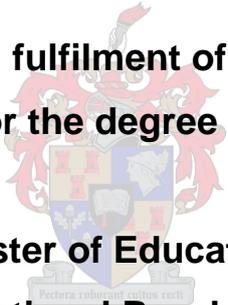


EXPLORING THE ASSET-BASED APPROACH WITH A LEARNER AFFECTED BY DISABILITY AND HIV AND AIDS

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**A thesis in partial fulfilment of the requirements
for the degree of**



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Supervisor: Lynette Colliar

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DECLARATION

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

Signature:.....

Date: 29 February 2008.....

ABSTRACT

The purpose of this study was to explore the effects of the asset-based approach through life skills facilitation with a learner with disability and affected by HIV and AIDS. The conceptual framework of the study was the HIV and AIDS pandemic, disability and the asset-based approach. I followed a qualitative research approach guided by a transformative paradigm and I used the action research design. I purposefully selected the case (a learner with disability and affected HIV and AIDS) and other participants (mother and community organisations) were identified in consultation with the learner and as the research process developed. Data collection consisted of semi-structured interviews, observation, journals, capacity inventory and collage. Data were transcribed verbatim and open-coding were used to identify themes that emerged.

Findings that emerged were viz. mobilisation of existing assets enhances and mobilises new assets; presence of positive emotions, agency and ownership were reported. These assets led to incidences of school and community engagement, with the participant as an asset in building, creating and strengthening other people, resources and systems. Previous feelings of dependency, powerlessness and hopelessness were replaced with increased confidence, empowerment and competence.

I propose the incorporation of the asset-based approach within the life orientation curriculum and the construct *asset-awareness* as a more user-friendly term for use in the school context. Asset-awareness refers to the raising and advancement of knowledge about abilities, gifts and assets and the *use* or application thereof in practice.

Key Words: Assets; Life skills; Disability; Cerebral palsy; HIV; AIDS

OPSOMMING

Die doel van hierdie studie was om die uitwerking van die bategebaseerde benadering deur middel van die fasilitering van lewensvaardighede met 'n leerder met gestremdheid wat ook deur MIV en VIGS geaffekteer word, te ondersoek. Die konseptuele raamwerk vir die studie het die MIV en VIGS-pandemie, gestremdheid en die bategebaseerde benadering behels. Ek het die kwalitatiewe navorsingsbenadering, gerig deur die transformatiewe paradigma, gevolg en die aksie-navorsingsontwerp gebruik. Ek het die geval ('n leerder met gestremdheid wat ook deur MIV en VIGS geaffekteer word) doelbewus geselekteer en ander deelnemers (die moeder en gemeenskapsorganisasies) is namate die navorsingsproses ontwikkel het, in samespreking met die leerder geïdentifiseer. Die data-insameling is deur middel van semi-gestruktureerde onderhoude, waarneming, joernale, 'n bekwaamheidsinventaris, en *collage* bewerkstellig. Data is getranskribeer en temas is deur oop kodering geïdentifiseer.

Bevindings wat na vore gekom het, was naamlik dat mobilisering van bestaande bekwaamhede sulke bekwaamhede verbeter en nuwe bekwaamhede mobiliseer; teenwoordigheid van positiewe emosies, bemiddeling en eienaarskap is aangeteken. Hierdie bates het tot betrokkenheid by die skool en die gemeenskap gelei, met die deelnemer wat as 'n bate by die uitbouing, skepping en versterking van ander mense, hulpbronne en stelsels betrokke was. Vroeëre gevoelens van afhanklikheid, magteloosheid en hulpeloosheid is met toenemende selfvertroue, bemagtiging en bekwaamheid vervang.

Ek stel voor dat die bategebaseerde benadering by die lewensoriënteringskurrikulum geïnkorporeer word en dat die *batebewustheid*-konstruk as meer gebruikersvriendelike bewoording in die skoolkonteks gebruik word. Batebewustheid verwys na die bevordering van kennis oor bevoegdhede, gawes en bates en die *gebruik* of toepassing daarvan in die praktyk.

Slutelwoorde: Bates; Lewensvaardighede; Gestremdheid; Serebraalverlamming; MIV; VIGS

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CHAPTER 1

CONTEXTUALISING THE STUDY

1.1 INTRODUCTION

HIV and AIDS have become part of the South African reality. This situation is featured in the newspapers, on television, radio, shopping malls, clinics, schools and in the curriculum. The HIV and AIDS pandemic impacts on children, families and communities. Direct impacts of HIV and AIDS on families and households include the emergence of child- or adolescent-headed households, an increase in the number of elderly caregivers and children caring for old people, increases in household dependency ratios, separation of siblings, family breakdown, child abandonment and remarriage (Richter, Manegold & Pather, 2004).

A new type of "family structure" emerges as an increasingly familiar pattern - the child headed household in which siblings are looked after by the eldest child in the family (Karim & Karim, 2005). Learners at school are forced to take on this role and face all the challenges that accompany it. The need for psychosocial support for families affected by HIV and AIDS has therefore come to be regarded as a matter of urgency. To date, the disability sector has largely been ignored in prevention programmes, yet this widely diverse group of people has very specific needs concerning making them less vulnerable to contracting HIV and AIDS (Mouton, 2003; Strydom, 2005; Bat-Chava, Martin & Kosciw, 2005).

After South Africa's first democratic elections in 1994, dramatic transformation followed, and new demands, challenges and pressures that had to be dealt with were created. Under the new Constitution, the rights of people with disabilities are protected. A paradigm shift at a policy level resulted in a shift away from the exclusion of learners with disabilities to their inclusion. This has influenced the official understanding of disability, but "[a] shift in paradigms

does not necessarily imply an overnight change in practice" (Swart & Pettipher, 2005:5) and the paradigm shift at a policy level has been slow to filter down to the operational grassroots level. My experience has revealed that, 13 years later, the medical model is still used to explain and describe disability in practice. The medical model has resulted in learners as young as three and four years (Mbeki, 1997; Rule, 2005) being sent away to special schools and being excluded and removed from their families and communities; the emphasis being on dependence and the nature of impairment. Services were provided and controlled by non-disabled people (Mbeki, 1997). This may have resulted in learners with disabilities not having had the opportunity to develop and practice the necessary life skills to deal with life challenges.

Life skills help us cope with problems, adapt to changes and effectively confront crises and conflicts. Although the exact nature and definition of life skills is likely to differ across social and cultural contexts, an analysis of the life skills field suggests that a core set of skills forms the heart of initiatives for the promotion of health and well-being (Division of Mental Health WHO, 1994 cited by Van Niekerk & Prins, 2001; Donald, Lazarus & Lolwana, 2002).

These include:

- Decision making
- Problem solving
- Creative thinking
- Critical thinking
- Effective communication
- Interpersonal relating
- Self-awareness
- Ability to empathise
- Coping with emotions
- Coping with stress

South Africa presents numerous circumstances that necessitate life skills intervention. The total number of people living with HIV in South Africa was estimated to be 5.2 million in 2005 (<http://www.journaids.org>, 22/07/2007). The presence of the HIV and AIDS pandemic intensifies the urgency of mastering life skills to enable people to cope with these situations, yet this is currently left largely to chance. Some people have limited opportunities for acquiring life skills in their parental homes, in classrooms, and during

recreation (Ebersöhn & Eloff, 2003). The acquisition of life skills then falls to the caring professions to facilitate.

1.2 BACKGROUND AND MOTIVATION OF THE STUDY

I have been working at a Special School for learners with Cerebral Palsy for more than ten years. In my role as School Psychologist I constantly receive and have been made uncomfortable by reports of and complaints about learners "not being able to do this" or "having problems with that". My first encounter with HIV and AIDS was in 1996 when a learner's parent disclosed her status to me. My contact with the family continued and the learner (being the eldest sibling in the family) repeatedly expressed the same concerns, relating to his mother's status, to me. Part of my role in the school concerns teaching life skills, which forms part of the Life Orientation curriculum. I began to wonder how life skills could be used to find answers to this learner's questions. In my search for a research topic I came to read about the asset-based approach and this led to the research question which I decided to investigate.

1.3 PROBLEM STATEMENT

Child-headed households and vulnerable children are and will continue to be a facet of life in societies with high HIV infection levels for several decades (Hunter, 2000:208). The HIV and AIDS pandemic impacts on the children and the youth of the day, demanding from them to take on the roles of being learners and part of their peer group, as well as caregivers of siblings and sick parents and we have to acknowledge the historic legacy of restricted opportunities and previous discriminatory policies that influenced personal, interpersonal, organisational and broader community and societal systems responsible for establishing, sustaining and promoting human wellbeing (Van Niekerk & Prins, 2001). Given that people with disabilities were seen as having to be "protected" and taken care of by non-disabled people, the challenges of caring for siblings and an infected parent can be so much more daunting. Various studies that made use of the asset-based approach have independently focused on learners with disabilities (Briedenhann, 2003; Smuts, 2004) and HIV and AIDS (Griessel-Roux, 2004; Ebersöhn, Smit &

Eloff, 2005; Viljoen, 2005). The present study combines the above topics while focusing on a learner who has a disability and is affected by HIV and AIDS in an attempt to fill a knowledge gap.

1.4 RESEARCH QUESTION

From the onset the learner reported having difficulty coping with the demands of being the eldest child, having to make adult decisions about finances, caring for his siblings and planning for his future after Matric. He shared feelings of powerlessness, hopelessness and not knowing where to start. He reported that he copes by "dividing" himself into two people namely the learner at school and the household head when he is at home; "he keeps his story to himself" and "sometimes surrounds himself with other people '.

The research question for this study is:

What is the effect of the asset-based approach to life skills facilitation with a learner affected by disability and HIV and AIDS?

Definition of "effect"

Result: a change or changed state occurring as a direct result of action by somebody or something else

(<http://uk.encyarta.msn.com/dictionary/exploring.html> Accessed 18/02/2008).

The signs that the researcher will be looking for in understanding the effect will be the following: attitude, feelings, behaviour and language.

1.5 THEORETICAL FRAMEWORK FOR THE STUDY

At the time that the asset-based approach emerged, the new decade also saw an increased worldwide move towards Positive Psychology. Positive Psychology focuses on intrinsic strengths, assets and resources, and positive constructive intra-psychic domains. These assets cannot be seen or touched but play a decisive role in mental health and wellbeing. Both Positive Psychology and the asset-based approach manifest a shift in both theoretical development and practice. The Positive Psychology movement has informed and enriched the development of the asset-based approach, which resulted in

a search for assets on the inside as well as the outside (Ebersöhn & Eloff, 2006).

Every single person has capacities, abilities and gifts. Living effectively depends on whether such capacities can be used, abilities expressed and gifts given. If this is possible, the individual will have a sense of value, feel powerful and well connected to the people around them. Each time a person uses their "gifts", the community is stronger and the person is more powerful. This basic truth about the "giftedness" of every individual is particularly important to apply to those persons who often find themselves marginalised by communities. It is essential to recognise the capacities of people who, for example, have been labelled as people with disabilities, being too young or being too old (Kretzman & McKnight, 1993). Persons living with or being affected by HIV and AIDS can be added to this category due to the stigma attached to this illness. Various authors (Richter, Manefold & Pather, 2004; Viljoen, 2004; Ebersöhn & Eloff, 2006) use the concept "vulnerable" to describe the physical, psychological and sociological circumstances of children. Smart, in Richter et al. (2004) and Ebersöhn and Eloff (2006) identify the following groups of children as being vulnerable: children with disabilities; children with chronic illnesses; children infected and affected by HIV/AIDS; children without care-givers; children living in poverty-stricken conditions; children who have been abandoned; children who work; children working as sex-workers; children living on the streets; children who are being neglected; children who are being/have been abused; children who are refugees and illegal immigrants; children used as soldiers. Vulnerable children are a reality in South Africa (Ebersöhn & Eloff, 2006). The learner in this study is marginalised, both as a person with cerebral palsy and as being affected by HIV and AIDS.

