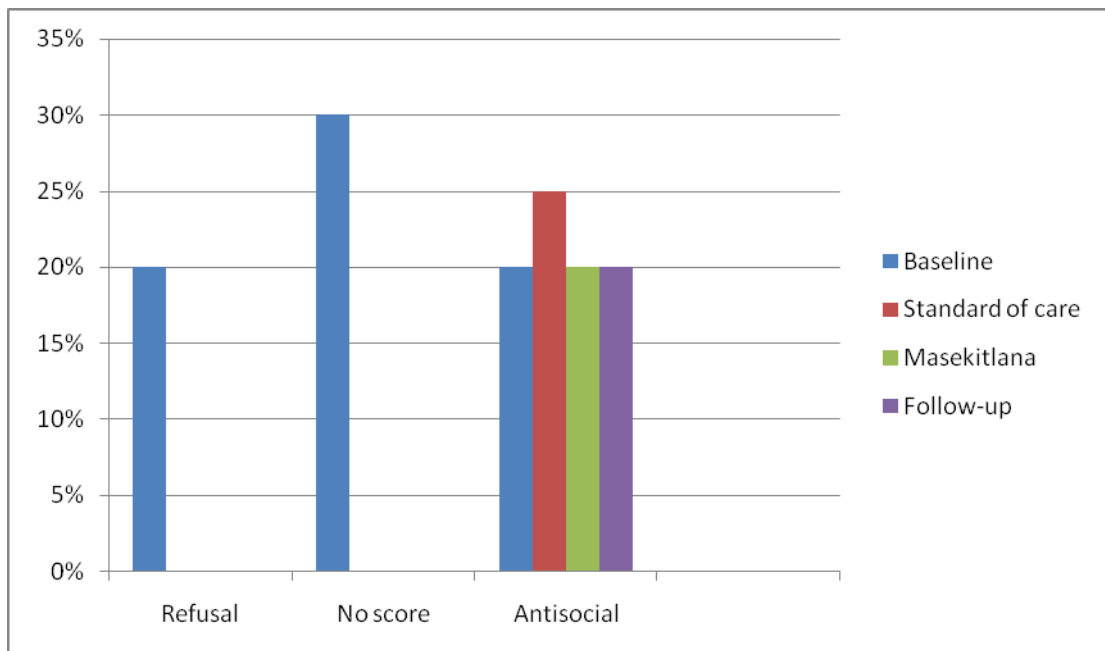
**Figure 18: Hlonipho: Outcome Scales<sup>23</sup>**

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

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

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

### 5.3.1.8 Hlonipho: Unusual or Atypical Responses



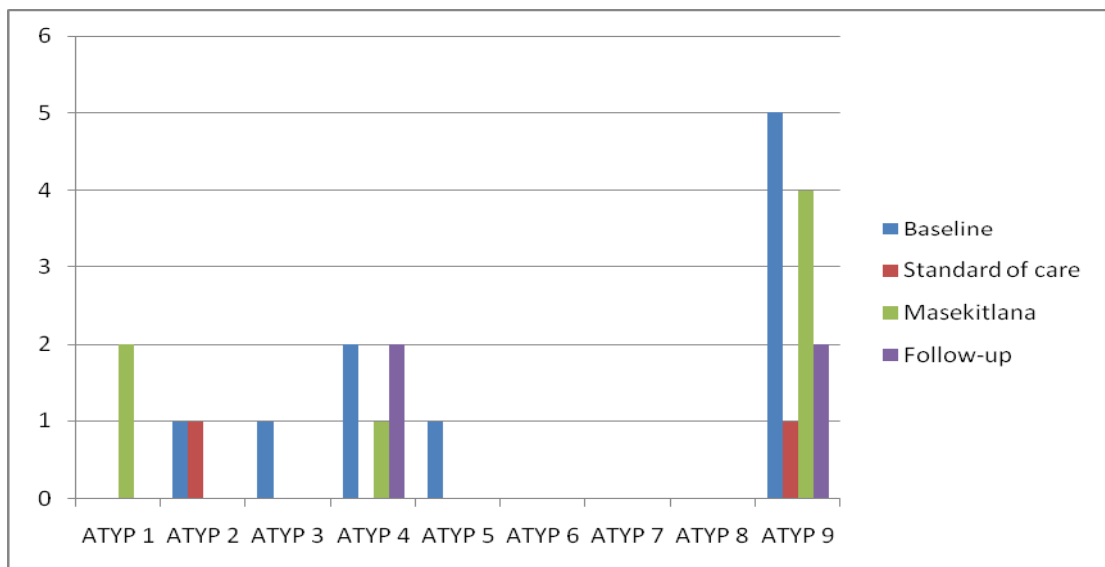
**Figure 19: Hlonipho: Unusual or Atypical Responses<sup>24</sup>**

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

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

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

### 5.3.1.9 Hlonipho: Atypical Categories



**Figure 20: Hlonipho: Atypical Categories<sup>25</sup>**

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

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

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

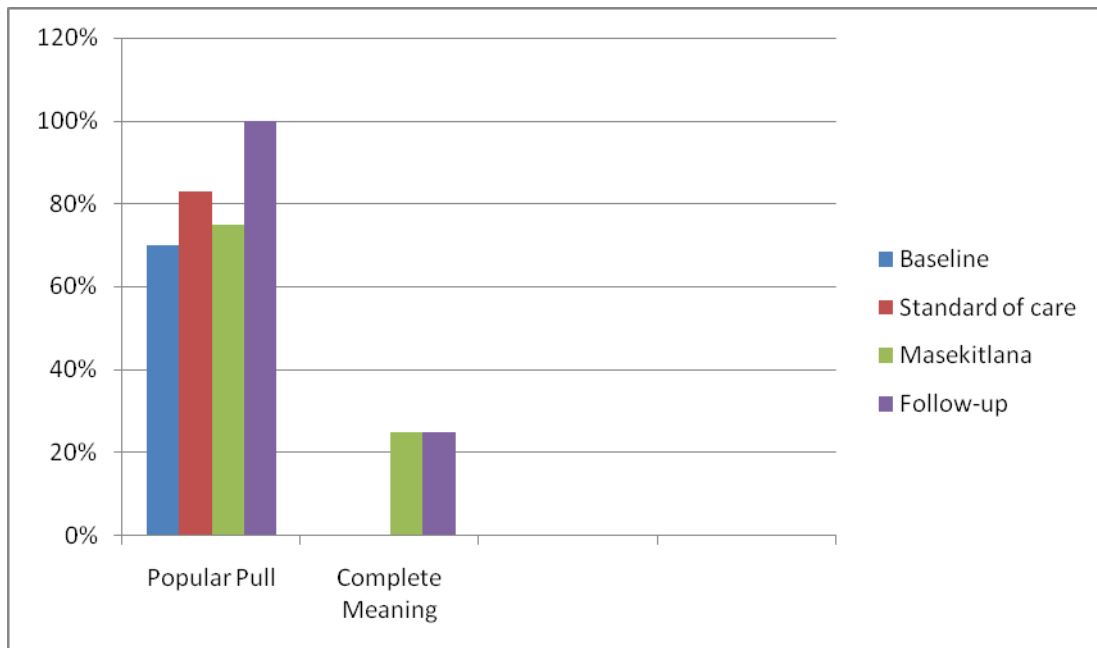
- **Atypical 2 (misidentification of theme, including obvious denial of pictured theme) and Atypical 3 (misidentification of person):** At baseline and after standard of care therapy (for Atypical 2) and at baseline (for Atypical 3), Hlonipho's stories indicated these atypical responses to one of the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

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

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

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

#### 5.3.2.1 Senzo: Popular Pull and Complete Meaning

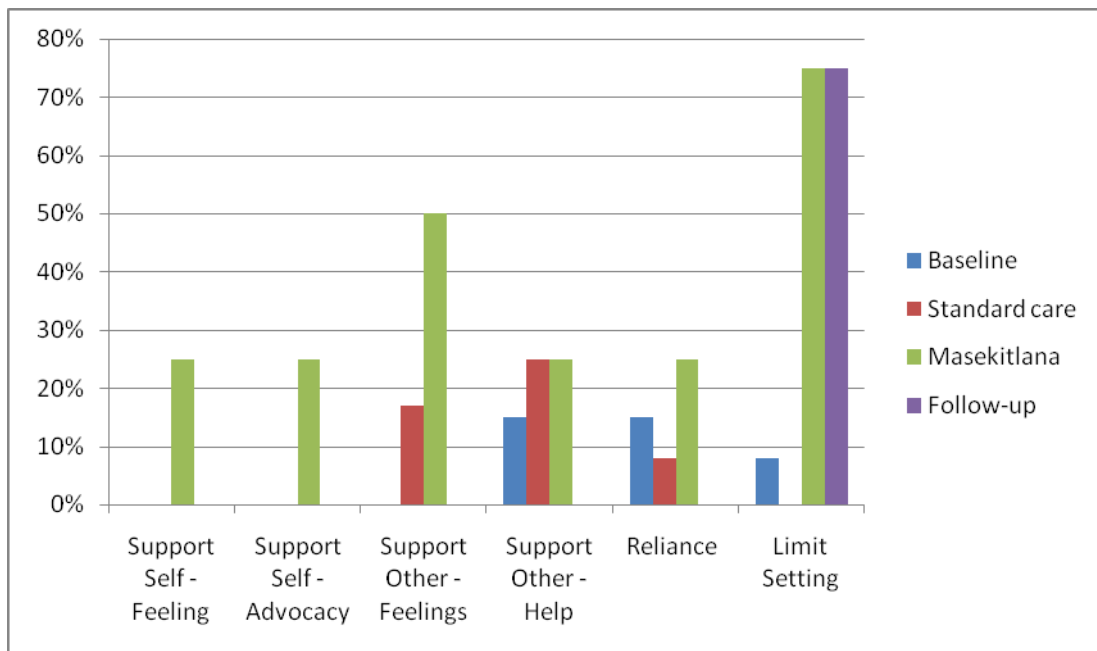


**Figure 21: Senzo: Popular Pull and Complete Meaning**

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

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

### 5.3.2.2 Senzo: Available Resources Scales



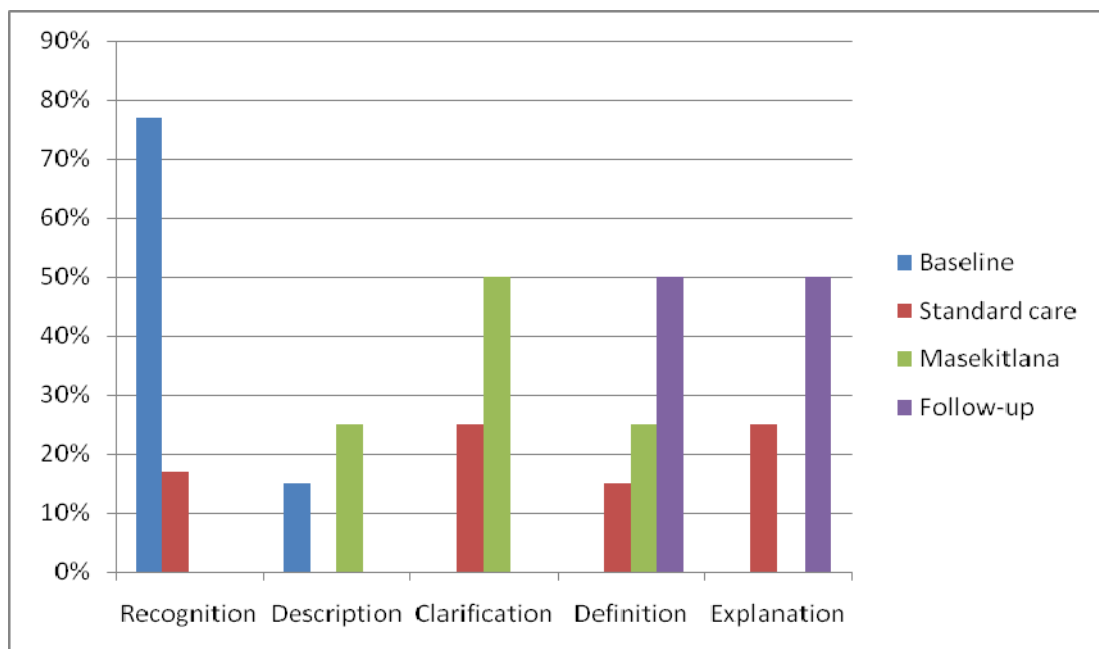
**Figure 22: Senzo: Available Resources Scales**

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

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

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

### 5.3.2.3 Senzo: Problem Identification Scales



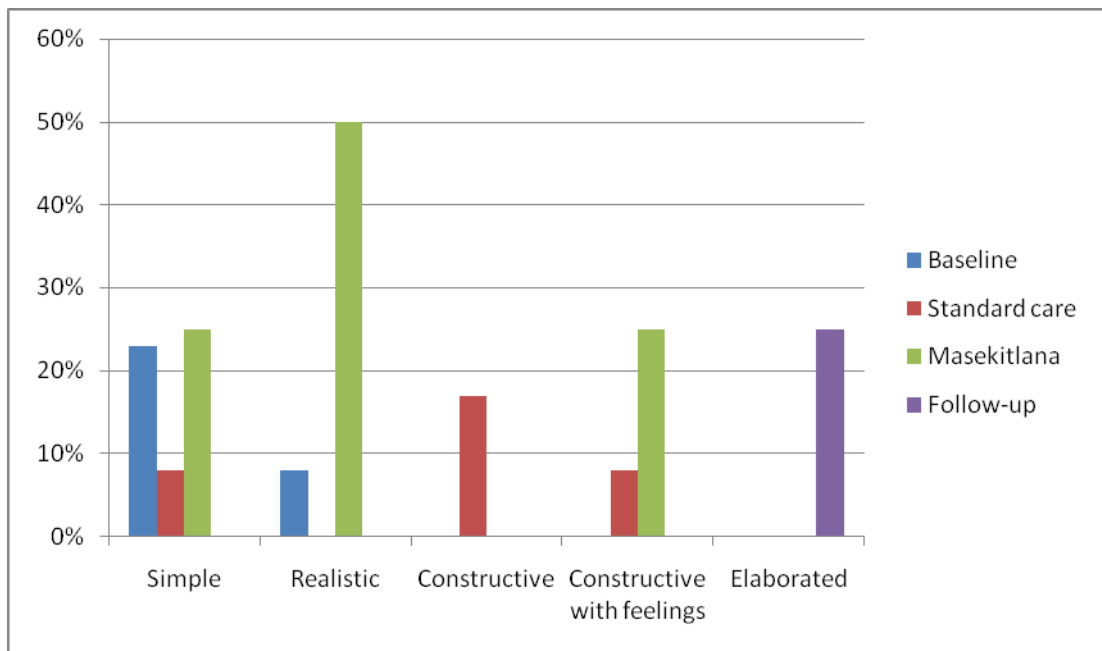
**Figure 23: Senzo: Problem Identification Scales**

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



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

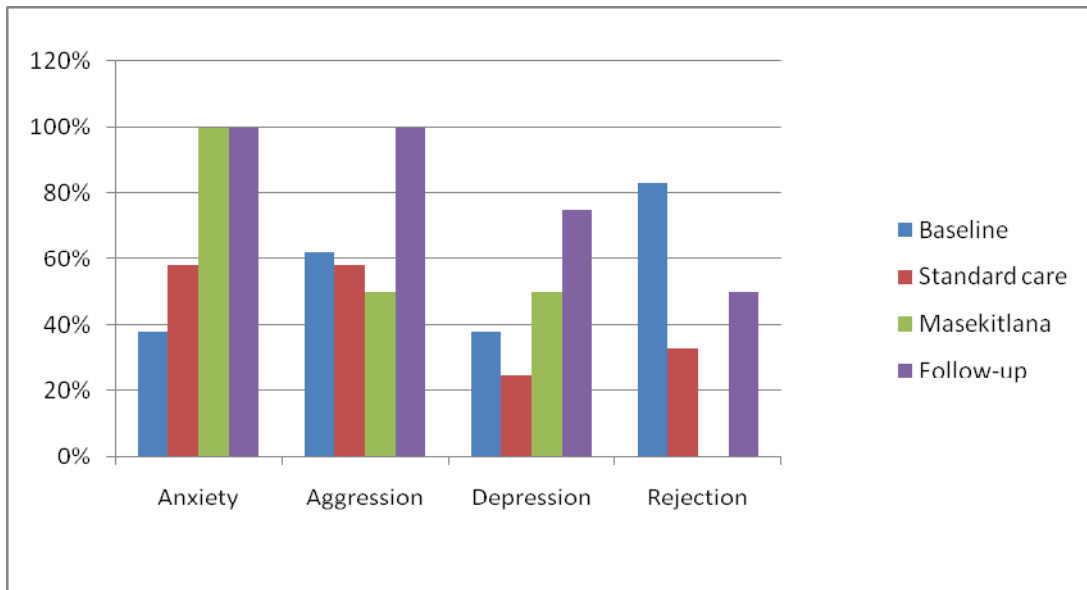
### 5.3.2.4 Senzo: Resolution Scales



**Figure 24: Senzo: Resolution Scales**

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

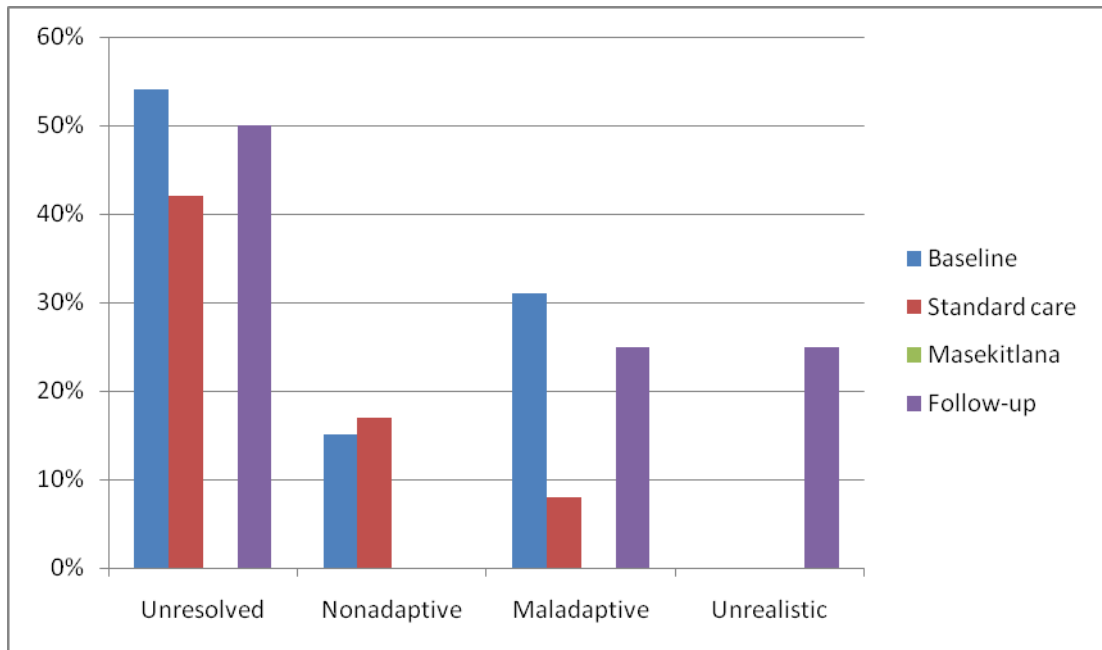
### 5.3.2.5 Senzo: Emotion Scales



**Figure 25: Senzo: Emotion Scales**

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

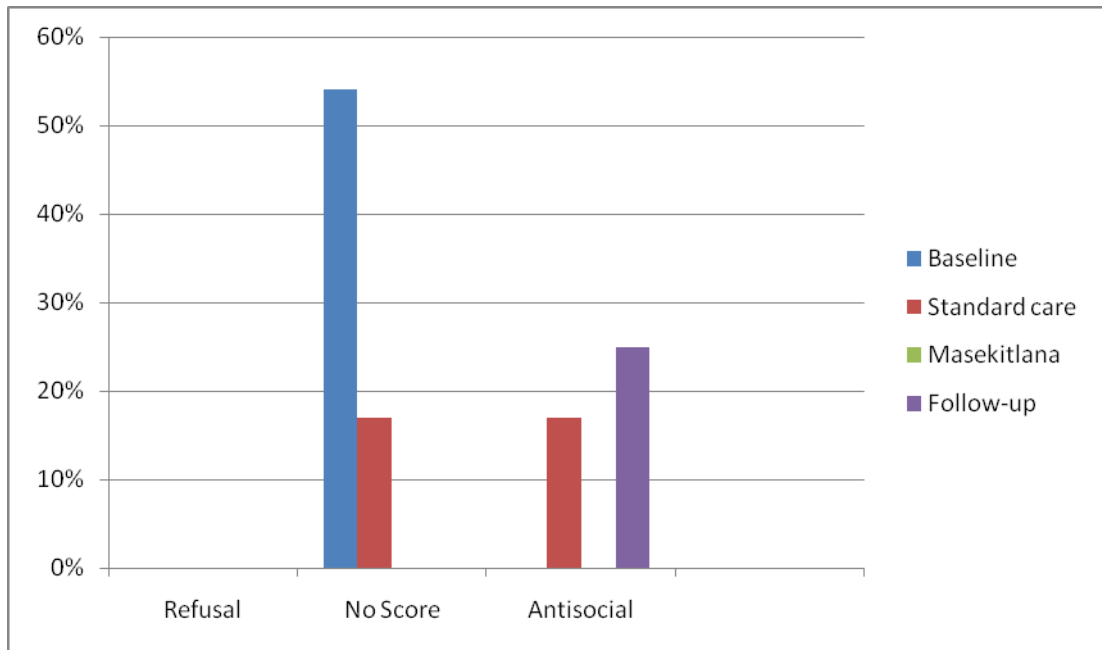
### 5.3.2.6 Senzo: Outcome Scales



**Figure 26: Senzo: Outcome Scales**

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

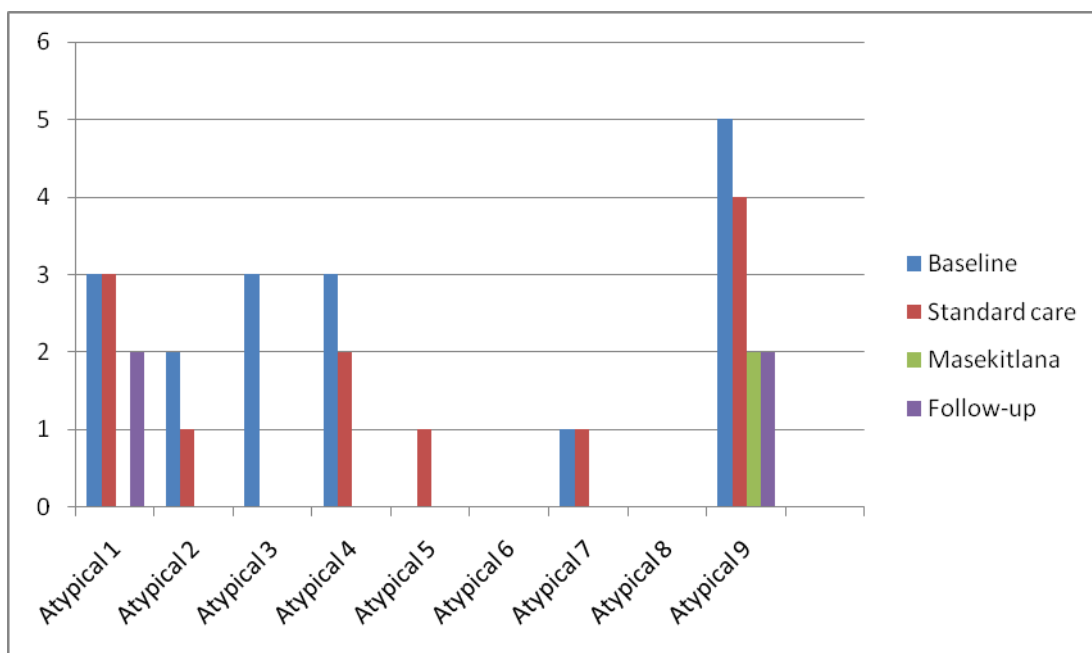
### 5.3.2.7 Senzo: Unusual or Atypical Responses



**Figure 27: Senzo: Unusual or Atypical Responses**

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

### 5.3.2.8 Senzo: Atypical Categories



**Figure 28: Senzo: Atypical Categories**

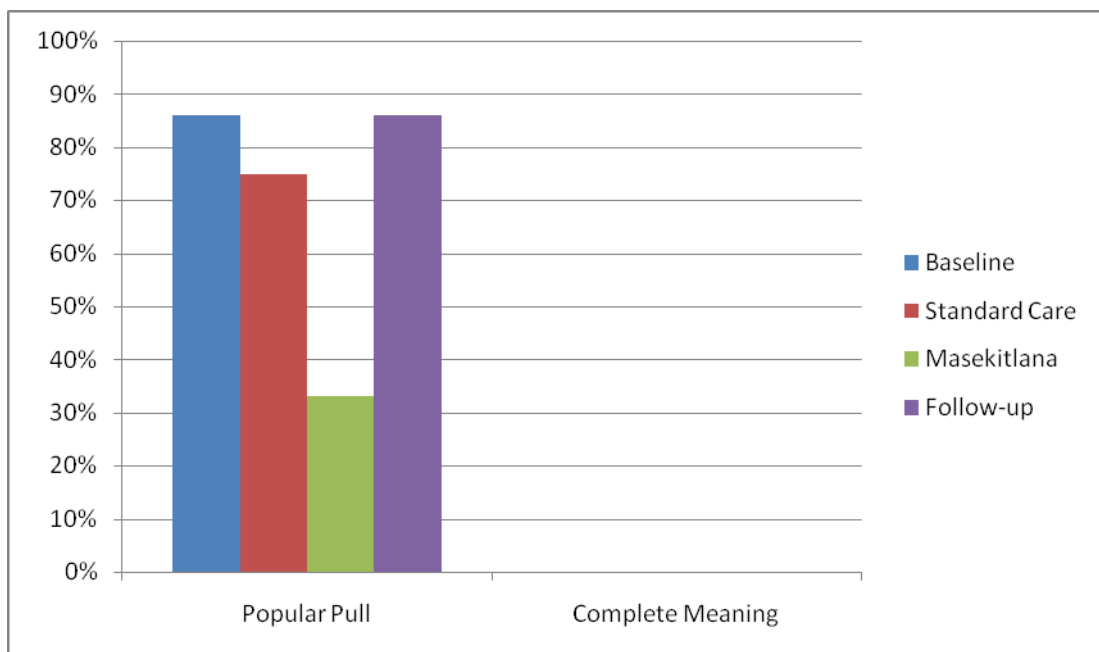
Senzo’s stories reflected 6 different types of Atypical scores at baseline. “More than one atypical score usually identifies a significant level of psychotic disturbance” (Roberts, 2009:125). Atypical 1 score indicated how Senzo tended to describe stories in an illogical way at baseline (for 3 out of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

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

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

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

### 5.3.3.1 Nana: Theme Overview Scales



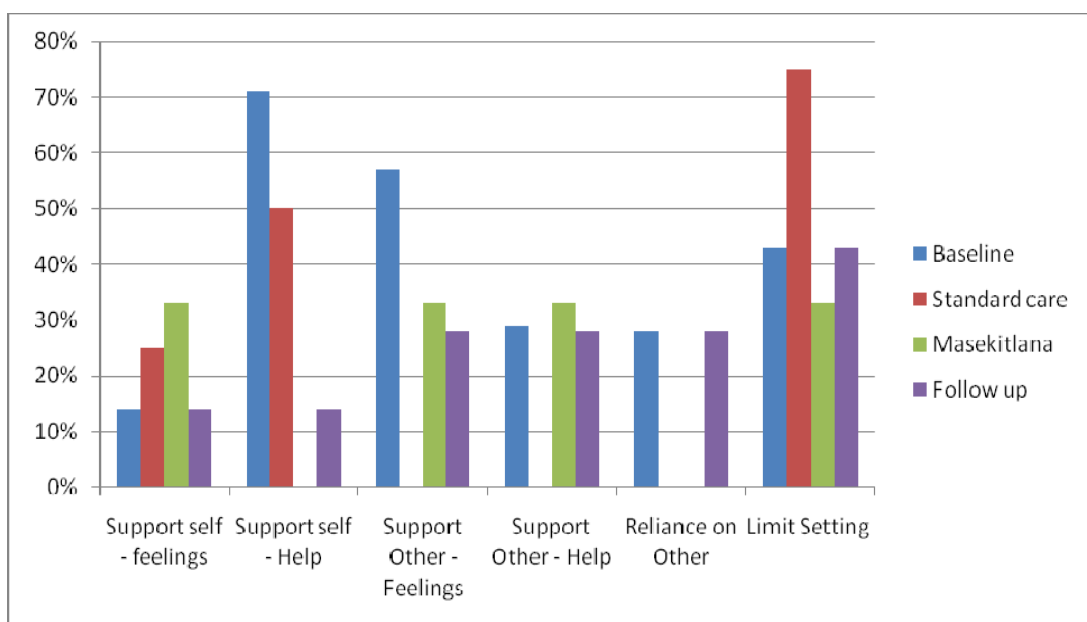
**Figure 29: Nana: Theme Overview Scales**

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

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

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

### 5.3.3.2 Nana: Available Resources Scales



**Figure 30: Nana: Available Resources Scales**

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

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

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

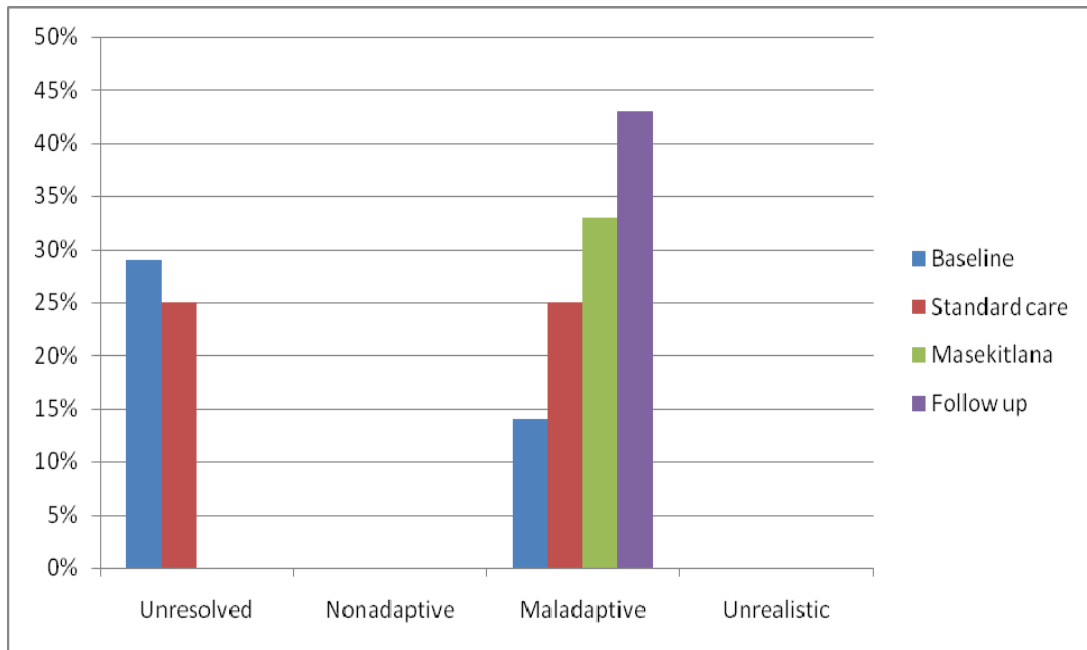


Similarly, in the Support Other – Help category, although Nana’s score after Masekitlana therapy indicated an increase of 30% from a nil score after standard of care therapy, her relatively low scores reflected her feelings that interactions with others did not yield any significant help in her life.

