CHAPTER 1
IDENTIFYING THE STUDY

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[1] 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[2]. 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

[1] 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.
[2] 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 ould 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[3] 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[4] 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.

[3] 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.

[4] 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.

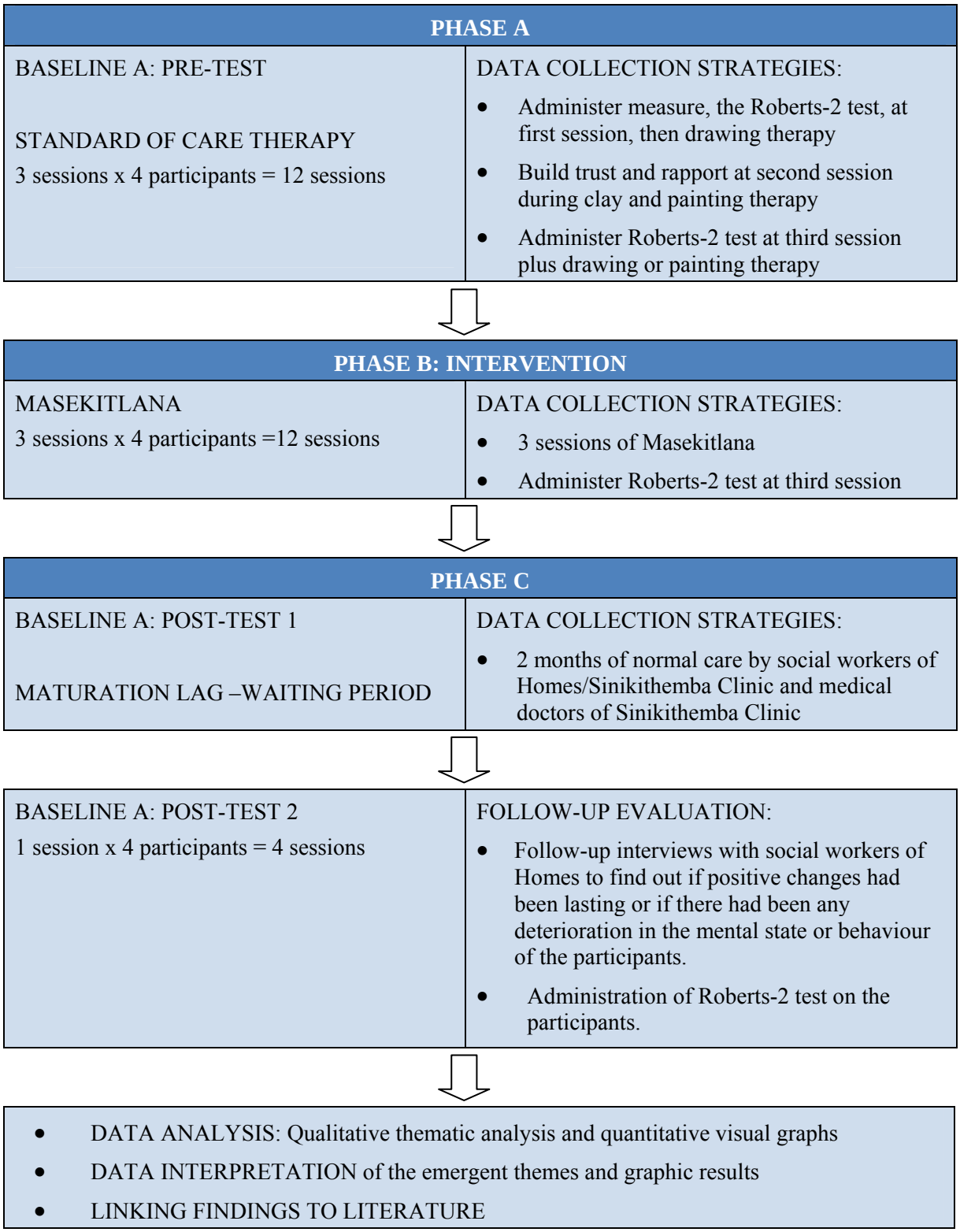

Figure 1: The research design

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[5] in the form of drawing and clay, followed by the intervention therapy of Masekitlana. In this way the research mimicked

[5] 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 Bouwer (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[6] then sits on the floor or at a table and bangs the stones together or throws them down, picks them up again or

[6] 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.

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 Bouwer (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 'polyphany' 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[7] 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

[7] 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, mm3) 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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