The research uses an asset-based approach to life skills facilitation in order to identify and mobilise individual and community assets with a learner affected by disability and HIV and AIDS. This approach creates opportunities to explore and generate new knowledge and to contribute to the existing body of knowledge. Ebersöhn and Eloff (2003; 2006) and Kriek (2003) describe the asset-based approach as a "bottom up" approach, which shifts the emphasis

from providing services to empowering individuals and communities. Whenever an individual uses his or her assets and capacities, the system becomes stronger and the individual is enabled.

The learner in this study had specific "problems" that he wanted to address. The asset-based approach is an approach that uses assets as a way of addressing problems in a variety of contexts. It involves "seeing the glass as half full", rather than as "half empty". It is based on the belief that all individuals, families and learning contexts have capacities, skills, resources and assets that can contribute towards positive change. The result is that people who feel connected through supportive relationships develop more readily and become people with resources who are able to solve problems in partnership with professionals (Ebersöhn & Eloff, 2003; Ebersöhn & Mbetse, 2003).

The asset-based approach does not deny the existence of needs. While the asset-based approach acknowledges needs, the main efforts of participants in an asset-based intervention are devoted to identifying assets, accessing assets and mobilising the assets for sustainable support. The assumption is that, while needs indeed are real, they can best be addressed by focusing on assets. This study aims not just to give a theoretical description or discussion but rather a practical implementation of asset-based activities to determine the effects thereof on the development of the learner.

1.6 PARADIGM

The study is placed within a transformative paradigm, focusing on the empowerment of the learner who has a disability and is affected by HIV and AIDS.

1.7 RESEARCH DESIGN AND METHODOLOGY

A participatory action research design (PAR) that involves the learner in the research process was used. The participatory action research design involves the learner as a participant in the research process. The following describes characteristics of participatory action research and the role of the researcher.

1.7.1 Characteristics

Kemmis and McTaggart, in Denzin and Lincoln (2005), identify seven key features of participatory action research:

1. Participatory action research is a social process.
2. Participatory action research is participatory.
3. Participatory action research is practical and collaborative.
4. Participatory action research is emancipatory.
5. Participatory action research is critical.
6. Participatory action research is reflexive.
7. Participatory action research aims to transform both theory and practice.

Some of these characteristics will be discussed in more detail in Chapter 3.

1.7.2 The role of the researcher

The role of the person who is traditionally called "the researcher" changes dramatically in action research. He or she becomes a facilitator or a consultant who acts as a catalyst to assist stakeholders in defining their problems clearly and to support them as they work toward effective solutions to the issues that concern them (Stringer, 1996).

Ebersöhn and Eloff (2003) advise the researcher who wishes to work according to the asset-based approach to integrate the principles that follow. With respect to the research participants, the researcher should firstly believe that everybody has assets, and secondly that whoever is present, is the right person to work with. With regard to the research field, the researcher should remind him- or herself that whatever happens is the only thing that could have happened. The question "so what will we do now?" should always be present in the researcher's mind. Ebersöhn and Eloff (2003) encourages the researcher to be open-minded about expectations, events and outcomes and to "be prepared to be surprised". This method of research complements the changing role of the educational psychologist emphasised by De Jong (2000), Nastasi (2000), Sheridan and Gutkin (2000).

1.7.3 Participants

The research journey will be shared mainly with a Grade 11 learner affected by cerebral palsy and HIV and AIDS. The use of an actual case study underlines what Denzin and Lincoln (1994) expresses: "The preferred way to communicate the practice of PAR seems to be through the description of actual cases."

The learner as a system does not function in isolation and the need to include other systems, viz. the family and the community, was deemed extremely relevant when the study progressed. The process therefore included the learner, the family and the community in identifying and mobilising individual and community assets. Two organisations in the community were identified as part of asset identification in an attempt to involve, interact and collaborate with organisations. These organisations will be discussed in greater detail in Chapter 3.

1.8 DATA GATHERING PROCEDURES

The following data gathering procedures were used:

- Semi-structured individual interviews - with learner, parent and other stakeholders, e.g. community organisations
- Facilitator's journal - to record observations, experiences and reflections on the research journey
- Participant journal - to record the participant's own experiences, thoughts and reflections
- Capacity Inventory and inventory proposed by Kretzman and McKnight (1993) to map individual and community assets
- Collaborative meetings with learner and community members - to mobilise support and build relationships

1.9 PRESENTATION OF DATA

The data will be presented in the narrative within the framework of the action research spiral of: plan, act, observe, reflect as proposed by Kemmis and Wilkinson (2003) and Kemmis and McTaggart (2005).

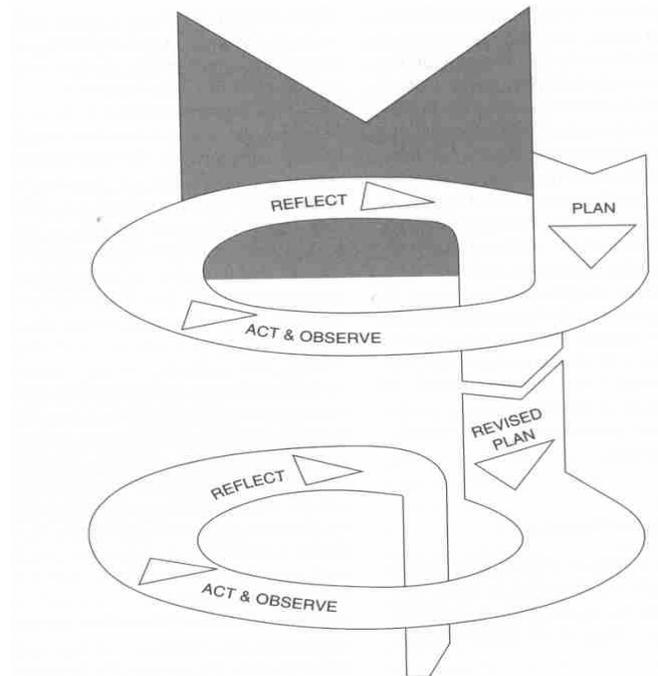


Figure 1.1: Action research spiral from Kemmis and McTaggart (2005)

1.10 ETHICAL GUIDELINES

Permission to proceed with this research was obtained from the Western Cape Education Department (refer to Addendum A) and informed consent to participation in the research was gained from the learner as well as the parent. Careful consideration was given to the protection of the anonymity of the learner, the family and the institutions that were involved.

1.11 DEFINITION OF TERMS

For the purpose of this research, the following concepts are defined on the basis of the literature in order to guide the reader:

Exploring

Investigate or study something: to make a careful investigation or study of something (http://uk.encycarta.msn.com/dictionary/_exploring%2520.html

Accessed 18/02/2008)

Assets

These refer to skills, talents, gifts, resources, capacities and strengths that are shared with individuals, institutions, associations, the community and organisations.

Individual Assets

Kretzman and McKnight (1993) propose an individual capacity inventory that lists the following skills: health skills (e.g. caring), office skills, construction and repair, maintenance skills, child care skills, transportation skills, supervision skills, music skills, security skills.

Community assets

Included in this are the more formal institutions located in the community, such as private businesses, public institutions such as schools, libraries, parks, police and fire stations, non-profit institutions such as hospitals and social service agencies.

Life skills

Life skills refer to a wide range of proficiencies (coping behaviours) that are fundamentally important for the individual's effective functioning in the modern world. The concept "life skills" is self-explanatory and is the general term for all the skills and capacities that an individual needs to be able to enrich his or her life in a meaningful way. All interpretations of the concept "life skills" have in common that the focus in each case is on skills and strategies that enable an individual to act in accordance with the demands of the self, others and the environment. In other words, the skills are those that are essential for individuals to cope independently and proficiently with day-to-day activities, demands and changes in various environments (Ebersöhn & Eloff, 2003).

Coping

Coping implies at its most basic conception, adaptation by an individual to demands (Ebersöhn & Eloff, 2002). Children choose from a range of coping strategies that are similar to coping strategies used by adults. Children's reaction to trauma and stress are often more non-verbal than verbal e.g. by:

- Internalising stress: When children react with depression and/or anxiety to a stressor or trauma
- Externalising stress: When children react to stress with disruptive behaviour, clowning or passive dependency

- Somatizing stress: When children develop abdominal cramps, stomach aches, head-aches, diarrhea or frequent urination or bowel movements (<http://www.aare.edu.au/02pap/elo02046.htm> Accessed 27/02/2008)

Disability

Defining disability is complex and controversial. Though arising from physical or intellectual impairment, disability has social implications as well as health ones. A full understanding of disability recognizes that it has a powerful human rights dimension and is often associated with social exclusion, and increased exposure and vulnerability to poverty. Disability is the outcome of complex interactions between the functional limitations arising from a person's physical, intellectual, or mental condition and the social and physical environment. It has multiple dimensions and is far more than an individual health or medical problem (<http://www.addc.org.au/disabilitypoverty.html> accessed 06/10/2007). This study uses disability as an umbrella term to describe "long term impairment leading to social and economic disadvantages, denial of rights, and limited opportunities to play an equal part in the life of the community" (<http://www.addc.org.au/disabilitypoverty.html> accessed 06/10/2007).

Cerebral Palsy

Cerebral Palsy is a condition that relates to the functioning of the central nervous system. Characteristically, areas of the central nervous system that control physical movement and coordination are affected. This may affect large body movements, such as hand-eye co-ordination, or the very fine movements involved in speech or the eye's movement across a line of print. Difficulties of concentration, perception, memory, language and conceptual development may be associated with the condition. Cerebral palsy has many complex variations relating to specific areas of the central nervous system as well as to the type of movement or co-ordination involved (Donald, Lazarus & Lolwana, 2002). Although there are physical, and sometimes associated learning and social difficulties, which can cause special needs, children with cerebral palsy have a range of needs similar to all children. Refer to Addendum G for further information on cerebral palsy.

HIV

HIV is the acronym for the Human Immunodeficiency Virus. HIV is transmitted through blood, semen and vaginal fluids. Once in the body, the virus uses CD4 cells of the body's immune system to replicate itself and in the process destroys these cells. These CD4 cells are vital as they co-ordinate the body's immune system, which protects us from illness. As the amount of HIV in the body increases, the number of CD4 cells decreases, weakening the immune system even further (Soul City Institute, 2004).

AIDS

AIDS refers to the collection of diseases that are 'acquired' through HIV once the immune system is no longer able to protect the body from illness. When HIV has weakened the immune system, a person with HIV develops a number of diseases that the body would normally be able to fight off. These are known as opportunistic infections. When a person's immune system has deteriorated so much that he or she starts becoming ill with life-threatening and often unusual illnesses, he or she is said to have AIDS (Soul City Institute, 2004).

Affected

In this study, affected refers to children, siblings, family members, neighbours or communities where a parent/s or relative is HIV positive or has AIDS.

1.12 OUTLINE OF THESIS

Chapter 1: Introduction

Chapter 1 provides the introduction to the study. It states the research question, defines the key concepts and explains the aims of the study. Chapter 1 also introduces the conceptual framework, the research design, the role of the researcher, ethical strategies and the chapter layout.

Chapter 2: Conceptual Framework

Chapter 2 focuses on the conceptual framework of the study and explores Positive Psychology, the asset-based approach and resilience. It highlights the importance of psychosocial support and the specific needs of people with disability and HIV and AIDS.