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

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

### 5.3.3.3 Nana: Outcome Scales

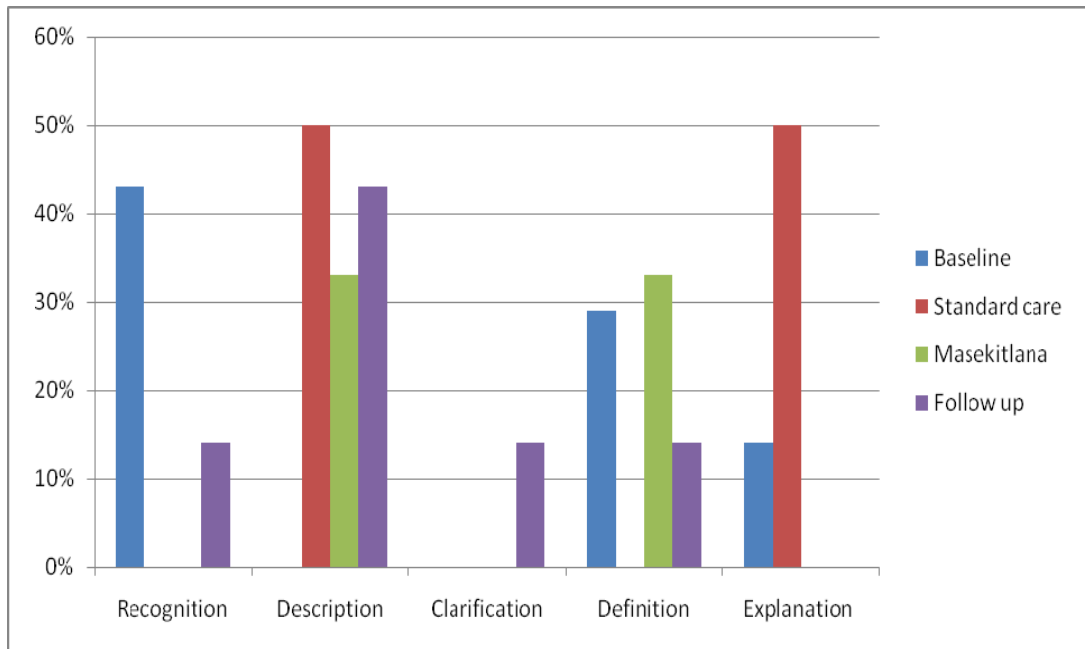


**Figure 31: Nana: Outcome Scales**

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

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

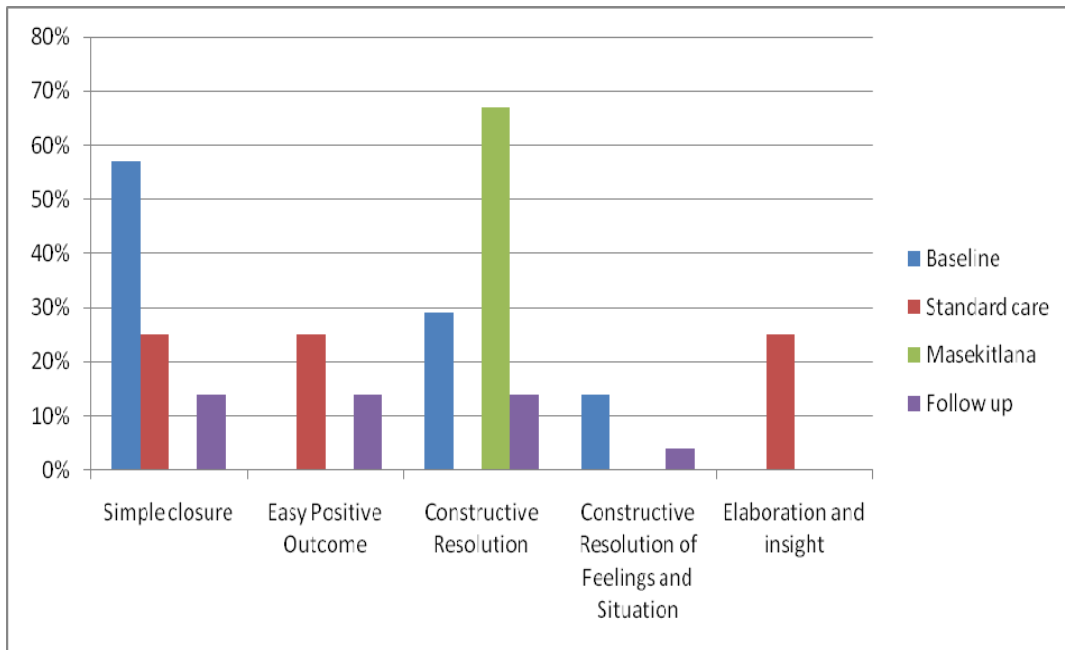
### 5.3.3.4 Nana: Problem Identification Scales



**Figure 32: Nana: Problem Identification Scales**

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

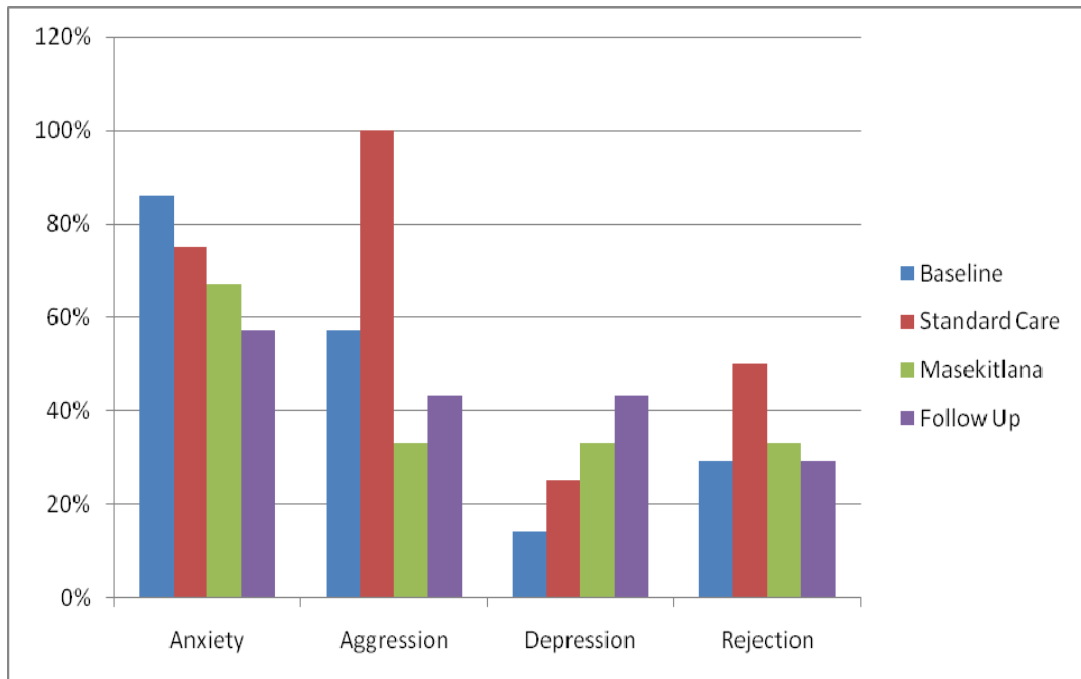
### 5.3.3.5 Nana: Resolution Scales



**Figure 33: Nana: Resolution Scales**

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

### 5.3.3.6 Nana: Emotion Scales

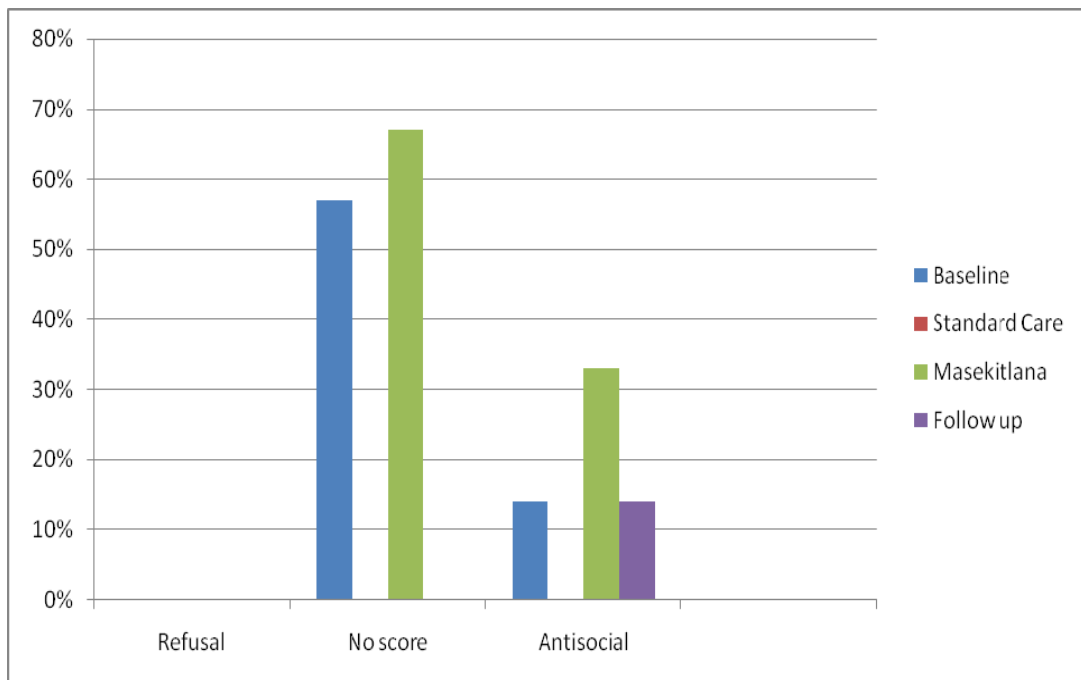


**Figure 34: Nana: Emotion Scales**

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

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

### 5.3.3.7 Nana: Unusual or Atypical Responses

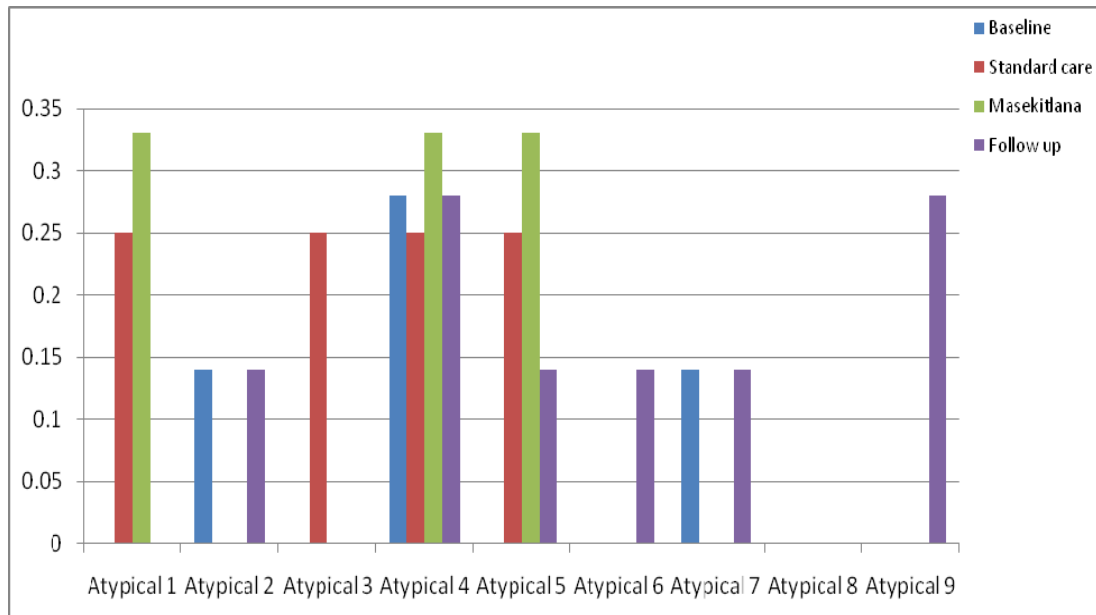


**Figure 35: Unusual or Atypical Responses**

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

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

### 5.3.3.8 Nana: Atypical Categories



**Figure 36: Atypical Categories**

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

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

#### **5.4 INTERPRETING GRAPHIC RESULTS: COMBINING AND COMPARING PARTICIPANT RESULTS**

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

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

- **Popular Pull**

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

- **Complete Meaning**

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



- **Available Resources**

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

- **Limit Setting**

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

- **Problem Identification**

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

- **Problem Resolution**

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

- **Emotions**

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

- **Outcome**

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

- **Unusual or Atypical Responses**

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

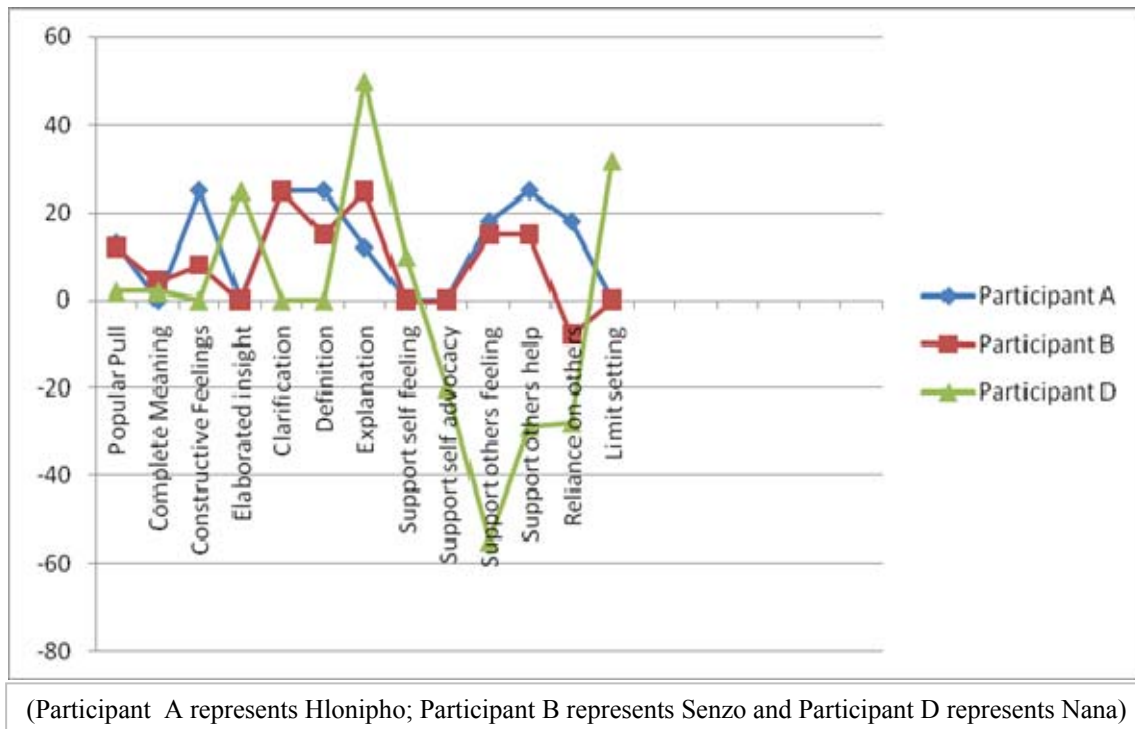
- **Atypical Categories 1 to 9**

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

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

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

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

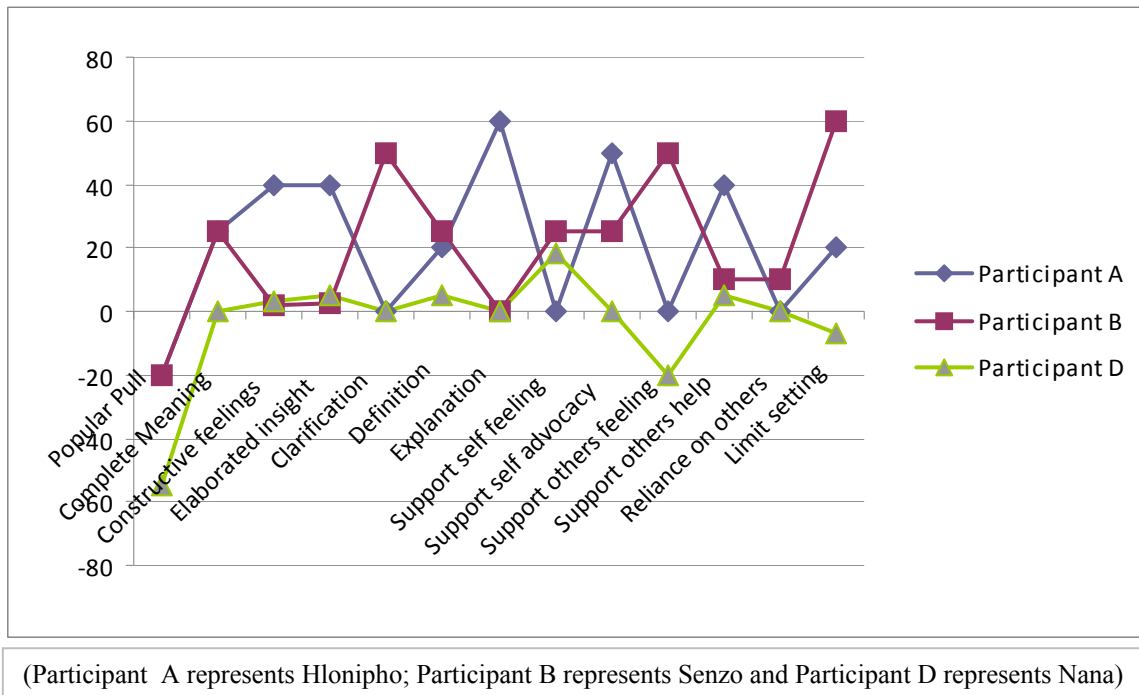


**Figure 37: Progress scores from baseline to end of *standard of care* therapy**

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

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

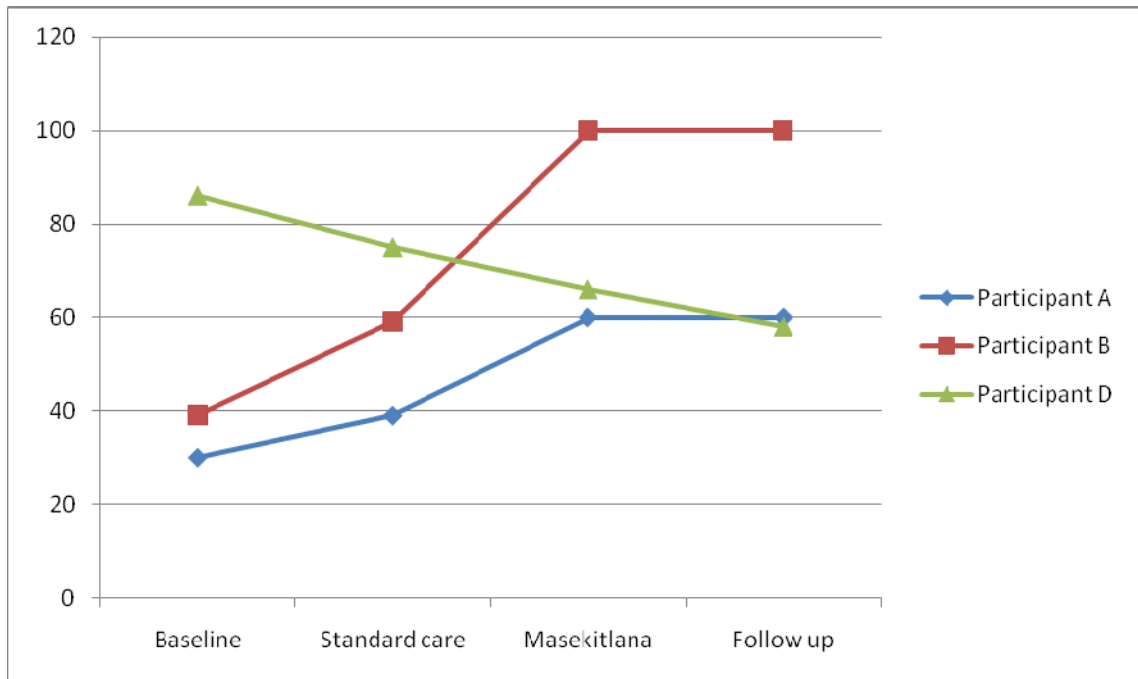
It can be seen from the above graph that progress scores, as a result of standard of care therapy, were predominantly in the range of between 0 and 23. Nana's scores were erratic, which was indicative of her attitude to therapy and the assessments, as reflective of her attitude to living in the Home.



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

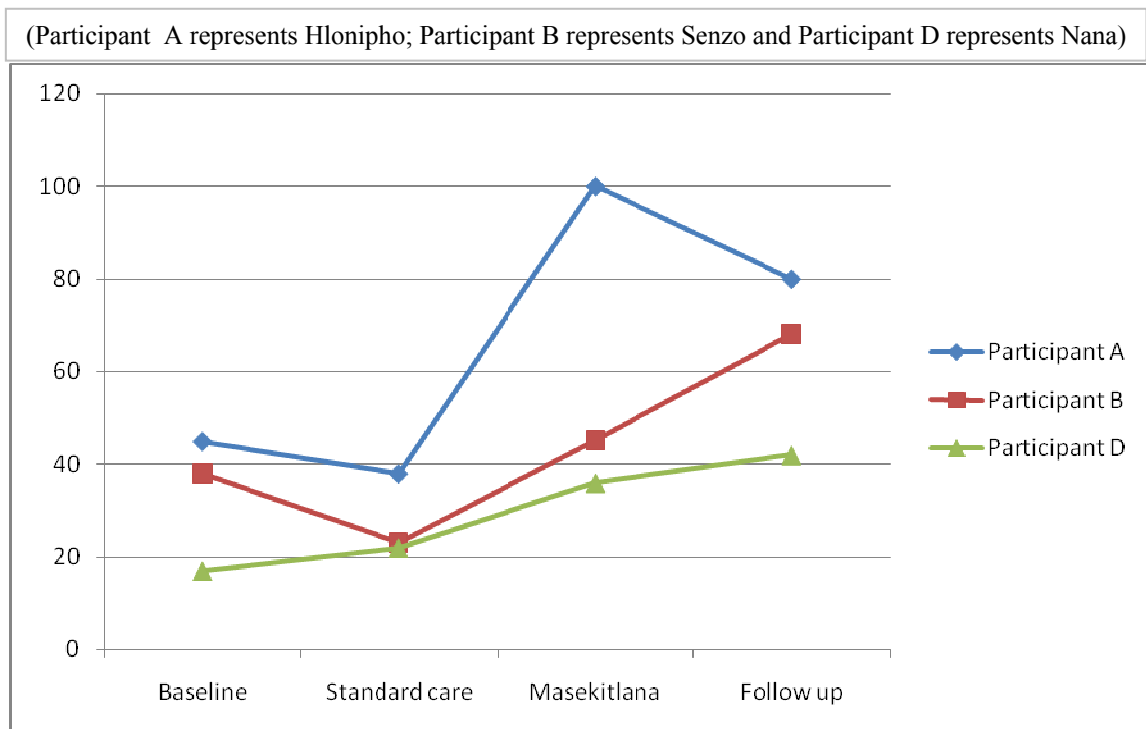
As an explanation, take the score of Senzo for Complete Meaning: his marker is at 23, which indicates that he improved by 23% between baseline and after *Masekitlana* therapy. It can be seen that progress scores for *Masekitlana*, indicated in the graph above, ranged predominantly between 0 and 45, hence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

### 5.4.2 CHANGES IN EMOTION LEVELS OF PARTICIPANTS



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

**Figure 39: Anxiety levels of participants as therapy progressed**

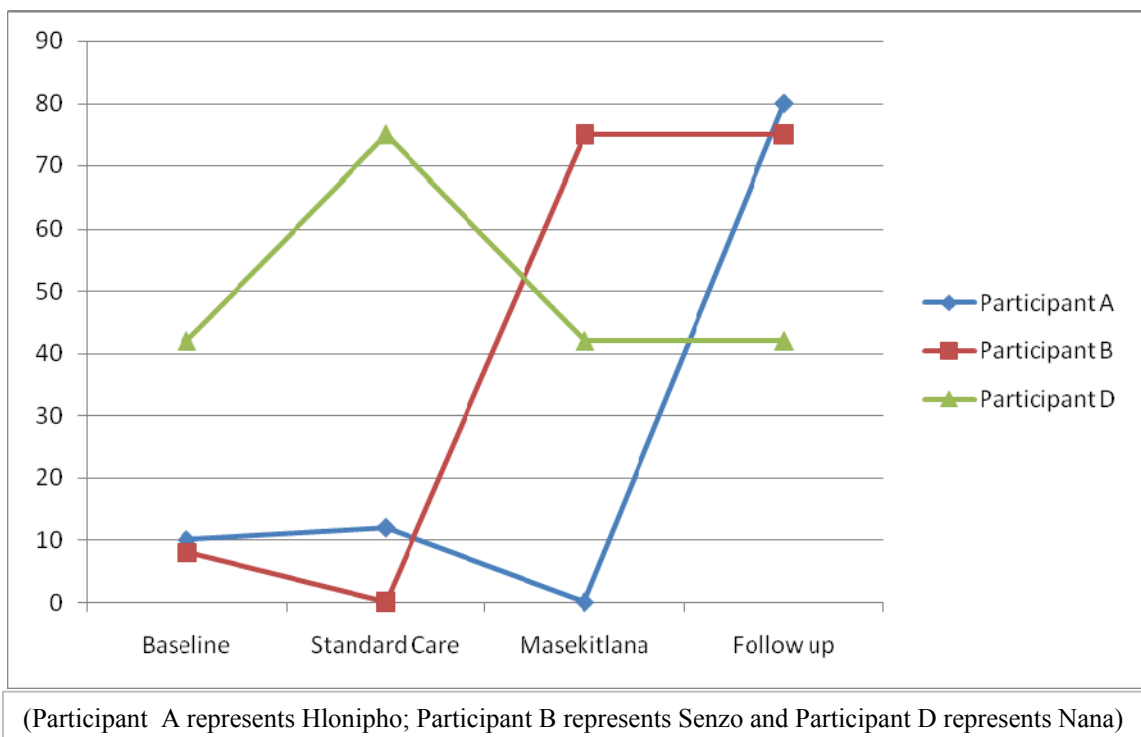


**Figure 40: Depression scores of participants as therapy progressed**

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

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

### 5.4.3 LIMIT SETTING SCORES OF PARTICIPANTS AS THERAPY PROGRESSED



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

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

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

## 5.5 CONCLUSION

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

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

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



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

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

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## CHAPTER 6 DISCUSSION OF FINDINGS

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*“It is a Native American legend that when the earth begins to die as a result of all the harm inflicted upon it, warriors will arise from all over the world to heal the earth. These warriors will be known as warriors of the rainbow. As we face the challenges of transforming psychology and helping our nation to heal and grow healthy, mental health professionals have the imperative to recognize the biases of their training and their own ethnocentrism and have both a professional and moral obligation to learn how to engage in this rainbow dance in order to take up the challenges facing our society and profession”* (Naidoo, 1996:11).

### 6.1 INTRODUCTION

The previous two chapters discussed the qualitative and quantitative analysis of the four participants’ narratives expressed in standard of care and Masekitlana therapy, as well as during the administration of the Roberts-2 test. This chapter integrates my findings with the literature in the field of indigenous knowledge systems and indigenous psychology.

Through the intervention of Masekitlana, participants expressed concerns, experiences, values and goals that were indicative of their cultural and indigenous background. In this discussion, I clarify and elaborate on aspects of the participants’ expressions as they were collated into themes that reflected their understanding of indigenous knowledge systems. Linking literature to participants’ responses during Masekitlana indicated the possibility of using an indigenous psychology framework to facilitate the therapeutic process, thereby highlighting the need for African-based forms of therapy.

The aim of this chapter is to demonstrate how the use of Masekitlana filled a gap in the literature on African forms of therapy. In this way this study will have made a contribution to the field of African indigenous psychology.

## 6.2 INDIGENOUS KNOWLEDGE SYSTEMS AND THE NEED FOR INDIGENOUS PSYCHOLOGY: REFLECTIONS ON PARTICIPANTS' RESPONSES TO MASEKITLANA AND THE ROBERTS-2 TEST

Masekitlana appeared to enable participants to express their traditional African beliefs. They did not talk about these until they started to play Masekitlana. In the sections below, I describe parts of their narratives and, with the use of literature, put them in the context of indigenous knowledge systems and indigenous psychology. I attempt to make sense of the participants' descriptions of parts of their lives through their traditional African, in particular Zulu, notions or ideological frames of reference. The participants, who were children affected by HIV/AIDS, expressed illness through the lens of their traditional African beliefs. I describe these perceptions, as they have a bearing on forms of therapy that could be of use for children affected by HIV/AIDS.

### 6.2.1 ZULU ANCESTRAL SPIRITS, BEWITCHMENT, COSMOLOGY AND RITUALS

*She got sick, she was seeing animals ... the snake came in ... it opened its mouth and it talked ... I heard it on my ears ... my father told us to leave it because maybe the ancestors were telling my mother that she needs to do Zulu rituals ... she left and went to her relatives where she died ...*

*I go to bed the ghost comes ... it gets sent to hit that other person at night ... but if I don't say it, it goes to sleep ... they put some muthi on her food ... when we woke her she did not want to wake up and she was dead ....*

In the first session of Masekitlana, Hlonipho narrated how his sick mother had been guided by her ancestors in the form of a “spirit-snake” (Krige, 1950:65) to return to her family home to perform rituals. Hlonipho might have been describing the Zulu rites that are performed on a dead person to take her home as an *idlozi* or ancestor (Ngubane, 1977). Hlonipho accepted this passage from sickness to death in his mother as, being of Zulu origin and culture, he would accept the jural powers of the ancestors over their descendants. His mother's ancestors from her family of origin would, according to Zulu custom, have “more ownership over her” than the ancestors of Hlonipho's father (Ngubane, 1977:91); hence, Hlonipho accepted her departure to her own family. Hlonipho's belief in the guiding powers of *amadlozi* ancestors in his mother's life might have comforted him in what otherwise would have been for him the traumatic departure of his mother. Furthermore, Hlonipho's story could have reflected the

belief that, according to African traditions, once a person dies, his or her spirit continues upon a journey that is similar to life (Mwizenge, 2011), as the “*mhondoro* or ancestor spirit is one of human life being indistinguishable from human death” (Holland, 2001:155).

The reason why Hlonipho mentioned *amadlozi*/ancestors during Masekitlana therapy might have been because banging stones together was an activity which “resonates with the way African people communicate with their ancestors in traditional rituals and ceremonies” (Buhrmann, 1984:14). Masekitlana might have resembled familiar Zulu rituals which, for Hlonipho, coming from a rural background, “revitalized his cultural memory” (Ratele, 2003:114) and enabled him to “reveal a functional belief in multiple worlds, that is, the material-transitory everyday life and the spirit-eternal traditional life’ (Misra & Gergen, 1993).

The fact that Hlonipho was too sick himself to be included in the *ukubuyisa* or departure ceremonies for his mother might have been the reason why he mentioned a mother so often in his descriptions of the Roberts-2 test. Instead of helping in the ceremonies, as is expected of the eldest son of a Zulu family (Ngubane, 1977), he was admitted to hospital, where he stayed for over a year.

During a Masekitlana session, Nana described a spirit or ghost who came around her bed at night, who fought off her enemies and then went to sleep. In the Western worldview, Nana’s and Hlonipho’s descriptions and perceptions might be considered paranormal or magical. However, in African cultures, the human being is believed to have many senses beyond the five known to the Western world (Mutwa, 1998), hence the discrepancy in sensate experiencing between an African person and a Western person, which might enable a child like Nana to be in touch with an extra psychic reality beyond what the Western mind is able to sense. This might have import on indigenous psychological therapy, and the psychologist from another culture who is attempting to try to understand the life world of an African client. However, even if he or she is from another culture, a psychologist with some knowledge of the traditional customs of the client could explore and interpret the client’s narrative with this understanding and sensitivity to the cultural norms of the client.

## 6.2.2 ILLNESS AND PSYCHOTHERAPY IN THE AFRICAN INDIGENOUS CONTEXT

*She dreamt about the snake, a big snake which has eight heads ... the snake ate her and it only left the head ... then another snake showed up and that snake had 50 heads ... the snake swallowed her whole head in its mouth.*

If Masekitlana enables the expression of traditional African beliefs, and if this form of therapy is offered to children of Zulu origin and culture, then how the children perceive their illness and “sick” identity in their indigenous context needs to be understood. The participants’ narratives in the current study indicated the influence that their African beliefs had over their perceptions of illness. Rather than reflecting an internal organic view of disease and death by illness, they described ancestors, spirits and snakes coming to hail sick people away, to poison people and to choke people.

A scientific approach, that is, the application of a Western form of laboratory science to understanding illness in South Africa, is considered wholly inappropriate and superficial for studying cultures (Misra & Gergen, 1993). Scientism is decried as being “absolute, overestimating of its power and restricting itself to scientific data without taking into account the influence of the paradigms defining the current state of knowledge” (Hountondji, 1983: xiii). I needed to understand how the participants of the current research perceived their or their family members’ illnesses and healing from it. This involved an exploration of the explanations for misfortune that form part of African indigenous knowledge.

There is debate in the literature as to whether African people externalize disease causation or whether they incorporate disease into their internal psychic structures and identities. Ngubane (1977) appears to favour an external focus, explaining that Zulu people handle mental illness by absolving themselves of the illness. They claim nothing is wrong with them, “rather, external, intruding spirits are to blame, hence, a person gets the support and sympathy that a depressed person longs for” (Ngubane, 1977:149). Illness and “misfortune are often interpreted as being brought on by a relationship breakup with the ancestors” (Maiello, 2008:225), where parents have angered the ancestors, resulting in the misfortune of their children (Ngubane, 1977).

Two of the participants were living with HIV yet at no stage did they describe their illnesses in a bio-medical Western sense. Nana related what Ngubane (1977) would describe as a

“night sorcerer” who visited her neighbours and put *muthi* or “black” African medicine into their food, resulting in the death of a mother and daughter. This was a case of Nana *externalizing* the problem of illness or the causation of illness, as did Hlonipho when he described how his mother was guided away by her ancestors to die. African people have a need to ask the “how”, “why” and “by whom” questions around misfortune and trauma (Burhmann, 1984), implying an externalization of the problem. When, in 2008, the cyclonic winds blew down homesteads in Embo, a rural area inland of Durban, causing the death of two young children, I was told by an elderly resident there that it was due to a large snake coming out of the earth to punish the youngsters of the community for their unruly ways and disrespect for their elders.

The other side of the debate is that certain cultural elements, such as the ancestors, have consequences for the *internal* objects and sense of identity of the African person and this contributes to the “patient’s specific ways of communication and expressing distress” (Maiello, 2008:241, 243; Steyn, 2003). As opposed to believing that the body is infected by a virus that may be cured by allopathic medicines, a traditional African person is likely to claim his or her dependence on an “internalized authority, an omnipotent (other) god who has caused or who ‘has the answer’ to his problems” (Mannoni, 1990:40, in Hook, Mkhize, Kiguwa, Collins, Burman & Parker (Eds.), 2004).

Children whose parents have died from disease are considered ‘polluted’ in the African sense as a result of a prolonged period of being with their sick parents (Ngubane, 1977). Similarly, sexually abused children are considered ‘polluted’. These concepts could have been explored with the participants, two of whom were sexually abused and two of who had lived with sick parents before they died. By being excluded from their indigenous environments, the participants were not able to observe *ukuzila* or withdrawal from society, which is a ritual of “pollution cleansing” (Ngubane, 1977). Their state of pollution would have involved being treated by herbal “black” medicine and then wearing red-and-white clothes and beads to effect transformation (Ngubane, 1977). Instead, the participants of the current study were offered Western medical care, in the form of anti-retroviral medication, and Western legal processes against the perpetrator of their sexual abuse.

These indigenous African concepts around illness could have important implications in establishing a therapeutic focus and a locus of agency for participants during Masekitlana

therapy. Therapists using Masekitlana need to be aware of the fact that African clients living with or affected by HIV/AIDS might externalize or internalize their illness and both foci would be based on traditional African thinking.

Literature has pointed to the “indivisible unity of the body and the mind” (Kruger, Lifschitz & Baloyi, 2007:326), which is the “core of the African view of the human being” (Burhmann, 1984:91), and the protection of the Whole or Gestalt (Misra & Gergen, 1993), which reflects in African cultural perceptions on illness. As the participants were observed using and moving the whole of their bodies while talking with the stones in Masekitlana, I believe that it could be used effectively as a therapy of healing and enabling dialogue around illness for the African patient. Eskell-Blokland (2005:172) makes an appeal for psychologists working in indigenous environments to “use a different set of tools which may not be tools at all in any conventional sense in psychology”. Masekitlana might be such a tool, as it has the potential to take the practitioner away from “just talking about healing through established practices, to talk from within and on the margins of various healing practices” (Kruger, Lifschitz & Baloyi, 2007:323).

#### **6.2.2.1 African animism and illness**

According to African concepts of animism, “the world is a community of living organisms and everything has a consciousness and a soul; this includes insects, animals, plants, trees, rivers and mountains” (Kruger, Lifschitz & Baloyi, 2007:333) and appeared to me in the current study to be linked to the participants’ concepts of illness. The participants described snakes, horses and wild animals in connection with nightmares (Nana and Senzo), death (Hlonipho), and happy times (Hlonipho). Hlonipho described how his mother was seeing wild animals before she died, a phenomenon that might have been diagnosed by a Western practitioner in terms of psychiatric pathology. However, looking through an African lens, this occurrence might have been understood as a person out of harmony with her environment or experiencing a visualization of “Ancestors of the Forest” in the form of “wild animals, physical and instinctual, who play a decisive role in the intra-psychic world of the African person and in the development of illness” (Buhrmann, 1984:29).