Chapter 3: Research Design

Chapter 3 discusses Qualitative research, the paradigm of the study, research design, participants, the implementation of the study and the data collection. Ethical considerations and limitations are presented. The chapter concludes with a discussion on the validity and reliability of the study

Chapter 4: Presentation and Discussion of Findings

Chapter 4 presents and discusses the findings of the study, highlighting the themes, and concludes with recommendations for further research and training.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 presented the reader with a general overview of the study. This chapter begins with a description of Positive Psychology, the asset-based approach, life skills and resilience and then highlights the importance of psychosocial support for people affected by HIV and AIDS. The reader then is introduced to the background to disability and the specific needs of people with disability and HIV and AIDS are investigated. The selection of these topics is purposeful for illustrating how they impact and influence each other.

2.2 POSITIVE PSYCHOLOGY

Positive psychology is the scientific study of the strengths and virtues that enable individuals and communities to thrive (<http://www.ppc.sas.upenn.edu/> Accessed 24/02/2008). Psychology after World War II became a science largely devoted to healing; concentrating on repairing damage using a disease model of human functioning. This almost exclusive attention to pathology neglected the possibility that building strength is the most potent weapon in the arsenal of therapy. The aim of positive psychology is to catalyze a change in psychology from the preoccupation only with repairing the worst things in life to also building the best qualities in life. To redress the previous imbalance, we must bring the building of strengths to the forefront in the treatment and prevention of mental illness (Seligman, 2002).

Positive psychology has three central concerns; positive emotions, positive individual traits, and positive institutions. Understanding positive emotions entails the study of contentment with the past, happiness in the present and hope for the future. At the individual level, it is about positive personal traits such as the capacity for love, work, courage, compassion, resilience, creativity, curiosity, integrity, self-knowledge, moderation, self-control and wisdom. Understanding positive institutions entails the study of the strengths

that foster better communities such as justice, responsibility, civility, parenting, nurturance, work ethic, leadership, team work, purpose and tolerance. Some of the goals of positive psychology are to build a science that supports:

- Families and schools that allow children to flourish
- Work places that foster satisfaction and productivity
- Communities that encourage civic engagement
- Therapists who identify and nurture their clients strengths
- The teaching of Positive Psychology
- Dissemination of Positive Psychology interventions in organizations and communities

The following section discusses the asset-based approach and how it links with and complements the Positive Psychology movement.

2.3 THE ASSET-BASED APPROACH

2.3.1 Background

This section introduces the background to the asset-based approach and the development thereof. Kretzman and McKnight (1993) introduced the asset-based framework by proposing the development and empowerment of communities from the inside out by focusing on the strengths, abilities, resources and possibilities that already exist. With the emergence of the asset-based approach, the new decade also saw an increased worldwide move towards Positive Psychology. Both Positive Psychology and the asset-based approach manifest a shift in theoretical development as well as practice. The Positive Psychology movement informed and enriched the development of the asset-based approach that resulted in a search for assets on the inside as well as the outside (Ebersöhn & Eloff, 2006). In South Africa, the ecosystemic approach (Donald, Lazarus & Lolwana, 2002) has made a valuable contribution to overcoming the limitations of the needs-based approach.

Every time an individual uses his or her assets and capacities, the system becomes stronger and the individual is enabled.

The asset-based approach is an approach that uses assets as a way of addressing problems in a variety of contexts. It is "seeing the glass as half full" and is based on the belief that all individuals, families and learning contexts have capacities, skills, resources and assets that can make contributions for positive change. This approach is based on a belief that people who feel connected through supportive relationships more readily develop and become people with resources who are able to solve problems in partnership with professionals (Ebersöhn & Eloff, 2003; Ebersöhn & Mbetse, 2003).

The asset-based approach does not deny the existence of needs. While the asset-based approach acknowledges needs, though, the main efforts of participants in an asset-based intervention are devoted to identifying assets, accessing assets and mobilising the assets for sustainable support. The assumption is that, while needs are indeed real, they can best be addressed by focusing on assets.

2.3.2 The asset-based approach and the needs-based approach

The asset-based approach contrasts with the deficit- or needs-based approach. Sustainability and intrinsic initiatives are strongly supported in the asset-based approach. The deficits approach encourages the belief that only outside experts can provide real help, thereby damaging the mutual support and problem-solving capacities of community members, and deepening the cycle of dependence. The assets-based approach to assessment begins with what is present in the community rather than what is absent. While identification of problems is an integral part of this model, it takes the "half full" rather than "half empty" approach, in which capacities and skills of community members are identified in addition to the problems they face. This leads to creating or rebuilding relationships among local residents, associations, and institutions (Ammerman & Parks, 1998). However, adopting a more assets-based approach to community assessment requires far more time and interaction with the community than does the deficits approach (Ammerman & Parks, 1998).

The needs-based approach also relies strongly on the practice of labelling individuals, families and learning contexts. Terms such as "a child with a

learning disability", "a poverty-stricken school" and/or "a culturally-deprived adolescent" with behaviour difficulties are used in an attempt to understand the needs of others (Ebersöhn & Eloff, 2006). This practice is seen as reductionist because it reduces the individual or learning context to a single dimension, namely problematic.

The asset-based approach is a bottom-up approach that shifts the emphasis from a service to an enablement perspective. It implies a shift away from a mentality of professional dominance to one in which collaboration, dynamic partnerships and participation are encouraged, emphasised and practised. The identification of problems is still an integral part of the approach, but problem solving focuses on creating and rebuilding relationships between individuals, associations and institutions (Kretzman & McKnight, 1993).

2.3.3 Asset mapping

Studies using the asset-based approach as a theoretical framework (Kriek, 2002; Briedenhann 2003; Viljoen, 2005) have highlighted the importance of relationship building in the asset-based approach. The importance of a continued emphasis on resources and the fact that an initial focus on resources and capacities does not necessarily result in a continuous positive focus is shown. The studies have shown that helping and teaching professionals need to continuously focus on the "half-full" part of the glass. The studies have also shared the phenomenon of unanticipated positive outcomes. This means that a focus on strengths and resources can result in surprisingly positive effects. One needs to "[b]e prepared to be surprised" (Ebersöhn & Eloff, 2003).

The way of recognising assets is by drawing an "asset map" of all the skills, talents, capacities and resources that are available. Ammerman and Parks (1998) propose three levels of community asset assessment:

- An individual capacity inventory of specific skills, talents, interests and experiences of community members.
- An inventory of local citizen associations and organisations that includes both formal and informal groups.

- An inventory of local institutions, e.g. parks, libraries, schools, colleges, hospitals, clinics, banks, police departments and other businesses.

Mobilisation involves connecting people with other people, local associations, local businesses, local institutions, and capital and credit (Kretzman & McKnight, 1993).

The Kretzman and McKnight model involves identifying and cataloguing resources at the individual level, as well as potential resources and capacity available through neighbourhood associations and institutions. Collecting this information is of little benefit unless it is used to link together individuals and agencies in the community for the development of the whole community based on shared strengths (Ammerman & Parks, 1998; Ebërsohn & Eloff, 2003; Orsulic-Jeras, Shepherd, Brad & Britton et al., 2003).

The capacity inventory should not be used solely to gather information about a person or persons and resulting in tables and charts showing numbers of skills, activities and enterprises. The basic purpose should be to help a person contribute to the community, develop employment or a business. It is also important to consider what will be done with the information collected from the individual in order to help them contribute their gifts, skills and capacities. This question should be answered in detail before beginning the inventory (Kretzman & McKnight, 1993; Orsulic-Jeras et al., 2003).

This basic truth about the giftedness of every individual is particularly important to apply to persons who often find themselves marginalised by communities. It is essential to recognise the capacities, for example, of those who have been labelled "mentally handicapped or disabled", or of those who are marginalised because they are too old, or too young, or too poor. In a community whose assets are fully recognised and mobilised, everyone will be part of the action, not as clients or recipients of grants, but as contributing to the community-building process (Kretzman & McKnight, 1993).

The above-mentioned literature agrees that the listings of assets are of not much use if they are not mobilised.

While Educational Psychologists, specifically, and teaching and helping professionals in general, may consider the contexts in which they are working

more carefully nowadays, they may still be prone to "deficit thinking" in that they might still be considering the larger context in terms of limitations and what is lacking. The study by Ammerman and Parks (1998) suggests that students studying the asset-based approach first will be better positioned to become partners in community interventions rather than merely providers of services.

In this day and age we need to look further than the traditional way of life-skills counselling specifically, in order to find approaches that are less expensive and more innovative than we have had in the past. The asset-based approach, although far from perfect, offers some possibilities for approaching professional practice in a new and refreshing way. It is also applicable across the board of caring professions - educational psychologists, occupation therapists, speech therapists, social workers, general practitioners, physiotherapists and educationists may all benefit from adapting their traditional approach to the asset-based approach (Ebersöhn & Eloff, 2003). Ammerman and Parks (1998) encourage universities to teach the asset-based approach to their students first, before focusing on needs.

I have noticed that writers (Ebersöhn & Eloff, 1993; Bredenhann, 2003; Kriek, 2004; Orsulic-Jeras et al., 2003), in introducing the asset-based approach, use this approach in contrast to the needs-based or medical model's approach. This is often done intentionally to indicate the differences rather than similarities of the two approaches. I question this intention. Is this done to accommodate the more "known" way of doing educational psychology, given our history? I believe that the value of the asset-based approach will be better emphasised on its own than in comparison with the deficits model. The next section briefly discusses life skills.

2.4 LIFE SKILLS

In South Africa, life-skills education has been incorporated into LIFE ORIENTATION, one of eight basic learning areas of the general education curriculum. The teaching and development of life skills is not regarded as an "add-on" to the normal business of teaching but as a central goal and integrated part of the curriculum (Donald, Lazarus & Lolwana, 2002:157). Life

skills programmes aim to assist people to become more balanced, independent and able to solve problems creatively in their daily lives. Many social systems such as families, cultures, communities, schools and institutions indirectly and unintentionally convey to us that 'responsibility for our progress, development, behaviour and welfare lies with somebody other than ourselves'. This can be disempowering and can restrict our self-development. However, life-skills programmes aim to empower people towards growth and development (Van Niekerk & Prins, 2001).

The Life Orientation learning area aims to empower learners to use their talents to achieve their full physical, intellectual, personal, emotional and social potential. It seeks to enable learners to make informed, morally responsible and accountable decisions about their health and environment. Learners are encouraged to acquire and practice life skills that will assist them in responding to challenges and to play an active and responsible role in the economy and in society. The aims of the asset-based approach, viz. empowerment and enablement, and the Life Orientation learning area complement and dovetail each other. Resilience also has to be mentioned when talking about the asset-based approach and life skills learning because a basic premise or aim of these approaches is to build, develop and strengthen resilience.

2.5 RESILIENCE

2.5.1 What is resilience?

"Resilience is one of the great puzzles of human nature and at the same time it appears to be an ordinary magic that enables some children to progress well despite difficulties" (Killian, citing Coutu Pharoah, 2004:33). Despite hardship and adversity, resilient children work well, play well, have well and expect well. Killian (in Pharoah, 2004) quotes studies that have shown how 50% to 60% of children growing up in circumstances of multiple risks appear to overcome the statistical odds and live lives that manifest coping and resilience.

Children can display extreme resilience when their lives are changed radically through illness or the loss of a parent. They take on new roles that include

acting as a heads of households, making household decisions normally made by an adult even when the parent is still living, and supporting younger brothers and sisters, at times while suffering great loss and peril themselves. They often help other children who are vulnerable by providing them with food, shelter, counselling and friendship, and are active members of orphan committees in AIDS affected communities (Hunter, 2000). Children often know about other children that might be at risk of abuse or exploitation. Hunter (2000) states that supporting children who are on their own in these independent roles that have been forced upon them, requires an enlightened social welfare system and government, creative thinking, and financial resources.