A Western counsellor might have tried to heal the participants of frightening snake images in their imaginations and dreams, interpreting them as hallucinations, and thereby ignoring the ‘taken-for-granted’ meanings behind what they were saying. Examples of these are that “man

stands in the middle of living creatures and not at the top” and the “soul (of man) goes on to a higher plane of existence by re-incarnating into a reptile, the red and green mamba in particular being carriers of the souls of recently departed persons” (Mutwa, 1998:601). Some African people, but especially initiates becoming *izangoma*/ spiritual healers, are “expected to experience the manifestation of animals in thinking, dreams and visions” (Buhrmann, 1984:84). A Western-orientated psychologist might want to diagnose as abnormal these types of thoughts, should they be experienced by African adults and children clients, whereas an African psychologist might be more inclined to interpret them in the light of indigenous knowledge systems and beliefs.

However, Nana appeared to be so traumatized, and her narrative and behaviour appeared to be so disturbed in the therapy sessions, that simply attributing her behaviour to *normal* African notions left me feeling perturbed that professionally I was not helping her enough. This is confirmed by Ross and Phipps (1986:255), who state that many “well-intentioned therapists adopt a culturally relativistic approach where divergent behaviours and traits are translated as being culturally appropriate”; they are then excluded from clinical judgment, which can “limit therapeutic range and effectiveness”.

#### **6.2.2.2 Traditional African healers**

Notwithstanding the above concern, one of the alternative paradigms to more conventional or Western forms of healing and therapy in South Africa is the use of traditional African healers such as *izangoma*/spiritual healers, *abathandazi*/prayer healers and *izinyanga*/herbal healers. For Hlonipho to make better sense of his narrative around ancestors, death and separation from his mother, and for Nana to explore the meaning of the spirit/ghost around her, I wondered whether they should have been referred to an *isangoma* rather than continuing therapy in the psychology clinic of the hospital with a therapist from a different culture. Masekitlana had enabled them to express their African beliefs, so to take them back to therapy of a more Western orientation might have been counterproductive. I felt that *izangoma*/spiritual healers would have been a complementary source of healing to Masekitlana in restoring harmony to the participants’ lives, but questioned whether the authorities in the Children’s Homes would have agreed with it.

Mkhize (2004) describes an incident where a nurse secretly referred a patient to a traditional healer as she felt it might be against the ethical code of her profession to do it openly. Mkhize



(2004:39) claims that this is a case of a “marginalised worldview operating underground, which could be avoided if there was open engagement between professionals from different cultures about different forms of treatment”. According to the World Health Organization, about 80% to 90% of people in developing societies rely on traditional healers for healthcare (Mkhize, 2004:32; Traditional Healer’s Conference, 2010; statistics confirmed by Dr. Mokgoba, vice-chancellor, University of KwaZulu-Natal), and more than 70% of South Africans consult indigenous healers (Kruger, Lifschitz & Baloyi, 2007:335). To refer Hlonipho and Nana to a mental health professional practising from a Western perspective might marginalise their traditional perspective, thereby contributing to a further suppression of their beliefs, natural instincts and intuitions. The result might be that knowledge itself, which they expressed through their descriptions in therapy, and which I felt so privileged to be part of, might become “marginalised knowledge, rendered invisible by the competition between cultural systems, of which the Western is the most dominant” (Mkhize, 2004:32).

### 6.2.3 CHRISTIANITY

*How does Satan kill people while God is there ... Who was the creator of Jesus Christ? ... I ask Him to help me.*

Three of the participants of the current study mentioned God and His influence in their lives, and all four participants went to church on Sundays with their peers in the Children’s Homes. I contemplated whether their Christian beliefs were complementary or contradictory to their traditional African ancestral and cosmological beliefs, and to what extent psychologists should incorporate Christianity and “Zulu religion” (Krige, 1950) into therapy with patients of Zulu culture and origin.

Nana and Senzo both expressed trust in a protective God but Hlonipho questioned why, if God is so powerful, He allows misfortune to befall people. Through these expressions on the subject of Christianity, the participants appeared to be in the process of taking into consideration *external* occurrences and effects in their lives, with the intention of *internalizing* them into their personhoods or identities. How then did they internalize apparently disparate belief systems into their single personhoods?

Mkhize’s (2004) theory of the “dialogical self” posits that an African child internalizes the social and cultural values of his community or environment. These are then integrated within

his personhood, the way he feels about himself and the way he talks. Because of the diversity of values that the child internalizes, he bears within his dialogical self several voices talking and debating with each other, which Mkhize (2004) calls “polyphony”. Hence, a Christian self and a traditional African self can exist side by side within one person in the form of “compound beliefs” (Holland, 2001:6) or “syncretism” (Jeske, 2010:118). The relationship appears to be more complex and there is a hierarchy of relationship: a Zulu person believes that it is the ancestors who communicate or negotiate with God on behalf of the living (Mkhize, 2004) and that the ancestors occupy a plane below God (Mutwa, 1998).

Masekitlana, being a traditional African game, appeared to enable expression of the duality of these beliefs and highlighted the necessity for psychologists to be aware of a divergent belief from the dominant Western perspective, whereby thinking is more centralized (Mkhize, 2004) and religious belief is usually in only one source of power, and that is God alone.

The viability of the above syncretism of beliefs is not borne out by all authors describing the subjects. It seems possible that a person’s Christian beliefs can conflict, in certain contexts, with their Zulu spirituality. Ngubane (1977) demonstrates this by explaining that if a Zulu person fails to perform certain Zulu rites and instead favours his trust in Christianity, the ancestors will not protect him or will bring misfortune upon him. Hence, even though Zulu people profess to believe in God, their “Zulu ways of doing things or *ukugcina isiZulu* might under certain circumstances have the greater influence on them” (Ngubane, 1977:20). Although Hlonipho mentioned that he was a Christian, he might have felt inadequate at not having performed, as the eldest (and only) son, the African rites of passage towards ancestor status for his mother at her funeral. Although Nana expressed that God told her what to say, she still explained how she has a spirit or ghost who surrounds her at night to protect her.

Understanding the complementary and, at times, conflicting beliefs of the participants against the backdrop of their more Westernized institutional as well as their traditional contexts was necessary when conducting Masekitlana with them.

#### **6.2.4 COMMUNITY CONNECTIVITY, FAMILY NEED AND ATTACHMENT**

*My mother loved me ... I am thinking about my mother ... dreaming about mother ... I just want a family to love me ... Mother did not like me ... I call gogo my mother because she gives me things.*

The participants of the current study were reluctant to talk about their emotions even during Masekitlana and the Roberts-2 test. Instead, it appeared that they expressed their feelings in terms of their relations with others, such as being misunderstood in conflicts with peers, being fearful of their educators or missing their homes and families. Talking about themselves mostly in relation to others, reflected the communal nature of African people in general (Maeillo, 2008), termed *ubuntu*, or the fact that it is “the community which defines the individual rather than his personal characteristics” (Holland, 2001:178). The individual does not feel anything alone but is a “being-with-and-for-others and not an isolated atomistic individual” (Mkhize, 2004:49).

The participants spoke often about their mothers or grandmothers. Even though three of the participants’ mothers had abandoned them, they were not critical of their mothers’ actions but expressed a prevailing need or longing for them and for extended family. This could have reflected the Zulu notion of health and harmony in life, which are the “outcome of a balance between man and his environment, which is comprised of the individual, his family and his clan or community” (Ngubane, 1997:5). African families are affirmers and teachers of cultural norms to their offspring. Of particular importance to a child of Zulu origin and culture is the mother, as she performs birth, puberty and incorporation rituals (Krige, 1950; Mkhize, 2004), and the “well-being of the child, in particular his moral values, depends on the mother’s conduct” (Ngubane, 1977:6). The mother is the overlap between the living world and the ancestors, and man enters and exits the world through her (Ngubane, 1977). Zulu rites of passage are not recognized out of the family or separate from the family unit, hence a child like Hlonipho might feel symbolically disconnected from his culture and community. Senzo’s mother had died so she was not able to fulfil the customary obligations of a daughter-in-law or *makhoti*/new bride to his paternal grandmother. This might have explained why Senzo felt duty-bound and proud to help his grandmother perform domestic duties such as dish washing and cleaning the house. Nana’s mother appeared to be a sex worker, which was very hurtful for Nana, as her mother would come home for a weekend but disappear in the night. Except for Hlonipho, who had no family members in contact with him, the grandmothers of the participants were the nurturers, the upholders of discipline and morality, and the teachers of customary behaviours in the lives of the participants.

Children in Children’s Homes and other similar institutions are separated from their family, clans and lineages, the “marks” and “anthems” of which are “normally a source of great pride

for the children” (Ngubane, 1977:13). For these institutional children, their peers and caregivers had become their family; hence harmony and balance within these Homes and between the participants and their peers were important for the participants’ well-being and sense of belonging. The structural notions of “hierarchies and boundaries”, “enmeshment” and “disengagement” (DiNicola, 1985:152) conceptualized by Western psychologists (Minuchin; Levi-Strauss) around nuclear families need not apply to the African child, who experiences more extended and flexible family systems. The notion that “parental responsibility is diffused among the extended kin” (DiNicola, 1985:152) was advantageous to the participants of the current study as they had other relatives to take care of them and might have been more ready to accept children’s home staff and peers as alternative forms of family.

However, a “detrified African is prone to worry and fear” (Mutwa, 1998:666), “to be disowned by family is to cease to exist” (Mkhize, 2004:49) and to be “apart from the family, a person could never be” (Johnson-Hill, 1998:92). Therefore treatment for children detached from their families needs to incorporate a “communal dimension” (Denis, 2003) as “mental dysfunction in the African context is not individual but requires the co-operation of the family and at times the active treatment of others in the family”(Buhrmann, 1984:25). I found that therapy in the Children’s Homes lacked this family dimension in the form of family involvement, support and information, and the participants lacked the advantage of extended family members, such as uncles and aunts, whom Zulu children call “little fathers” and “little mothers”. Also very much part of the Zulu family are the family ancestors. Family education from early childhood is recognized as critical to the nurturing of indigenous knowledge, as families are generators and primary repositories of knowledge (Mokwena, 2009).

The participants, in the context of the Children’s Homes, found it difficult to act out the promise of their names, the significance and purpose of which would have been established at birth in the bosom of their families (Ngubane, 1977). Hlonipho expressed a preference for a non-Zulu name. Furthermore, topics such as respecting elders, sexual and romantic relations, menarche and reproductive rites of passage, which are usually discussed in families (Wilbraham, 2004), were being addressed within in the Homes in support groups by volunteer social workers and psychologists from Western environments. This was dissimilar from the ways they would have been addressed in traditional Zulu families. I felt that the participants were lacking the “custodial role of parents”, whereby parents play a “protective and

preventative” role in addition to a nurturing role, which is important in view of HIV risk behaviours (Wilbraham, 2004:489-490).

The participants referred less frequently to their fathers than their mothers and grandmothers. This might be explained by the father’s position in the family, which, in contrast to the mother, is “conventionalised as expressively marginal, whether he is physically present or not” (Simanski, 1998; Wilbraham, 2004). However, the importance of the father to a “child’s motor development, mental developmental tasks and social responsiveness” has been emphasized by Kiguwa (2004:296).

Despite the fact that the participants were not in their communities and lacked the cultural and nurturing influences of their own families, the story-telling aspect of Masekitlana was important for them in that it helped them to “recall their origins” and to “bless their memories”. Although they were “feeling bruised by their pasts”, they were able to “reconcile with themselves” by making meaning of the “experiences that defined them simply as human beings” (Finca, 2000:13).

#### **6.2.5 DISEMPOWERMENT AND LANGUAGE**

Discussing traditional African beliefs with children of Zulu origin in psychotherapy and the advantage this might have for their sense of African identity has been discussed in section 6.2.1. In addition to this, I felt that Masekitlana might encourage authentic expression through the use of their Zulu language which would mark a beginning of participant empowerment and self-understanding.

The participants, by having been removed from their families, had been stripped of their identities, in particular their language identities, as their schools and the Children’s Homes were multilingual environments. “Every language in a unique way defines *how* things are talked about and which *concepts* for making sense of the world are fundamentally assumed” (Gilbert, 2006:15). The consequences of “applying a monolingual (English) First World or Western psychology to indigenous populations who have different native tongues”, have not received serious attention (Moghaddam, 1987:914). Hlonipho expressed the greatest amount of knowledge and awareness of African traditional customs, which might have been because he came from a rural background, he had been in the children’s home for a shorter period than the other participants, and he spoke Zulu consistently during the therapy sessions.

Those who speak the language of the majority in any situation hold the power (Gilbert, 2006:15). The way the participants interchanged their languages depending on who they were with, might have been a reflection of the power dynamics between themselves and those around them (Mkhize, 2004). If language imposes culturally specific concepts, then the imperialism of English (Gilbert, 2006) in the Children's Homes surely denied the participants certain traditionally unique aspects of their Zulu language. Furthermore, not speaking their own familial language might have prevented the participants from expressing their inner selves in their everyday lives (Gilbert, 2006).

Mandla explained that he had Coloured "blood" and often talked Afrikaans in his home environment but he was also denied the use of this language in the children's homes as there were no other Afrikaans-speakers. Speaking English in their schools might also have led to a form of disempowerment and dislocation for the participants from indigenous knowledge systems. Education as it is taught in South African confers more of a Western understanding on children (Mkhize, 2006). Zinyeka (2011) has made a plea for the introduction of indigenous scientific knowledge into mainstream education but states that this has been received with reluctance by educators.

The process of translation of the participants' narratives in the current study might have contributed to a loss of some of the participants' authentic 'Zulu-ness' or 'African-ness'. This concern has been mentioned in literature on the translation of the Bible into African languages. The "coherence thought has in the language it really lives in" is sometimes lost when translating into another language (Tshehla, 2003:171). The language that I used to describe the process of therapy to the participants risked reflecting Western prescriptive terminology and power dynamics within the therapist-participant relationship. Hence, I described the therapy of the current study as "talking with the help of art, clay and stones". Gilbert (2006:16) describes how a group of "highly educated mental health professionals" in Lesotho could not find an equivalent term for *counselling* and "eventually settled on three words that fully captured the essence of the one word in the English language".

In light of the above discussion, I feel that it is the role and responsibility of psychologists to reconnect children of Zulu origin and culture to their authentic indigenous identities. This can be done by having knowledge of, being sensitive to and respecting the cultural notions that their language represents beyond mere talking. Besides language concerns, the participants

expressed further disempowerment by not having being informed of why they originally came to the Homes, when they were going to be returned to their families, and when holidays were going to begin or end. Once they were with their families in the holidays, they said that no one told them when they were returning to the children's home, and the Home transport simply arrived to take them back. Therefore, the participants would be further empowered by being informed of the facts of their family backgrounds, details of contact with families, and honest about the realities of their future.

#### **6.2.6 MORAL AUTHORITY AND CONFLICT WITHIN CHILDREN'S HOMES**

*We must respect older people and ... we must not fight.*

The participants expressed a need to be guided by older people, to reduce conflict in their lives and, except for Nana, to be policemen when they grew up. I questioned what the linkage or *leitmotif* was that underpinned these needs. I identified an emerging sense of moral authority in the participant, whereby they were searching to establish forms of order and control in their lives. They seemed to believe that to be law enforcers of people would restore an intrinsic sense of personal power over their lives that was lacking at the time of the current study. However, an intrinsic sense of personal power appears not to be in accord with literary opinion on how the African person views himself. The African person is seen as being less ego-orientated and less self-centred than a typically Western person. Hence, it became more appropriate to link the participants' sense of moral authority with their community spirit.

The term *ukunxulumana*, loosely translated as "to stand beside one another" or "side-by-sideness" (Malan, 1994, in Johnson-Hill, 1998:81) is a more authentically Zulu and lesser known term than *ubuntu*. It is the antithesis of insensitivity and expresses the core African value of empathy for suffering families and neighbours. *Ukunxulumana* encompasses an African form of moral authority, as expressed in the concepts, ways of living and values listed below, which I intuitively felt the participants, especially Hlonipho and Senzo, were attempting to express or develop in their lives:

- The need to serve their community (including the children's home community).
- The need to preserve their reputation and to be considered worthy by family and community (including the children's home community) as an African person only becomes a person through rising up to the standards of others (Mkhize, 2006).

- The importance of “the survival of the group and its healthy functioning” (Buhrmann, 1984:25).
- Wanting to be policemen alongside “viewing gods or ancestors as the policemen of society” (Holland, 2001:196); a morality which “implies good relationships with the ancestors who will ensure harmony in the environment and balance between a person and people surrounding him” (Ngubane, 1977:25)
- African morality as distinctly different from Western psychological theories of moral reasoning and responsibility developed and held by an individual in his own private and internal world.
- When people are *balungusiwe*, that is, “balanced or in good order”, when “they act dutifully and responsibly, respecting themselves and others”, then “sorcery and other environmental hazards will ‘bounce off’” (Ngubane, 1977:131).

The participants’ descriptions of facets of their lives that reflected the above values were helping old people to cross the street (Senzo), mediating fights between peers (Hlonipho), forgiving peers for hitting them, and thereby being accepted back into the peer group (Nana), listening to one’s elders (Hlonipho), and helping grandmother with home chores (Senzo and Mandla). Divergence, though, was expressed by Mandla, who said that he was used to seeing violence and would readily stab somebody to death, accepting that he might be stabbed himself in the process. Mandla’s description reflected a lack of harmony, balance or good order in his particular community, which the therapist informed me, was a violent community.

Participants frequently reported that they were involved in fights in the Homes, where they were blamed for causing them and which they did not like being part of. The cause of this conflict in the Homes might have been indicative of the participants fighting and quarrelling with each other in their reconstituted Home families as children do in nuclear families. It might also have been due to the fact that the rules for behaviour in the Homes might have been different from the traditional codes of behaviour, such as honouring, protecting and older siblings taking responsibility for younger siblings in Zulu families (Krige, 1950; Ngubane, 1977). These issues could have been explored with them in Masekitlana.

Nana’s altercation with her peers, which from a Western perspective appeared to be a form of bullying and victimization, might have been explained to her through an African knowledge system called *umnyama* ‘pollution’ (Ngubane, 1977:7). It might have helped Nana if she



could have interpreted her problem as that of suffering from the “mystical force called *umnyama* pollution, which creates repulsiveness and leads to others around her disliking her without provocation” (Ngubane, 1977:7). This could have been cured by a ‘red’ form of Zulu medicine called *ubulawa*, followed by ‘white’ *ubulawa*, as well as asking the ancestors to help her. This is different from a Western child’s developmental viewpoint, which could also have complemented help available to Nana with her experiences. Coming from this premise, a therapist could have explained to her that she was in the stage of her life (Piaget’s formal operations stage) whereby her identity in relationship to social issues becomes a new focus, peer relations become important and in this context she can begin to determine qualities, plans and goals for the future that she wanted to strive for in her life (Hipsky, 2008). Piaget’s sense was that children construct knowledge actively as they manipulate and interact with their environments, and, accordingly, a therapist could have encouraged her to achieve a better fit with her external reality by applying her indigenous knowledge (*ubulawa*, pleas for protection from ancestors) as well as using the resource of her developmental stage of cognitive competence (Hipsky, 2008). In this way Nana could have attributed the problem to an external cause while at the same time establishing a personal sense of agency.

Psychologists can encourage children from difficult backgrounds in South Africa to look forward to a better future. Through reflecting on the picture cards of the Roberts-2 test, which mostly depicted scenes of a negative nature, participants were able to articulate something they did not approve of. Senzo described how a boy was hit for something he did not do, and then when he hit back, he was blamed for causing trouble. Nana described a mother holding her baby and not allowing her daughter to hold the baby; instead, she told her daughter that if she touched the baby she would slit her neck. Being able to express what was happening or had happened in their lives, and the differences they wished for, appeared to help participants in their healing process. Similarly, Johnson-Hill (1998), in the context of describing transformation of university students, cites the theologian and historian Schillebeeckx’s (1969, in Johnson-Hill, 1998:6) concept of a “negative contrast experience”, whereby, if “people emerging from socially undesirable circumstances can become aware of the fact that the situation can improve”, they can have the “impetus to resist the source of (their) discontent” (Johnson-Hill, 1998:6).

The process of identity formation occurs through the positive assimilation of the attributes of the other as well as through negation of the attributes of the other, in other words, “I am....

because I am not” (Hayes, 2000:45). In this way, the participants were able to eschew the blame that their peers at times put upon them for causing fights. A therapist, while performing Masekitlana with children experiencing conflict, could equate their experience to the resolve that a traditional African wife or *makhoti* employs, in the face of conflict and bullying, when she goes to live with her mother-in-law. She expects to be called all sorts of names such as “sorcerer”, “lazy”, “thief” and “selfish”, but “she knows that she must never let whatever they call her come true” (Ngubane, 1977:43). A therapist explaining this form of African knowledge to children can encourage them to be more magnanimous in the face of conflict.

I felt that on this subject of conflict, a certain amount of introspection into historical circumstances would help children from traumatic circumstances. One of the challenges that the participants were dealing with was their intergenerational setbacks in the form of disintegrated relationships, economic deprivation and political oppression in their familial environment before they even came to the Homes. The result is a “cycle of confusion and pain transmitted through the generations” which disables adults from coping with their children’s concerns (Boston & Szur, 1983, in Stellerman & Adam, 2006:106). Fighting with and harsh treatment of children becomes the norm rather than negotiation. This ethos appeared to be reflected in the conflict between peers in the Home and is further exacerbated by the minority of firm male role models for the children in the Homes as compared to the female caregivers. The situation is succinctly explained below and, although it refers to the context of black<sup>26</sup> American scholars, it appears relevant to the South African context:

“At least the girls have older women to talk to, the example of motherhood. But the boys have nothing. Half of them don’t even know their own fathers. There’s nobody to guide them through the process of becoming man ... to explain to them the meaning of manhood. And that’s a recipe for disaster. Because in every society young men are going to have violent tendencies. Either those tendencies are directed and disciplined in creative pursuits or those tendencies destroy the young men, or the society, or both” (Obama, 2008:258).

Creating timelines with stones in Masekitlana therapy encourages children to reflect on their past and future experiences. During the Roberts-2 test the therapist probed the participants on their “negative contrast experiences” (Johnson-Hill, 1998) using the Dynamic Assessment model of Matthews and Bouwer (2009). In this way she was able to be sensitive to the

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<sup>26</sup> I use this term ‘black’ here to refer to an American person of African origin as I have noticed that this term is used in American literature without apparently creating sensitivity amongst American people.

dialogical process (Mkhize, 2004) of conflicting and complementary voices within the participants and was able to generate a deeper-level form of reflection whereby the participants came to a new and original form of moral order or resolution around the negative experiences of their lives. In the process of comparing themselves to others in the Home, and remembering their African codes of behaviour and knowledge systems, the participants were creating their identities and were developing a form of “moral authority” (Johnson-Hill, 1998). Out of this was emerging an intrinsic sense of justice, whereby they were learning right from wrong.

### **6.2.7 SCHOOLING CONCERNS**

The participants in the current study expressed a negative impression of their school-going experience. Hence, I questioned how relevant school procedures and subject content were to their central tenets of outlook, to their notions of discipline and to their indigenous knowledge bases. The following quoted critique by a black Chicago school principal, Asante, on the schooling system for black Americans as communicated to Obama (2008:258) appears relevant for the context and concerns of the participants of the current study:

“Just think about what a real education for these children would involve. It would start by giving a child an understanding of himself, his world, his culture, and his community. That’s the starting point of any educational process. That’s what makes a child hungry to learn – the promise of being part of something, of mastering his environment. But for the black child, everything’s turned upside down. From day one, what’s he learning about? Someone else’s history. Someone else’s culture. Not only that, this culture he’s supposed to learn is the same culture that’s systematically rejected him, denied his humanity ... Where I can, I try to fill the void. I expose students to African history, geography, and artistic traditions. I try to give them a different values orientation – something to counteract the materialism and individualism and instant gratification that’s fed to them the other fifteen hours of their day. I teach them that Africans are a communal people. That Africans respect their elders. Some of my European colleagues feel threatened by this, but I tell them it’s not about denigrating other cultures. It’s about giving these young people a base for themselves. Unless they’re rooted in their own traditions, they won’t ever be able to appreciate what other cultures have to offer.”

I felt that the incorporation of indigenous knowledge systems into the South African school curriculum would engage scholars more, especially those scholars living in situations similar to the participants of the current study who are cut off from their original and traditional Zulu or African communities. This is because, in contradiction to typical exchanges of knowledge within Western knowledge systems, in the African world, the whole community participates in the learning process (Duncan, Bowman, Naidoo, Pillay & Roos, 2007). A model of teaching science involving indigenous knowledge systems has been proposed by Zinyeka (2011). He claims, however, that in his experience South African educators resist change and new ideas, and have been reluctant to incorporate indigenous knowledge into their more Western-based scientific knowledge. It might, therefore, require a mentoring process in indigenous education to enable educators to acquire the various skills to teach indigenous knowledge (Cajete, 2000, in Duncan, Bowman, Naidoo, Pillay & Roos, 2007).

When questioned by the therapist on the subject, I noticed the participants' lack of interest in school work and subject content and yet they expressed concern that they were not progressing well in school. I perceived a lack of the sort of nurture that would normally be given by interested parents to be one of the causes, although participants said that their caregivers or 'aunties' in the Homes did help them with their homework. The death of parents, in particular the mother, has an "impact on children's schooling and potential success"; the extended family or the institutional family in the case of the participants of the current study, does not "provide an adequate enough safety net and in time this will impact on the whole economy of South Africa" (Ardington & Leibbrandt, 2010:3). For children, "encouragement is linked to motivation so for scholars with learning difficulties, personal guidance and counselling are required for those, (like the participants of the current study), who experience personal problems such as feeling inadequate, inferior to others, rejected or doubting their scholarly skills" (Nwanna, 2006:154). I questioned whether the 'aunties' in the Homes had enough education, psychological insight, emotional energy or time in their daily routine to provide the support, encouragement, personal guidance and counselling that Nwanna (2006) advocates.

Alienation from traditional indigenous knowledge systems as a result of globalization is one challenge for educators who teach children of Zulu origin and culture (Mkhize, 2004). Furthermore, psychological intervention into South African children's schooling concerns needs to address their historical social and economic influences (Mkhize, 2004) on the child

such as illiteracy of parents and poverty. The participants of the current study expressed anxiety that they would forget or did not have the required school clothes or equipment. In other words, all levels of social systems affecting South African scholars need to be addressed, not just the traditional as espoused in the current study, as “change at one level will have a ripple effect on the other levels” (Nwana, 2006:153).

#### **6.2.8 EVERYDAY CONCERNS**

My ideological presupposition or frame of reference in the current study was that the participants had ‘roots’ in their traditional Zulu customs and beliefs or were helped during Masekitlana to reconnect to their ‘roots’. The danger of such a central tenet is that it reifies African culture and experience, to the exclusion of other influences in the participants’ lives. Authors such as Holdstock (1981, 1982), Buhrmann (1984), Mutwa (1998), Hayes (2000), Holland (2001), Mkhize (2004) and Gilbert (2006) have for many years been calling for an increase in awareness of the authentic African context when researching or working with South African populations of African origin and culture. Other authors offer a challenge to this approach when they state that the African orientation seems to support a “different treatment approach which might oversimplify the black situation by not paying sufficient attention to levels and varieties of black experience and cultural transitions” (Dawes, 1985:57) and, in the context of research with Aboriginal cultures, the elevation of core ethnic values obscures individual variation and the constant flux of personal and social definitions of self and other (Kirmayer, Macdonald & Bras, 2000).

In the current study, I looked for expression from the participants, as stimulated by Masekitlana that reflected their indigenous Zulu notions. However, I needed to remind myself that “Africanization is not just about reliving the past as it was, or inaugurating some utopian dream in the future” (Johnson-Hill, 1998:70). It is the “everyday-ness” of people and so it was important that I understood the participants in their wholeness and not just as indigenous beings. The participants of the current study talked about cars (Mandla), branded clothes (Senzo and Mandla), washing dishes (Senzo), and preferred foods and the route to school (Nana), in other words, what appeared to me to be the more mundane aspects of their lives but were important and integral to the participants. Their stories did not just consist of great events or grand narratives with grand beginnings and endings, but consisted of everything that happened in between, including their wishful or fantasy thoughts. Masekitlana is a narrative game and as children “anticipate ... plan ... construct ... gossip ... and day dream in

narrative” (Hardy, 1975, in Balcomb, 2000:50), this form of therapy enabled them to express their everyday interests and desires.

Hence, the different voices and personhoods that the participant narratives reflected indicated that the participants were in the process of transition, a continual process of ‘becoming’ (Mkhize, 2004), with their feet in two worlds: a traditional African world and a modern world that all children are part of, despite also coming from their own particular cultural, ethnic and religious backgrounds. Globalization has made the world appear to be a smaller place in that children, through television and the import of consumable goods from all over the world, develop tastes for and are influenced by goods and trends similar to all children universally. Mkhize (2004) draws attention to the ease of travel of South African youth across the globe and how this affects the African personhood.

#### **6.2.9 EXPRESSED EMOTION**

I contemplated the reasons for participants’ lack of overt emotional expression and words for their emotions. I expected that due to the traumatic circumstances of their lives, prior to placement in the Homes, they would grasp at the opportunity to reveal the hardships of their lives and would readily describe their feelings. Although they did not openly express sadness or regret at the beginning of therapy, at the end of the third Masekitlana session, their descriptions of the Roberts-2 test picture cards indicated high levels of anxiety, depression and rejection. I was perhaps expecting more of a response from them but came to realize that their form of communicating emotions, or lack thereof, might have been idiosyncratic to the participants as a result of repression in their institutional environment or it might be something common to most adults and children who struggle to name their emotions.

It might also have been a typically Zulu form of bearing emotions. Flaunting or the over-expression of emotions is socially unacceptable among people of Zulu origin and culture, who encourage introversion and withdrawal in times of crisis. “Wailing and weeping are associated with helplessness, while power is demonstrated by courage and aggression” (Ngubane, 1977:93-4). How emotion is expressed in South Africa has been identified as one of the cultural barriers to mental health care (Kritzinger, Swartz, Mall & Asmal, 2011). Each culture has its particular way of expressing emotional distress, yet “counselling is often offered by others coming from a different approach from that in which healing and helping in a particular culture was originally developed” (Gilbert, 2006:11). For instance, Western

people “talk and think in terms of psychotherapy, while African people act out and represent their feelings in dance, songs, rituals and ceremonies” (Buhrmann, 1984:13).

How South African psychologists view emotional expressiveness in children is “dictated by Western socialization, whereby children are encouraged to have their own repertoire of thoughts, feelings and actions”, as opposed to children from traditional cultures, where “connection and interrelations with others are the basis of psychological well-being” (Gilbert 2006:13). I felt that the participants were almost in the process of what DiNicola (1985:159) describes as “cultural or global ‘flows’, whereby individuals experience adaptational changes in behaviour repertoire due to culture change and environmental movement or migration”. Participants of the current study appeared to be developing their unique thoughts and feelings, which also took into account the actions and needs of others and the environment of community in the children’s home and their schools. Nana cried profoundly when she was hit by her peers, and the male participants were able to express anger over the peer fighting in the Homes. They all expressed fear and hopelessness over school problems. However, I expected them to express more hurt over the experiences of their past lives before they came to the Homes. I was perhaps expecting them to have undergone more of a personal analytical process of thinking about their pasts whereby they might have developed forms of regret, attributions of blame and self-pity. This proved not to be the case.

Pain and trauma in the indigenous context appears to be an externalized phenomenon in that it is “conceptualized as being isolated from community” (Parsons, 2006:42). Parsons (2006) describes how a victim of abuse was isolated from his community as a result of the abuse, and it was this isolation that he experienced as traumatic, rather than the abuse itself. Similarly, all of the participants in the current study expressed regret at being taken away from their family homes rather than showing sadness for the reasons behind their removals, that is, sexual abuse and neglect (Nana and Hlonipho), death of mothers (Hlonipho and Senzo) and abandonment by mothers (Nana and Mandla). Mkhize (2004) explains that it is through externalization of misfortune and trauma that the Zulu person can prevent neuroses and mental imbalance from developing. This externalization of their problems could be linked to the participants’ lack of expressed emotions.

Despite the above explanations, I feel externalization of problems, often encountered when studying African indigenous cultures, need not negate intrinsic and intra-psychic factors

affecting expression of emotions in children. As Dawes (1985:57) explains in considering the role of the clinical psychologist in the South African community arena, there can be a transformation or utilization of individualistic conceptualizations of a person “locked into a psychic dilemma, to a person whose (intra-psychic) dilemma is understood in the context within which it occurs”. In this way, the context of collectivism and its effect on the thinking of a person and on his sense of individualism “need not be mutually exclusive” (Moghaddam, 1987:917). According to the notion of psychological or psychic prioritization, when a person’s concrete needs are taken care of, as was the case with the participants of the current study, then the more abstract emotional, interpersonal and intra-psychic concerns will emerge and the demand on the psychologist is to meet these needs (Perkel, 1988). Hence, participants were at the stage in their lives when their feelings were able to be interpreted. Stellerman and Adam (2006:12) appear to combine intra-psychic factors with contextual effects in a way pertinent to the participants of the current study:

- When children lack “containers of their chaotic thoughts” in the form of interested parents who would have helped them to make meaning of them, they become adept at “killing thoughts and breaking links as a defense against psychic pain”.
- When children experience the loss of one valued object (their mother for instance) after another, they lose the “ability to keep these objects alive in their thoughts”.
- The space left is then filled with “persecutory and attacking internal objects, and identifying with the aggressor is often a way for these children to assimilate their malevolent internal objects” (refer to conflict in the Homes and identifying with aggressive police behaviour).
- A confused sense of identity and values in children can lead to “self-destruction, anxiety, the lack of normal development of imagination and thinking, and the experiencing of learning difficulties”.

I identified these phenomena within the participants and felt that a lack of connectivity to parents, their communities and their indigenous knowledge systems and values was the possible cause thereof. I hoped that Masekitlana would revive or stimulate a certain memory or feeling for their indigenous roots and connections. Masekitlana, in its original form of a circle of children sitting around a central speaker, might approximate a form of group or ‘community’ problem-solving similar to the discussion and negotiation around problems that involved natural products, such as the rustling of banana leaves and drinking of beer together



in traditional Zulu environments (Krige, 1950). In this way, Masekitlana might enable more expression of emotions.

#### 6.2.10 CONTRADICTIONARY VOICES

It can be seen how I found it hard as the researcher in the current study to categorize exactly who and what the participants represented: ‘been’, ‘being’ or ‘becoming’ indigenous African individuals or emerging Western institutional children. This ambivalence was reflected with the contradictory nature of the participants’ narratives between one session and the next. I searched for an explanation for this ‘changeableness’.