Resilience refers to a class of phenomena characterised by patterns of positive adaptation in the context of significant adversity or risk (Masten and Reed, 2002).

2.5.2 Models of resilience

Two major approaches have characterised the research of resilience in development viz. person-focused and variable-focus. Person-focused approaches identify resilient people and try to understand how they differ from others who are not fairing well in the face of adversity or who have not been challenged by threats to development. Variable-focus approaches examine the linkages among characteristics of individuals, environments, and experiences to try to ascertain what accounts for good outcomes on indicators of adaptation when risk or adversity is high. This method effectively draws on the power of the whole sample or the entire risk group, as well as the strengths of multivariate statistics. It is well suited to searching for specific protective factors for particular aspects of adaptation (Masten & Reed, 2002).

Table 2.1 lists the most frequently reported protective process (Pharoah, 2004:52).

Table 2.1: The most frequently reported protective processes

| Internal personal Strengths | Interpersonal Resources | External supports and skills |
|--|---|--|
| <ul style="list-style-type: none"> • Good intellectual skills • Sense of self-efficacy and self-esteem • Autonomy and sense of control over one's own life • Achievement oriented • Problem-solving skills • Creative, innovative, resourceful personality • Appealing or easy temperament • Talents valued by self and society • Ability to focus and maintain attention • Ability to experience and express a wide range of emotions | <ul style="list-style-type: none"> • Trusting relationships • Secure attachments • Sense of humour • Sense of being loveable • Socially competent • Ability to regulate oneself socially • Ability to empathise and consider situations from another's perspective • Receiving recognition for achievement • A sense of meaning in life, usually in the form of faith and religious affiliations | <ul style="list-style-type: none"> • Caring, supportive parents • Connections to caring and competent adults • Parental encouragement, praise and active involvement • Positive role models • Emotional support outside of the family • A sense of belonging, cultural and family heritage • Socio-economic advantages • Stable school • Community resources • Access to health facilities • Routine and rituals • Child-aware and sensitive community and country |

2.6 HIV AND AIDS

2.6.1 The importance of psychosocial support

The following literature review emphasises the need and importance of psychosocial support for persons affected by HIV and AIDS, which affect not only the infected person but also the family and significant others. It is not just a medial crisis but also a psychosocial one (Temoshok & Baum, 1990). The stigma attached to HIV and AIDS is a major barrier to families, friends and communities in being able to speak freely about the multitude of feelings, fears and concerns that the disease provokes. For this reason, there is much to be said for promoting activities and projects explicitly designed to stimulate and support emotional or psychological resolution (Karim & Karim, 2005). The community response to HIV/AIDS and the available support services can also affect the psychosocial adjustment of the person with AIDS and his/her family.

Psychosocial stress may interfere with medical treatment and may also interfere with the ability of people to function at an optimal level but the psychosocial needs of the family too often go unrecognised (Karim & Karim, 2005).

As far as vulnerable children are concerned, psychosocial support continues to be one of the most neglected areas of support for them. The specific needs of children with disabilities as part of "vulnerable groups", "marginalised groups" or "disadvantaged groups" must be explicitly identified with the specific challenges that are presented by the disability. In this regard, "[t]he HIV epidemic has increased the urgency to address psychological problems of children in equal proportion to other interventions" (Family Health International, 2001, cited by Richter, 2004) The long-term consequences for children who experience profound loss, grief, hopelessness, fear and anxiety without assistance can include psychosomatic disorders, chronic depression, low self-esteem, low levels of life skills, learning disorders and disturbed social behavior.

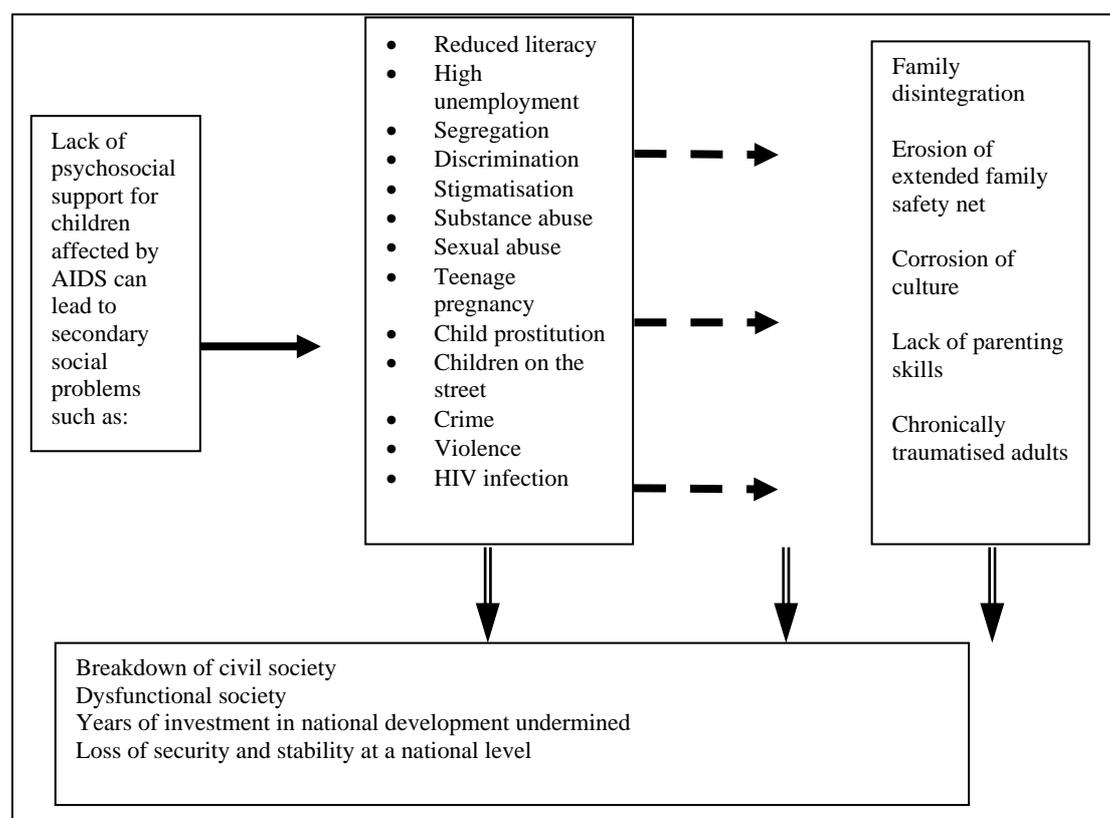


Figure 2.1: Potential long-term impact of poor psychological support systems (Source: REPSSI, 2001, cited by Pharoah, 2004)

Psychosocial support is an ongoing process of meeting a child's intra-personal and inter-personal development needs. This incorporates physical, emotional, mental and spiritual dimensions. Given that HIV/AIDS is creating and exacerbating, not only physical poverty, but also emotional, psychological and social poverty in the lives of affected children, and that poverty can have profound personal, familial and societal implications, it is imperative that psycho-social support is strategically integrated into programmes for children affected by HIV/AIDS (Pharoah, 2004).

It is difficult to overstate the trauma and hardship that children affected by HIV/AIDS are forced to endure. They try to help but often can only watch as one parent, then possibly the other, gradually become more ill and die. A myriad of interrelated factors take their toll; grief over the death of a parent, fear about the future, separation from siblings, distress over worsening economic circumstances and HIV/AIDS related discrimination and isolation. In addition, orphans and widows can face loss of inheritance, which further impoverishes them (Kallman, 2003).

Although many organisations are aware that children are affected emotionally by the losses associated with HIV/AIDS in their homes and communities, less attention is generally given to children's psychosocial needs compared to their material needs (Subbarao & Coury, in Richter et al., 2004). In many contexts in Southern Africa, children's emotional needs are not responded to in ways which help them to cope. For example, children are seldom told about their parents' deaths in an effort to protect the child. Creating awareness of children's needs and ongoing support for children is an important component of psychosocial interventions for children. The Regional Psychosocial Support Initiative (REPSSI) for children affected by HIV/AIDS is one attempt to redress the imbalance.

Children impacted by HIV/AIDS are also at serious risk of exploitation, including physical and sexual abuse. Isolated from emotional connections with the family, some turn to risky sexual behaviour. Those forced to live on the street may turn to prostitution and crime as a means to survive. Whilst most of these children are born free of HIV, they are highly vulnerable to infections (Kallman, 2003). The department of social development formulated a draft

strategic framework for children infected and affected by HIV/AIDS in November 1999 that identified a range of needs of children infected or affected by HIV/AIDS, namely medical care; alternative care (which should preferably be community based); basic needs such as food, clothing, shelter and general nurture; education; life skills and vocational training; and assistance with psychosocial needs.

Losing a parent in adolescence is of particular concern because it may affect developmental processes of self-concept and identity formation, interpersonal relations, schoolwork, family involvement and psychological wellbeing (Pequegnat & Szapocznik, 2000). The negative impact on adolescents whose parents live with HIV/AIDS may be even greater than would be suggested because these families experience additional AIDS-specific stresses, including stigma (Pequegnat & Szapocznik, 2000, citing Herek & Capitano, 1993). The literature on childhood parental loss has focused mainly on post-death factors and has tended to neglect pre-death factors. Parents who are dying of AIDS are often burdened by poverty, inadequate medical care and a host of other interrelated social problems (Pequegnat & Szapocznik, 2000). The physical, material, intellectual, educational and psychosocial needs of affected children are radically undermined when they prematurely take over adult responsibility such as parenting and maintaining households (Giese in Griessel-Roux, Ebersöhn, Smit & Eloff, 2005). Young people infected and affected by HIV and AIDS experience loss, whereas normal psychological development requires that the person leave home and develop a sense of "I", an ego. It is about the experience of separateness and identity and gaining status in society through leaving home, finding work, learning how to enjoy and create a meaningful life (Mead & Willemsen in Sherr, 1995).

Both parents and children have asked for emotional support with some of their problems. Adults want emotional support to disclose their status to their children. They want support in helping their children cope with their fears of the future; the reality of looking after an ill parent; and the responsibility of heading a household. Children who are orphaned also ask for guidance and support from adults (Save the Children, 2000).

Social support can have a direct effect on health outcomes by alternating distress and thus improving immune functioning. It can also provide a buffering effect by protecting people living with HIV/AIDS (PLWHA) from the stress and strain associated with HIV/AIDS (Malgas, 2005 citing Cohen & Wills, 1985; Syrotuik & D'Arcy, 1984). Psychosocial resources such as social support mediate the effects of stresses and thus affect health outcomes positively (Malgas, 2005 citing Peterson, Folkman & Bateman, 1996).

The review of the literature on social support and HIV and AIDS indicates that most of the research has been conducted on samples that are American, white and homosexual and the findings of the research, as such, needs to be generalised with caution. There appears to be limited research on social support and HIV/AIDS in the South African context and this represents an opportunity for social scientists to start conducting research in this area which could play a key role in the management of the disease in the long run (Malgas, 2005).

Extended families take on the overwhelming majority of orphans who lose both parents. In many cases, orphaned siblings are sent to different households and experience a second profound loss through separation. Many foster families are poor and have to stretch already inadequate resources to provide for both the orphans and their own families. Let us look in the following section at the different roles that significant others, e.g. health workers, communities, schools, school psychologists and neighbours can play in supporting infected and affected individuals.

2.6.2 Significant role players

Many helpful interventions are not implemented because policymakers are uninformed, are in a state of denial about the effects of the pandemic, or are unwilling to support children in the independent roles they have been forced to assume (Hunter, 2000).

The HIV and AIDS pandemic presents a crisis to health care workers in South Africa and the challenge is to reframe this crisis and to see it as an opportunity for growth, hope and optimism, to tap into the collective fighting spirit that exists among healthcare work against HIV/AIDS (Malgas, 2005).

Adults who regularly come into contact with children - guardians, teachers, health workers, faith-based groups and youth volunteers - can be trained to identify children's emotional needs and to give children support. Amongst others, children's sadness, apathy, fearfulness, aggression, poor concentration and social isolation are easily recognisable, but adults and young people need training and support to respond to these manifestations of children's distress. This will support capacity building within the community.

Courage to Care (Catholic Institute of Education, 2003) proposes that schools support and strengthen the ability of a family to cope with illness and death. For example, teachers of life-orientation could encourage parents to talk to their children about the future and prepare them for a time when they have to cope without parental guidance and support. Suggestions include a family life-skills programme that guides parents to introduce children to the people they can turn to in times of need, or a workshop that helps parents to make a will. Memory projects (e.g. NACWOLA in Uganda) and Richter et al. (2004:35), Viljoen, J. (2005) and Karim and Karim (2005) stress the importance of memories in helping children to cope with the death of a parent and help children not to lose their sense of identity. Family memorabilia and shared anecdotes, e.g. memory "boxes" or "books", videos, making banners or quilts can be valuable starting points for stimulating open discussion and disclosure and planning for the future (Karim & Karim, 2005). The growing awareness of the long-term negative effects of psychosocial factors on children's development has resulted in governments looking at schools as settings for promoting resilience (Frydenberg et al., 2004). Schools as nodes of care and support for vulnerable children would serve as intersections between communities and service providers (Ebersöhn & Eloff, 2006). The school psychologist can play an integral role, as suggested in the following paragraph.

De Jong (2000) suggests that school psychologists make a valuable contribution to develop health-promoting schools by using their "assets" or traditional strengths. School psychologists are in a strategic position to mediate the relationship between a school's internal and external worlds, focus more explicitly on health promotion, develop schools as organisations,

actively build a supportive psycho-social learning environment, develop thinking skills and contribute to staff development.

School psychologists have traditionally relied on the medical model paradigm, with primary attention upon assessing, diagnosing and treating learners referred to them. These practices are relevant to clinical work, but are too restrictive. A move toward promoting wellness, developing strong working linkages with schools, families and communities should be the cornerstone of the work in the 21st century (Sheridan & Gutkin, 2000:6; Frydenberg et al., 2004). I propose that educational psychologists, in collaboration with other significant role players, can forge strong relationships in supporting learners, families and communities affected by HIV and AIDS. Parents and guardians can be assisted and supported to accomplish disclosure, make provision for substitute care and legal protection. The educational psychologist can play a role in mediating discussions with extended family and neighbours to help ensure that the wishes of affected parents and children are implemented (Richter et al., 2004).

2.7 DISABILITY AND HIV AND AIDS

2.7.1 Background

Historically, people with disabilities have constituted minorities and have been the objects of unfair discrimination and stigmatisation. People with disabilities still suffer indignity, widespread discrimination and lack of economic independence. The vast majority of people with disabilities in South Africa have been excluded from education, housing, transport, employment, information and community life. They have been prevented from exercising fundamental political, economic, cultural and developmental rights. The inequality between the able-bodied and the disabled was reinforced by the injustice of the apartheid system. During the apartheid regime, laws supported the cumulative isolation of people with disabilities. These injustices continue to be perpetuated by prejudices that see people with disabilities as dependent and in need of care (http://lawspace.law.uct.ac.za:8080/dspace/bitstream/2165/304/1/BugaH_2006.pdf. Accessed October 6,2007).

To date, the disability sector has largely been ignored in prevention programmes, yet this widely diverse group of people has very specific needs regarding becoming less vulnerable to contracting HIV/AIDS. Issues such as a lack of knowledge, lack of resources and social support, extreme poverty, continued discrimination and stigmatisation are contributing to their vulnerability to contracting HIV/AIDS (Mouton, 2003; Strydom, 2005; Bat-Chava, Martin & Kosciw, 2005).

Tire (2003) and Loebenstein (2005) discuss the moral model, the medical model and the social model to describe various ways in which disability is perceived. The medical model locates disability within an individual as a problem that can be measured, needs to be cured by medical or other professional experts and diminishes the quality of life of the person. In contrast, the social model is based on the belief that the circumstances of people with disabilities and the discrimination they face are socially created phenomena and have little to do with the impairments of the person. The social model promotes advocacy and the ability of people with disabilities to have agency in their world and not need other people to act or advocate on their behalf. The medical model has dominated the way disability has been perceived, yet there is deliberate movement towards the social model. In South Africa after 1994, policy-making processes underwent a tremendous change with regard to disability, compared to that of the apartheid era. Before 1994, the services tended to be welfare orientated, creating the perception that those with disabilities were being looked after or being provided for. This, in turn, encouraged an attitude of dependency (Tire, 2003). The integrated National Strategy (Mbeki, 1997) states "dependency on state assistance has disempowered people with disabilities and has seriously reduced their capacity and confidence to interact on an equal level with other people in society".

People living with disabilities are mostly marginalised and should rather be integrated into the community as far as possible in order to spread information about disabilities and the circumstances of the disabled and to bring the community into contact with people living with disabilities (Strydom, 2005).

Both the White Paper on an Integrated Disability Strategy (Mbeki, 1997) and the Integrated Provincial Disability Strategy for the Western Cape (draft document, 1999) recommend that power should be shifted from the professional to persons with disabilities and their representative organisations (Frieg & Hendry, 2001; Loebenstein, 2005). South Africa and Uganda have achieved the social model within their political systems, but this has not meant an end to poverty and exclusion (Flood, 2005).

2.8 DISABILITY AND POVERTY

Disability is both a cause and consequence of poverty. Eliminating world poverty is unlikely to be achieved unless the rights and needs of people with disability are taken into account (<http://www.addc.org.au/disabilitypoverty.html> Accessed October 6, 2007).

In developing countries, people with disabilities are over-represented among the poorest people. Poverty results disabilities and can lead to secondary disabilities for those individuals who are severely disabled as a result of their poor living conditions, malnutrition, poor access to health care and education opportunities. Poverty and disability together create a vicious cycle (<http://web.worldbank.org> accessed 06/10/2007 and <http://www.addc.org.au/disabilitypoverty.html> accessed 06/10/2007).

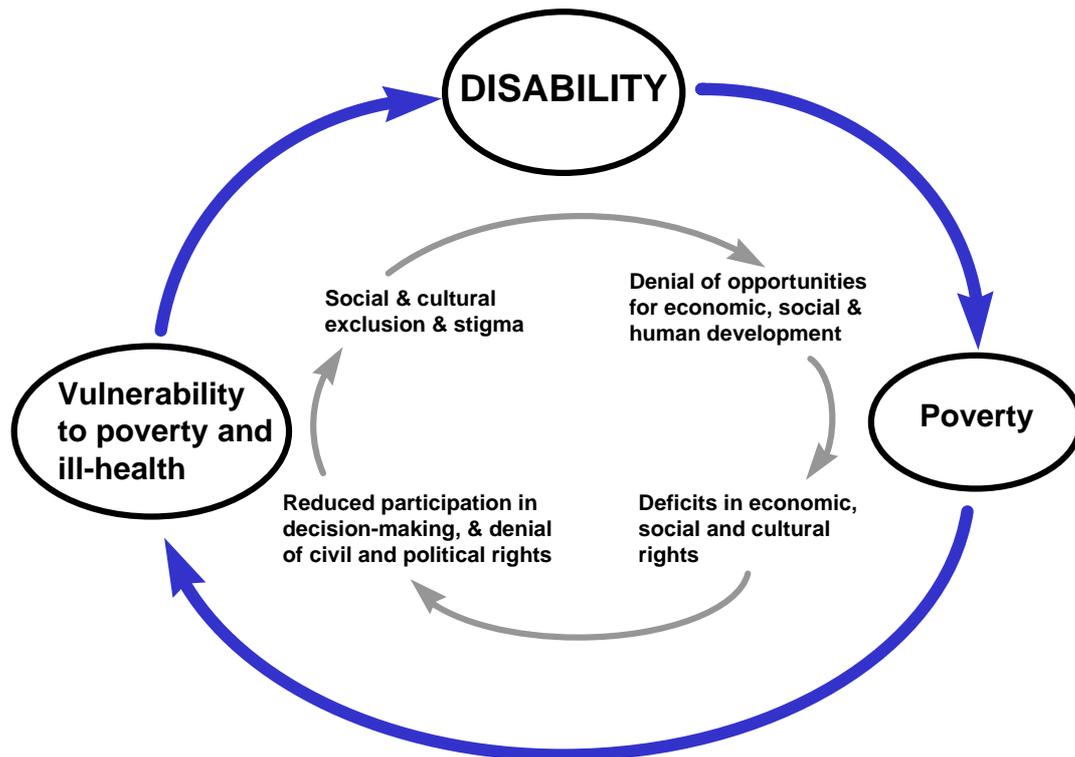


Figure 2.2: Poverty and Disability - a vicious cycle

(<http://www.addc.org.au/disabilitypoverty.html> accessed 06/10/2007)

The result of the cycle of poverty and disability is that people with disabilities are usually amongst the poorest of the poor and their literacy rates are considerably lower than the rest of the population. This has an impact on them finding employment.

2.7.1 Disability grant

In South Africa employment opportunities are scarce and many citizens rely on social assistance for basic subsistence. Mbeki (1997) has indicated that approximately 30% of those persons with disabilities who received a disability grant in 1993 often had to support entire families with the grant (Frieg & Hendry, 2001).

Disability grants are available to all "severely physically and mentally disabled people older than 18 and younger than 65. The system works according to a "medical model" which instructs those responsible for recommending patients for disability grants to judge whether they are capable of working - irrespective of whether work is available (Nattrass, 2005 citing Simchowitz, 2004). People

who are in stage four of AIDS (i.e. are AIDS sick) are eligible for disability grants (as long as they pass a fairly generous means test). Medical officers review disability grants by every six months or five years, depending on the grant.

Disability grants are an important source of income for AIDS-affected households in South Africa and losing such a grant can have serious implications for household living standards. Seven hundred and eight-nine respondents in a survey agreed that the disability grant helped people with HIV to be more accepted by their families (Nattrass, 2005).

There is a great controversy around social assistance for persons with disabilities and it is suggested that social grants compound discrimination, have a de-motivating effect on people with disability and add to dependence (Frieg & Hardy, 2001).

2.7.2 The specific needs of people with disabilities and HIV and AIDS

Many people living with HIV and AIDS are also living with different kinds of disabilities. Studies show that people with disabilities have very specific recommendations/requirements when HIV/AIDS information is distributed, i.e. the need for inclusive methods within the media, sign language, use of visual material and Braille, etc. Other challenges include the need to adapt awareness information, for example, on how to put on a condom when you are blind or can't use your hands. There is a call for greater openness.

Mouton (2003) mentions the following as obstacles or barriers identified by participants discussing HIV and AIDS in a workshop:

- Persons in the disability sector are largely regarded as asexual beings, which leads to the misconception that people with disabilities are sometimes "immune" to contracting HIV.
- Unwillingness to use reproductive health services due to the patronising attitudes of staff, who often counsel clients/parents on sterilisation processes as opposed to safe-sex options.
- It emerged that male and female condoms either had never been tried, or that specific problems regarding their use were expressed, e.g. poor

quality, the availability of condoms, and inability to access health services to obtain condoms. The packaging of the female condom was not user-friendly to blind women. Questions regarding other safe-sex alternatives where the male or female condom is not an option were not addressed.