A person is “capable of telling different stories from different vantage points, reflecting the multiple worlds in which he or she has grown up in” (Mkhize, 2004:72). The participants’ narratives reflected an interplay between the occurrences in the Children’s Homes and their experiences of their family and community. Even Hlonipho, the most traditionally indigenous of the participants, reflected in his narrative a ‘to-ing and fro-ing’ between the children’s home issues and the fantasy world of his life as he perceived it to have been when his parents were alive. Mkhize (2004) describes further how, in a person’s dialogical self, rivalries, tensions and disagreements can occur between his different voices (polyphony) and contradictions are felt between his social self and his inner tensions. This explains why Mandela was able to express a need to be a policeman when he grew up in order to catch *izigebengu* or criminals, and yet he was prepared to stab anybody as he had witnessed it being done in his home community.

Different voices in dialogue with each other have different positions in space, which Mkhize (2004) calls “spatialization” of the dialogical self. I thought that the therapist during the Masekitlana sessions helped Hlonipho and Nana to express their different voices in the different spaces of their dialogical selves so that they were able to reconcile their traditional selves where rituals, bewitchment and ancestral reverence held true, with their more modern Home values. Similarly, recognizing the different voices of the participants helped the therapist to understand the occasional oppositional attitude of the participants to the process of therapy and the Roberts-2 test.

Contradictions and contrariness of the participants could have been, in the South African context, a “ventriloquating” expression of a “collective voice” around the idea of power

dynamics and historical oppression that the participants had subliminally assimilated into their selves and identities (Mkhize, 2004). Mkhize (2004) encourages psychologists to ask, “Whose ideas are being ventriloquated, those of society, those of the family or those of the person?” In the current study, the voices of the Home, peer groups, school authorities and, of prime importance for the focus of the current study, traditional African culture, could have been included in this question. To have reflected back these different voices to the participants, in particular their indigenous voice encouraged by Masekitlana, would have helped them to understand themselves as a reflection of their different worlds and in the wholeness of their personhood.

There was a tangible ‘addressivity’ to the participants’ narratives in that the way that they talked, whether shocking or appealing, was intended to elicit a response from the therapist or myself (Mkhize, 2004). This addressivity also extended to dialoguing with imagined or absent mothers and fathers, which had therapeutic value for the participants. Being aware of the intention of the participants’ narratives as “responsive-interactive” units, and asking, “who is saying this, why at this particular time and for what reasons?”, the narratives can become part of a “knowledge-production process” (Mkhize, 2004:66). As Masekitlana enables the expression of traditional African beliefs, asking these questions could reveal more about the interface between indigenous knowledge and the participants’ accommodation of it into their urban institutionalized lives as orphans and children living with HIV. This would then inform theories and needs around indigenous psychology.

#### **6.2.11 MASEKITLANA AND AFRICAN SYMBOLISM AS IT INFORMS PSYCHOLOGICAL THERAPY IN AFRICAN SETTINGS**

Masekitlana in the current study offered to the participants a form of symbolic or metaphorical representation of their lives. The different shapes and sizes of the stones represented different members of their families (Mandla), or the structure of their family homes and villages (Senzo), or the route to school (Nana). Masekitlana also involved the whole body in that Nana rapped two large stones together rhythmically and repetitively while describing her protective spirit, and the male participants rolled the stones up their legs, flicked them at each other in the form of an African marble game, or played other traditional African stone games while narrating their life stories. Masekitlana could have approximated for the participants typically African rituals of dancing, singing or chanting in concentric

circles reminiscent of the “oral-recitative tradition of ancient peoples which was accessible to everyone regardless of social status or access to schooling” (Denis, 2000:74).

Western psychologists are “apt to look for deeper meanings in ritualized story-telling or they try to adapt it to their own understanding and training” (Holland, 2001:57). However, West (2003:54) posits that the indigenous method of interpretation capitalized on “recalling, narrating and dramatizing the story without explicitly defining what it meant”. However, my need to interpret the participants’ metaphors of snakes and spirits and the belief in bewitchment, was not to find a deeper meaning in the Western sense but to link the metaphors and symbols they used to the body of indigenous African knowledge, thereby entering into the world of the African client (Buhrmann, 1984). I was not looking for the “immediate truth or meaning” of the symbolism in the participants’ narratives but was interested in what it represented, for instance, the ancestral snake representing the rite of passage from life to death for Hlonipho’s mother. Buhrmann (1984), in her study under a Xhosa *igqira* or healer, identified an inner world in African people where symbols represented images of the collective unconscious. Hence, Masekitlana, as a symbolic form of therapy, might revive in the participants associations with their collective beings.

For people of Zulu origin and culture, speaking is not just for “establishing the truth” but is “mainly for *ukuhlambuluka* or self-cleansing purposes” (Ntsimane, 2000:25) and for “enhancing memory” (Denis, 2000:74). I felt that Masekitlana might have provided for the participants an arena for expression of a traditional oral-recitative form, and this is what it appeared to encourage in Nana. Stones and rocks have always been of symbolic value to Zulu people. Engravings on rocks are called ‘reminder pictures’ and piles of stones or *izivivane* alongside rural roads in KwaZulu-Natal are created by travellers who pass by and add a stone there to ensure they will return, or they mark the death and burial of a fellow traveller. The stones in Masekitlana might evoke cultural associations with these forms of stone symbolism and therefore, Masekitlana might be considered culturally familiar for children in therapy.

Intrinsic, although not always explicit, meanings and situations in Zulu people’s lives are represented by Zulu symbols and externalization of expression such as singing, dancing and recitation. Similarly, Buhrmann (1984) explains how her child patients drew or modelled in clay the frightening parts of their recurring nightmares, which usually resulted in the problem ceasing. She believed that creative and projective therapy evoked the unconscious element of

the patient. The result was that patient left behind his thinking and intellectual functions and instead gave more external concrete forms to inner fantasies or chaotic states of mind. Similarly, manipulation of stones in Masekitlana allows for a more concrete way of representing inner states of mind, and symbolically encourages the patient to conjure up meaning from an African perspective.

#### 6.2.12 REFLECTING ON THE RESEARCHER'S ROLE

*“No trace in memory, not even the image transposed onto film by a camera lens, is a simple reflection of events”* (Harris, 2000:118).

Voices in literature helped me to make sense of *my* position or ‘space’ in the current study as well as the process of taking participants’ narrative in research and creating the end product of a written thesis. My exploration into literature describing traditional Zulu culture revealed a common humanity between myself and the participants. I lived for many years in a rural Zulu environment in Northern Zululand, where political pressures such as the Group Areas Act were not enforced. There was therefore an inevitable “intussusception” or “imbrication” (Hayes, 2000) of traditional Zulu customs and values into the life and consciousness of my family. However, I was still challenged in the current study to confront my intrinsically ‘White South African’ values and beliefs in the light of Apartheid and European/American/Western influences in my life (I attended an “all-White” school and university, and I travelled abroad).

In confronting the challenge of my unique socio-political background in South Africa and the general *process* challenges of conducting research, I identified the following factors that can complicate or compromise the process of research, or might be omitted in the writing up of research:

- A researcher is usually positioned, to a greater or lesser extent, outside of the lives and experiences of participants.
- A researcher “interprets the participants’ interpreting their lives”; this “double hermeneutic” (Giddens, 1987, in Hayes, 2000:36) creates distance from the original experience.
- Due to the subjective, “deconstructive/reconstructive/re-descriptive nature of interpretation” (Hayes, 2000:36), a researcher should ask, “*Why* or *how* is this being

said?” and not, “*what* was said?”; it is the *constructing* as opposed to the *construction*, the rich meaning as opposed to petty description that is important.

- The reader is cut off from the facial expression and bodily gestures of the participants, whose words have been “subjected to translation and jostling” into categories of the researcher’s choosing, and then described in academic language rather than “reflecting the everyday vernacular of the original utterance”. Sienaert and Conolly (2000) put it clearly as follows:

“With words on the page we cannot present the oral-aural features of rhythm, alliteration, assonance, tonal, repetition, pitch, pace, pause inflection, volume, timbre, or the gestural/visual features of movement, costume and gesture. At best, we (researchers or recorders of narratives/stories/performances) can deal, in a flawed way, with visual indications of the balance and repetition of patterns of expression, which we refer to as sounds and words” (Denis, 2000:72).

- In the current research it was difficult to convey in writing how, as Masekitlana therapy progressed, the participants:
  - ✧ Smiled and moved their bodies more, and enlarged the area where they were playing with stones.
  - ✧ Washed teacups with me.
  - ✧ Examined my recording equipment.
  - ✧ Walked to my car to explore the other play therapy tools in my boot.

In this way the therapeutic space was broadened and the relationship between the participants, me and the therapist was deepened. These observations were in contrast to how participants reacted to therapy and showed body language in response to the therapist and to me in the pre-test phase as follows:

- ✧ They sat with their backs to me.
- ✧ They glanced over their shoulders in what appeared to be shyness.
- ✧ They fiddled with their hands.
- ✧ They did not attempt to engage with me in conversation.
- ✧ They appeared bored.

In the post-test phase participants:

- ✧ Greeted the therapist and myself happily.
- ✧ Expressed regret when we had to leave them.

- ✧ Asked when we were coming back for future sessions.
  - ✧ Actively asked to play with stones.
  - ✧ Identified the stones they liked and asked if we could buy them their own stones, as well as other toys such as marbles and soccer balls.
  - ✧ Started talking about what had happened in their days since we last saw them without even the use of stones or clay or paint.
  - ✧ Asked if they could continue to see us at McCord Hospital or if we could come back to simply visit them at the Homes.
- I was aware of the ethical dilemma that in the telling of their stories, the participants were giving away or losing their stories. “In the moment of recording, the event—in its completeness, its uniqueness – is lost” (Harris, 2000:118). When I questioned Hlonipho, eight months after the recorded therapy sessions, about the events around his parents’ disappearances, he refuted the incidents that he had narrated in therapy.
  - I felt that, as Wright (2000:130) corroborates, I might have “*given* meaning, rather than *found* meaning” in the participants’ narratives, according to my research needs and my own “historical roots, assumptions” and practices of my profession. The result is that participant “voices might have been subordinated and their authority relocated or dislocated in a process of material custody” (Denis, 2000:112).
  - I was aware of the ethical difficulty of terminating the sessions at a stage when participants were beginning to reveal their feelings, and after only three intervention sessions. Participants had built trust in the therapist and me, and were speaking about aspects of their pasts for the first time. Then we left them with only the assurance that they could see a psychologist, whereas they expressly asked to continue therapy sessions in their environment exactly as it had been during the research. It was difficult for us to leave them at this stage and it felt slightly unethical.

Hence, certain aspects of participants’ expressions and how they related to the research team were difficult to portray, and other aspects might not have been reflected accurately enough simply through research ‘distance’ (double hermeneutic) and researcher bias.

### 6.3 CONCLUSION

Of importance to the focus of the current study was whether Masekitlana proved to be as relevant to children of Zulu origin and culture as it had been for Sotho children. I found

indeed that Masekitlana enabled the participants to reflect on their traditional African beliefs and to project their emotional lives onto the picture cards of the Roberts-2 test after the Masekitlana sessions. In using Masekitlana on this Zulu cohort of participants, it was necessary for me to understand the meaning and relevance behind the participants' explanations and to link their narratives to their indigenous African ways of being and thinking. This then enabled a more honest, open and authentic therapeutic process for these children of Zulu origin and culture.

To understand as fully as possible the indigenous African, in particular Zulu, world of the participants, I immersed myself in the literature of African peoples, especially the original anthropological texts of Mutwa (1998), Buhrmann (1984), Krige (1950) and Ngubane (1977). Writings from people who had lived and worked among African people, or were of the same culture as the participants in the current research, revealed for me a more experienced and essentially more authentic understanding of African people than my own. Through my readings I was able to form an opinion on whether the intervention of Masekitlana would be relevant to the traditional African roots of the participants of the current research. I was also able to better understand and elaborate on the participants' references to African belief systems.

At the same time, I was aware that they were children living in multicultural institutions where they were, probably through television more than any other influence, immersing themselves in Western values and culture. Living in an urban environment, and attending English-speaking schools alongside various ethnic groups, they were exposed to effects different from the environments of their families of origin. Hence, theories in literature such as Mkhize's (2004) dialogism and polyphony helped to explain the different, contradictory voices of the participants and their socially reflective personae. I was also aware, as emphasized by DiNicola (1985), that to describe people as exclusively coming from or reflecting their *traditional* backgrounds might marginalize them and put them into the category of the *other*, which is not in the best interests of the client. As DiNicola explains, although in connection with migrant families but of relevance to dislocated children:

“Migrant families move between cultures and a host of factors determines whether they will experience liminality, being at the threshold of new experiences with many possibilities as potential insiders, or marginality, being at the periphery of society,

outsiders with no perceived entrance into the mainstream. The two terms differentiate Turner's (1969) more general notion of 'threshold people'" DiNicola (1985:160).

As a result of the above issues I strove to perceive participants as individuals with integrated traditional and Western values and identities. The aim in using Masekitlana therapy was to help participants to reveal their authentic selves as a product of all their experiences in life, traditional and modern, and to experience liminalism as explained by DiNicola (1985).

In the next chapter I clarify further how participants responded to Masekitlana, the role of Masekitlana in making meaning in the participants' lives, and how Masekitlana can contribute to the field of indigenous psychology, and I will attempt to make recommendations for the field of African psychology based on my experience and findings in the current study.

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## CHAPTER 7

### CONCLUSIONS AND RECOMMENDATIONS

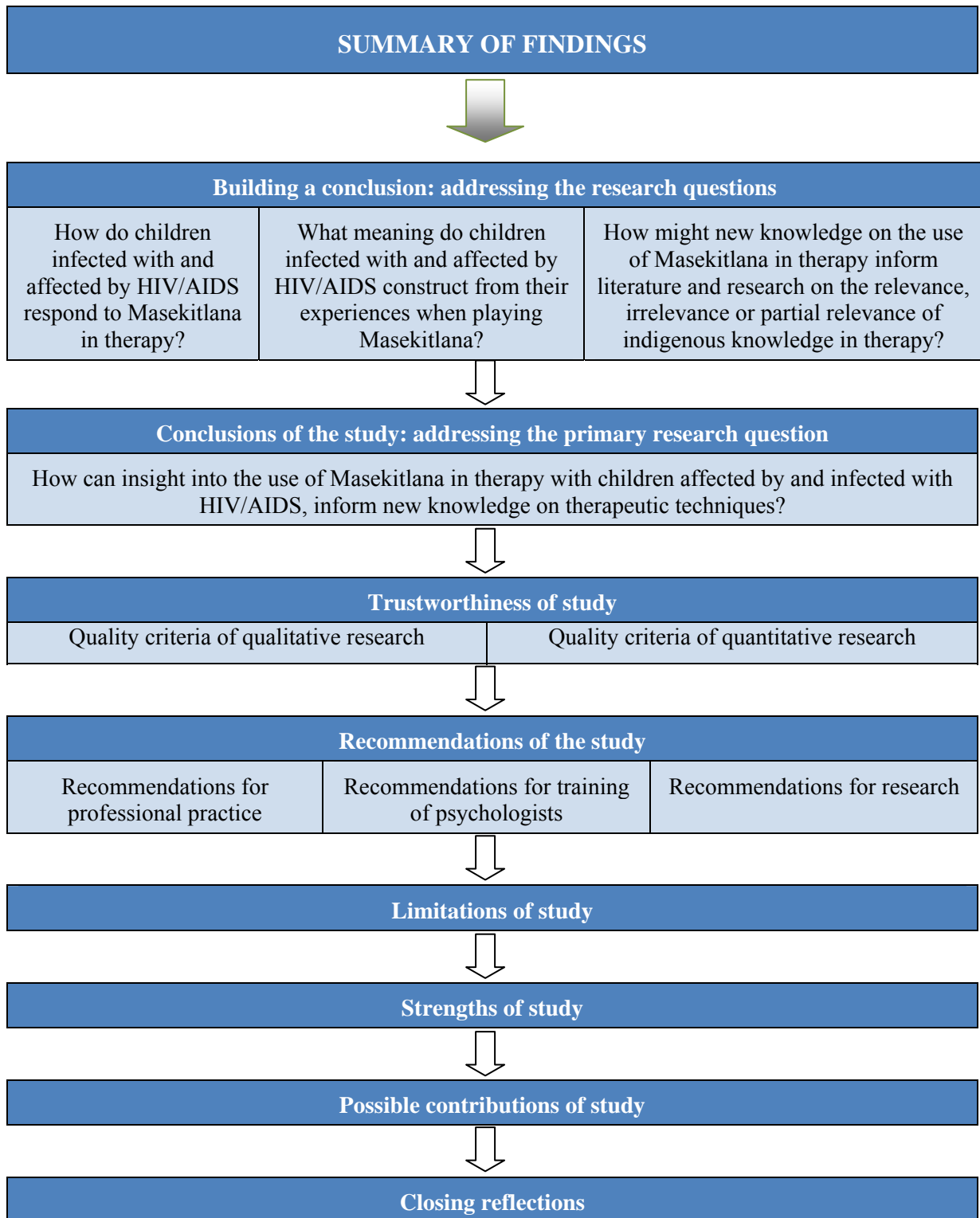
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#### 7.1 INTRODUCTION

This chapter concludes the current study on how the use of Masekitlana in therapy with children who are affected by and infected with HIV/AIDS can inform new knowledge on therapeutic techniques in indigenous African, in particular Zulu, settings. In this chapter I re-examine the research questions and link them to the findings of the study. I also incorporate recommendations for therapy in indigenous contexts and make suggestions for further studies and training in the field of psychology. Finally, I discuss the limitations and ethical conclusions, as well as strengths and contributions of the study.

Children affected by HIV/AIDS, particularly those who have lost one or both parents, often experience depression, anxiety or anger, which can lead to learning and behavioural problems. As has been noted, the purpose of the current study was to explore whether the ancient seSotho narrative game, Masekitlana, would help traumatized children of Zulu origin and culture to express themselves. Being an indigenous African game, the assumption was that the participants would feel that this form of therapy was familiar to or symbolic of their traditional cultural origins and environments, and therefore would enable the participants to express themselves more authentically.

In this chapter, I draw conclusions on how the findings of the research study may add to the existing body of indigenous knowledge and may inform the field of indigenous psychology. In the diagram below, I present an overview of Chapter 7.



**Figure 42: Overview of Chapter 7**

## 7.2 SUMMARY OF FINDINGS

The participants of the current study indicated that they preferred to play with clay that was offered to them in standard of care therapy and the stones in Masekitlana therapy. Although

they were reluctant to talk about the picture cards of the Roberts-2 test initially, they did so more readily when they could simultaneously play with the stones. The meanings that the participants created from their life experiences reflected their traditional Zulu beliefs as well as their multicultural urban environment of the Children's Homes. At no stage did they mention the terms HIV or AIDS. Instead, they discussed death through descriptions of ancestors in the form of talking snakes, snakes throttling children at night and people being bewitched by strangers and dying. They were not able to overtly describe or show their sense of sadness or regret over the losses in their lives, but their narratives during Masekitlana and their descriptions of the picture cards of the Roberts-2 test indicated that they missed their families and their communities and felt misinformed as to the reasons why they could not live with them. Their sense of disempowerment and need to serve their communities appeared to be counteracted by their desire to be policemen to restore order and to punish wrongdoers in their lives. The results of the Roberts-2 test indicated that the participants, through the assumed projection of their lives onto the picture cards, were expressing an increasing amount of anxiety, depression and sense of rejection as Masekitlana progressed. They also expressed their fears and frustrations around peer conflict in the Homes, and their challenges with schoolwork, school teachers and not having the right equipment for school. Aligned with their ancestral and spiritual beliefs, the participants expressed their faith in Christianity and the protective role of Jesus and God in their lives.

The results and findings summarized above addressed the various research questions of the current study.

### **7.3 BUILDING A CONCLUSION: ADDRESSING THE RESEARCH SUB-QUESTIONS**

The following sub-questions form a framework for building a conclusion, which in turn addresses the primary research question of the current study.

#### **7.3.1 SUB-QUESTION 1: HOW DO CHILDREN INFECTED WITH AND AFFECTED BY HIV/AIDS RESPOND TO MASEKITLANA IN THERAPY?**

The answer to the above sub-question was to be found in the physical responses of participants to Masekitlana, to the way that this form of therapy resonated with traditional

African forms of story-telling and their need for expression in play, and in how it offered participants a symbolic representation of their cultural beliefs.

### **7.3.1.1 Masekitlana stimulates a full body response**

In the first session of standard of care therapy, when the therapist was becoming acquainted with the participants, I noticed how the participants fiddled with their hands and moved about on their chairs. They did not appear to be very comfortable with being interviewed. They relaxed more when they were encouraged to paint and play with clay. When Masekitlana was introduced to them, they readily responded to it by eagerly sitting on the ground next to the pile of stones with smiles on their faces. They appeared to regard it as a game that they anticipated to be fun. They seemed to be familiar with the idea of talking and playing with stones and had to be restrained from throwing the stones up in the air, as in the African stone game, *diketo*, which is often played by African children, especially girls. Participants touched and felt the different shapes of the stones, and they chose and made comments about the size, shape and colour of stones of their preference before they began to talk about their lives.

I noticed that different participants used stones in different ways. Hlonipho knocked two stones quietly together and, when he was revealing details of his life that he might seldom before have spoken about, he moved the stones very slowly and gently together. Nana, on the other hand, banged together two large stones, one a big white quartz stone, so hard that she left a light carpet of stone chips around her. The chips appeared to me to be metaphorically symbolic of her fragmented selfhood and the force she demonstrated on the stones seemed to indicate her anger at being in the Home and towards the conditions in the children's home and school. Mandla rolled a stone up and down his leg while he talked. He also flicked one stone at the others, using his thumb and forefinger, while he was talking and demonstrating, as he told us, an African form of 'marble' playing.

The therapist at the end of a Masekitlana session taught Nana another African game of stones that resembled the written game of noughts and crosses, but using stones. I noticed how much Nana enjoyed this stone game, and how relaxed and bonded she appeared to be with the therapist.

Participants used different stones to represent different members of their family or to demonstrate the shape and size of their family homes. The way the participants responded

with their whole bodies to Masekitlana appeared to substantiate Buhrmann's (1984) claim that Western people are more likely to talk and think in therapy, while African people are more likely to act out their feelings through moving their bodies.

During the Roberts-2 test assessments, participants showed some resistance to the task, which was alleviated by suggesting to them that they play with stones while they described the scenes on the picture cards. They readily accepted this and it appeared to enable freer narrative. I noticed that participants more frequently looked down at the stones in therapy than at the therapist's face. I posit that, because it is not considered polite in Zulu custom to look an elder or woman in the eye when addressing her or being addressed by her, manipulating stones in therapy while talking enabled participants to adhere to this traditional mannerism, which forms part of a larger set of Zulu 'rules' underlying the concept of *hlonipha* or respect.

### **7.3.1.2 Masekitlana as a form of narrative therapy resonates with Zulu story-telling**

Masekitlana might have, for the participants, resonated with traditional African rituals involving story-telling around fires or under trees in rural villages, where indigenous people make sense of their experiences by relating them to similar incidents in their history. Story-telling has a strong tradition in African cultures and folklore, and it is the way that stories are passed down through the generations (Mutwa, 1998). I found that the participants were particularly adept at telling stories during Masekitlana. Their stories enabled them to retrieve memories, good and bad, which might have been otherwise suppressed by the environment of the Children's Homes, where so many other children also bear the burden of sad pasts and are distanced from their families.

Through prompting the participants as their stories unfolded, the therapist encouraged a detailed form of story-telling. Murphy and Maree (2006) call this the 'mediating' process of dynamic assessment, which they claim is more natural and taps into more of the child's potential than a pen-and-paper questionnaire would. They advocate it for cultural settings where norms and language might be different from the original test context. Furthermore, it helps the child to continue to talk more creatively about a picture card than the previously advocated one-sentence directive to the child or adult using the Child's Apperception Test or the Thematic Apperception Test (Murray, 1971).

I noted in the current study how the length and number of sentences increased, and the projections became deeper when dynamic assessment methods, as delineated by Matthews and Bouwer (2009), were applied when the Roberts-2 test was administered to the participants. Through their descriptions of the picture cards, the participants appeared able to be honest about situations involving families and peer interactions without feeling that they were being disloyal to their own parents or siblings. To dishonour a deceased or absent parent is hard for a child, especially in light of the need I identified in the participants to idealize and fantasize about their parents. This was confirmed by Mohangi (2009) in her study on institutionalized children affected by HIV and AIDS:

“Denial of loss is used to report on the cognitive and affective behaviour of children who speak of their dead parents as though they were still alive; to do this seems to deny the parent’s absence or death. Living in a world of fantasy and make-believe is one of the ways in which the children coped with challenges in their life” (Mohangi, 2009:147).

In the original form of Masekitlana, “comments, remarks, suggestions and questions are usually posed or made by the listeners” (Kekae-Moletsane, 2008:368). In this way dynamic assessment techniques complemented and formed an integral part of Masekitlana therapy.

In the process of hitting the stones together and responding to the therapist’s questions and prompting, the participants projected their feelings of regret, fear, guilt, sadness and uncertainty onto the stones. It appeared almost to be a partial ‘giving away’ of the feelings that they had been holding close to themselves, and an unpicking and re-managing of the details of their ongoing and past traumatic experiences. Denis (2010) maintains that sharing intimate experiences and remembering the past means the teller is never the same again as he or she was before, but is on the path to healing. The participants of the current study had begun a journey of recovery that would need to be continued, shared and reinforced by therapists, in particular on occasions such as birthdays, graduations and marriages. At these times the effect and memories of abandonment, abuse and loss of parents might be keenly felt or revived in their minds, despite regaining happiness by recreating their lives.

### **7.3.1.3 Masekitlana is symbolically significant for children of Zulu origin and culture**

The participants of the current study might have felt familiar with stones in Masekitlana as they reminded them of traditional African stone games. Stones have always been of particular

symbolic significance for Zulu people, such as in Primordial or Primary Counting Necklaces (Sienaert & Conolly, 2000) used for recitative teaching and learning, and in African beadwork to symbolize various events, messages, feelings or desires (Tyrell, 1971). A Zulu person is also aware of Biblical references to stones, and sacred stones are believed to confer great power on Zulu prophets. Hence, participants might have been aware of the significance of stones in therapy.

Simply touching and playing with something so typical of the African natural environment and the outdoor life of children appeared to please and relax the participants. They were playing with something that belonged to them that they understood. Nana even asked to keep the stones with her as she had become used to their shapes and they symbolized parts of her life. Zulu people often talk in metaphors, using references from nature such a *kuzempondo zenkomo* or “it is the horns of the cattle” to refer to dawn. Similarly, stones in Masekitlana might have acted as symbolic metaphors for participants’ lives.

#### **7.3.1.4 Masekitlana satisfies children’s need to play**

Masekitlana resembled spontaneous play for children, as it did not present to the participants any rules, external goals or expectations from the therapist as other more formal assessments do. The stones appeared to offer the participants a form of representational play in its purist, symbolic form (McCune, 1998). It represented a form of simple play such as they might have experienced on the streets around their original homes with their friends when parents had gone out to work. Masekitlana is only one of the many forms of play using products from nature that are essential diversions for children in environments of poverty. Moving stones or seeds around holes in smoothed out wood, drawing shapes in sand and hopping over stones in the shapes (an African form of the Western game called ‘hop-scotch’), playing with sticks and creating animal figures out of river clay are some of the games African children traditionally play.

After narrating with stones, participants progressed naturally onto playing traditional African stone games with the therapist. They taught her and she taught them some of these games. Demonstrating learned skills resulting from play activities is an important part of child development (McCune, 1998). Masekitlana in the current study encouraged the participants to ‘show off’ their skills with stones. This resulted in a fun-filled, light-hearted way to end the intervention sessions.

Cultural aspects of play have not been given enough attention in research (Pellegrini & Smith, 1998, in Byers, 1998). Pellegrini & Smith (1998) hypothesize that a social institution such as Western schooling with its intellectual emphasis might suppress the expression of natural behaviour such as play during a sensitive period of brain motor function development. African children play stone games from a very early age and this might serve a motor spatial function as well as developing counting abilities in young children. Masekitlana in a therapeutic capacity as well as in an informal group play context might be a useful and culturally relevant addition to the Zulu child's stone play repertoire. If psychologists are aiming to offer play therapy that feels familiar to children from indigenous contexts, that might remind children of their original indigenous contexts and that reflect indigenous forms of play, then the incorporation of Masekitlana into play therapy programmes might be appropriate.

### **7.3.2 SUB-QUESTION 2: WHAT MEANING DO CHILDREN LIVING WITH AND AFFECTED BY HIV/AIDS CONSTRUCT FROM THEIR EXPERIENCES WHEN PLAYING MASEKITLANA?**

Through the use of Masekitlana, participants were able to express themselves in an open and relaxed way, enabling them to create meaning out of the traumatic experiences in their lives. The impression I obtained during the course of the current study was that if the participants had continued to suppress their feelings about their experiences and had not been encouraged to express them through Masekitlana, they would not have been able to create constructive meanings from their past. In this section, I discuss how participants created meaning during Masekitlana in the following areas: their expression of African belief systems, beliefs in Christianity, relationships with others, need for families, disempowerment, everyday concerns, moral authority, and internal processes such as participants' different internal voices.

#### **7.3.2.1 The expression of African belief systems**

During Masekitlana sessions, participants described stories from their lives that reflected traditional African belief systems such as the spiritual world of ancestors, the embodiment of animals with the spirits of their ancestors, and bewitchment. The African nature of the narrative game resonated with the participants' cultural beliefs. Most African people are part of a strong spiritual world, which they express when they are amongst themselves. African



people might not admit to being immersed in this world to persons of American or European ancestry, but they have strong leanings towards it as a result of the long heritage in Africa of spiritual and cosmological beliefs.

The participants in this study expressed being guided by ancestors in the form of a snake, being frightened in dreams by snake images, being in frequent communion with a friendly spirit and having experienced the bewitchment of the neighbours by visiting house guests. If the participants had been subjected to a Western model of therapy, they might not have had the opportunity to express these beliefs. In the current study I concurred with Buhrmann's (1984) emphasis on the importance of understanding the African person on an intuitive level and in his authentic African indigenous context rather than with a logical Western focus that lends itself more to concrete assessment, recording, scoring and understanding.

I sensed during the course of the current study that the participants needed to know that there was a greater power than them guiding them and conferring a sense of order in their lives. They expressed this as the power of their ancestors, the *amadlozi* or 'living dead' who, they narrated, lived around them and in them as a spiritual presence. Ancestors in the African sense have ways to show their acceptance or non-acceptance of what their living relatives are doing on a day-to-day basis, and they guide their living descendants into correct customs and behaviour. Through talking about their ancestors, other spirits and bewitchment, participants expressed their psychic distress and their own culturally assimilated personalized form of resolution. Although not familiar to a Western-orientated therapist such as myself, I realized that their culturally-bound explanations were of comfort to the participants, who had undergone traumatizing experiences. For instance, Hlonipho's belief that his mother has been called home by her ancestors might have been more acceptable and of greater relevance to him than to think that his mother has died of Aids.

The mind and body, the psyche and the soma, are one and the same in African conceptualization of illness. Accordingly, participants of the current study demonstrated a holistic concept of HIV whereby they regarded it as not just a disease demonstrated by bodily malfunction but also a spiritual and social phenomenon. The participants' narratives around illness demonstrated how a culturally-relevant therapy like Masekitlana could help them to reveal their whole selves as influenced by their cultural beliefs.

The way the participants of this study addressed their physical ailments and those of their families indicated that they preferred to interpret them through the African belief that nothing just happens by chance. For instance, a traditional African explanation for illness in children is that the child looking after a terminally ill relative can become ‘polluted’ by the illness of the patient (Ngubane, 1977). Participants’ stories indicated that there was a reason for the deaths they had experienced in their lives and these were usually mediated by the ancestors or were a direct result of *thakati* or African bewitchment.

The participants, in their descriptions of snakes, spirits and ancestors, appeared to be in touch with an extra-psychic reality beyond what the Western mind is able to sense. Perhaps it is true that Africans, as Mutwa (1998) affirms, have the use of twelve senses as opposed to the Westerner, who has only mastered five senses. Therefore, what appears to be paranormal or even magical to a Westerner might be absolutely normal experiencing for an African. Similarly, in the therapy sessions, the participants appeared to be perfectly comfortable with their expressions of spiritual involvement in their lives, expressions of phenomena which were unfamiliar to the researcher’s life.

### **7.3.2.2 Participants’ expressions of belief in Christianity**

During Masekitlana, participants created meaning out of their experiences through expressing a syncretism or dual belief in African spirituality and Christianity. This is a difficult notion for a Westerner, who believes in one centralized thinker who conceptualizes and rationalizes in a concrete and logical manner as opposed to living close to the world of the unconscious, where intuition, feelings, dreams and images are relied on. However, in the current study, this syncretism allowed the participants to find strength from both God and their ancestors without any ambivalent feelings. This might have been grounded on the African belief that ancestors serve as a link for the living person to God and that if a person lives an exemplary enough life, he or she will be elevated to the status of an ancestor who is admitted to the presence of God (Mutwa, 1998; Mkhize, 2004; Jeske, 2010).

Hlonipho was hospitalized towards the end of his mother’s life and was never reunited with any family members again. Under normal circumstances he would have been called upon to perform certain burial rituals for his mother, as he was her only son. Not having done so might have made him feel that the natural connection in his life between the ancestors and

God had been broken. However, he made sense of this discontinuity and dislocation in his life through exploring the dualism of his ancestral beliefs with God and Satan.

Nana's narrative around the trauma of rape, the death of her neighbours and her subsequent dislocation also demonstrated how chaotic happenings are more easily explained and accepted by an African person through the dual beliefs of Christianity and witchcraft. She described the Roberts-2 picture card of a child with a frightened face in bed as a child waking up with a snake around her neck. A Western child would be less likely to give this explanation. Nana also stated that she has a spirit or ghost who lives alongside her as well as God, who she constantly prays to, to protect her in her life.

Through the process of 'dialogism', participants had incorporated the values, opinions, norms and ways of behaving of those around them and were reflecting them in their different voices, called 'polyphony' (Mkhize, 2004). In this way they demonstrated how they could accommodate into their identities and voices the Western concepts of Christianity (although these have been adapted over many years to suit the African context) and traditional African beliefs.

### **7.3.2.3 Community connectivity, family need and attachment**

Much of what the participants spoke about reflected their relationships with others. The participants, through their stories, were able to express their need for and dependence on others in their lives. This is indicative of the African sense of becoming and being a person through the relationship with other people, as opposed to the more Western idea of individualism, self-centredness and personal achievement goals. In Masekitlana, the participants were able to talk about their longing for their mothers and their biological families, their need to help their grandmothers, their desire for guidance from their elders and others wiser than themselves such as fathers, and their need to create order in society by disciplining others.

- **Need for biological family and their original communities**

In African culture, individuals expect to have life-long connections with their family of origin, their clan and their community (Mutwa, 1998; Mkhize, 2004). Their personhood and personal identity is tied up with their family, their kin and their lineage (Ngubane, 1977). The

participants in this study all expressed, openly or through their descriptions of the picture cards, a need to leave the Homes and return to their families. Even if they had experienced traumatic circumstances in their families or in the environment of their families, their identity appeared to still reside in their home communities. Only Hlonipho said that he would go to live with any family of any colour who would love him. The participants implied that nobody can love you as well as your family. The surnames of the participants implied, in the Zulu culture, that they were part of a very large clan all bearing the same surname. Whoever bears that surname is related in some way to a lesser and greater degree. For this reason, the Home authorities were hoping to find a family with the same surname as Hlonipho to adopt him, even if no direct connection to his family of origin could be established. They felt that this would give him some form of identity.

It was a challenge for the therapist to help create a happier, more positive reality for the participants in therapy without the co-operation of the families of the participants. Identified a great lack in the participants of the extended Zulu family, which normally consists of uncles and aunties, called ‘little fathers’ and ‘little mothers’, as well as cousins and siblings. I wondered in what way unity with other Home children might approximate the security and values of a traditional Zulu family with its customs and life stage rituals. However, Masekitlana therapy did help the participants to symbolize the different members of their family in the form of stones, to bang the stones together in anger over the abuse they had experienced in their lives and to express their losses. Through understanding how their lives could be better, that is by acknowledging “negative contrast experiences” (Johnson-Hill, 1998), they were able to look forward to creating secure, healthy families with spouses and their own children in the future.

- **Need for a mother/grandmother, and to a lesser extent, a father**

The participants made reference to their mothers (and grandmothers, whom they referred to as their mothers) more than any other family members. They seemed to idealize their mothers in their descriptions of the picture cards and in simply talking about the influence that their mothers had on them. The attachment of a baby and then a child to a mother is one of the strongest family forces and the initial validation of emotions is performed by a mother on her child. Although all four participants’ mothers had either died or, to a large extent in their present lives, had abandoned or neglected them, the participants did not express anger over this.

The participants displayed an awareness of the importance of the mother figure in their lives, and as a result, they idealized their mothers. Of the four participants, only Nana described a mother in a picture card who was rude and rejecting of her child. This form of mother idealization was confirmed by the social workers of both Homes and provided the participants a fantasy mother to hold on to in the rigorous and sometimes impersonal lives of the Children's Homes. By believing in and imagining a nurturing mother, the participants were healing themselves of the hurts they had experienced. By describing the love their mothers had showed them, they were enunciating what might have been and what still might be one day. It *is* possible that the two existing mothers of Mandla and Nana would mature one day into loving parents.

In Zulu families, the grandmother can play a greater part in the life of a child than the mother, particularly if the child lives in the care of the grandmother. This was the case with Senzo, who related many stories around his 'mother', who turned out to be his grandmother. Nana and Mandla also lived with grandmothers who seemed very involved in their lives outside of the Children's Homes.

The father, although appearing more of a distant figure in participants' lives, was depicted in the image of a person who would guide and protect them and act as mediator over problems with school authorities. Although they did not see their fathers as loving or as nurturing, as they saw their mothers, they expressed a need for them in their lives. However, not one of the participants had an actively involved father who lived in the family home.

#### **7.3.2.4 Disempowerment and language**

Participants were able in therapy to find some form of meaning around their sense of disempowerment in the children's home environment, if only through being able to express it. The participants were to a certain extent 'children without pasts' as they often had not been fully informed about the reasons for their dislocation from their original families and their placement in the Children's Homes. They often did not understand how, when and why they had been rejected by their parents. Nor, if they had HIV, had they been told about the full details and ramifications of their disease. In a sense this disinformation or scantiness of information was a form of disempowerment and neglect of the rights of the child. They did not seem sure if and when they were going to visit or return to their families.

Many rituals or rites of passage of the African child occur during their upbringing with their families. The children were not exposed in the Homes to the stories of their forefathers or to the men and women, particularly the men, of the village gathering to discuss conflict and values. These are the meditational skills whereby children internalize their cultural values. Not being exposed to the different generation's way of behaviour created a cultural vacuum in the lives of the participants, and denied or disempowered them of their cultural identity. Hlonipho definitely appeared to be searching for a cultural identity and so, through Masekitlana, he was able to begin a process of expressing and developing this side of personhood. Manhood for a Zulu person is conferred at stages through distinct cultural ceremonies. I feared that the participants of the current study might not have experienced the distinctive privilege of these rituals.

As participants did not live in their communities of origin, they were addressed by others often in the medium of English. The interactions in the Homes involved the different cultural groups mixing Zulu language with English. I wondered whether the participants might be losing the ability to feel and describe their inner feelings authentically, as they were not speaking their own language regularly. Of the four participants in therapy sessions, only Hlonipho spoke Zulu all of the time and he was the participant who expressed the most about his Zulu traditional values. The language that is spoken the most often has a dominant effect on the values and thinking of children. The fact that this appeared to be English in the Homes, might lead again to power dynamics whereby authentic Zulu expressions are suppressed.

This dominance of the English language as well as what appeared to be a conspiracy of silence around the HIV status of the participants might indicate further disempowerment of children living with and infected with HIV/AIDS. However, traditional forms of therapy might offer a bridge to ameliorate this situation. Participants of the current study made no reference in their narratives to their HIV status in the Western medical sense but Masekitlana appeared to enable them to make meaning of it through a more traditional African sense (ancestors, snakes, and bewitchment).

#### **7.3.2.5 Conflict in Children's Homes, moral authority and creation of order within society**

The participants complained a lot about fighting in the children's home and school environment and they wished that they could be treated more fairly. The fact that they

expressed that matters could be dealt with differently and better, led me to believe that they were attempting to create their own form of moral authority. Under more ideal circumstances, they would be living up to the ideals of their communities. In their original, traditional environments they would have belonged to a particular family, clan and lineage known by others in the community and within this predictable structure they would be guided by the wisdom of their elders. However, Johnson-Hill (1998) emphasizes that if youth are aware that there can be a different and better order in their lives, they will create better circumstances for themselves. Through capitalizing on their assets and resources in their environments, they can improve their circumstances. Research on street children has indicated how this cohort of South African youth has developed a form of bonding and brotherhood with each other and that learning to fight has become part of their repertoire of positive assets and survival skills (Malinda & Theron, 2010). Children can creatively formulate ideas to change their circumstances that adults might not have thought of. Watching the children of the Homes play together with any resources they could find, led me to believe that a different form of family order or bonding with each other might become apparent to the children.

All three male participants wanted to become policemen. In expressing their hopelessness with the fighting and coalitions within the home, and their fear over being in trouble with school authorities, the participants were indirectly confirming a form of loss of control in their lives that had begun with their relocation away from their families and contracting an illness under circumstances beyond their control. Becoming policemen and having power over people in the community might be seen as a way of regaining control and integrating themselves back into communities. Being empathetic towards the needs of others and serving one's community is part of African 'ubuntuism', also enunciated in the term *ukunxulumana* which, loosely translated, is 'to stand beside one another' or 'side-by-sidedness' (Malan, 1994, in Johnson-Hill, 1998:71). Three of the participants expressed, during Masekitlana, the need for a meaningful and secure moral order, described as the personal inner knowledge of right from wrong and through disciplined relations with others.

The exception to the above was Mandla, who expressed a form of criminality that took the therapist and me by surprise. He expressed no fear of killing and using knives on others. His form of policing, that he said he would perform, was of a violent nature whereby wrongdoers would be beaten and shot. He came from and described a particularly violent home environment and had experienced extreme physical violence at the hands of his uncle, which

resulted in his running away from his home to that of his grandmother. I felt that Mandla's concerns and values needed to be monitored in the Home environment and the therapist informed the social worker of this.

Mkhize's (2004) ideas on dialogism, and how children learn from those around them and then incorporate these ideals into their ways of thinking and their voices, lends a cautionary air to dislocated children. If children do not learn the laws of their culture firstly from their families on an interpsychological level, then the internalization of these mores and values might not be assimilated on an intrapsychological plane, and hence will not be available for generalizing to other situations in their lives. The result might be lack of self-esteem and confidence in their own abilities to make a difference to their lives and those of others, and they might accordingly find it difficult to access appropriate and entrenched behaviour patterns. Not having parents to encourage and validate the behaviours of children makes it that much more important for the child to be self-motivated to develop his or her own inner form of moral authority. However, I was encouraged by the moral authority that participants displayed in their lives. Through story-telling in Masekitlana and in response to the picture cards of the Roberts-2 test, they were able to identify more clearly this part of themselves. Talking in Masekitlana might also have helped the participants to connect to their traditional cultural roots where remembered forms of behaviour were prevalent.

#### **7.3.2.6 Everyday concerns**

Like all children everywhere, participants talked about everyday concerns like wanting to own motor cars, the television programmes they enjoyed, helping grandmother to wash dishes and the route they took in the Home taxi to school. Balcomb (2006) confirms that mundane stories about everyday events are just as important as ultimate or grand stories because they too give every day meaning as the big stories give ultimate meaning. The children's stories demonstrated that they live their lives in two worlds. They experience a modern, global world where children like to dress as children dress in the United States of America and where they watch American television and enjoy and identify with the dramatized scenes. They also experience a traditional African world where tribal culture, clan kinship and spiritual beliefs are important. Negotiating and moving between the two worlds appeared to be commonplace and almost sub-conscious. As the participants effortlessly described believing in Christianity alongside their ancestral and spiritual beliefs, so they could talk about the typically Western-modelled facets of their lives alongside their traditional cultural experiences. Participants



seemed to be able to integrate what is relevant in modern life with what is important in their cultures and their historical contexts.

The problems that participants were experiencing in their schooling reflected a lack of individual attention given to them and a lack of parental motivation and encouragement. Participants did not appear to find anything interesting in what they were learning at school. Mkhize (2004) and Nwanna (2006) both believe that all levels involved in schooling should be addressed, not just the individual level. The problems that the participants were describing did not just concern themselves as individuals but indicated situations of poverty, and under-resourced and understaffed schools with too many children in each class. Therefore, the problems the participants complained about concerned educational issues that operate to a large extent at the level of national governance.

#### **7.3.2.7 Internal processes**

How the narrative of the participants unfolded in therapy indicated a step-wise process of being initially reserved and withholding of their emotions, to tentative ‘reaching out’ in the form of questions to the therapist and me about life, wanting to know about the therapist and me, and asking to spend more time with us, to, finally, relatively intense expressions of emotions projected into the Roberts-2 test picture cards and reflected in their scores.

- **Blocking of emotions**

The participants appeared to suppress or deny their emotions at commencement of therapy. Standard of care therapy enabled them to begin to be more open and Masekitlana unlocked their feelings further. Although the participants were not able to express their own sadness, their stories in response to the picture cards were replete with indications of rejection, hopelessness, negativity and a need for nurturance and love. An African child is not used to seeing himself and his feelings in isolation from those around him so this was perhaps the reason why they had not considered their individual interests in great depth before therapy began. The children in the Home might not have been asked by their house mothers how they were feeling as much as a child in his home living closely to a mother and father. Hence, it appeared that participants were not prepared initially to reveal their feelings.

The researcher came into this environment with theoretical assumptions that came from a particular view of ‘self’ that might have been more Western and did not expect that the participants from another culture might have their own particular ways of expressing emotional distress. From the narrative of the participants, it became clear that they prioritized their connections and interrelations with others rather than expressing their own internal repertoire of feelings.

- **Psychic defences**

Stellerman and Adam (2006) explain how, without a mother or father to contain or help the child to hold on to and make meaning of chaotic thoughts and happenings in his life, situations which are part of normal development, the child obliterates these feelings and, with the loss of one valued object after another, he loses the ability to keep the absent objects alive in his thoughts. Instead he fills the space with persecutory and attacking internal objects. This then leads to children who lack imagination, who are fearful and timid, or act out in the form of aggression and impulsivity and who experience learning difficulties as a result. Some of the violent descriptions of the picture cards offered by the participants might have been the result of their identifying with their malevolent internal objects. Mandla, in particular, expressed great violence, and at such a young age, revealed that he would readily stab someone and did not mind if he was going to be killed in the process. The researcher feared that the sorts of internal processes described and demonstrated by Mandla might be one of the reasons for the high level of crime amongst South African youth.

- **Different voices**

Participants revealed a multiplicity of selves and attitudes through their stories. They presented and projected peaceable and helpful attitudes at times, and at other times they appeared angry and negative, and became oppositional and resistant to therapy. What they said in one session would be contradicted in the next session. Mkhize (2004) explains these different and contradictory voices through the process of dialogism and polyphony, which resonates in the narratives of participants in this study. Participants were reflecting the contradictory facets of the different communities in which they lived, and the different opinions and values that they were inculcating from people around them. The violent and oppositional opinions expressed at times by the participants might have demonstrated what Mkhize (2004) describes as the process of ‘ventriloquating’ whereby the participants did not

only express their points of view but were expressing the views of South African society that they had assimilated into their selves and identities.

I anticipated that participants would talk with many different voices, especially in view of the fact that they lived two different lives, one Western and one traditionally African. These lives though were not entirely distinct from each other in that their traditional culture flowed into their more modern lives through a process of adaptation, assimilation and accommodation. I realized that if participants polarized their two different environments this might lead to either a marginalization of their traditional voices or a rejection of them. I felt that it was preferable to see and help participants to understand that they can be “threshold” (DiNicola, 1985) children whereby they could benefit from and be proud of both worlds. Through a process of ‘liminalism’, children can conceptualize a ‘both-and’ rather than ‘either-or’ experiencing of Western and traditionally African worlds.

In this study I paid particular attention to the responsive–interactive function of participants’ utterances, as described by Mkhize (2004). Although the participants were talking to the therapist, there was a distinct ‘addressivity’ in their words to the people they were talking about. When Hlonipho was talking about the love of a mother for her child and when Nana was angrily talking about the rudeness of a mother to her child, they were actually conducting an internal dialogue, albeit out loud, to their deceased or neglectful parents as much as they were addressing the therapist. As therapy progressed, the participants actually became more demanding on the therapist and asked for responses to their questions and answers to their dilemmas in life from her. Due to this interactive aspect of ‘addressivity’ on the part of the participants, it became incumbent on the therapist and me to ask ourselves why these children were saying these things at this particular time. The narratives and stories became part of a knowledge production process, in particular a contribution to indigenous knowledge.

Therapy conducted in the current study was confined to a short and particular time of the participants’ lives. The African person is continually in the process of developing, reforming and transforming through various ceremonial rites of passage and through political and economic changes. In particular, the participants had been exposed to great change in their lives from familial to institutional living, and from African cultural to Western lifestyles. They were affected by the HIV/AIDS disease and resultant sequelae (organic, familial and social) that are receiving immense attention through local and international research and are

constantly changing as far as medical and psychological conceptualization of the disease and treatment for it is concerned. Their lives will be subject to more change when they leave the Homes. Hence, I felt that I was a witness to only a part of who they were as people and who they would become. Children sometimes find creative solutions to conducting their lives that adults would not have thought of. Research on how street children in South Africa survive and create their own unique street culture is evidence of this (Malinda & Theron, 2010). This highly resilient and rather unconventional way of children creating their own, albeit harsh, sense of order on the streets as described in this study, might provide an interesting new slant to the asset-based approach to helping children in South Africa. Another study that explored the experiences of youth in a city environment or *barrio* in South America found that youth often take a “different approach to life’s challenges by pointing to positive actions and circumstances that escape an adult’s observation” (Hardoy et al., 2010:371).

Having established the meaning participants created around their life experiences through the use of Masekitlana, the broader significance of Masekitlana for the field of indigenous psychology needs to be addressed. The following sub-question 3 will focus on the contribution that Masekitlana can make to literature and research in indigenous psychology in general and the main research question will hone the field down to the role that Masekitlana can play in informing new knowledge on indigenous therapeutic tools for children affected by HIV/AIDS.

### **7.3.3 SUB-QUESTION 3: HOW MIGHT NEW KNOWLEDGE ON THE USE OF MASEKITLANA IN THERAPY INFORM LITERATURE AND RESEARCH ON THE RELEVANCE, IRRELEVANCE OR PARTIAL RELEVANCE OF INDIGENOUS KNOWLEDGE IN THERAPY?**

Knowing how Masekitlana inspired children in the current study to express their traditional African beliefs, could inform psychological literature and encourage research to be aware of African children’s natural intuitions, whereby they are guided by dreams, symbols, ancestral spirits, and omens or phenomena emanating from the natural world. Many forms of psychological therapy and assessment being conducted on indigenous African children in South Africa are based on Western psychological theories, premises, assumptions, norms, explanations and methods. This might exert pressure on participants to express their more modern, Western frames of reference to the detriment of their traditional beliefs.

The effect that Masekitlana had on participants of Zulu origin and culture in the current study lent weight to the argument that psychologists in South Africa would benefit from knowing and using indigenous knowledge in therapy. The success of the indigenous narrative therapy intervention of the current study suggested that, if psychologists can offer in therapy skills and tools familiar to the often unexpressed traditional side of Zulu children's lives, they are more likely to help traumatized children to make sense of their lives through connecting them to their authentic familial and cultural beliefs and behavioural dictates. As Masogo (2003:217) claims, narrative theory in an African context, in his case African divination, can bring "previously marginalized discourse and practice into the centre of debate and scholarship as oral narrative discourse offers this displaced discourse the opportunity to occupy its rightful place".

The question arises as to how to produce a body of knowledge that can provide psychologists with the know-how, and the equipment or assessment instruments appropriate for use with indigenous populations. The Third World's own "capacity to produce psychological knowledge is still very low" (Moghaddam, 1987:913). It is possible that psychologists who have grown up in traditional backgrounds might be better equipped in an emic way to create, through empirical research, indigenous psychological methods. However, in South Africa most of the "historically black universities during the apartheid era did not train psychologists and as a result South Africa has relatively few black psychologists, although the number is increasing" (Moletsane, 2004:5). Psychologists from all cultural and ethnic backgrounds are therefore being confronted with African children in therapy and need to meet the traditional cultural needs of these children. Masekitlana, although an indigenous African narrative game, does not embody or use complicated cultural rituals that require a psychologist of African culture to administer it. Masekitlana as used in the current study did not need to be trained to the therapist.

The strength of Masekitlana also lay in the fact that it appeared to satisfy the participants in an immediate sensate and symbolically African way. Children in poverty-stricken environments, in townships and in rural areas, have traditionally played a variety of stone games. Natural products such as stones, sticks and clay are readily available to them and learning to manipulate and use them in various ways becomes a unique skill of the African child. Similarly, Masekitlana has no specific rules, uses a familiar earthy product and is easily recognized and grasped by most children of African culture and origin. African people

traditionally express themselves through narrating poems, epic stories, dancing and singing. Masekitlana as a narrative game and its usage of the whole body is strikingly similar to African rituals and traditionally African forms of expression. It appeared to satisfy a need in the participants for sound and movement in therapy. Hence, in its simplicity and appropriateness to the traditional African context, Masekitlana could inform literature and research on the relevance of indigenous knowledge in therapy. As Moghaddam (1987:917) emphasizes, “the growth of an indigenous Third World psychology could potentially lead to fresh ideas that could only spring from the work of Third World psychologists, with beneficial results for all of psychology”.

The point that remains to be addressed under this section is whether indigenous forms of therapy like Masekitlana are partially relevant, wholly relevant or irrelevant for children of African origin and culture, in particular Zulu children. The findings of the current study rule out a conclusion of irrelevance. However, the way that participants responded to Masekitlana indicated that African children in South Africa are not unidimensional in nature, unicultural or solely traditional in outlook and habits. They are at the same time both highly individualistic and highly collectivistic. Kirmayer et al. (2000) caution that recognizing a practice as ‘traditional’ marks it off from the everyday practices of a people and community and almost puts indigenous people into the category of ‘other’. Therefore, therapeutic techniques cannot concentrate solely on the traditional side of children but need to take into account children’s identities that reflect urban Western or global behaviours, trends, attitudes and values. Masekitlana in the current study appeared to be able to bridge the traditional and the everyday practices of the participants in that it appeared to encourage participants to express their traditional indigenous identities as well as their modern urbanized identities. Therefore Masekitlana contributes to the field of indigenous knowledge by not only offering something of therapeutic relevance to traditional indigenous persons but by demonstrating that children of African origin and culture benefit from therapy that spans both traditional and modern, that is, Third, First and Second worlds. Indigenous psychology and First World or Western psychology should not be mutually exclusive. In fact the recognition of this alternative perspective is one of the contributions that Masekitlana can make towards informing literature and research on the relevance and partial relevance of indigenous knowledge in therapy.

#### **7.4 PRIMARY RESEARCH QUESTION: HOW CAN INSIGHT INTO THE USE OF MASEKITLANA IN THERAPY WITH CHILDREN AFFECTED BY AND INFECTED WITH HIV/AIDS, INFORM NEW KNOWLEDGE ON THERAPEUTIC TECHNIQUES?**

HIV and its ramifications amongst the youth of South African is only now beginning to be understood as the first HIV-affected and infected babies and children grow into adolescence and early adulthood. Learning from them as to how they are going to find their own solutions to navigating life without parents and with HIV might be more effective than devising programmes for them that have been found to be suitable in the Western world. The central tenet behind using Masekitlana as a therapeutic technique for children affected by HIV/AIDS was not to replicate studies conducted in developed societies using imported theoretical frameworks but to create something that local populations already know works. Masekitlana as an ancient Sotho narrative game had already been used in the context of informal counselling and self-expression amongst children. The use of Masekitlana was extended in the current study to provide a form of indigenous therapy for children affected by HIV/AIDS in order to inform new knowledge on therapeutic techniques.

As there is a lot still to be discovered pertaining to HIV, whether in the medical or psycho-social fields, children affected by and infected with HIV can be considered a population group in the process of becoming. This gives psychologists the scope to create interventions that may assist these children to become everything that they have the potential to be. This includes linking them to their cultural past and present, and enabling them to adapt to a multifaceted life ahead, which is most likely to be a fusion of indigenous and Western elements. Participants in the current study demonstrated how they were in the process of becoming and could reinvent themselves in the light of new meanings they created with the medium of a new form of therapy. Masekitlana appeared to allow for the expression of the multiple voices of participants that reflected their various inner and outer worlds and identities. In light of the above, the findings of the current study demonstrated that therapeutic methods need to allow for flexibility of expression in order to allow children to express their different voices and reflect on their different lives.

Furthermore, insight gleaned from the use of Masekitlana in the current study demonstrated that therapeutic methods should mimic the commendable flexibility and adaptability of African children, who are able on one day to be involved in a cultural ritual in the

environment of their rural homestead, and the next day to attend a Christian service with their parents followed by a shopping expedition where the latest Western-style clothes are bought or a Western movie is enjoyed. It is this plurality of inner selves that enables the African child to move between the environment of institutional homes and their own familial homes at an age when they would by Western standards be considered too young for the boarding school environment. Masekitlana appeared to allow participants to talk about their different worlds. It adds to the knowledge on therapeutic techniques that they need and can be flexible enough to be relevant to all of these contexts.

Masekitlana's usefulness and versatility rest on the fact that it allows participants and therapists to use it in imaginative ways, it does not rely on logical, reductionist forms of reasoning upon which question and answer or pen and paper assessments are usually based, and it can be conducted on illiterate children. Participants in the current study devised their own idiosyncratic ways of using the stones and demonstrated their natural skills with stones. This appeared to build their self-esteem, and the camaraderie and relaxation of playing stone games built the rapport between the therapist and participants. This tends to suggest that a mixture of playfulness, relaxation and skill in the content of play therapy techniques might be needed even in the serious context of children affected by HIV.

Masekitlana capitalizes on the typical way that people of African origin and culture express themselves through metaphors and symbols. This was demonstrated by participants in the current study, who created metaphorical meanings from their lives in their narrative whilst manipulating stones. This informs psychologists in indigenous contexts of the need to develop more of an intuitive understanding of the children's lives rather than tapping deep psychological meanings through Western psychoanalytical methods of understanding psychological phenomena. Masekitlana in the current study was non-directive and accordingly might inform researchers using therapeutic techniques that, "across the cultural divide, they might need to be satisfied with being merely active listeners" (Gilbert, 2006:23) and observers.

Masekitlana demonstrated in the current study that children affected by HIV/AIDS did not express their illnesses as they would have predictably done in more Western forms of therapy. In fact, their explanations indicated traditional beliefs that might only be familiar to people understanding the African world of spirituality, cosmology and animism. In this way



Masekitlana may inform new knowledge on therapeutic techniques for children affected by HIV/AIDS in that psychologists, researchers and literary theorists professing or expecting to know what the solutions would be for a client in a cross-cultural situation should endeavour to be aware of differences and similarities between themselves and the clients and an intuitive knowledge of the unity between all living things. This might entail asking clarifying questions that encourage the client to explore and reveal his/her own cultural perceptions and devise new or already existing traditional answers to the problems expressed.

Psychologists from Western traditions expect a catharsis of feeling and then a lessening of distressful emotions in therapy. This did not appear to happen as Masekitlana progressed in the current study. Participants' emotional scores pertaining to depression, anxiety and rejection on the Roberts-2 test *after* Masekitlana therapy was completed increased, as compared with *before* Masekitlana therapy. This fact might inform therapy in indigenous contexts with children affected by HIV/AIDS that there is much repressed matter within children due to the stigma of the disease. New knowledge might be that therapy in this context requires more than three to six sessions for children to express the full extent of their trauma before therapy can even begin to help them to deal with their emotions so their levels of emotions can be ameliorated and lessened.

The African child's natural intuitions and his supposedly extra senses (Mutwa, 1998) could be capitalized on to find solutions to his concerns. Therapeutic techniques for children affected by HIV/AIDS might have to encompass concepts such as 'pollution', 'black', 'red' and 'white' African medicine, ancestral calling and bewitchment. Psychologists might have to be prepared for the fact that a child of Zulu origin and culture might never mention the words *isandulela ingculaza* or 'HIV' but might describe snakes wrapping themselves around his neck to make him sick, or, instead of recognizing anti-retroviral medication, he might say that his protective spirits are going to make him better. It is only when practitioners', researchers' and academic writers' Western traditions are disturbed by new knowledge, such as the usefulness of a form of therapy such as Masekitlana, that they will be challenged to learn from the insights and needs of indigenous people. If a therapist does not present to the African child something representing his cultural mores and values, the therapist will be denied the participant's use of indigenous knowledge to create meaning and healing. When Masekitlana enabled participants to speak that which was healing for them, especially about how

HIV/AIDS had affected their lives, they were not necessarily enunciating the truth as much as they were self-cleansing, which, according to Ntsimane (2000), is typical of Zulus.

Masekitlana as originally used by Sotho children was a communal game (Kekae-Moletsane, 2008). In this study, it was used successfully as therapy for Zulu-speaking *individual* participants. However, the African person is typically not a self-contained, independent-minded and autonomous individual. He<sup>27</sup> sees himself through the eyes of others in his community and he regards himself according to the esteem he is accorded by others in his family, clan and community. His sense of achievement is bound up with serving others around him. Hence, Masekitlana as it was used in this study can be extended to group work and can inform group therapy in that, as in the ancient Sotho game, the person who is holding the stones can be given the privilege of talking. How he bangs the stones can complement his story-telling and give an indication of his feelings. Passing the stones to another person will enable that person to talk. In this way, Masekitlana and its adaptation to group therapy can awaken participants' African sense of drama around story-telling as heard at the fireplace or at community *izindaba* or gatherings in their rural or indigenous environments.

The important point of this study is that it informs new knowledge on therapeutic techniques by encouraging psychologists to search for forms of therapy that are relevant to the indigenous environments and cultures where they work. This might also imply an awareness of the multicultural aspects of South African children where the integration of old and new, local and imported, Western and Eastern and African forms of therapy is to be encouraged. The youth of South Africa are now travelling and crossing boundaries physically and culturally, so a pure form of indigenous psychology would not be possible. As the first missionaries into Africa had to incorporate into their teachings the mindsets of Africans on subjects such as polygamy and the dualism of spiritualism and Christianity, so psychologists can learn from their indigenous clients as to what works for them and what is meaningful in therapy.

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<sup>27</sup> I am still using the male pronoun for consistency reasons although I am not in this context confirming myself to participants of this study.

## **7.5 TRUSTWORTHINESS OF THE STUDY**

The criteria used as a yardstick of quality in the current study include, for the qualitative data, plausibility, credibility, transferability, dependability and confirmability, and, for the quantitative data, reliability and validity, outlined as follows:

### **7.5.1 QUALITY CRITERIA OF QUALITATIVE RESEARCH**

#### **7.5.1.1 Plausibility**

In the current study, I attempted to represent the data and what I observed during the research process in as close a way as possible to what was said and done in the therapy sessions. I attempted to present a report on my findings that adequately and faithfully reflected the reality of the lives of the participants as they saw it. Furthermore, the results should have appeared plausible to other practitioners in the field. On discussing my findings with the social workers and caregivers who live with and managed the participants, they agreed with what I had found and commented that my results rang true to them in their experience of the children.

#### **7.5.1.2 Credibility**

An important part of credibility in the current study was the intentions of the participants and that they felt that their narratives were correctly interpreted. After the recorded, formal part of the therapy session was over, the therapist and I would discuss with the participant what he had expressed to ascertain whether we had understood exactly what he had been saying. Paniagua (1998) believes that participant credibility in the effectiveness of the counselling process is established through cultural sensitivity. By using a therapeutic technique familiar to the African child's play repertoire, and by including a "cultural insider" (Moghaddam, 1987) in the form of a Zulu-speaking therapist, I believe that I established culturally sensitive participant credibility. I also feel that credibility was ensured through the congruence between the data obtained and the research goals, questions and framework. The research findings satisfied the research questions, thereby lending credibility to the results obtained.

#### **7.5.1.3 Transferability**

I attempted to present in this written record of the findings, a detailed enough description of the contextual background, methodology, outcomes and limitations of the research process

and therapeutic interventions so that this study will be able to be transferred or generalized to other settings. The sample size was small, so generalizability is questionable for this reason. However, the richness of the descriptions of the narratives of the participants and the explanations as to how Masekitlana and the assessment instrument, Roberts-2, were used, will help psychologists in other settings to replicate some of the processes of this research.

#### **7.5.1.4 Dependability**

Dependability of this study is based on the accurate reporting of the narratives and behaviours of the participants, which includes the actual quotations of the participants as well as reporting all themes and trends that were identified, and not just those that were interesting to me as the researcher. Dependability was also ensured through my methodology, intervention, and data analysis following, as Schwandt (2007) emphasizes, a logical and traceable process.

#### **7.5.1.5 Confirmability**

As with dependability, the confirmability of the study was determined by whether the findings reflected accurately the data presented or whether they were the result of my biases. Confirmability would not be ensured should another researcher use the methods and models of therapy of this study with a similar cohort of children and find quite a different result. This would then indicate that my needs, personal intent and purpose had superseded the actual results of this research. My self-reflective journal and the crystallization of the topic, where various facets of the enquiry were recorded, validated and presented from different angles, qualitative and quantitative, helped to ensure confirmability.

Ultimately, the test of trustworthiness of the current study will be if psychologists in the field believe strongly enough in its findings and if they rely on them enough to begin to use the same model of research or the method of Masekitlana in their own work and practice.

### **7.5.2 QUALITY CRITERIA OF QUANTITATIVE RESEARCH**

The criteria that helped to achieve quality in the quantitative focus of this study pertained to the results of the measures and the quantifiable markers and indicators of participants' behaviours and attitudes. They can be delineated as follows:

### 7.5.2.1 Validity

The results of the Roberts-2 test were considered valid in that the quantifiable analysis of the participants' story-telling actually indicated the coping abilities and emotions that were reflected in the qualitative themes that emerged from analysis. The purpose of the Roberts-2 test is to assess for social and emotional adjustment problems as well as social cognitive competence. Validity was ensured in the current study in that the results adequately reflected the intended purpose of the test, which was to gauge the extent to which Masekitlana assisted children affected by HIV/AIDS to adjust to their life circumstances. Various forms of validity were met in this study as follows:

- Face validity is demonstrated if a study “seems to address what it claims to address” (Knight, 2002:130). Face validity in the current study was ensured in that the intervention of Masekitlana assisted the participants to express and cope with their trauma in a culturally relevant way.
- Construct validity was ensured in that the constructs of anxiety, depression and anger experienced by the participants were clearly understood, described and reflected in the themes. How they were to be measured and operationalized was followed clearly in the scoring procedure during the Roberts-2 assessment.
- Concurrent validity was demonstrated adequately in the current study in that the intervention produced results that were consistent with the studies done by Kekae-Moletsane (2008) and Odendaal (2010) using the same intervention.
- Predictive validity was demonstrated in that the predicted effect of the intervention, that is to help children express their trauma in a culturally sensitive way, was proven to actually occur during the study.
- Member checking, that is checking the validity of the findings with other colleagues involved in the current study, strengthened the overall validity of this research.

### 7.5.2.2 Reliability

Reliability in the current study referred to how consistently the intervention could be performed, irrespective of when and on whom it was used (Huysamen, 1983). The performance of Masekitlana in fact did produce not identical, but similar results when administered on different occasions and in different venues to the four participants. A test of reliability will be whether other practitioners find that it is equally effective in their sites of work.

## 7.6 RECOMMENDATIONS

In the light of the findings of the current study I would like to make recommendations to the field of psychology in general, the field of HIV psychology and the field of indigenous psychology. These are not discreet fields, as will be seen in the section below. In my recommendations, I have focused on the three areas of professional practice, training of psychologists and research, as they pertain to the African context of children of Zulu origin and culture affected by HIV/AIDS.

### 7.6.1 RECOMMENDATIONS FOR PROFESSIONAL PRACTICE

My recommendations for professional psychological practice encompass the issues of indigenous psychology, HIV in therapy, empowerment of children through knowledge of their life's circumstances, *Ubuntu*, or African humanity, and institutional living, therapeutic environment, and therapist's role in child/client self-reflexivity.

#### 7.6.1.1 Looking at indigenous psychology in the HIV therapeutic environment

Psychologists are privileged to be able to help youth who are part of the constantly evolving history of the HIV epidemic in South Africa, where researchers are learning more about the manifestations of the disease and how it is affecting the South African population. Situations arising from HIV/AIDS and dislocated families have a uniqueness that needs to be experienced and shared by psychologists with others who are not similarly affected. I believe that psychologists, and all people involved in helping others cope with HIV, will look back on this era with amazement at the degree of tragedy and amount of emotion surrounding it, not to mention the degree of discrimination and stigma that people living with HIV have had to suffer. As Denis (2003) suggests, discrimination surrounding people living with HIV is as dire as that faced by Jews, immigrants and homosexuals.

Psychologists and allied professionals, such as social workers and counsellors, are assisting the first cohort of teenagers growing up with HIV or affected by HIV, to navigate their social lives, relationships and future family plans. They should therefore document and disseminate the stories of these youngsters so that they become part of the oral history of this country. In this way psychologists can be part of the body of what Lente (2003) calls "cultural producers and commentators". Psychologists can translate, transform and present the traumatic

experiences of African children to interest others in order to create a helping forum. To this end, psychologists are to be encouraged to use therapeutic media that resonate with the cultural environments of South African youth, in order to elicit authentic stories reflecting the African person's own cultural healing concepts, rituals and customs in the face of trauma and disease.