- The lack of confidentiality that this group is often exposed to was another barrier that was identified
- Participants raised the issue of difficulties around negotiating safe sex with potential or steady partners. Relationships are sometimes complicated and compounded by issues such as dependency and financial need. IN the case of persons with disability having able-bodied partners, the issue of the fidelity of their partners was confided, to put the threat of contracting STDs and HIV/AIDS on the table.
- Community health services are not easily accessible in terms of geographical proximity, physical access, communication (e.g. the deaf) and confidentiality. Pregnant women with disability hardly ever make use of antenatal clinics and therefore often remain oblivious to their HIV status. This has a direct impact on current HIV surveillance statistics and the inclusion and participation of people with disabilities.

2.8 CONCLUSION

In reviewing the literature, it became clear to me that psychological support for families affected by HIV and AIDS is crucial, whether it is aimed at using memory boxes or books, quilts, videos, etc. I propose the asset-based approach for use to strengthen an individual sense of value, meaning and ability to cope with the many challenges faced by people affected by HIV and AIDS. South Africa, with its many diverse groups of people, clearly needs to review its strategy in addressing the HIV and AIDS pandemic that threatens the very same democracy we fought so very hard to achieve. Literature shows that the unique needs of people with disabilities are not being addressed adequately with regard to HIV and AIDS. Once again, the people of South Africa, the government, NGOs, health care workers and people who are affected must unite against the challenge that threatens not just human life but our very existence.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research design as well as the methodology that I used as the framework for the research study. The research design is a strategic framework for action that serves as a bridge between research questions and the implementation of the research (Durheim, 1999:29). This is an important part of the research process that guides the research. I chose participative action research because of its collaborative nature, and used the research spiral as a practical guide and as most appropriate for the aim of the study. The participants are introduced whilst ethical considerations and the limitations of the study are also mentioned.

3.2 THE RESEARCH QUESTION

Research problems are often formulated in the form of questions as a way of focusing the research problem (Mouton, 2001:53).

My research question is:

- What is the effect of the asset based approach to life skills facilitation with a learner affected by disability and HIV and AIDS?

3.3 THE AIM OF THE RESEARCH

The aim of the research was to embark on a developmental journey with the learner using participatory action research for finding answers to the real-life challenges that he experienced. The additional aim was to empower the learner by using life skills facilitation through the asset-based approach and to determine how this strengthens him to cope with the challenges of disability and HIV and AIDS.

3.4 QUALITATIVE RESEARCH

Qualitative research is an umbrella concept covering several forms of inquiry that explain and help us to understand the meaning of social phenomenon with as little disruption of the natural setting as possible (Patton, 1985). Qualitative research "is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself, so that it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting; what it means to be in that setting, what their lives are like, what is going on for them, what their meanings are, what their world looks like in that particular setting ... The analysis strives for depth of understanding" (Patton cited by Merriman, 2002). The first characteristic of qualitative research is that researchers strive to understand the meaning people have constructed about their experiences and their world.

The researcher is the primary instrument for data collection and data analysis. Researchers are able to be responsive and adaptive and can expand their understanding through non-verbal as well as verbal communication, process, clarify and check with respondents for accuracy of interpretation. They are also able to explore unusual or unanticipated responses. The researcher as a human instrument has shortcomings and biases that might have an impact on the study, but these biases or "subjectivities" should be monitored and identified rather than trying to eliminate them. Another important characteristic of qualitative research is that the process is inductive, i.e. this type of research builds abstractions, concepts, hypothesis, or theories rather than test existing theory. Qualitative research is often undertaken when there is a lack of theory, or existing theory fails to adequately explain a phenomenon. Finally, since qualitative research focuses on process, meaning and understanding, the product of qualitative study is richly descriptive. The next section introduces the paradigm of the study.

3.5 TRANSFORMATIVE PARADIGM

A paradigm is a way of looking at the world. It is composed of certain philosophical assumptions that guide and direct thinking and action (Mertens, 2005).

The transformative paradigm recognizes multiple realities but stresses the influence of social, political, cultural, economic, ethnic, gender, and disability values in the construction of reality. It also emphasises that that "which seems real" may be reified structures that are taken to be real because of historical situations (Mertens, 2005:23). In participatory action research, the relationship between the researcher and participants are interactive and should be empowering to those without power. "In transformative research that comes from the participatory action research tradition, it is viewed as essential to involve the people who are the research participants in the planning, conduct, analysis, interpretation, and use of the research. A common theme in the methodology is "inclusion of diverse voices from the margin" (Mertens, 2005:26).

I chose the transformative paradigm because the focus is on empowering and on listening to the voice of a learner who is traditionally marginalised because of disability and is also affected by HIV and AIDS. In South Africa, people with disabilities were marginalised under the previous government due to the 'protective' approach by which they were set apart, as discussed in Chapter 2. Mertens (2005) describes the transformative paradigm as characterised by placing central importance on the lives and experiences of marginalised groups. The transformative paradigm is described as an umbrella term that incorporates other pragmatic perspectives, which include emancipatory, participatory and critical approaches and is made most articulate in the work of writers such as particular feminists, people with disabilities and their advocates, and others who represent marginalised groups such as racial and ethnic minorities (Mertens, 2005; Loebenstein, 2005).

Transformative work is characterised by the following:

- The assumption that knowledge is not neutral but rather directly influenced by human interests and values;

- The understanding that all knowledge is a reflection of the power and various social relationships within society;
- The conviction that a fundamental intention of knowledge construction should be to assist people to improve society (Banks, in Loebenstein, 2005).

Researchers working in this paradigm involve individuals of the communities affected by the research in decision making regarding both the research programme and the methodologies used to evaluate the programme (Mertens, 1999 in Loebenstein, 2005).

The action-reflection research cycle is considered to be integral to the transformative paradigm and necessitates the involvement of the researcher in the communities affected by the programme, to the degree where deep understanding can be gained (Mertens, 2003b in Loebenstein, 2005).

3.6 THE RESEARCH DESIGN

"A research design is a plan or blueprint of how you intend conducting the research" (Mouton, 2001:55). I have used a participatory action research design (PAR), which involves the particular participants in the research process, with explicit recognition of power issues and a goal of transforming society. The focus is on the people's participation in setting the agenda, participating in the data collection and analysis, and controlling the use of the results. PAR emphasises the use of methods that allow the voices of the most oppressed to be heard (Mertens, 2005:244).

In walking a path with the learner, it was of utmost importance that the features and aims of PAR be used and respected. I chose PAR to create opportunities for participation and collaboration, given the background and the history of people with disability as discussed in Chapter 2.

3.7 PARTICIPATORY ACTION RESEARCH

Cresswell (2005) points out that individuals refer to participatory action research by different names, such as *community-based inquiry* (Stringer, 1999:9), *collaborative action research* or *participatory research* (Kemmis & McTaggart, 2000:567), or *critical action research* (Mills, 2000:7). This study

uses the term *participatory action research* to acknowledge the participative and collaborative nature of this type of inquiry.

As mentioned in Chapter 1, Kemmis and McTaggart, in Denzin and Lincoln, (2005) identify seven key features of participatory action research:

1. Participatory action research is a social process.
2. Participatory action research is participatory.
3. Participatory action research is practical and collaborative.
4. Participatory action research is emancipatory.
5. Participatory action research is critical.
6. Participatory action research is reflexive.
7. Participatory action research aims to transform both theory and practice.

I chose PAR to create opportunities for participation, collaboration and the link between researcher and participants, to place the learner in a position of "empowerment" that allowed guiding, directing and doing research *with* the researcher. The learner had specific outcomes that he wanted us to achieve at the end of the research journey. A brief description of some of these principles will be discussed in the following sections.

3.7.1 The role of participation

Participation is about the shift in roles of the "researcher" who becomes a facilitator and the "subjects" who become participants. In this partnership the "researcher" takes part in the research and guides and directs the cyclical research process. When a researcher becomes a partner in the research, a democratising of the research takes place. Control is allocated to the participants when the researcher works in collaboration with them. This shift in roles complements the asset-based approach and the transformative paradigm where theory and approach meet with the united concern to empower and enable people. The asset-based approach is relationship driven. Relationships are built and rebuilt between individuals, local associations and institutions through the process of facilitation (Ebersohn & Eloff, 2003). This approach offers several returns in terms of ownership,

shared responsibility, immediacy, relevancy and practicality of solutions, flexibility, mutual support and a caring environment, as well as individual capacity building (Ebersöhn & Mbetse, 2003).

In this study, I adopted the role of facilitator and partner from the start by constantly checking, liaising, planning and collaborating with the learner. This process asks for the facilitator to be tentative about when to guide or direct, and when to step back and observe.

3.7.2 The role of the researcher

Ebersöhn and Eloff (2003) advise the researcher who wishes to work according to the asset-based approach to integrate the following principles. With respect to the research participants, the researcher should firstly believe that everybody has assets, and secondly that whoever is present, is the right person to work with. With regard to the research field, the researcher should remind himself that whatever happens is the only thing that could have happened. The question "so what will we do now?" should always be present in the researcher's mind. Ebersöhn and Eloff (2003) and Viljoen (2005) encourage the researcher to be open-minded about expectations, events and outcomes and to "be prepared to be surprised".

This shift in roles complements the asset-based approach and creates the opportunity for theory and practice to meet in addressing concerns. It creates opportunity for people to become aware of assets and to become enabled and empowered through this process. The necessity of the shift in the role of the educational psychologist is encouraged increasingly in literature (De Jong, 2000; Sheridan & Gutkin, 2000).

Mertens (2005:244) provides a list of questions researchers can ask themselves to establish whether they are doing PAR.

The questions that are related to Participatory Action Research include the following:

1. Was the problem addressed by the research originally identified by the community who experienced the problem?
2. Was the goal of the research to fundamentally change and improve the lives of people with disabilities (or other marginalised, oppressed groups)?
3. Did the research process give the power to participants?
4. Did the research participants belong to the group - usually a marginalised or oppressed population - that experienced the problem being studied?
5. Will the participants experience increased consciousness, skill development, and resources?
6. Do researchers and participants share a peer relationship?
7. Can the results be used by and benefit the participants?

SOURCE: Adapted from Doe (1996)

As the School Psychologist in the school attended by the learner, I was aware of my position of authority from the point of view of the learner. In this study, however, I adopted the role of facilitator and collaborator. The data will be presented in terms of the action research spiral of plan, act, observe, reflect proposed by Kemmis and Williamson (2003); Kemmis and McTaggart (2005).

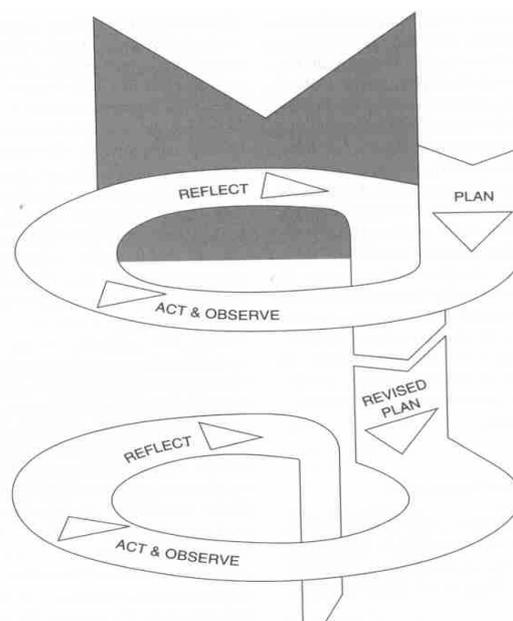


Figure 3.1: Kemmis and McTaggart (2005)

Even though the research spiral is presented in a linear format, it followed a continuously interactive set of activities. This is to say that the research process was not a neat, orderly, step-by-step process, but an interactive process characterised by iterations of revisiting, adding and rethinking the next step.