Children of Zulu origin and culture, in particular those living in urban environments, do not only reflect values inculcated in their indigenous and cultural origins. They are children influenced by Western forms of media such as the Internet, television sitcoms and computer games, as well as magazine and television advertisements dictating tastes and values of a Western (American and European) nature. Therefore, psychologists should be encouraged to attend to the zone between indigenous and Western worldviews. In doing so, they could consider creating forms of therapy that can be constructively supported by Western forms of psychology, such as narrative therapy, but are idiosyncratic to the child's traditional Zulu background. In this way various forms of indigenous psychology in the African context can be self-reliant without being isolationist (Moghaddam, 1987).

In African thinking, the person is always in the process of becoming: the African translation for "person" is *ubuntu* which indicates a process of 'becoming' and is reflected in the words *inkambo* or life journey, and *impilo* or healthy life. As children are always in the process of becoming (Mkhize, 2004), they need not feel that their lives are irretrievably damaged as a result of HIV and past trauma. Psychologists helping children affected by HIV may encourage them to reinvent themselves in the light of improving medical treatment and through being offered new and relevant forms of therapy. Practising psychologists from all cultures can create interventions that may assist these children to become everything that they have the potential to be. This includes linking them to their cultural past and present, while equipping them to adapt to a multifaceted and multicultural life ahead. Through the use of indigenous forms of therapy and culturally symbolic forms of therapy (such as Masekitlana), psychologists would equip African children to understand themselves and embrace with confidence their traditional identity. Furthermore, through utilizing the principles of dialogism in therapy, whereby a child is encouraged to express his many different inner selves and voices created by and mediated by his external familial, community and cultural influences, a child can integrate and reconcile his indigenous and Western worldviews.

### **7.6.1.2 Children's knowledge of and expression of factors influencing their lives**

I recommend that the disempowerment of traumatized children placed in institutional care should be addressed by all mental health professions. Children need continuity between past and present. Self-understanding for any person requires knowing where you have come from and where you are going. Therefore, information about the past and future lives of children affected by HIV and other traumas, such as loss of parents, should be freely shared with them. There should be no 'hazy cover-up' for the supposed good of the child. The narratives recorded in the current study indicated a need in the participants to create stories around their lives as they perceived them to have happened and were happening in and out of the Homes. Often their stories lacked a beginning and end, as the participants did not know why or when their mothers or fathers had left them or died. Psychologists can help children to create meaning through being able to relate beginnings, middle parts and endings to episodes in their lives, including grand and small stories, which must surely lead to more stable children emotionally.

Psychologists in practice can play an important role in emphasizing the relevance of and dissemination of truthful knowledge pertaining to children affected by HIV/AIDS. This might not necessarily imply concrete facts about the virus and how it is affecting the child, as participants in the current study appeared not to even want to mention HIV. Rather, I felt that importance should be attached to finding out reasons for the dislocation from families and the relocation or placement into institutions of orphaned and/or HIV-affected children by professionals, welfare workers and care takers, and that these details should be communicated to the children. Psychologists can help children to progress constructively in their lives if they are aware of the harsh realities as well as the comforting aspects of their pasts and their future prospects. Participants of the current research clearly indicated the need to probe and preserve the memories of family, in particular the love and nurturance of their mothers and the guidance and protection of their fathers. These memories seemed important to hold on to and to build on as a form of resilience.

Psychologists can play a large part in encouraging the traditional narratives around healing in children affected by HIV/AIDS. This is especially important for children from indigenous environments who are relocated to urban, Westernized environments where they have not been encouraged to talk about non-mainstream beliefs, such as ancestors, traditional African medicines and their relevance to healing. The therapist, through simply being an active



listener, and probing where necessary, can allow children to talk and tell stories about their past lives in order to deal with unfinished business, to unpick it and to re-manage it. Psychologists should realize that each life, each story is unique, and each child's perception of his trauma or illness, or how that of others has affected him, is not easy to share.

After seven therapy sessions, participants of the current study appeared, although more emotionally open, to be suffering from the feelings they had been encouraged to express. It is not a Zulu tradition to complain of mental manifestations (Ngubane, 1977). This might inform psychologists that in the context of children of Zulu origin and culture, they need to be aware that initial therapy sessions are only the first part of children's journeys to mend the effects of abandonment, abuse and loss from their past. Furthermore, I recommend that psychologists discuss with traumatized children the possibility that each stage of development in their lives, each new event in their lives, such as marriage and having children, would bring up associations from the past and would require further honest examining of inner feelings and motivations. Memory, for traumatized children, is a life-long process that involves a continual and ongoing ordering, discarding and selecting of facts and interpretations. Psychologists can play a part in children experiencing a constant process of remembering what they lost alongside a process of regaining happiness by recreating their lives and, thereby, replacing the losses. It is a dynamic process that has no ending in a once-traumatized person's life.

### **7.6.1.3 Living in Children's Homes and *Ubuntu***

Psychologists can play a large part in mediating the dislocation and relocation process of children from their original familial and traditional homes to their adaptation to institutional environments. This might involve a process of 'deculturalization' as, in Children's Homes, children are denied their traditional African cultural rites of passage and rituals of transformation marking their transition from childhood to adulthood. Psychologists might be aware that, should children be isolated from traditional cultural practices, as they often are in Children's Homes, they might find it harder to develop a sense of identity and wholeness as an African person, or have a distinctive ethnicity such as 'Zuluness'. Furthermore, to cut off the individual child, who is already traumatized from losses, disruptive family processes in his life, and his own ill health, from his authentic cultural sense of becoming, appears unnecessarily cruel and detrimental to his development as an African. I recommend, therefore, that traditional healers (*izangoma*), traditional diviners (*izinyanga*), African doctors (*ubathandazi*), African faith healers and cultural mediators are consulted by Children's

Homes in order to perform rituals that children of African culture might require. Psychologists remembering their own traditional ways or psychologists with knowledge of indigenous folklore and culture might offer Home children exposure to music, poetry and stories of African origin in order to develop themselves in the direction of their “natural aesthetic” identity (Johnson-Hill, 1998:88) alongside their inevitable more modern Westernized selves.

If community implies an “association of people who have a special commitment to one another and a developed or distinct sense of their common life” (Mkhize, 2004:46), then Children’s Home children and children affected by HIV might be able to become part of a special type of community. Although the Home culture might be a somewhat artificially or newly created form of community where the children have a more superficial commitment to each other than in their original familial communities, Home children might be instrumental in creating their own distinct form of Home culture, involving community and solidarity, such as South African street children have created.

Psychologists can learn from the voices of children and the individualism of each child. Youth have an inner resilience that adults are not always aware of and therefore their own resourcefulness and creativity in enriching their lives should be capitalized on. “Citizenship-as-practice suggests that young people learn to be citizens as a consequence of their participation in the actual practices that make up their lives” (Hardoy et al., 2010:379). Hence, in whatever environment vulnerable children and orphans find themselves, they need to feel a *sense of agency*. Children become very disappointed if they are let down, or if answers and actions are not quick enough, as they have a low threshold for frustration and patience. The capacity of therapists to transform situations is tied up to the need for traumatized children, such as children in Homes, to have a space that is open to all of them where they can negotiate and discuss rules, roles and responsibilities, and which is flexible enough to adapt to their needs.

Psychologists from all cultures in South Africa need to understand the concept of *ubuntu*, which most certainly will manifest in some way in their patients’ lives and can be used to the benefit of the child. *Ubuntu* can be considered a form of indigenous knowledge that may enable psychologists to alleviate the isolation of their children as a result of

institutionalization and living with HIV. The following aspects of *ubuntu*, therefore, might be pertinent to psychologists relating to African children in therapy:

- It is an African concept whereby persons depend on persons to be persons.
- It is by belonging to the community that they become themselves.
- It enables an individual to become a unique centre of shared life.
- It does not simply swallow the individual up.
- It arose in a pre-literate society and was expressed in songs and stories, and the customs and institutions of the people.
- It is a form of humanity that calls for an understanding of one another and a dependence on one another.
- Each person has a special role to play in the whole, like each part of an organism.
- Each individual depends on the community, not because he is in some way less than it but because he is an identical part of it.
- It is something that the dominant Western culture tends to have forgotten and that Western psychological concepts might not take into consideration.

By remembering and utilizing the principles of *ubuntu* in therapy, psychologists might:

- Help vulnerable children taken out of their communities not to feel different from others in their community.
- Help institutionalized children to become part of and depend on others in their newly constructed institutional community.
- Be part of the process of encouraging communities in South Africa to embrace orphans and vulnerable children as if they were their own, incorporating them into families and traditional rituals wherever possible.
- Help different cultures to learn to understand each other by walking across the bridge into unfamiliar territory and lending a helping hand.
- Learn from original indigenous forms of narrative and healing which appeared to reflect *ubuntu*, such as:
  - ✧ the original game of Masekitlana, which demonstrated a communal form of sharing problems, the child's version of African men sitting around the fire discussing their problems, and
  - ✧ ancient negotiation and narrative techniques performed in families and at community gatherings, such as those utilizing banana leaves (Krige, 1950) and African counting beads (Hayes, 2000).

As a result of the need to help children affected by HIV, *ubuntu* is evident in the helping environments in South Africa in that many community projects already embrace these children, and many selfless people are dedicating their weekends to organizing activities for these children. Others are opening extended homes for orphaned children. Psychologists who are able to offer a variety of forms of therapy and are able to understand the need for relocated children to keep alive their traditional beliefs may be invaluable in these settings.

#### **7.6.1.4 Time and rapport in therapy**

In the current study, the value of spending an afternoon with each individual child was recognized. The normal practice of one-hour psychological sessions would not have resulted in the richness of expression and the depth of rapport that was created in this study between the participants and the therapist and researcher. A relaxed atmosphere, with tea and cake provided, helped to create an atmosphere similar to a child returning home from school to his mother who sits with him and chats over an afternoon snack. I encourage psychologists in African settings, especially those where children are denied individual nurturing and attention, to give as long a time as possible to children (and adults) in therapy because story-telling, in true African fashion, is something to be revered and not limited by time. Most African children, as part of their traditional communal life, have participated in formal and informal story-telling as interactive oral performance; in fact, basic training in a particular culture's oral arts and skills is an essential part of children's traditional indigenous education on their way to initiation into full humanness (Sheppard, 2004). If psychologists encouraged this oral interactive skill of African patients, they might more easily facilitate effective therapy in group or individual settings.

There are further African constructs, knowledge of which would assist psychologists in African settings. The psychology of healthy relationships is typified by the African concepts and everyday practices of *ukuhlonipha*, or respect, and empathy (Edwards, 2011). These are clearly demonstrated in the *vumisa* methods of ritual and dialoguing of the *isangoma*, who sympathizes and confers with his clients as to his findings, and are evident in the social mutuality of *ubuntu*. I feel that psychologists could learn from these components of Zulu healing rituals and use them to good effect in the therapeutic situation, if they are not already doing so. In the current study, participants only expressed their true emotions towards the end of the therapy sessions. Therefore, psychologists are encouraged to give traumatized children time to relax and develop trust, and in time they will reveal their suppressed feelings.

#### 7.6.1.5 Client self-reflection

In therapy with children separated from their families and subjected to trauma, I recommend that psychologists encourage children to incorporate ‘praxis-centred’ self-reflexivity into their lives. Johnson-Hill (1998:95) describes the praxis-centred self as one “who has critically reflected upon his or her taken-for-granted ways of acting at various times in the past, and has altered his or her ways of acting in the light of that reflection”. Psychologists can help children’s home children to reach a point in their lives where they are able to reflect on the disunity between their traditional family environment and the social ethos of the Home, in order to integrate the better aspects of both into a praxis-centred self. This will enable them to act towards their own betterment, to integrate the diffuse elements of their internal selves, and to develop a sense of authenticity of action.

As part of inculcating this self-reflexivity, therapy with dislocated children should encourage in them an awareness of others and sympathy for the plight of others. Despite being part of the everyday routines of a Home ‘community’, traumatized and children isolated from their families can withdraw into themselves into a form of “elective mutism” (DiNicolì, 1984), and not only become reluctant to express their feelings about themselves but also oblivious of the feelings of others. Psychologists need to be sensitive to the possibility that institutionalized children of African origin and culture risk losing the value of caring for others, as *ukunxulumana* or ‘side-by-sidedness’ is replaced by a sense of individual survival and guarding one’s own territory in the Home.

Psychologists might help to remind children in Children’s Homes that they are part of the suffering that their extended families in communities undergo on behalf of their children in order to further their children’s education and careers. Johnson-Hill (1998:82) calls this a “moral capability of the highest order” amongst African people who have a “deeply-rooted, taken-for-granted value orientation about how people within families should look after one another’s needs, especially with respect to the ways they may have suffered in the past” (1998:83). Psychologists might be encouraged to help children to take part in community projects whereby they learn to reach out to help other needy children in communities outside of the Homes. Psychologists and social workers could be part of an already existing tradition of hierarchy that I noticed in the Children’s Homes whereby they could help train, supervise and designate older children to mentor those younger than themselves.

## 7.6.2 RECOMMENDATIONS FOR TRAINING

Understanding clients in the context of their traditional cultural beliefs should be a prerequisite for all new psychologists working with indigenous people. At the annual congress of the Psychological Society of South Africa in August 2000, Deputy Education Minister Father S'Mangaliso Mkhathshwa urged the country's predominantly white psychologists to learn "at least one black language ... given that psychology is traditionally known as the talking cure". He told delegates that there was a need to "develop local models of care that are culturally centred and recognize the lived realities of our people" (Holland, 2001:67). The teaching of African knowledge systems should, therefore, become an integral part of psychology for undergraduate and post-graduate students. Instead, it has tended to be the domain of philosophy, social anthropology and theology.

Psychologists need to be trained in methods of therapy that embrace traditional beliefs, such as the faith in the strong guidance of the ancestors. Holland (2001:65) described a form of therapy called "imaginative psychotherapy" in which therapists connected a cohort of Mozambican children with their ancestors by allowing them to imagine a safe space where they were with their protecting ancestors. By witnessing healing rituals, Holland (2001) believes that these therapists broadened the therapeutic space by participating in local traditions that had significant therapeutic value, not only for the youth but also for the community at large. In this way, training therapists can develop the ethos that therapy is not a matter of taking the child out of his traditional environment and trying to cure him as an individual with an individual problem, as this is not in accordance with the collective, communal spirit of the African person.

In order to understand the cultural beliefs and ideologies of African clients, psychologists need also to understand the historical roots of African people. I therefore advocate strongly that training psychologists have some actual lived experience of the lives, likes, dislikes, hopes, hardships and traditional rituals of Africans, even if it means that part of their university practical experience or internship is for students to be placed in the homes of Africans in urban 'locations' or rural communities for an adequate enough period to gain a solid understanding of African ways of living and thinking.

Isasi-Diaz (1993, in Johnson-Hill, 1998) believes that the researcher should be a "cultural insider", trying to understand empathically the values of the participants. Sikkema and

Niyekawa-Howard (1997) specify that, in order for students to begin to integrate a different culture's beliefs and traditions into their way of thinking, the students have to live with and observe the ways of that culture for a period of at least eight weeks. Furthermore, they encourage psychology students to use divergent thinking when they go to live in different cultural communities as opposed to convergent thinking, which is what, they claim, the education of students in American colleges encourages. Divergent thinking is fostered when students placed in different cultures from their own initially just observe how people are and only at a later period should students analyze what they saw and how it differed from their own perceptions of their own lives.

I recommend that psychologists need to learn methods that are as naturalistic as possible to the African person. Therefore, by experiencing the natural environments of African communities, psychologists will metaphorically learn to roll up their pants and not be afraid of mud between their toes when helping people in South Africa (Jeske, 2010). The clinical environment of psychology departments in hospitals or rooms in private homes and medical centres might not be the environment for psychologists to learn how African clients live and what their requirements might be in therapy. Going out to do community work and learning from the people as to what their needs and challenges are would give training psychologists a more authentic training experience. Training psychologists might learn more from the resilience of African people living in adversity than the latter are able to learn from the training psychologist about coping with life.

### **7.6.3 RECOMMENDATIONS FOR RESEARCH**

I recommend that more research into indigenous methods of therapy be encouraged. Books written by people who have lived and worked with African people, such as Buhrmann (1984), Mutwa (1998), Ngubane (1977) and Krige (1950) may be recommended to research psychologists. From the descriptions of the work of these pioneers in the field of indigenous psychology, new methods of empirical research might be devised.

“How to guard against the potential misuse of psychological tests and the need to adapt and develop culturally appropriate measures has been an important point of discussion but few concrete steps have been taken to redress the situation” (Kekae-Moletsane, 2004:10-11). In assessing African children for scholastic reasons, I have found few intelligence tests valid for the South African environment. Researchers might subject Masekitlana to a form of

standardization on African children to be used as a form of intelligence testing. A standardized intelligence test of an indigenous variety might be more culturally relevant and therefore more valid for African children as it could make use of exercises and skills with stones and other natural products instead of children having to identify shapes, forms and concepts unfamiliar to them, as is the case with existing intelligence tests originating in Europe and America.

Existing cognitive screening tests that the psychology team of McCord Hospital use in rural KwaZulu-Natal hospital clinics indicate that most users are cognitively deficient to a greater or lesser degree. However, this might arise from the fact that the tests involve a form of shape identification similar to children's puzzles, which rural children have seldom had the privilege to play with. Another of these screening test demands copying of abstract shapes that have no resemblance to anything from the rural child's environment. Hence, Masekitlana as a standardised cognitive or intellectual test might be fairer and more representative of people of African origin and culture.

I suggest that research methods might capitalize on solutions and explanations from indigenous populations about concerns identified in the current study, such as illness, conflict with peers, and dislike and fear of school. Such African forms of knowing might become of use for all psychological, health and educational settings, indigenous and Western, as well as to aid political conflict and to address economic difficulties (Mutwa, 1998). In particular, the psychological component of healing in the Africa indigenous context could be subjected to further in-depth research. As Edwards (2011) points out:

“Although indigenous healing is essentially holistically, biologically, psychologically, socio-cultural and spiritual in nature, many authors have noticed the importance of the psychological component. While there have been many articles on indigenous and/or traditional healing, many of which have been written by psychologists, very few have focused on the actual psychology of indigenous healing ... It is predicted that investigations into the psychology of indigenous healing may reveal more essential structures of a perennial psychology, as old as humanity, which forms the foundations for all contemporary psychology. It may well be that such investigations may reveal original, hitherto undiscovered foundations and practices of this perennial psychology that underpin both modern scientific and traditional folk psychologies” (Edwards, 2011:224).



At present, Masekitana has only been investigated as a form of therapy for *individual* children. As it was originally a narrative game used by groups of children, I recommend that research be conducted using Masekitlana in a *group* therapy situation.

## **7.7 CONFIRMATION OF ASSUMPTIONS**

As Masekitlana is a form of ‘emic’, ‘bottom-up’ therapy originating in the cultural context of the participants of this study, it was assumed that it would prove familiar to participants. It was found to do so and it enabled participants to describe some of their traditional beliefs. I assumed that a certain amount of familiarity with the participants’ indigenous knowledge systems would be necessary in order to understand their expressions during the intervention therapy. I found that literature informed me on aspects of indigenous knowledge systems such as ancestors and the symbolism of snakes, which then clarified for me the meaning behind participant narratives. The assumption that participants would demonstrate how they experienced living in between traditional and Western cultures, their cultural in-betweenity (Pederson, 2009; Mkhize, 2004), proved to be the case. Masekitlana enabled them to talk about their experiences through the lenses of both of these worlds in what Mkhize (2004) describes as polyphony or multiple voices. I assumed that a form of therapy whereby therapist and participant were co-creators of participant reality rather than a structured therapist-directed form of therapy would be useful for participants. This proved to be the case as participants created various forms of narrative play with stones. They additionally chose to describe the picture cards of the quantitative measure, the Roberts-2 test, while playing with stones. My final assumption was that I would have to beware of bringing my own cultural preconceptions, values and research into the interpretation of data and into the process of therapy. This proved to be a challenge as it was not possible to remain an objective researcher. I could not eliminate my own feelings when I observed therapy sessions and heard the content, and inevitably interpretation of data might have included my personal convictions. However, the reflexive journal helped me to come to terms with this honestly.

## **7.8 LIMITATIONS OF THE STUDY**

Inevitably the current study presented with certain limitations concerning the relationship of the research team and participants, the conceptualization of the research and how to implement its goals and faithfully portray its results, as well as some methodological design and process variables such as sample size and translation.

### 7.8.1 ROLE OF THE RESEARCHER

In cultural psychology, there is a “dialectical and dynamic connection between the knower and knowledge, between person and context, between the practitioner and his practice” (Mkhize, 2004:27). This statement brings to mind the elements of contradiction, dissimilarities, similarities and synthesis between myself and participants, between my background and theirs and many other links or disconnections I encountered in the current research. As opposed to my everyday role as psychologist-therapist for the same cohort of children from the same Children’s Homes in this study, I felt that I was now in the context of research and the observer-recorder-photographer and so was ethically bound to a certain severing of the link between myself and the participants. I presumed I could not become wholly part of the context.

This created personally experienced ambivalence in the process of research in the current study, as the participants and therapist sometimes brought me into therapy, and at times I felt I had to intervene and become part of the therapy. Therefore relatedness and connectivity between all of us involved in the current study, not just between participants and therapist, became an imperative. I found it hard to remain objective and so inevitably I did become part of the context. This substantiated the cautions of Mkhize (2004) and Strydom (2005a) that practitioners and researchers cannot remain isolated unto themselves and cannot remain objective in African cultural settings. My dilemma was further clarified by Masogo (2003:225), who felt dissatisfied with being an outsider or “observer-researcher” and so crossed over into the “specialized space” of becoming an *ngaka (isangoma)* or African diviner in order to give the “esoteric knowledge (of an outsider in research) personal, social, and bodily legitimacy”. Masogo explains his reasoning as follows:

“We still know far too little about the anthropological activity of boundary crossing, and how this reacts with the participant’s own boundary management. Dealing with other people’s existential questions, existential questions of our own cannot be avoided; nor can these all be suffocated under increasingly convoluted and elegant discourse, no matter how many levels of structure, transformation, binary and ternary logic they may contain” (Masogo, 2003:225).

In an attempt to ameliorate my insecure feelings over ranging between being objective and subjective, I discussed my ambivalence with the therapist and the research supervisor. Notes

in my reflective journal indicated how I grappled with the blurring of research boundaries and the inevitable involvement of my personal feelings.

- *What I found was that it was harder for me to relate to the boys as I was not doing the therapy. When I said goodbye to them, I felt that they did not really know me. I felt it hard for them and me to be out 'on a limb' recording them but not being part of the therapy. I would have wanted to ask them some questions but had to leave this to..... (therapist) (9/6/2010:6).*
- *I find it hard to just be an observer. I want to actively participate in the session to make it more fulfilling in my eyes and to elicit more information. In this way, I am trying to fit the session into my agenda rather than allowing it to naturally follow its course and allow the ..... (therapist) to express their own styles of managing the session (9/6/2010:7).*
- *While I was washing (tea cups and cake plates) with Hlonipho, I asked him about his family and he told me that his mom had died. I was not sure whether I should interact with him in this way but I felt that it was necessary for me to also have a rapport with him and it is my natural inclination to feel with him and to help him. Washing with the little children is often a time when they talk about other things of their life and when further questions can be asked of them. I see it as an activity that their absent mother would do with them and that they now can enjoy doing with me as a surrogate mother (23/6/2010:9).*

### **7.8.2 LOSS OF CULTURAL AUTHENTICITY**

In cross-cultural research such as the current study, there is the risk that researchers can only interpret what they see through the lens of their own perceptions. It can be very difficult for researchers to put aside their own preconceptions when examining the lives of others. As mentioned above, Masogo (2003), in conjunction with his position as a university lecturer, became an *ngaka* or diviner, which enabled him to embrace more effectively the cognitive and emotive components of narrative discourses of African people. One of the limitations of this research was that I was from another ethnic group (of European culture and origin) from the participants and therefore, although a resident of Africa and having lived in rural Zululand, I still had not completely immersed myself in African traditional life and so did not share all of the cultural beliefs of the participants. Self-reflexivity became an important part of this research and I questioned frequently whether my presence as a white, middle-aged lady in the therapeutic space did not inhibit and limit the expressions of the participants. Hence, the

written results of the current study are probably only an approximated reflection of what the participants wanted to reveal and were able to reveal about their lives.

### **7.8.3 TRANSLATION CONCERNS**

Translation from Zulu to English in this study had its limitations. It was difficult to portray accurately, in writing up the research results, what the participants had authentically said and felt. From my understanding of what I heard in the sessions, I realized that some of the meaning, cultural insinuations and indications that the participants uttered were lost in the translation. I also noted that some of the meanings and terminology of Western nature were not understood by the translator and therefore not accurately translated. This challenge was emphasized by Tshehla (2003:186) who, in the context of Biblical translations from English into seSotho, states that “no culture can be reproduced completely in any literary text, just as no source text can be fully reproduced in a translation”. Fortunately in the current study, I was able to follow and absorb the Zulu narrative in the sessions before some of the meaning was lost in the transcription and translation.

### **7.8.4 LOSS OF TRAUMATIC CONTENT**

The written record of the participants’ narratives could not adequately convey the intensity of the trauma that the participants expressed. The traumatic content of the participants’ narratives was felt in therapy by me and the therapist in a way that words could not describe. Krog (1999, in Lente, 2003) explains how she felt this in connection with the narratives recorded during the Truth and Reconciliation Commission Enquiry of 1995. She describes how unsuitable the written text is as a form for re-presenting performed stories (such as the participants’ narrative while playing with the stones) and for re-presenting traumatic oral narratives. In this research, utterances of the participants were presented in the written record in isolated ‘chunks’. This divorced them from the context of the full conversation in therapy, the limitation of which must be recognized. Krog (1999, in Lente, 2003) does, however, believe that a new literary medium can be moulded that would re-present traumatic stories, perhaps in on-line, dramatized theatre form, as opposed to the written word.

### **7.8.5 SMALL SAMPLE SIZE**

The goal of qualitative research is generally to understand the uniqueness and complexity of people’s experience; hence, qualitative research is usually conducted on small samples

(Manning & Morant, 2004, in Lees, Manning, Menzies & Morant, 2004). In this research, only four participants were studied in detail. This means that assuming that the results can be generalized, a larger population must be considered with caution as the results might not adequately represent all traumatized children living with or affected by HIV.

#### **7.8.6 SOURCES OF BIAS**

In exploring themes, patterns and associations within the data, my personal whims, goals and needs for the research might have been a source of bias. Participants might have tried to respond to therapy in ways that they thought I, as the researcher, would have liked. The ‘allegiance effect’, that is, the researcher’s allegiance to a particular form of therapy and his need for the outcome to be a positive one (Lees et al., 2004), might have been a possible source of bias in the current study. To reduce this bias, I discussed the themes and outcome frequently and at length with the therapist, as well as with the social workers of both Children’s Homes.

#### **7.8.7 CHALLENGES OF RESEARCH WHERE THE RESEARCH TEAM IS AFFECTED BY HIV/AIDS**

A great challenge for me in the current study and one that I did not anticipate was how the effect of HIV illness on the research team would in turn affect the progress of the research. One of the participants was in hospital during part of the time period planned for his therapy sessions, so his therapy had to be delayed and the flow of the research was affected. The translator became ill and delayed translation by six weeks. Eventually a second translator had to be contracted. The therapist’s sister fell ill and passed away during the course of the therapy sessions so these had to be postponed for a month. Furthermore, research fell over the Soccer World Cup period and three of the participants who had families were sent home for six weeks. This left one participant to work with over this period. The discontinuity of intervention sessions might therefore have affected the content of the sessions.

#### **7.9 STRENGTHS OF THE STUDY**

The strengths of the study emanated from study design and study intervention as follows:

### **7.9.1 THE USE OF MIXED-METHODS DESIGN AND CRYSTALLIZATION IN SINGLE-SYSTEM RESEARCH**

The lens of crystallization, that is, “multiple sources of evidence viewed in different dimensions and from different approaches”, rather than the “fixed, flatter, two-dimensional triangulation approach”(Mohangi, 2009:101), enabled a rich, deep investigation of the subject of this study. Data collected in a variety of ways, that is, interviews, casual discussion, observations, therapeutic narrative play, formal assessment, audio and visual recording, member checking and a reflexive journal enabled a thorough investigation of each system or case. The mixed-methods design allowed for quantification of data presented in graphic form, which was then tested against the qualitative data. Quantitative data provided more concrete information, while qualitative data collection enabled deeper, subjective meanings to be revealed. Because there was a follow-up session two months after the intervention was complete, the lasting effect of the intervention therapy could be tested. Performing therapy on participants for seven sessions each, that is, a total of twenty-eight sessions (of between twenty-eight and forty-two hours total duration) meant that a rich knowledge of the participants’ lives was gleaned. Furthermore, twelve sessions in all of Masekitlana therapy allowed for a comprehensive testing of the intervention and a sound observation of the effects of the intervention.

### **7.9.2 SINGLE-SYSTEM DESIGN PROVIDES ITS OWN CONTROL**

The strength of the single-system research design is that each participant (or system) is his own control. This is ethically fair in that the intervention is applied to all participants, as opposed to omitting interventions on control participants, the latter being the case for other designs. As each participant was his own control, extraneous and confounding factors that may occur when researchers compare one person with a different person, were eliminated. The time delay between the last intervention session and final assessment indicated whether there would be lasting effects from the intervention.

### **7.9.3 REVELATION OF AFRICAN BELIEFS AND AN EMIC APPROACH TO PSYCHOLOGICAL THEORY**

Masekitlana produced the effect of enabling the participants to express their African belief systems. This enabled the participants to reveal a part of them that might have been

suppressed if the study had involved Western forms of therapy. I did not commence the research with presuppositions on how the participants would react nor did I test their narratives against any specific theory or hypothesis. I adopted an inductive and open-ended approach of letting the participants teach me what was of value to them. I simply absorbed and recorded the narrative expressions and actions of the participants in order to thereafter explore the meanings and themes that arose against the theoretical framework of indigenous psychology and indigenous knowledge systems.

#### **7.9.4 MASEKITLANA IS A SIMPLE FORM OF INTERVENTION**

Masekitlana is an intervention that represents indigenous knowledge, which therefore implied that I was utilizing an emic or bottom-up perspective on studying participants in indigenous contexts. This avoided the dominance of an intervention from a Western worldview, with which participants might have felt unfamiliar. Masekitlana is also simple and non-directive, and so allows participants freedom of expression and allows for creativity of activity response. The Roberts-2 test was particularly suited to children of African culture and origin, in comparison with other projective tests of its type, as the pictures depicted children looking like African children.

#### **7.10 POSSIBLE CONTRIBUTIONS OF THE STUDY**

The strengths of the study resulted in findings that I believe have made and will continue to make notable contributions to the field of psychology in general and indigenous psychology in particular, in the following way:

##### **7.10.1 ADDITION TO INDIGENOUS KNOWLEDGE**

The current study has contributed to the body of knowledge on indigenous psychology in that it has proven that offering Zulu-speaking children a form of therapy that resonates with their traditional cultural environment, enables them to express their authentic cultural beliefs. This research, therefore, adds to the collection of literature on indigenous knowledge systems and how psychology can form a part of this body of literature.

### **7.10.2 ENCOURAGEMENT TO OTHER PSYCHOLOGISTS AND ALLIED PROFESSIONALS**

This study might serve to encourage other psychologists and related professionals to employ methods of therapy that originate in the historical and cultural lives of African persons. African people have been using their own rituals of healing throughout the ages. This study has shown how one such form of healing, Masekitlana, can be used as a valid therapeutic method for traumatized children. Further forms of indigenous therapy and research might be encouraged as a result of the current study, which “could have explicit or implicit functions of honouring original, local, evidence based, best practice, effective, research methodologies, diagnostic techniques and therapeutic modalities, which have stood some test of time and cultural approval” (Edwards, 2011:225).

### **7.10.3 RESILIENCE OF CHILDREN**

The current study revealed the fact that even though children in South Africa are undergoing a considerably traumatic period due to the effects of the HIV pandemic, they are still able to develop their own form of moral authority and resilience in the face of adversity. This study also revealed the fact that children of Zulu origin and culture suppress their emotions and it takes a number of sessions of therapy, in particular, an African form of therapy, for them to show how they truly are feeling. In this way, the current study, using a form of psychology created by an African community itself, might have demonstrated one possible solution for the crime situation involving adolescents and young adults that has resulted from these youngsters acting out their anger at society by becoming criminals.

### **7.10.4 HIGHLIGHTING CONCERNS IN SOUTH AFRICA**

This study has revealed the situation that is typical of so many children in this country, who live without the support of family, have been affected by sexual abuse and live with HIV. A contribution of this study has been to alert psychologists and the general public, through the narratives of the participants, to the intensity, direness and complexity of the situation. Another contribution is that it has highlighted difficulties that minimally nurtured children are experiencing in their school environments.



### 7.10.5 GUIDELINES FOR CHILDREN'S HOMES

This study has offered guidelines for Children's Homes and other environments where orphans and children affected by HIV are being raised. It has cautioned caregivers in these environments not to neglect the African cultural backgrounds of these children, as this might constitute a further tearing away of these children from their roots. A contribution of this study is to show how the ethos of *ubuntu* and the spirit of collectivity, empathy and living through the respectful eyes of those around one can be brought into these environments.

### 7.11 CLOSING REFLECTIONS

With the pandemic of HIV, South Africans are experiencing an epoch in history the only precedent of which could be the bubonic plague of the Middle Ages. Psychologists are not only privileged to be part of this era where knowledge of HIV and methods of treatment for HIV are evolving and improving all the time, but have an enormous responsibility to point out the psychological and social ramifications of the disease in the lives of the people of our nation. They are also in a position to offer solutions through their psychological skills. It is an era for South African psychologists to become as creative as they can and to use the resources that they have on hand and the strengths of South African people to right themselves.

I believe that we have at our doorstep a wealth of African indigenous knowledge that only needs to be tapped in order to offer a source of great healing power to the nation. Mutwa (1998) has stated that the extra-sensory power of the African person could be used to great strategic value. I believe that these same powers of intuition of the African person could be used by professionals to create concrete methods of healing in the psychological profession.

When I began to study the ancient narrative game of Masekitlana, I embarked on a fascinating journey of discovery into the ancient and modern cultural beliefs, healing practices and story-telling ability of the African person, in particular Zulu-speaking people. The journey became a voyage of discovery of myself and my professionalism in that I was forced to question my beliefs as well as the forms of therapy and assessment that I had been conducting in my professional life. Masekitlana presented a new path of therapy for me. It answered what I felt was missing in the therapy of children affected by HIV, which was for psychologists in indigenous contexts to "use a different set of tools which may not be tools at all in any conventional sense in psychology" (Eskell-Blokland, 2005:172). Masekitlana represents for

the field of indigenous psychology a different set of tools, one which capitalizes on a form of therapy and healing that already existed in the indigenous Sotho culture (Kekae-Moletsane, 2008, 2004; Gilbert, 2006) and was found, in the current study, to be relevant for children of Zulu origin and culture. Through Masekitlana and other similar forms of therapy, psychological intervention can be “restored to its primal simplicity in order to reveal, by contrast, the extreme complexity of the intellectual, cultural, political, economic and social life of the [African] continent” so as to “truly appreciate the internal dynamics, imbalances and tensions” that exist there (Hountondji, 1983:xi). I was grateful that my work and research into Masekitlana in the current study took me away from “just asking about healing through established [in my case, Western] practice” (Kruger, Lifschitz & Baloyi, 2007:323) to attending a traditional healers’ conference, to involving myself in a research project exploring the cross-usage of anti-retroviral medication and traditional African medicine, and to talking to *izangoma*/spiritual healers, *izinyanga*/herbal healers and *abathandazeli*/faith healers who are on the margins of various healing practices.

A colleague, who had also based her research on Masekitlana, and I demonstrated our findings on Masekitlana at a conference in August 2010. An academic stood up and cautioned us against involving ourselves in something we did not know enough about. I concurred with him but added that this was why more researchers in the field of psychology, even those from Western backgrounds, should conduct more research into different forms of authentic African therapy. This would inform new knowledge on indigenous methods, to enlighten the Western world as to what indigenous environments already use that might be useful in the therapeutic environment of children who are broaching both worlds, indigenous African and modern Western. It is time that psychologists helped to give credibility to indigenous forms of therapy. It is time that indigenous environments exposed to the world what they have to offer. It is time that indigenous forms of therapy are supported by those of the Western world and it is time “for an integral approach that includes and transcends diverse perspectives” (Edwards, 2011:225).

“Through recent legislation and establishment of a Traditional Healers Council, the South African government has paved the way for legal recognition of traditional practitioners and referrals between modern and traditional health care sectors” (Edwards, 2011:214). I would like to encourage a similar form of collaboration and referral system between South African registered psychologists and their traditional counterparts, such as traditional healers<sup>28</sup>, who would complement the work of psychologists in offering holistic care to the African patient.

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<sup>28</sup> Treatment by traditional healers and/or modern therapists essentially consists in re-establishing spiritual, human and environmental relationships, performing appropriate rituals to both protect and strengthen the vulnerable individual family and community and promote their future health, well-being and fortune (Edwards, 2003:218).

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## APPENDICES

- Appendix A: University of Pretoria Ethics Clearance Certificate
- Appendix B: McCord Ethics Clearance Certificate
- Appendix C: Letter of invitation to caregiver of Sinikithemba Paediatric Clinic
- Appendix D: Letter of invitation to child patient of Sinikithemba Paediatric Clinic
- Appendix E: Letter of invitation to social worker of Sinikithemba Paediatric Clinic
- Appendix F: Letter to HIV Coordinator
- Appendix G: Letter of Explanation to HIV Coordinator
- Appendix H: Caregiver Consent Form
- Appendix I: Participant Assent Form
- Appendix J: Declaration of Responsibility (Social Worker)
- Appendix K: Letter of Code of Ethics to Translator
- Appendix L: Social Worker Interview Questions
- Appendix M: Roberts-2 Picture Cards
- Appendix N: Roberts-2 Coding Protocol
- Appendix O: Example of Completed Scoring Protocol
- Appendix P: Description of Roberts-2 Objective Scales
- Appendix Q: Feelings Drawing Test During Standard of Care Therapy
- Appendix R: Content Analysis of Hlonipho's Narrative Results According to TAT
- Appendix S: Structural Narrative Analysis According to Dynamic Assessment Method
- Appendix T: Example of Therapy Transcript with Colour and Theme Coding
- Appendix U: Example of Field Notes





ETHICS CLEARANCE CERTIFICATE



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA  
Faculty of Education

RESEARCH ETHICS COMMITTEE

|   |   |
|---|---|
| <b>CLEARANCE CERTIFICATE</b>  | <b>CLEARANCE NUMBER :</b> <span style="border: 1px solid black; padding: 2px;">EP 10/02/02</span>       |
| <b><u>DEGREE AND PROJECT</u></b>  | PhD<br>The use of Masekitlana as a therapeutic technique for children affected by HIV/AIDS              |
| <b><u>INVESTIGATOR(S)</u></b>   | Sally John  |
| <b><u>DEPARTMENT</u></b>  | Educational Psychology  |
| <b><u>DATE CONSIDERED</u></b>   | 27 March 2012   |
| <b><u>DECISION OF THE COMMITTEE</u></b>   | APPROVED  |
| <br>Please note:<br><i>For Masters applications, ethical clearance is valid for 2 years</i><br><i>For PhD applications, ethical clearance is valid for 3 years.</i> |   |
| <b>CHAIRPERSON OF ETHICS COMMITTEE</b>  | Prof L Ebersohn<br> |
| <b>DATE</b>   | 27 March 2012   |
| <b>CC</b>   | Jeannie Beukes<br>Dr. Kesh Mohangi  |

This ethical clearance certificate is issued subject to the following conditions:

1. A signed personal declaration of responsibility
2. If the research question changes significantly so as to alter the nature of the study, a new application for ethical clearance must be submitted
3. It remains the students' responsibility to ensure that all the necessary forms for informed consent are kept for future queries.

Please quote the clearance number in all enquiries.



McCord Research Ethics Committee



28 McCord Road,  
Overport,  
Durban 4001.  
P.O. Box 37587,  
Overport 4067 KZN,  
South Africa.

Tel : 031-2685700. Int. 2731-2685700  
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P.B.O. No : 18/11/13/4121  
Fundraising Authority : 06 600386 000 9

Medical Superintendent : Dr Helga Holst  
Financial Director : J E Carroll  
Senior Nursing Service Manager : Mrs Z E Mageba

7 May 2010

Dear Ms John

**Re: The use of Masekitlana as a therapeutic technique for children affected by HIV/AIDS**

This study was reviewed by the McCord Research Ethics Committee (MREC) on the 30<sup>th</sup> April. Full approval for the study has now been granted. Please see accompanying clearance certificate for study number.

We wish every success with your research.

Sincerely

Dr CL Kerry

**Research Coordinator  
McCord Hospital**



## **McCORD RESEARCH ETHICS COMMITTEE**

### **CLEARANCE CERTIFICATE**

**DATE: 7 May 2010**

**STUDY NUMBER: 300410/6.2 sj**

**PROJECT TITLE: The use of Masekitlana as a therapeutic technique for children affected by HIV/AIDS**

**INVESTIGATOR (S): S John**

**MREC DATE APPROVED: 7 May 2010**

**DECISION OF COMMITTEE: Full approval**

**Dr Claire Kerry  
Research Coordinator McCord Hospital**

## APPENDIX C

### LETTER OF INVITATION TO CAREGIVER OF CHILD PATIENT OF SINIKITHEMBA PAEDIATRIC CLINIC TO PARTICIPATE IN THE RESEARCH PROJECT

My name is Sally John and I am a Counselling Psychologist. I am a PhD student at the University of Pretoria and I work as a psychologist in McCord Hospital. I would like you and the child in your care to be part of a research project. I am interested in finding out more about Masekitlana as a cultural form of play with the purpose of using it as a therapeutic method for children affected by HIV/AIDS.

If you agree, I would like to be able to use some of the information that you and your child will be asked to give me during the sessions. The social worker will have a discussion with you about your child and will ask you to bring any documents about your child, such as school reports and your child's clinic file for us to read. Your child will be required to come to the clinic for 8 sessions, one each week if possible. During these sessions, your child will be asked questions about him/her and will be shown how to play Masekitlana. This is a game whereby the child will use two or more stones to bang or rub together while he talks to the social worker about his life.

The sessions will be in Zulu and will be between the social worker and your child. They will be video-recorded by me. You will remain anonymous throughout the research. Your child can choose another name for him/herself to protect his/her identity. All documents and videoed material will be kept in a locked cupboard and will also be shared with my supervisor, Dr. Mokgadi Moletsane. She will also keep it safe at the University of Pretoria.

If you have any questions about this study or would like to receive a final copy of the report of this study, please contact me on 082 9260147 or (031) 2685825. You may also contact my supervisor, Dr. Mokgadi Moletsane, at (012) 4202767.

Regards

Sally John, Counselling Psychologist ..... Caregiver ..... Date .....

## APPENDIX D

### LETTER OF INVITATION TO CHILD PATIENT OF SINIKITHEMBA PAEDIATRIC CLINIC TO PARTICIPATE IN RESEARCH

My name is Sally John. I am a PhD student at the University of Pretoria. I am busy with a research project that aims to find out about Masekitlana. I am hoping that you will be willing to play Masekitlana with a social worker while I watch you. Before we begin this game you will be asked questions about yourself and will be shown pictures about which I want you to tell stories.

I am asking you to allow me to ask these same questions and show you the same pictures four times during this study. The study will also include one normal therapy session like the sessions you have in the clinic sometimes when you visit the social worker. Masekitlana is a game where you hit two stones together and talk about your life. This game is a form of therapy and will happen over three sessions in the clinic.

This project will involve you in 8 sessions in all and each session will last for about one hour.

Your caregiver has given permission for you to take part in the project. She has signed a form to say this. You will also be asked to sign a form to show you agree to take part in this study. You may also stop at any time and your medical care will always be the same whether you are part of the project or not.

The information that you share with the social worker and me will stay with me in a locked cupboard and will also be kept by my supervisor, Dr. Mokgadi Moletsane. All the sessions will be recorded and filmed by a camera held by me. You can choose another name for yourself to be used in the sessions so if anybody else hears the recording, they will not know your name.

If you have any questions about this project, you can talk to me, or Dr. Mokgadi Moletsane. My telephone number is 082 0260147 or (031) 2685825. Dr. Moletsane's telephone number is (012) 4202767.

Regards

-----

Sally John

-----

Participant (child)

-----

Date

## APPENDIX E

### LETTER OF INVITATION TO SOCIAL WORKER OF SINIKITHEMBA PAEDIATRIC CLINIC TO PARTAKE IN RESEARCH

As a PhD student at the University of Pretoria, I am conducting a research project relevant to the field of research I am pursuing which is indigenous psychology. This degree involves not only theoretically acquainting oneself with the field of study but also carrying out a research project to explore a particular aspect relevant to the field and that will make a contribution to the field of study.

This project will undertake to investigate Masekitlana as a projective and narrative play technique for children between the ages of 7 and 9 years who are affected by HIV/AIDS. I anticipate that the findings of this research could contribute to more culturally appropriate forms of therapy in the African context. In the context of the paediatric clinic, I hope that this research project will improve the standard of psychological care for the patients.

Please be advised that all information revealed in this project will be stored in a safe place and the identities of the individuals involved will remain confidential and anonymous through a process of coding and pseudonyms. You are further advised that should you wish to withdraw from the project at any time, you may do so. Assistance in this research project is voluntary and obligation-free.

This research project expects you identify three HIV positive patients between the ages of 7 and 9 years who have lost a parent/s to AIDS or are affected by HIV/AIDS. Their caregivers will also be involved in that they will be expected to offer information on the children in their care.

Furthermore, the research project expects you to act as a therapist to the participants in that you will ask the participants questions about themselves, you will be conducting therapy in the normal manner of the clinic, and you will be playing Masekitlana with the participants.

Please be advised that the outcomes of the research will be shared and discussed with a supervisor, following which the findings of the research will be presented in writing and

orally to a review board as part of an evaluation process. With the exception of the above-mentioned persons and the translator of the data, no other person apart from those directly participating in the research will be granted access to the research material. The findings of the research could be made available to the participants if requested. At a later stage, at the discretion of the reviewers and supervisors, the research might be published and made available to other scholars. Should this occur, the names and identifying details, including name of institution, of the participants will not be revealed and the faces of the participants will be blanked out.

You need to understand the ethical code of conduct when taking part in research and you need to take the necessary steps to abide by this code to protect the rights of all participants involved in this research project. You will be requested to treat all the data and information during this project as confidential and ensure that all participants remain anonymous.

I thank you in advance for your time and participation in this project and I hope it will be a meaningful learning experience for you. I hope that it will provide a form of intervention that will be of use in the paediatric clinic of Sinithemba in the future.

Regards

-----  
Sally John  
Counselling Psychologist

-----  
Lungile Shangase  
Social Worker

-----  
Date



**LETTER TO HIV CO-ORDINATOR**

2<sup>nd</sup> February 2010

Attention: Dr. Peninah Thumbi: HIV Coordinator

McCord Hospital  
McCord Road,  
Overport, Durban  
4001

Dear Doctor Thumbi

**Letter of invitation to participate in research in McCord Hospital**

I, hereby, request permission to conduct a research project in the Sinikithemba Paediatric Clinic of McCord Hospital. The research project is in the process of being evaluated by the Ethics Committee of the University of Pretoria. Should it be accepted, I shall submit a Research Ethics Proposal Form to the McCord Research Ethics Committee.

This project will form part of a thesis that I am writing for a PhD degree in Educational Psychology through the University of Pretoria. The subject of my research is Indigenous Psychology. The purpose of the project in McCord Hospital is to investigate the use of an authentic African game, Masekitlana, as a therapeutic technique for children traumatized by HIV/AIDS. I will be ascertaining whether this game, traditionally played by Sotho children, can be as useful for Zulu children. Another purpose of this research is to establish whether this form of therapy can become standard of care in an HIV clinic where children are regularly counseled for stress-related mental health concerns resulting from HIV. A broad purpose of this research is to encourage psychologists to be aware of the fact that traditional or indigenous forms of psychology might be beneficial to black South African children, either in complement to more Western forms of therapy or in replacement of Western forms of therapy.

The research will use quasi-experimental, mixed methods, qualitative and quantitative, research paradigm consisting of pre- and post- test measures and the intervention of Masekitlana on three HIV positive patients between the ages of 7 and 9 years. Their caregivers will be interviewed and patient files and any documentation pertaining to their lives and their mental health and welfare, such as school reports, social worker, psychologist or counsellor reports will be reviewed. The project will be explained to the caregivers and the participants in language relevant to their age and cultural understanding. Consent and assent forms will be presented to the participants and their caregivers. These forms will be explained adequately and will be signed by the participants and caregivers. It will be explained clearly that participation is voluntary and will not affect the medical care of the children in any way. There will be no inducement offered for them to participate. There will be 8 sessions per Hlonipho and the sessions, during which measures and the interventions will be performed, will be conducted by the Head Social Worker of the Paediatric Clinic, Ms. Lungile Shangase. She will be adequately trained for this purpose and will understand the ethical requirements of a research assistant. All sessions will be conducted in Zulu and will be videoed by the researcher. Data will be locked up safely and identities of participants will be protected by coding, pseudonyms and blanking out of faces.

I will endeavour to comply with all ethical constraints necessary for this type of research and required within the environment of McCord Hospital.

I thank you for your consideration.

Yours truly

(Mrs.) Sally John

Counselling Psychologist

Head of Psychology Department, McCord Hospital.

**LETTER OF EXPLANATION TO HIV CO-ORDINATOR**

Head of HIV Business Unit  
Sinikithemba Clinic  
McCord Hospital

19<sup>th</sup> April 2010

Dear Dr. Thumbi

**Re.: Research study: The use of the projective play game, Masekitlana, as a form of therapy for children affected by HIV/AIDS.**

I, hereby, request permission to conduct a research project in the Sinikithemba Paediatric Clinic of McCord Hospital. The research project has been accepted by the Ethics Committee of the University of Pretoria. It has been reviewed by the McCord Hospital Research Forum and is to be submitted to McCord Research Ethics Committee.

This project will form part of a thesis that I am writing for a PhD degree in Educational Psychology through the University of Pretoria. The subject of my research is Indigenous Psychology. The purpose of the project in McCord Hospital is to investigate the use of an authentic African game, Masekitlana, as a therapeutic technique for children traumatized by HIV/AIDS. I will be ascertaining whether this game, traditionally played by Sotho children, can be as useful for Zulu children. Another purpose of this research is to establish whether this form of therapy can become standard of care in an HIV clinic where children are regularly counselled for stress-related mental health concerns resulting from HIV. A broad purpose of this research is to encourage psychologists to be aware of the fact that traditional or indigenous forms of psychology might be beneficial to black South African children, either in complement to more Western forms of therapy or in replacement of Western forms of therapy.

As discussed with you in our meeting of 19/04/2010, I will lay out the logistical details of conducting the above study in Sinikithemba Clinic, McCord Hospital.

The research will use quasi-experimental, mixed methods, qualitative and quantitative, research paradigm consisting of pre- and post- test measures and the intervention of Masekitlana on three HIV positive patients between the ages of 7 and 9 years. Their caregivers will be interviewed and patient files and any documentation pertaining to the participants' lives and their mental health and welfare, such as school reports, social worker, psychologist or counsellor reports will be reviewed. The project will be explained to the caregivers and the participants in language relevant to their age and cultural understanding. Consent and assent forms will be presented to the participants and their caregivers. These forms will be explained adequately and will be signed by the participants and caregivers. It will be explained clearly that participation is voluntary and will not affect the medical care of the children in any way.

Ms. Lungile Shangase, Social Worker and Head of Sinikithemba Paediatric Clinic has agreed to carry out the therapy sessions with the three participants. She will be adequately trained for this purpose and will understand the ethical requirements of a research assistant. All sessions will be conducted in Zulu and will be videoed by the researcher. Data will be locked up safely and identities of participants will be protected by coding, pseudonyms and blanking out of faces.

The study will comprise of, in total counting all three participants, three consenting sessions, where the caregivers will also take part in a semi-structured interview, and twenty-one therapy sessions, four of which will involve measurements using the Revised Robert's Apperception Test. Each participant will undergo seven therapy sessions in all, one per week for six weeks and then a final session three months later. It is proposed that Ms. Shangase will conduct three therapy sessions in total per week, should the participants arrive at the clinic as planned.

Ms. Shangase will not be remunerated for her time. It is felt that she will benefit from the experience of performing therapy under the guidance of a registered Counselling Psychologist. She will also be learning a new form of therapy that, it is hoped, will continue to be used on children in the clinic in future. It is also felt that the three participants from the clinic, chosen for being traumatized, will obtain the benefit of eight hours of therapy which is considered medium to long term therapy. Sally John will track the hours spent doing research in the Clinic and will do the equivalent amount of hours for McCord in her private time.

The researcher will endeavour to comply with all ethical constraints necessary for this type of research and required within the environment of McCord Hospital.

I thank you for your consideration and interest in this study.

(Mrs.) Sally John  
Counselling Psychology  
Head of Psychology Department, McCord Hospital

**CAREGIVER CONSENT FORM**

Letter to Parent/s or Caregiver/s

My name is Sally John and I am a student at the University of Pretoria where I am reading for a PhD degree. This degree involves a research project that I am doing at McCord Hospital. I am also employed by McCord Hospital as a Counselling Psychologist.

I would like you and your child to be part of the research project.

I am interested to find out whether Masekitlana, a Sotho cultural game, might be useful as a form of therapy for children affected by HIV.

Being part of this research will mean bringing your child to Sinikithemba Paediatric Clinic for sessions, one per week, with each session lasting for one hour. Then after a three-month break, I will ask you to bring your child again to the clinic for one more session. At the beginning of the first and at the end of the eighth session, a Zulu-speaking social worker will be asking you questions about your life with your child. In four of the sessions, the social worker will be asking your child questions about how he/she is feeling about his/her life with the use of tests or questionnaires. In the other four sessions, the social worker will be talking to your child and will be playing the stone game, Masekitlana, with him/her.

Participation is voluntary and you and your child are allowed to withdraw from this research project at any time. Whether you are part of this project or not, or if you withdraw from it, you will be receiving the normal medical treatment in the clinic.

You and your child will each be paid R70 every time you come for a session. This is to pay for your bus or taxi fare or the petrol cost to come to the clinic and return home.

The sessions will be videotaped. You and your child's names may remain anonymous throughout the research project. You may choose to change your names for the recordings. Should the tapes be shown at a later stage, your faces will be blanked out. All documents and tapes will be kept in a safe place and the information that you share will be kept by me, Sally John, and my supervisor, Dr. Mokgadi Moletsane.

If you have any questions about this study or should you like to receive a final copy of the report, please contact me on 082 926 0147 or (031) 2168 5703.

This letter will serve as a consent form for you and your child. If you have any questions about this research project, please call Dr. Mokgadi Moletsane on 083 4617638.

Signed at McCord Hospital, Overport, Durban on .....2010.

-----  
Sally John (Researcher)

-----  
Parent/Caregiver

-----  
Parent/Caregiver

## APPENDIX I

### PARTICIPANT ASSENT FORM

#### Letter requesting assent from a child to be part of the Masekitlana research project

My name is Sally John. I am studying for a PhD degree at the University of Pretoria. I am also a Counselling Psychologist at McCord Hospital. I am busy with a research project that aims to find out whether a stone game, called Masekitlana, helps children to talk more easily about their lives. I am hoping that you will be willing to answer questions about your life and whether you will be willing to play Masekitlana. A Zulu-speaking social worker will be asking you questions and will be playing the game with you.

Answering these questions and playing the game will take place over eight sessions lasting about one hour each session. Sessions will be once a week, so you will need to come to the clinic each week for seven weeks. Then there will be a break for three months after which there will be one last session.

I would like your permission to use the answers to my questions in my research report. You will also be videotaped. Should the tapes be played to anyone else beside my teacher/supervisor and me, your face will be blanked out. You may choose to call yourself by another name during the research project. The information that you share with the social worker and me will be kept safely by my teacher, Dr. Mokgadi Moletsane and me. Nobody else will know your name.

Your parent/s or caregiver/s has/have given permission for you to take part in the project. You may also stop at any time. Your medical care in the clinic will not be affected by taking part in this project.

If you have any questions about this project, you can talk to me, or Dr. Mokgadi Moletsane. My telephone number is (031) 268 5703 or 082 926 0147. Dr. Moletsane's telephone number is (012) 420 2767.

Signed at McCord Hospital, Overport, Durban on .....2010

-----  
Sally John (Researcher)

-----  
Participant (child)



## APPENDIX J

### DECLARATION OF RESPONSIBILITY (SOCIAL WORKER)

I, ....., do hereby declare that I will conduct myself in this research in a responsible and professional manner. I shall endeavour to conduct therapy on the participants in a manner that will do as little harm as possible and as much good as possible, that is, will as much beneficence and as little maleficence as possible.

At all times, I will keep all information presented to me in confidence. I declare that I shall not discuss any information from the sessions with any person outside of the research unless it becomes my professional responsibility to reveal a situation to the necessary authorities that might be damaging the participants.

Signed on .....2010, at McCord Hospital, Overport, Durban.

.....

(Mrs.) Lungile Shangase

Social Worker

Manager Paediatric Clinic, Sinikithemba Clinic, McCord Hospital.



## APPENDIX K

### LETTER OF CODE OF ETHICS TO TRANSLATOR

Dear Makhosi

I thank you for agreeing to translate the data of this study from Zulu into English. I ask you hereby to understand the ethical code of conduct when taking part in research. As researchers, we need to take the necessary steps to abide by this code to protect the rights of all participants involved in this research project. For this reason I request you to treat all the data and information during this project as confidential and ensure that all participants remain anonymous. All data must only be in your possession or in my possession. When translation is complete, I request you to delete any data in your possession as it can only be used for the purposes of this project. As discussed, please do not type out the names of participants as you might hear them in the recordings but note down Participant A to Participant D instead.

I thank you for your diligence in this respect.

Signed on 28/02/2012 at DURBAN

MNDlalisa

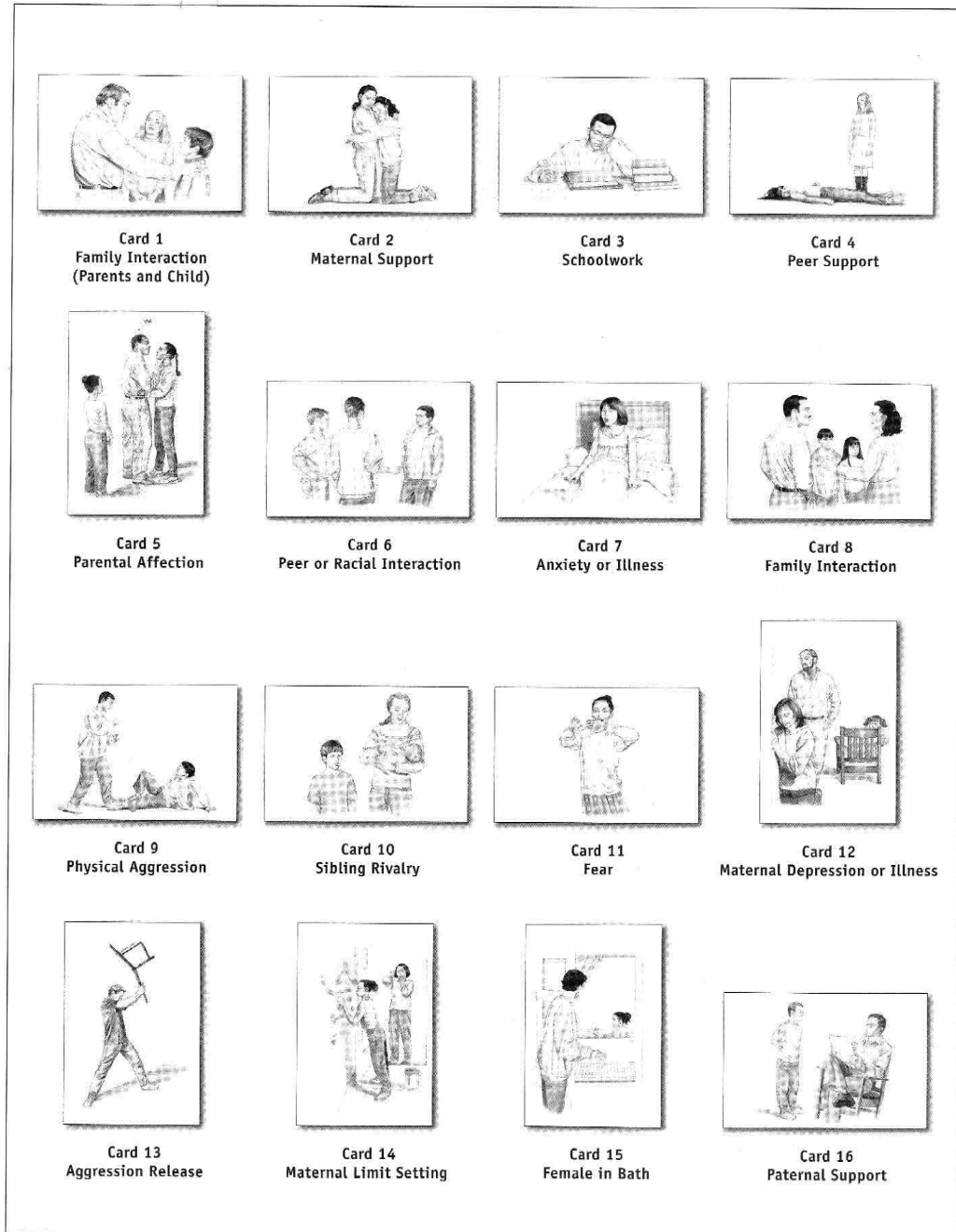
Signature

**SOCIAL WORKER INTERVIEW QUESTIONS**

**Questions to the social worker in Children's Home**

- What is your relationship to the child in your care?
- If you are not a parent, where is the parent/s or what has happened to the parent/s and how did the child come to the Home?
- How long has the child lived in the Home?
- How is the health of your child?
- Have you disclosed to your child about his status?
- What do you feel the child knows about HIV?
- How do you feel the child feels about having HIV?
- How does the child feel about not living with, or not having a mother/father or not having either parent still in his life?
- Does the child as far as you know suffer any form of problems such as anxiety, anger, depression, conduct or learning problems?
- Do you have any communication problems with this child or any other challenges?
- How does your child get on with the other children in the Home?

**ROBERTS-2 PICTURE CARDS**



**Figure 4**  
The Roberts-2 Picture Cards



ROBERTS-2 CODING PROTOCOL

| CODING PROTOCOL   |   |
|---|---|
| <p><b>Roberts-2<br/>Record Form</b></p> <p>Glen E. Roberts, Ph.D.,<br/>and Dorothea S. McArthur, Ph.D.</p> <p style="text-align: center;"><b>wps</b><br/>Test with Confidence</p> | <p>Child's Name or ID: _____ Administration Date: _____</p> <p>Age: _____ Gender: _____ Grade: _____ Date of Birth: _____</p> <p>Assessment Administrator: _____ School or Agency: _____</p> <p>Reason for Assessment: _____</p> <p>_____</p> |

|   | CARD NUMBER |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    | Total<br>Count |
|---|-------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----------------|
|   | 1           | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |                |
| <b>Theme Overview Scales</b>                              |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Popular Pull .....  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Complete Meaning .....                                    |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| <b>Available Resources Scales</b>                         |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Support Self—Feeling .....                                |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Support Self—Advocacy .....                               |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Support Other—Feeling .....                               |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Support Other—Help .....                                  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Reliance on Other .....                                   |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Limit Setting .....                                       |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| <b>Problem Identification Scales</b>                      |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 1—Recognition .....                                       |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 2—Description .....                                       |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 3—Clarification .....                                     |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 4—Definition .....  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 5—Explanation .....                                       |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| <b>Resolution Scales</b>                                  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 1—Simple Closure or Easy Outcome .....                    |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 2—Easy and Realistically Positive Outcome .....           |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 3—Constructive Resolution .....                           |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 4—Constructive Resolution of Feelings and Situation ..... |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| 5—Elaborated Process With Possible Insight .....          |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| <b>Emotion Scales</b>                                     |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Anxiety .....   |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Aggression .....  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Depression .....  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Rejection .....   |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| <b>Outcome Scales</b>                                     |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Unresolved Outcome .....                                  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Nonadaptive Outcome .....                                 |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Maladaptive Outcome .....                                 |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Unrealistic Outcome .....                                 |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| <b>Unusual or Atypical Responses</b>                      |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Refusal .....   |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| No Score .....  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Antisocial .....  |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Unusual (total count for all three categories)            |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |
| Atypical Categories (total count for each card)           |             |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |                |

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APPENDIX O

EXAMPLE OF COMPLETED SCORING PROTOCOL

SIPHELELE 1

23/6/10

CODING PROTOCOL

Roberts-2  
Record Form

13 cards

|   | CARD NUMBER |    |    |    |    |    |    |    |    |    |    |    |    | Total Count |    |    |
|---|-------------|----|----|----|----|----|----|----|----|----|----|----|----|-------------|----|----|
|   | 01          | 22 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 |             |    |    |
| <b>Theme Overview Scales</b>                        |             | ✓  |    |    |    | ✓  | ✓  |    | ✓  | ✓  |    | ✓  | ✓  | ✓           |    |    |
| Popular Pull  |             | ✓  |    |    |    | ✓  | ✓  |    | ✓  | ✓  |    | ✓  | ✓  | ✓           |    |    |
| Complete Meaning                                    |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| <b>Available Resources Scales</b>                   |             | ✓  |    |    |    |    |    |    |    |    |    |    |    |             |    | ✓  |
| Support SAH—Feeling                                 |             | ✓  |    |    |    |    |    |    |    |    |    |    |    |             |    | ✓  |
| Support Self—Advocacy                               |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| Support Other—Feeling                               |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| Other Help  |             |    |    |    |    |    | ✓  |    |    |    |    |    |    |             |    | ✓  |
| Reliance on Other                                   |             |    |    |    |    |    | ✓  |    |    |    |    |    |    |             |    | ✓  |
| Limit Setting                                       |             |    |    |    |    |    | ✓  |    |    |    |    |    |    |             |    | ✓  |
| <b>Problem Identification Scales</b>                |             | ✓  |    | ✓  |    | ✓  | ✓  | ✓  |    |    | ✓  | ✓  | ✓  | ✓           | ✓  |    |
| 1—Recognition                                       |             | ✓  |    | ✓  |    | ✓  | ✓  | ✓  |    |    | ✓  | ✓  | ✓  | ✓           | ✓  |    |
| 2—Description                                       |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 3—Clarification                                     |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 4—Definition  |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 5—Explanation                                       |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| <b>Resolution Scales</b>                            |             | ✓  |    |    |    |    |    | ✓  |    |    |    |    | ✓  |             |    |    |
| 1—Simple Closure or Easy Outcome                    |             | ✓  |    |    |    |    |    | ✓  |    |    |    |    | ✓  |             |    |    |
| 2—Easy and Realistically Positive Outcome           |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 3—Constructive Resolution                           |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 4—Constructive Resolution of Feelings and Situation |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 5—Elaborated Process With Possible Insight          |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| <b>Motion Scales</b>                                |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| Anxiety   |             |    |    |    |    | ✓  | ✓  | ✓  | ✓  |    | ✓  | ✓  | ✓  | ✓           |    |    |
| Aggression  |             |    |    |    |    | ✓  | ✓  | ✓  | ✓  |    | ✓  | ✓  | ✓  | ✓           |    |    |
| Depression  |             |    |    |    |    | ✓  | ✓  | ✓  | ✓  |    | ✓  | ✓  | ✓  | ✓           |    |    |
| Self-Hatred   |             |    |    |    |    | ✓  | ✓  | ✓  | ✓  |    | ✓  | ✓  | ✓  | ✓           |    |    |
| <b>Outcome Scales</b>                               |             |    |    | ✓  |    | ✓  | ✓  |    | ✓  |    |    |    | ✓  | ✓           | ✓  |    |
| 1—Resolved Outcome                                  |             |    |    | ✓  |    | ✓  | ✓  |    | ✓  |    |    |    | ✓  | ✓           | ✓  |    |
| 2—Nonadaptive Outcome                               |             | ✓  |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| 3—Maladaptive Outcome                               |             |    |    |    |    | ✓  | ✓  | ✓  |    | ✓  |    |    |    |             |    |    |
| 4—Realistic Outcome                                 |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| <b>Unusual or Atypical Responses</b>                |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| Refusal   |             |    |    |    |    |    |    |    |    |    |    |    |    | ✓           | ✓  | ✓  |
| No Score  | ✓           | ✓  |    | ✓  |    |    |    |    |    |    |    |    | ✓  | ✓           | ✓  | ✓  |
| Antisocial  |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| Unusual (total count for all three categories)      |             |    |    |    |    |    |    |    |    |    |    |    |    |             |    |    |
| Atypical Categories (total count for each card)     |             | A1 | A2 | A3 |    | A4 | A4 |    | A6 |    | A8 | A9 | A1 | A1          | A3 | A9 |

## APPENDIX P

### DESCRIPTION OF ROBERTS-2 OBJECTIVE SCALES

The Roberts-2 comprises seven groups of scales, each with from two to six sub-scales:

#### 1. Theme overview scales

- **Popular Pull** (how the majority of non-referred children perceive the picture)
- **Complete Meaning** (the ability of the participant to construct a story that is complete)  
If a participant offered no stories with completeness of structure might indicate that the Nana did not understand instructions to achieve the task of telling a complete story, or that he was unable to develop a successful outcome. In this study and taking into account the life experiences of the participants, it is thought that the latter explanation is the more likely one.