In reality the process might not be neat as this spiral of self contained cycles of planning, acting, acting and observing and reflecting suggests. The stages overlap, and initial plans quickly become obsolete in the light of learning from experience. In reality the process is likely to be more fluid, open and responsive (Stringer, 1996:17; Kemmis & McTaggart, 2005:563).

The next section introduces the participants and describes the implementation of the research and how the process developed.

3.8 PARTICIPANTS

The participant was selected through purposeful sampling, described by Creswell (2005:204) as "researchers intentionally select individuals and sites to learn or understand the central phenomenon".

The participant was selected through purposive sampling because of the sensitivity of the topic and because the learner approached me to request help and assistance with challenges in his life.

The process included the learner, the family and the community in identifying and mobilising the individual and community assets as part of the research. The contextual and historic factors concerning the learner, the family and the community as the "participants" in the study are described in the following section. Two existing theories, the theoretical framework for the eco-systemic perspective as developed by Donald, Lazarus and Lolwana (1997) and the theory developed by Kretzman and McKnight (1993), bear relevance in the creation of a theory for the asset-based approach. As mentioned before Kretzman and McKnight (1993) proposed the development and empowerment of communities from the inside out by focussing on the strengths and abilities that already exist.

The Participant

Camelot (pseudonym) is an 18-year old young man in Grade 11. He has attended a school for learners with cerebral palsy and learning disabilities since the age of six years. He was diagnosed with cerebral palsy and referred to a special school away from home on the basis of the medical model. His frame is small for his age and he presents with right hemiplegia. He received physiotherapy, occupational and speech therapy to address his needs. He was hospitalised on occasion due to surgery. He finds it difficult to keep up in class with writing, which he experiences as a tedious task and so prefers to talk. He plays soccer, sings in the choir and is a member of the RCL (Learner Representative Council). He has resided in the school hostel since the age of nine and goes home during the school holidays. Recently he started going home during weekends due to his mother's deteriorating health.

The school, with its residential facility, is situated on the Cape Flats, in the Western Cape Province of South Africa. The institution is one of the few special schools catering for learners from previously disadvantaged backgrounds that were not eligible to go to other special schools reserved for whites under the apartheid system. The school was started by a few concerned individuals who included parents of children with cerebral palsy.

"Special needs education is a sector where the ravages of apartheid remain most evident. Here, the segregation of learners on the basis of race was extended to incorporate segregation on the basis of disability. Apartheid special schools were thus organized according to two segregation criteria, race and disability. In accordance with apartheid policy, schools that accommodated white disabled learners were extremely well-resourced, whilst the few schools for black disabled learners were systematically under resourced" (Education White Paper 6, 2001).

The Community

The family lives in an informal settlement on the Cape Flats, Cape Town, South Africa where most families live in wooden structures on an open piece of land. The rate of unemployment is high and most families depend on a state grant to survive. Organisation A is a training and development centre

with a crèche for children, which was started in the nearby settlement. The organisation is funded by overseas church organizations and private donations and relies on the assistance of volunteers. Organisation B is a community branch of the large, internationally known group actively involved in the news and media due to their action and treatment campaign against HIV and AIDS. The community branch consisting of about 15 members was started by a concerned community member who saw a need within the community. The members meet on a daily basis to learn, discuss and plan action in addressing issues regarding HIV and AIDS. These meetings take place at the home of one of the members. All the members are residents in the community.

The Family

The family consists of the learner's mother, two younger brothers and a sister. The mother's boyfriend also shares their home with them. The learner describes his family as very close and loving. His younger brother is visually impaired and attends a school for learners with special educational needs (LSEN) in Cape Town. He also stays at that school's hostel and goes home on week-ends. His youngest brother (eight years old) and his sister (six years old) attend a primary school in the area. He lovingly describes his sister as a beautiful girl that "I love very much". His mother disclosed her HIV positive status to them in 2000. She tries very hard to give them of her best. The family struggles financially with the only form of income being state grants amounting to R1800 per month for the six people to survive. The mother managed to do a skills course and worked for a while, but became too sick to continue. The family owns their two bedroom house. Camelot describes mother's illness as a disability with which one gets a cold and others do not get a cold. In the beginning Camelot did not want to involve his family in the research but he changed his mind as the process developed and decided to involve his mother.

3.9 THE CYCLICAL PROCESS

Introduction

The purpose of this research report is to give the reader a clear picture of how the research was conducted and how the cycles, developed. This process happened over a period of six months. The research process started with weekly meetings between the learner (the participant) and the researcher (the facilitator). These meetings took place after hours for one-and-a-half to two hours at a time so as not to interfere with the participant's contact time at school. Semi-structured interviews were conducted in the participant's first language, which is Afrikaans. Data was recorded, using an electronic tape recorder. After each meeting I listened to the recording to reflect and plan for the next meeting. The learner was very clear and specific from the beginning regarding the problems/issues that he wanted to explore and discuss. This resulted in follow-up meetings being predetermined by themes presented in the present meeting, e.g. Meeting 1 would guide the discussion in Meeting 2 and Meeting 2's discussion would guide discussion in Meeting 3, and so on. How this took place is explained below.

3.10 THE STAGES OF THE ASSET-BASED APPROACH AS PROPOSED BY EBERSOHN AND ELOFF (2006)

Meeting 1: Learning and gaining awareness through introducing the Asset-based Approach

Goal: To explain the asset-based approach.

In the first meeting, the asset-based approach was explained through the use of the "half full-half empty glass" analogy. The participant was then asked to identify and name his own assets. Shortly after identifying his assets, the participant indicated that there were difficulties or concerns that he wanted to mention. The participant decided to call this "My gedagtes is vol" (my thoughts are full).

Method: Assets were listed on newsprint. At the request of the participant, his concerns were also listed.

Meeting 2: Collage and Capacity Inventory

(a) Collage

Goal: To reinforce the learner's understanding and to increase his awareness of his assets.

Method: The learner created a collage of "who he is" in order to create a visual representation of his personal assets. Enquiring took place by means of conversational interview, observation and examination of visual data (collage). (Example of collage in Addendum E.)

(b) Capacity Inventory (Kretzman & McKnight)

Goal: To make the learner aware of his gifts, assets and capabilities.

Method: The facilitator went through and discussed the capacity inventory with the learner. The learner indicated 'yes' or 'no' to questions.

Copy of inventory: Appendix D.

Meeting 3: Identification of Community Assets through Asset Mapping

Goal: Identification of community assets and creating an opportunity for the learner to use or mobilise the assets that were identified; to put theory into practice.

Method: The facilitator went into the community beforehand to identify possible community organisations in order to assist the participant in getting started. Organisation 'A' was identified by the facilitator and the learner was requested to go out on his own to inquire about what services they offer and how these services could be accessed.

Asset mobilisation

Meeting 4: Feedback from practice

Goal: To get feedback from learner about action set out in Meeting 3.

Method: The learner decided to use an interview guide to obtain information, and minute the process and action in a journal to give feedback after the holiday.

Description: The learner described process and experience when he went out into (made contact, interacted with) the community for the first time to find out about what Organisation A offers. He recorded his questions, thoughts and challenges in detail, using his journal. The feedback was recorded on tape and the facilitator asked questions to clarify or understand certain things. The learner offered to do a presentation for the youth to inform them about people with disabilities.

While the learner engaged and interacted with people in the community, he identified and became aware of another organisation (B) that focuses on the treatment and the effects of HIV and AIDS in the community. He attended a meeting held by Organisation B and indicated that he would like to become more actively involved with them.

Please note that the facilitator only identified Organization A and that nothing was "set up" for the learner. The learner had to plan, set up, take action and follow up on his own. The facilitator adopted the approach that the learner would ask for assistance if needed.

Meeting 5

Goal: The learner indicated that we should address the concerns that he expressed in Session 1 (viz. what would happen to him and his siblings when mother dies? Issues regarding funeral, house, contact with extended family).

Method: The learner and facilitator created a plan of action to address his concerns.

As the research developed, the learner realised that, in order to address certain issues, he needed to involve his mother. This led to the interview with his mother that took place in Meeting 6.

Meeting 6: Discussion with mother

Goal: To find answers to concerns expressed by the learner in Meetings 1 and 5.

Method: The learner prepared a list of specific questions that he wanted to ask. The facilitator introduced and set the background to the meeting; the

participant then posed his questions directly and discussed his concerns with his mother.

Meeting 7: Meeting with Organisation B

Goal: To mobilise a support network for the learner's mother whilst the learner is at the school hostel in residence.

Method: Learner and facilitator met with Organisation B and requested their assistance.

Meeting 8: Mobilising and sharing community assets

Goal: To organise that Organization B could address other learners at the school regarding HIV and AIDS.

Method: The learner arranged with Organisation B to come to the school to conduct an HIV and AIDS awareness campaign. The learner welcomed and introduced members of the organisation to the audience. The learner recruited peers to become involved in the organisation.

Result mapping

Meeting 9: Reflection and conclusion

Goal: To revisit what learner and facilitator had discussed and implemented in previous meetings. Even though this process continues, the facilitator decided to conclude for the purpose of this study.

Method: The learner and facilitator reviewed the journey or process. The learner identified the changes that occurred within him and the assets that he identified and mobilised throughout our journey.

At the beginning of the action research cycle in meeting 1, the participant in this study reported feelings of powerlessness, hopelessness and of not knowing what to do to address the stressors that result from his mother's illness. He reported that he copes by 1) not sharing his story with others 2) surrounding himself with other people 3) dividing himself into two viz. a learner when he is at school and household head when he is at home. He also said that the family members never talk about his mother's illness. The

participant was also adamant that none of his other family members should be involved in the research.

During the action research cycle, in meeting 5, the participant indicated that he was ready to approach his mom about the issues that he had raised in meeting 1. In meeting 6 the learner and facilitator met with his mother to get her opinion and input about the questions that the learner had re the house, the children and the funeral.

In the final stage of the action research cycle, in meeting 8 and 9, the learner's focus of attention shifted away from himself towards others e.g. the community, his peers.

I refer the reader to addendum G for a narrative description of the intervention.

3.11 DATA COLLECTION

Patton (1987:75) describes participant observation as an omnibus field strategy that simultaneously combines document analysis, interviewing of participants, direct participation and observation and introspection. The purpose is to develop an insider's view of what is happening; to not only see what is happening but also to feel what it is like to be part of the group.

The following procedures for gathering data were used:

- Semi-structured individual interviews with learner, parent and other stakeholders, e.g. NGOs. All interviews were recorded and transcribed. (See addendum F)
- Facilitator's journal in which my own observations, experience of and reflections on the research journey were recorded.
- Participant's journal to record his thoughts, experiences and reflections.
- Capacity Inventory and inventory proposed by Kretzman and McKnight (1993) to map individual and community assets. See addendum D.
- Collaborative meetings with learner and community members to mobilise support and build relationships.