#### 2. Available resources scales

- **Support Self – Feelings** (when a character experiences positive feelings, happiness, pride, love, admiration, and pleasure)
- **Support Self – Advocacy** (the ability of character to be resourceful and gain insight from experience)
- **Support Other – Feelings** (where the participant experiences the support system or environment as positive, protective, loving, helpful and responsive)
- **Support Other – Help** (where the participant experiences help and support or offers help and support to someone else)
- **Reliance on Other** (this scale addresses the tendency of characters to seek help or reach out to their support system for help with problems)
- **Limit Setting** (includes all types of consequences or punishment, enforcing a boundary, or the setting or establishment of rules)

#### 3. Problem identification scales (scales form a hierarchy of problem-solving skills)

- **Problem Identification 1 - Recognition** (simple recognition of feeling or behaviour in the present situation without explanation of preceding factors and without clear definition of problem or reason for feeling or behaviour)

- **Problem Identification 2 – Description** (this level includes an explanation for the situation with feelings sometimes defined and described. There is a definite description of the situation but an internal process is not achieved and preceding factors are not well defined)
  - **Problem Identification 3 – Clarification** (this is characterized by a simple statement of present internal conflict, with limited description of preceding factors. The description of the problem situation might be elaborated)
  - **Problem Identification 4 – Definition** (a conflict or problem is defined, the reason for it or prior circumstances are described, and internal processes are elaborated)
  - **Problem Identification 5 – Explanation** (the problem situation is identified fully with the preceding factors and reasons for the problem situation well articulated, and the resulting internal conflict adequately described. The present feelings of the character are fully identified and related to the causes and conditions preceding the situation in the picture)
4. **Resolution scales** (form a hierarchy of increasing and more adaptive problem-solving skills and indicate the participants' ability to develop a positive outcome for the story)
- **Resolution 1 – Simple Closure or Easy Outcome** (this involves a simple or abrupt ending to situations without a logical or realistic closure; there is no mention of process or mediating steps)
  - **Resolution 2 – Easy and Realistically Positive Outcome** (the ending is related to the content and a positive outcome is achieved but there is no description of process or how the solution was achieved)
  - **Resolution 3 – Process Described in Constructive Resolution** (some process is included and described in the constructive resolution of the present problem situation but feelings may not be addressed or resolved unless the story is focused only on the problem feelings)
  - **Resolution 4 – Process Described in Constructive Resolution of Feelings and Situations** (the process is included in the constructive resolution of the present problem situation, and the related feelings are addressed and resolved)
  - **Resolution 5 – Elaborate Process With Possible Insight** (the process is fully elaborated in the constructive resolution of both feelings and the problem situation, and frequently insight is developed and applied to learning in future situations)



5. **Emotion scales** (these scales group together, in four general categories according to certain commonalities, a variety of basic human emotions which represent the wide range of feelings that children and adolescents experience in life)
  - **Anxiety** (represents in general the reaction to or apprehension about the demands of the environment and includes content of illness, accidents, the death of people both depicted and not depicted in the card, feelings of guilt, self-doubt, worry, embarrassment, and regret)
  - **Aggression** (includes the various states of anger such as rage and frustration, and numerous expressions of aggression such as arguing or making fun of (verbal aggression) and attack or destruction of property (physical aggression))
  - **Depression** (includes presence of emotional responses such as sadness, depression, sorrow, unhappiness, crying, disappointment, and physical symptoms such as apathy, tiredness and the inability to handle a situation)
  - **Rejection** (identifies content representing separation or distancing from a person, family, and peer group, ethnic or social group. The predominant theme is one of abandonment or loss of attachment figures such as during divorce situation but feelings of jealousy, discrimination, making fun of someone or refusal of needs or requests is also included)
  
6. **Outcome scales** (represents the ability or inability of the participants to solve problems or feelings in a positive or successful manner)
  - **Unresolved Outcome** (when the story is left in the present situation and the situation or feelings remain unprocessed)
  - **Nonadaptive outcome** (an outcome that does not contribute towards resolving the problem successfully nor does it contribute additionally to the problem; an ineffective outcome)
  - **Maladaptive outcome** (outcomes scored on this scale tend to make the situation worse or more problematic and often represent acting-out behaviour, such as destructive behaviour, giving up or failing. Death of a person or violence is also scored here)
  - **Unrealistic outcome** (the outcome of a story involves an ending that may be positive but is unrealistic, irrational and represents fantasy and wishful thinking; there is usually no process involved in reaching the outcome)

**7. Unusual or atypical responses** (scales which tend to identify responses that denote a disturbance in functioning or serious pathology)

**Unusual:**

- **Unusual – Refusal** (identifies the inability or the unwillingness of the participant to respond to the task of constructing a story or responding to the card; it can represent a delay in cognitive functioning)
- **Unusual – No Score** (cards cannot be scored as participant has only demonstrated concrete physical descriptions of the picture without any abstract content, therefore a lack of abstract thinking involving emotions or interpretations of interactions)
- **Unusual – Antisocial** (involves behaviour that is against or breaks family, school, or community rules, laws or principles; failure to conform to social norms)

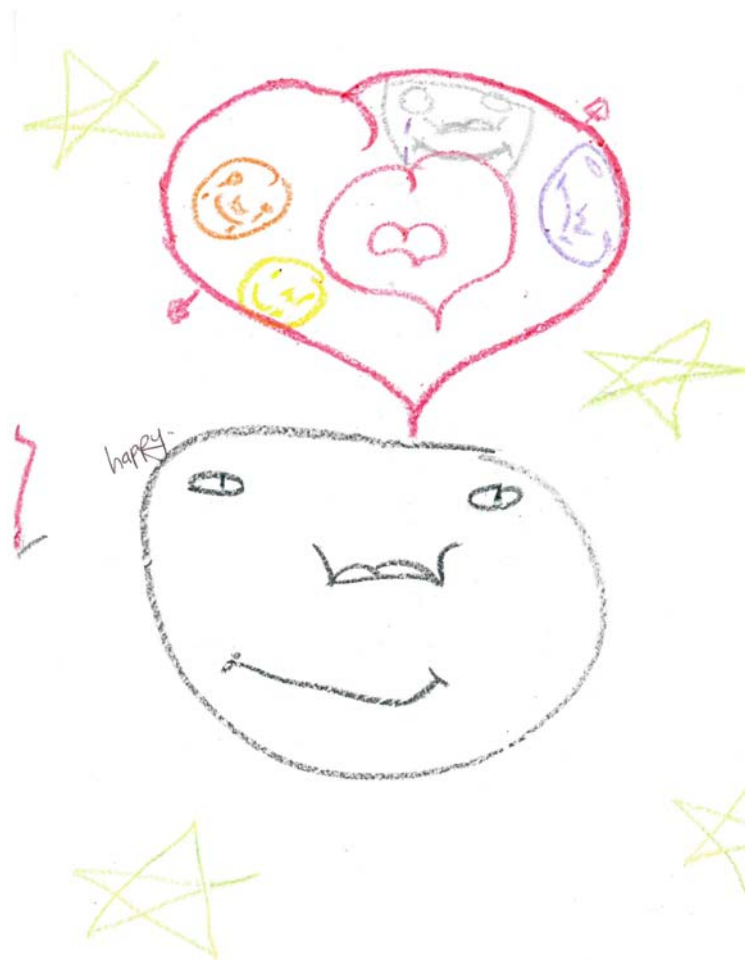
**Atypical** (these scales identify content that deviates significantly from the usual perceptions of nonreferred children and adolescents; material scoreable in this area is comparatively rare)

- **Atypical 1** (illogical content, including cognitive distortion and looseness of thought)
- Third session – two such responses
- **Atypical 2** (Misidentification of theme, including obvious denial of picture theme)
- **Atypical 3** (Misidentification of person)
- **Atypical 4** (Violence or excessive aggression)
- **Atypical 5** (Abuse, including physical, sexual or deprivation)
- **Atypical 6** (Imaginary content, such as monsters or ghosts)
- **Atypical 7** (Death of main figure depicted in card)
- **Atypical 8** (Sexual content of any nature)
- **Atypical 9** (Other unusual content or clinically significant material; includes perseveration of a theme, overreaction to the content of the card, unusually long pauses, and any other unusual verbalization or behaviour)

## APPENDIX Q

### FEELINGS HEART DRAWING TEST USED DURING STANDARD OF CARE THERAPY

This is a test devised by counselling psychologist, Dixon, C. (2000, unpublished), to help children express their emotions. The child is asked to draw a large heart on a piece of paper with four faces below depicting expressions of happiness, sadness, anger and fear. The child is then asked to put each face in the place in his heart where he feels it the most. While he does this, the psychologists probes him for the reasons why he is placing the heart where he chooses to and the reasons why he feels in his life like the face depicted. In this study, the researcher found that this was an easy exercise for the participants to begin their first session with. It appeared to relax the participants before they were asked to talk about the picture cards.



## APPENDIX R

### **CONTENT ANALYSIS OF HLONGIPHOS NARRATIVE RESULTS ACCORDING TO TAT**

In addition to thematic analysis, I scored the content of Hlongipho's narrative according to the scoring principles of the Thematic Apperception Test (TAT) (Murray, 1943). This was used to validate the findings of the Roberts-2 test and to confirm my qualitative analysis.

#### **SCORING CONTENT ACCORDING TO MURRAY (1971) TAT PRINCIPLES AND GUIDELINES**

I performed a *content* analysis of Hlongipho's descriptions of the pictures according to the scoring principles of the Thematic Apperception Test (TAT) (Murray, 1943) as described by Henry A. Murray, M.D., and staff of the Harvard Psychological Clinic (1971). I felt that the scoring procedure as laid out by Murray *et al.* was more detailed and intricate than that of Roberts-2 test (2009) and therefore might reveal more about the personality and needs of Hlongipho. Murray (1943) called The TAT was described as a projective test which exposes the underlying inhibited tendencies which the subject/participant/patient is not willing to admit, or can not admit because he is unconscious of them; it also reveals dominant drives, emotions, sentiments, complexes and conflicts of personality (Murray, 1971:1).

#### **ANALYSIS OF MEASURE: ROBERTS-2 ACCORDING TO MURRAY ET AL. (1943) SCORING MANUAL**

The following steps were followed for the content analysis of each picture card:

- 1) Identifying the hero and
  - a) The forces or forces emanating from the hero and
  - b) The force or forces emanating from the environment
- 2) Motives, trends and feelings of the heroes
- 3) Forces of the heroes' environment
- 4) Outcomes
- 5) Themes
- 6) Interests and sentiments
- 7) Assumptions (application of projections to participant's life)

The detailed explanation of the above stages of analysis is explained below:

The first step in analysis of each successive event described by the participant is to identify the hero and then analyze (a) the force or forces emanating from the hero, and (b) the force or forces emanating from the environment. An environmental force is called a *press* (plural *press*). The hero is usually the person who most resembles the Hloniphond whose story is the most interesting to him. The hero's story usually shares the participant's sentiments and aims, and point of view. Some stories have multiple heroes, partial heroes and object heroes, as opposed to subject heroes, with whom he does not identify but has observed almost as strangers.

After identifying the hero, the interpretation requires observing what the heroes feel, think or do noting down anything unusual, unique, or common, and unusually high or low intensity of frequency. In analyzing or formulating the reactions of the heroes the interpreter is free to use any set of variables he chooses (Murray, 1971:8). He can interpret depending on what he wants to know about the participant. He may be looking for constructs such as anxiety and guilt or he may want to 'trace deep-rooted sentiments to their source'. A comprehensive list of needs or drives, and inner states and emotions are provided by the authors. No scoring was performed as the stories told by the participant were found not to be long enough to yield enough variable points.

In analysis, note must also be taken of how the environment affects the hero, the press of his environment or other humans mentioned in connection with the story he is telling. The absence of required beneficial press (e.g. deprivation, loss) and bodily disturbances to which the personality must adjust (e.g. disease, physical pain) must also be noted. The scoring structure of the above is the same as for the scoring of needs and emotions, that is, a scale of 1 to 5, and compared to standardized averages for male college students.

Further analysis involves the *outcomes*, which is the comparative strength of the forces emanating from the hero and the forces emanating from the environment.

The interaction of the hero's need or fusion of needs and an environmental influence or press, or fusion of the latter, together with the outcome (success or failure of the hero) constitutes a *simple thema*. Combinations of simple themas, interlocked or forming a sequence, are called *complex themas* (*otherwise described as abstract dynamical structure of an episode, plot, motif, theme, and principal dramatic feature of a story*). *Interests or sentiments* are analyzed

by noting in particular the value or appeal to the participant of the older women, older men, same-sex females and same-sex males (some may be sibling figures).

Finally two tentative assumptions are made, to be corrected later if necessary. The first is that the attributes of the heroes (needs, emotional states and sentiments) represent tendencies in the participant's personality, albeit symbolic or unconscious. These tendencies belong to his past or to his anticipated future, and hence stand presumably for potential forces which are temporarily dormant, or they are active in the present. The second assumption is that the press variables represent forces in the subject's apperceived environment, past, present or future. Roughly they are the participant's view of the world, the impressions he is likely to project into his interpretations of an existing situation and into his anticipations of future situations.

#### **EXAMPLE OF ANALYSIS OF HLONIPHO'S DESCRIPTION TO ONE OF ROBERTS-2 PICTURE CARDS**

##### **PICTURE CARD OF BOY IN PUNCHING POSITION WITH ANOTHER BOY LYING ON FLOOR**

The heroes are other boys. Hlonipho is not the person who fights. Identification with the subject did shift during the description. Two forces of the participant's personality might be represented here, a law abiding person and a person who fights.

The needs or feelings of the hero are indicated by expressions of submission, being blamed when it is not his fault. Traits reflected in the conversation are abasement, intraggression (feelings of remorse, inferiority), lack of nurturance and understanding of the situation, passivity, lack of seeking for succorance, intranurturance (to comfort himself with some self-pity), blame avoidance, conflict (opposition between need to fight and defend himself and need to keep out of trouble), dejection. Another inner state is distrust and melancholy.

Forces of the hero's environment expressed are *affiliation*: absence of adult mediating figures, lack of association with friends, *aggression*: lack of emotionality, emotional aggression shown by others in his environment, physical aggression has an effect on him, *dominance*: coercion (he cannot fight because he will be blamed), *restraint* (he is blamed if he fights or defends himself), lack of nurturance: by someone else of his needs, *rejection*: (he is rejected if he fights), *lack*: he lacks being able to express himself naturally like a boy of his

developmental age, *physical danger*: nothing overt, *physical injury*: he lives with the potential of being hurt by others.

Outcomes: In the face of opposition, the hero does not strive with renewed vigour or counteraction. Things happen to him rather than him making things happen. He is manipulated by the opposing forces rather than them manipulating him. He does show some form of moral significance to the scene.

Themes: There is an unusual amount of passivity and disempowerment.

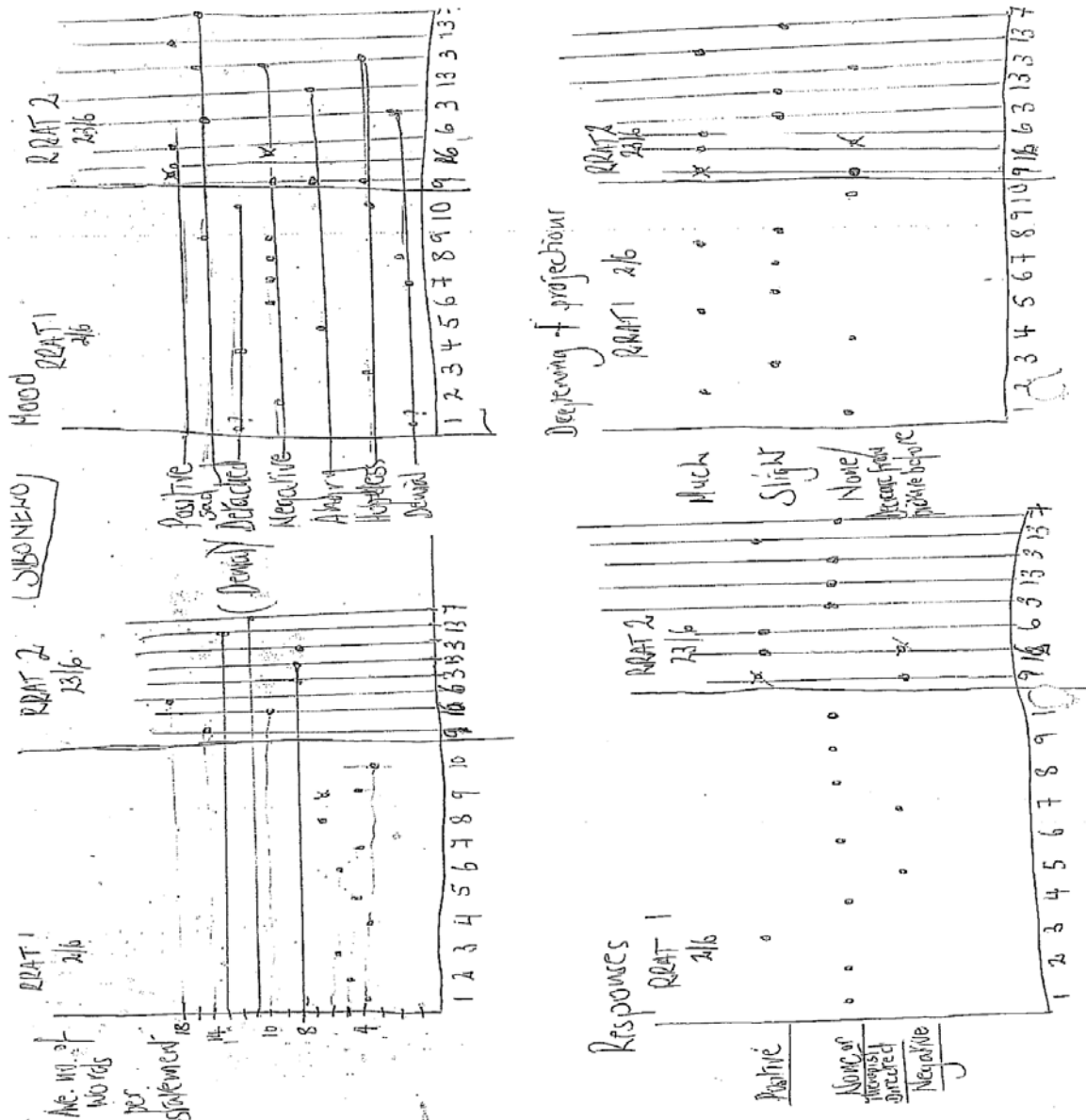
Interests and sentiments: He shows a negative cathexis (value, appeal) of association with other boys around him.

Assumptions: First assumption is that Hlonipho has developed a way of responding passively to forces around him in order to avoid trouble. The second assumption is that forces in his environment are such that he will not be able to empower himself in the present situation based on the experiences of his past. His response to this plate is assumed to be more a reaction to his past than to his present situation in the home.

**STRUCTURAL NARRATIVE ANALYSIS ACCORDING TO DYNAMIC ASSESSMENT METHOD (MATTHEWS & BOUWER, 2009)**

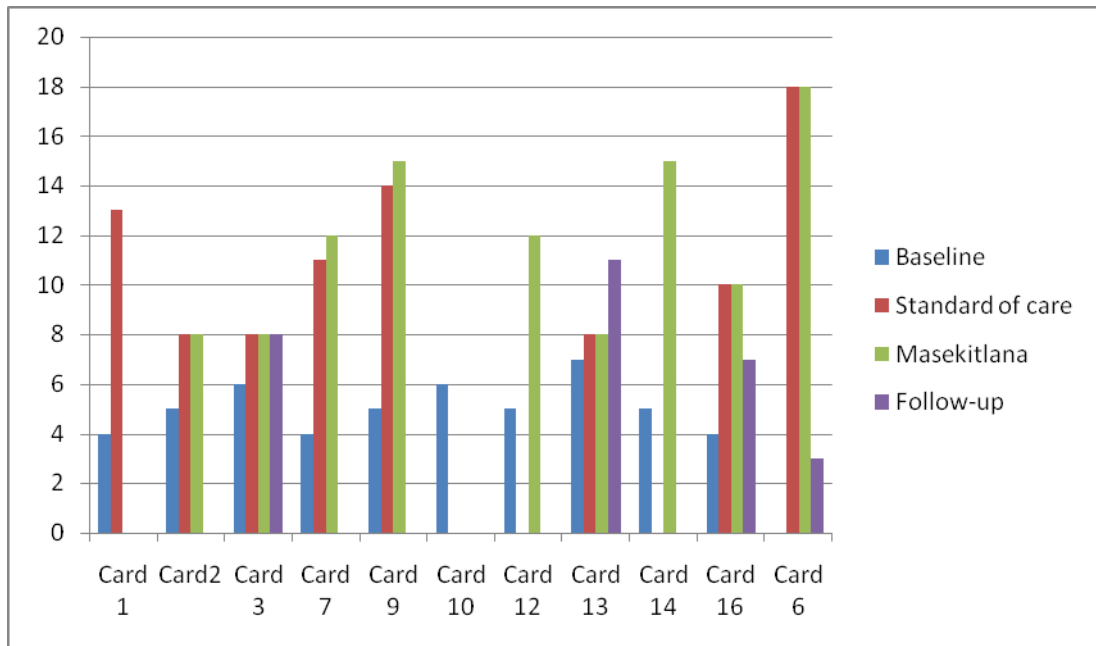
As the Roberts-2 technique of administration of the picture cards to children was similar to the method of Dynamic Assessment as described by Matthews & Bouwer (2009), a *structural* analysis, as pioneered and described by Matthews and Bouwer (2009), of one participant, Hlonipho, was done. This is represented in graphic form below.

**ROUGH SCORING OF RESPONSES**



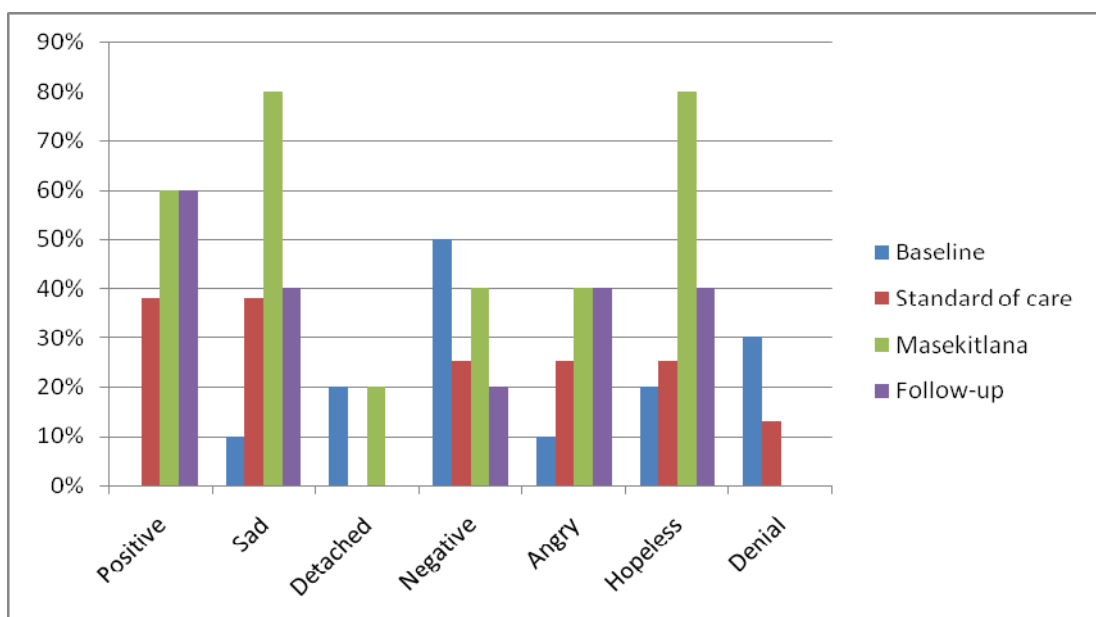


## AVERAGE NUMBER OF WORDS PER STATEMENT



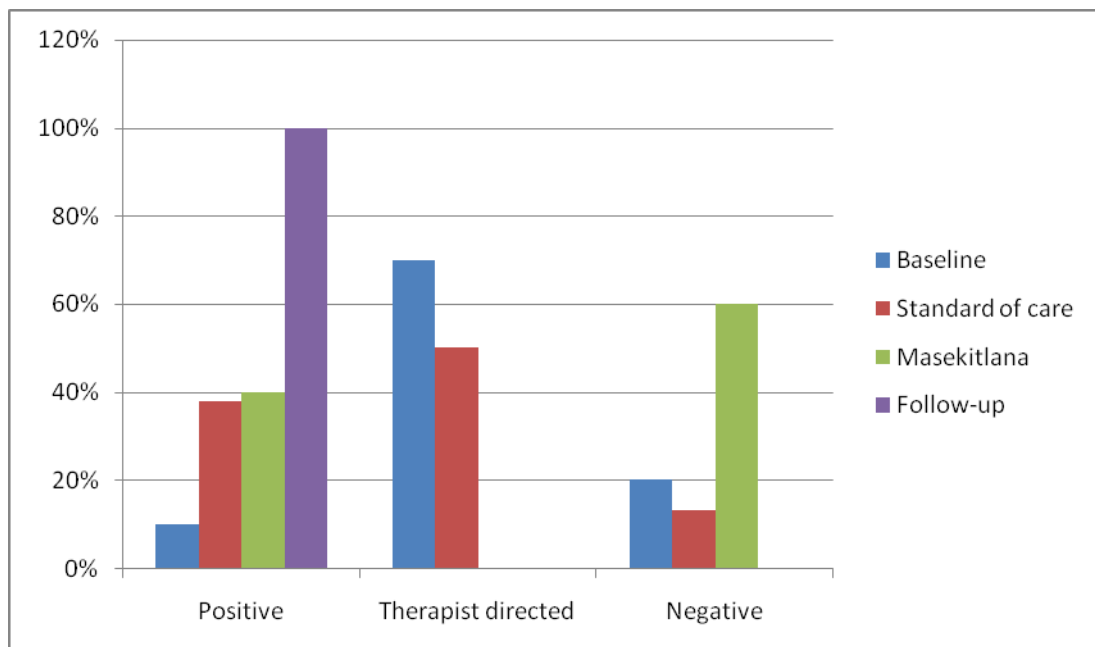
Hlonipho's explanation statements increased in length after standard of care therapy and to an even greater extent after Masekitlana. This might indicate that he was more confident in himself and his expressions of events. However, he seemed to lack interest in giving detailed descriptions of the picture cards at the follow-up session (it was at this session that he appeared more interested in writing a letter to his mother).

## MOOD DURING ASSESSMENTS



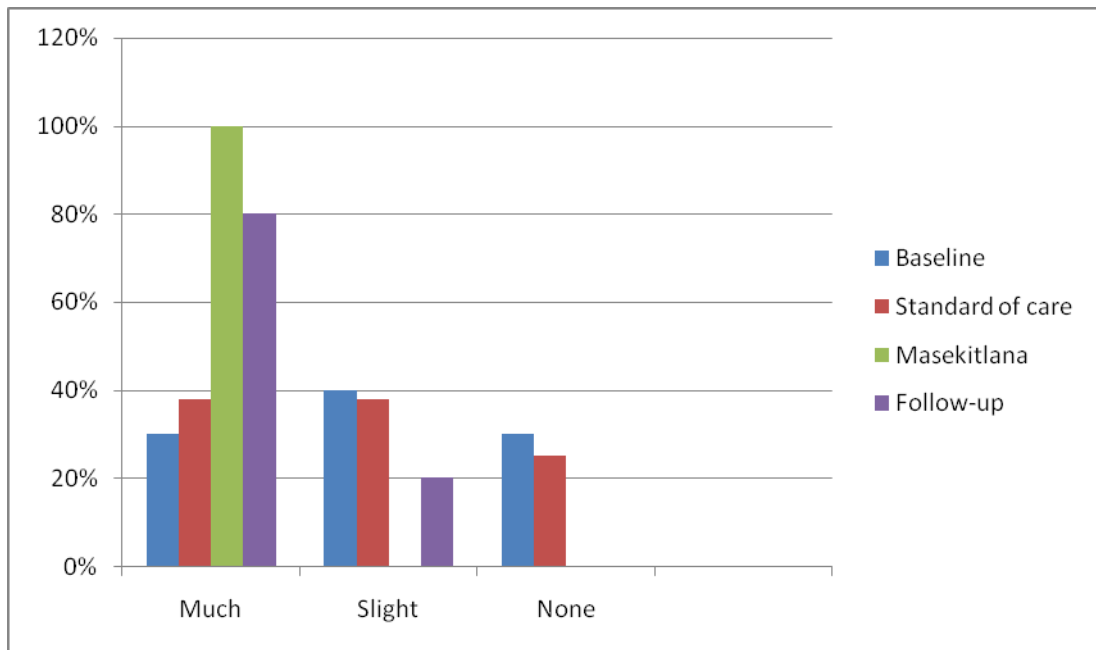
Hlonipho was not positive at baseline but this improved to 38% after standard of care therapy, to 60% after Masekitlana and remained at 60% at follow-up. He appeared saddest after Masekitlana, probably because he explained in detail the situation around his mother’s death. Negativity decreased as therapy progressed, despite an increase of 15% between standard of care therapy and Masekitlana. He appeared to become more hopeless and angrier after Masekitlana, probably because he also became more expressive of his emotions at this stage. His anger might have been an ‘acting-out’ form of expression which masked an underlying depression and hopelessness due to being a child without a family. Hlonipho’s denial of true feelings or situations was not maintained after standard of care therapy or after Masekitlana. Being allowed to talk in therapy might have enabled him to see beyond his denial.

### RESPONSES TO THE THERAPIST



Although Hlonipho’s statements and explanations were more therapist-guided at baseline and after standard of care therapy, this changed after Masekitlana. Immediately after Masekitlana, Hlonipho’s statements appeared to be his own expressions but they also seemed negative (60%). Perhaps this was because he was more open with his feelings of sadness and regret at this stage. At follow-up, he appeared to be expressing himself more positively to the prompts of the therapist.

## DEEPENING OF PROJECTIONS



A deepening of projections can be noted in Hlonipho's narrative after Masekitlana and at follow-up.

## APPENDIX T

### EXAMPLE OF THERAPY TRANSCRIPT WITH COLOUR AND THEME CODING

#### UNIT 632-640

P: my mother was sick and she used to see animals. but eventually she died. and I don't know if that is what made her die (Theme: African child's worldview of animals and ancestry, animation and human connection to animals and the natural world)

I: Sally, he is concerned because his mother was sick and she was seeing things that we couldn't see. She was seeing animals. What kind of animals?

P: She used to say it's something scary. When you come into her room, she would say they are going away

I: There are different things that could cause that according to my thinking. Maybe you find that your mind doesn't work well anymore. Then maybe you have this thing called schizophrenia. It's being disturbed in your brain. Or your brain shows you things that are not there or sometimes you find that there is something inside your brain. But we can't be too sure about that. But there are a lot of things that cause people to see things that are not there.

I2: If she was seeing the animals, maybe her mind was not working properly because she was sick (Theme: Western responses to African perceptions of illness)

P: She used to say there was a snake that used to come in and sit on her bed and do nothing, it would just sit there

I: Did you also see the snake or was she the only one who was seeing the snake?

P: We used to see it

I: How big was the snake?

P: It was green

#### UNIT 641 - 663 SESSION 4 MASEKITLANA

I: How big was it?

P: It was long and big

I: When did it come in during the day or at night?

P: It came in during the day

I: Were you also there?

P: I was there in the house eating

I: Where did it go?

P: It went on the bed and its mouth began moving

I: Did it fold itself or was it just long?

P: It was long, it lifted its head and its mouth was moving. I don't know what it was doing

I: Do you think it was talking? Was your mother there in that house?

P: Yes

I: Who chased the snake away eventually?

P: No one

I: So what did it do?

P: It went to the bed. It sat there. After it had finished moving its mouth it went out

I: You didn't hit it?

P: No, my dad told us to leave it because maybe the ancestors were telling my mother that she needs to do Zulu rituals. So we left it and it went out. The next day my mother left

I: She went to her relatives and that is where she died?

## EXAMPLE OF FIELD NOTES

**26<sup>th</sup> May 2010**

It is interesting to me that I am becoming used to the disorganization of doing research in a busy clinic. When I heard that my participant had arrived, I was not unduly distressed that I was not prepared. I knew that I would have to take extensive notes instead of electronic recording. I realized that I would have to deviate from ethical procedure and would have to obtain written consent after the process of therapy had already begun.

The session with the child was conducted in Lungi's office with the door open. Painters, student from the Durban University of Technology, were painting the walls all around the clinic with colourful murals. The frequently passed the door. Other staff members popped in and the phone rang a few times and Lungi answered it. All of this did not seem to distract from the therapy process. The child appeared able to continue to engage no matter what else was going on. He sat calmly and quietly.

I did though notice tears welling up in his eyes at one stage. I also noticed that he expressed himself minimally with little details. He stated happiness was questioned by me. I felt that he just was not able to express his innermost feelings and was just saying what he felt he was meant to be feeling (YEAH SAYING AS MENTIONED IN LITERATURE). When I spoke to him on his own, he appeared more honest. When Lungi asked what he would like that would make him happy at the next session, he was not able to answer. I have the feeling that children do not actively contemplate their own happiness at this stage.

**2<sup>nd</sup> June 2010**

I was anxious that my technology was not working. I discussed this with Lungi on the way to the home in the car. I said that in this study, technology had been my challenge. She said that expressing herself clearly in English was always her challenge. She asked me how I would do if I had to write up my study in Zulu. We laughed at that. I shared how Nerine was also second language writer in her masters research and I had helped to edit her work. I explained to Lungi that I would also have to make use of the services of professional editor for my final dissertation.

What I found was that it was harder for me to relate to the boys as I was not doing the therapy. When I said goodbye to them, I felt that they did not really know me and they did not know me. I felt it hard for them and me to be out 'on a limb' recording them but not being part of the therapy. I would have wanted to ask them some questions but had to leave this to Lungi.

Lungi and I discussed afterward some of the details of the boys' lives and questioned the validity of what they had said. I would have like to have sat longer discussing the boys but both of us had to return to family and lifts home. It was after 17h00 when we left the home. It was so good to peep into the hall and see the boys and nuns practicing for the AGM concert the next day. I was so impressed to see a lot of the boys carrying violins. Lungi said that she would love to play the violin or the recorder. I encouraged her into playing the recorder and explained that she could teach herself at home. On the way home, we discussed the difference between how she had to relate to the father of her child and how my daughters and my culture views and conducts relationships before marriage. Her partner has paid partial lobola, has been going out with her for 10 years and yet they still cannot live together.