3.12 DATA ANALYSIS

A manual tape recorder was used to record all meetings involving the facilitator and other parties. These interviews were conducted in Afrikaans, the participant's mother tongue, a language in which the facilitator is fluent. In qualitative research, data analysis is simultaneous with data collection, namely through analysing data with the first interview, the first observation, the first document accessed in the study. This allows the researcher to make adjustments along the way, even to the point of redirecting data collection and to "test" emerging concepts, themes, and categories against the subsequent data (Merriam, 2002). The overlapping of data collection and analysis improves both the quality of the data collected and the quality of the analysis, as long as the researcher is careful not to allow initial interpretations to bias additional data collection (Patton, 1987:144).

In this study, each meeting was recorded and the tape-recorded data was transcribed verbatim after each session. The transcriptions were read repeatedly, to get a holistic understanding, and reflected upon. This was used as the basis for planning the next session with the participant. Open coding, whereby units of meaning (any meaningful word, phrase, narrative, etc) were identified and compared with other units of meaning, whilst looking for common themes across the data, was used. The themes that emerged were given codes (names) and were refined and adjusted as the analysis proceeded (Merriam, 2002). (Example in Addendum F)

The data was sorted according to the themes that emerged. Data from the interviews, observations, the collage, the participant's journal and the facilitator's journal were continuously compared for consistency or differences. Once the themes were constructed, the facilitator consulted with the participant to verify the themes. The findings will be presented in the following chapter.

3.13 ETHICAL GUIDELINES

Permission to proceed with the research was obtained from the Western Cape Education Department (refer to Appendix A).

Informed consent was gained from the learner as well as the parent to participate in the research. Careful consideration was taken to protect the anonymity of the learner, the family and the institution.

The relationship between the researcher and the learner was characterised by continuous collaboration, discussion and checks to ensure that ethical guidelines were followed.

3.14 LIMITATIONS

The study was limited to one case. Criticism from outside focuses on the fact that many of these cases lack the kind of detail that would enable a reader to comprehend fully and learn about the approach taken (Denzin & Lincoln, 1994). The use of an action-research design may affect generalisation and lead to the possibility of strong causal and structural explanations (Mouton, 2001; Viljoen, 2005). This study, however, aimed at an in-depth understanding of a learner affected by disability and HIV and AIDS and of how the asset-based approach can bring change and empowerment to challenge the consequences and legacy of the medical model. Mouton (2001:151) states that the main sources of error in participatory action research is that researchers can become overly emotional or subjective through their involvement and that participants in the research process can manipulate the research to serve their own interests. I was aware of my emotional involvement in the study and therefore I had regular meetings with my university supervisor and consulted with a colleague in the field of educational psychology to try to counteract the above-mentioned concerns. Some readers may consider the use of disability as an umbrella term to be a limitation; I noticed that the participant referred and introduced himself as a person with disability and not as a person with cerebral palsy.

3.15 VALIDITY AND RELIABILITY

Qualitative research uses different terms from quantitative research to describe the criteria in judging the quality of a study. Mertens (2005) parallels credibility with internal validity, transferability with external validity, dependability with reliability and reliability and conformability with objectivity.

"In qualitative research, the credibility test asks if there is a correspondence between the way the respondents actually perceive social constructs and the way the researcher portrays their viewpoints" (Mertens, 2005:254).

The importance of research being trustworthy for professionals in the applied field is referred to by Merriam (1998) as the extent to which reliability and validity are accounted for. The importance of conducting research in an ethical manner is part of ensuring validity and reliability (Collair, 2001).

I employed the following strategies and procedures in order to meet the criteria of credibility.

- **Member checks**

Member checks are referred to as "the most important criterion in establishing credibility" (Mertens, 2005:255). I discussed the data that were collected with the participant (the learner) after every meeting to make sure that I understood and presented his viewpoint correctly. The data obtained was also used in our planning for the next step. Member checks were done throughout the course of the journey; this didn't only enhance credibility but also strengthened the relationship between the researcher and the participant.

- **Triangulation**

"Triangulation is the process of corroborating evidence from different individuals, types of data (e.g. observational field notes and interviews), or methods of data collection (e.g. documents and interviews) in descriptions and themes in qualitative research" (Cresswell, 2005:600).

I used a collection of different data collection methods and sources in triangulation. The researcher used semi-structured interviews and meetings with the learner, parent and community members; the facilitations journal where observations, field notes and reflections were recorded; the participant's journal and the capacity inventory proposed by Kretzman and McKnight (1993) as well as the use of a collage.

- **Peer review**

This was done by a colleague in the field of educational psychology. The topic was new to the colleague, who was asked to scan some of the raw data and assess whether the findings were plausible based on the data.

Reliability refers to the extent to which research findings can be replicated. The more important question for qualitative researchers is whether the results are consistent with the data that recollected (Merriam, 2002). In this study, the researcher recorded reflections, observations, questions and decisions in collected data in a journal. A detailed description and an account of how the research developed are also included in Section 3.9.

3.16 GENERALISABILITY OR EXTERNAL VALIDITY

I attempted to provide the reader with a rich, dense description of the study within the ambit of anonymity. This facilitates the ability to determine how closely situations match and whether findings can be transferred.

3.17 CONCLUSION AND REFLECTION

This chapter presented the plan or the blueprint for the study in order to guide the reader through the process but also to provide a framework for the researcher. I constantly reminded myself to be true to the research methodology and to consult and collaborate with the participant, but at the same time remain flexible and open to the unexpected. The next chapter presents the findings and discusses the themes that emerged in the study.

CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

In this chapter I present and discuss the results of this study, as derived from the narratives that emerged during data analysis. The results are presented in the narrative, with direct quotes in Afrikaans and translations into English by the researcher, and this is followed by a discussion. Recommendations for further research and training will be made in conclusion.

4.2 STAGES OF THE ASSET-BASED APPROACH

I decided to present the findings with the use of the stages of the asset-based approach as introduced by Ebersöhn and Eloff (2006:40), *viz.* becoming aware and learning to focus on assets and capacities; identifying assets and compiling an asset map; mapping access to assets, relationships and power relations; mobilising assets by using the information from the asset map to build partnerships in the immediate system; using information to build partnerships outside the immediate system; sustaining the mobilisation and revisiting, revising, reflecting and reconsidering continuously. These stages are not separate but interlinked, interdependent and interwoven. I decided to combine some of these stages to adapt to the context and process of the study.

4.2.1 Asset mapping

The first two stages, *viz.* gaining awareness and learning to focus on assets, were achieved by using the analogy of the "half-full", "half-empty" glass. This was followed by the identification of assets and the compilation of an asset map, which will be described next.

After the asset-based approach was explained to the participant, he identified the following assets: pride, trustworthiness, sensitivity, friendliness, good

communication skills, leader, positive attitude, perseverance, active in sport, innovative, ability to plan and solve problems, team player and good organisational skills. Added to this list were assets that were identified with the use of the capacity inventory as proposed by Kretzman and McKnight (1993), for instance repairs at home, caring for others (e.g. the sick and people with disabilities), administrative skills and organising events. In addition to the listing of assets, and the capacity inventory, the participant made a collage (Addendum E). These activities did not only create awareness of assets, but it was visually reinforced by the making of the collage. The process of asset-mapping was an interactive process between the participant and the facilitator. The assets listed were mainly intrinsic strengths, assets and resources that are emphasised by Positive Psychology (Ebersöhn & Eloff, 2006). The reader will notice that, in meetings 1, 5, 6 and in the collage, the asset-mapping was fringed or "shadowed" by the problems expressed by the participant. The facilitator and participant decided that the challenges expressed by the participant would be addressed by focusing on the identified assets.

Despite the identification of the above assets, gifts and strengths, the participant indicated that he had specific problems that he wanted to share and address. These problems were presented in meetings 1, 5, 6, the collage and the participant journal through the following: "I worry about my younger siblings. Who will take care of them if mom is sick? Is there enough food and electricity for them? What happens if mom dies? The funeral arrangements? The house? Will we be split up? What about my future?" We decided that we would mobilise his assets to address his concerns.

I found that this process of sharing the participant's concerns and his being heard was an important part of the "freeing process" or emancipation. The participant, accustomed to hearing about his problems and things that he could not do (a legacy of the medical model), was asked to use a different lens or approach. This could have been a daunting task, but Camelot was willing to explore this.

4.2.2 Mobilising of assets

The relationship between the participant and the facilitator (as mentioned in Chapter 3) was that of partnership, collaboration and consultation. The participant indicated his readiness to mobilise and identify assets in the community. This section describes how the participant mobilised his individual assets to identify other assets in his community.

The participant was tasked with investigating the services and resources offered to the community. He reported that he **prepared** and **planned** for his appointment beforehand, by dressing neatly and **preparing questions** that he wanted to ask.

At the meeting, the participant was challenged by members of the organisation with questions and remarks such as "Why do you ask all these questions? You're not disabled! This organisation does not do anything for the disabled; the people out there make fun of them. We also don't have ramps for wheelchairs ...". Camelot **persevered** by continuing to ask the questions that he had prepared. "I am here to ask something." His **perseverance** showed again when he arrived at the youth meeting and the doors were closed. "I went back a second time." Camelot proudly told the youth members, "We (people with disabilities) are very talented; we organise our own sports, concerts, and like to learn about new things." Based on his meeting with Organisation A, Camelot realised that there was a lack of understanding and a gap in knowledge about people with disabilities and offered to present a workshop on the topic of disability to the youth in the following week. Camelot **prepared** for this workshop on his own, using **friendliness, communication** skills, a **positive attitude** and **innovation**. "I divided the youth in groups to role play different persons with disabilities e.g. blind, deaf and physical". He went on to say "I wanted them to feel what it was like ..."

4.2.3 Identification and mobilisation of new assets

Subsequent to his experience at Organisation A, he used his own initiative and identified another asset in the community, *viz.* Organisation B. Organisation B focuses on the treatment and the creation of awareness of people infected and affected by HIV and AIDS. He decided that he would like

to become an active **member** of this organisation. Camelot's involvement with Organisation B extended beyond the community to the school. He **planned** and **organised** for Organisation B to come to the school and do a presentation in order to raise awareness about HIV and AIDS. He encouraged and **recruited** his peers to join the organisation. This initiative led to Camelot's involvement in other community projects that were initiated by the school. **New assets included: Own initiative, advocate for disability, recruitment and further involvement in community projects.**

4.3 FINDINGS

The following changes will be discussed in this section, viz. identification and mobilising of new, additional assets, presence of positive emotions, increased ownership and incidences of school and community engagement. Result mapping is a way of accounting for changes that includes anecdotal accounts that support data and/or visual artefacts that demonstrate different levels of change (Ebersöhn & Eloff, 2006).

4.3.1 Identification of new assets

Mobilisation of existing assets leads to identification and mobilisation of new assets. The participant used his own initiative in identifying an organisation in the community that focuses on treatment and raising awareness of HIV and AIDS.

Na 'n tyd het ek gewonder as ek nogge taak sal baasraak en dis waar ek die organisasie ontmoet het.

"After a while, I wondered if I would succeed in another task and that is when I found Organisation B".

(Participant Journal)

He uses this initiative and offered to present a workshop to youth regarding disability.

Hulle dink net mense in rystoele is gestremd.

"They (the youth) thought only people in wheelchairs have disabilities ..."

Ons gestremdes is baie talentvol sê ek vir hom. Ek sê by my skool reël ons self onse konserte, onse sport, ons leer nuwe dinge en ons hou van uitdagings sê ek vir hom.

"I told him, we are very talented, we organise our own sports, concerts and like to learn new things"

He became an advocate for disability by telling and educating others.

Ek sê toe, grade 11, we do the same work. We do everything the same. We do maths the same, bio the same, natural science the same, everything the same. No difference, no.

"I told them about grade 11, we do the same subjects ..." (Meeting 4).

The participant decided to share his knowledge about Organisation B with his peers at school. He took on the **leadership** role of preparing, organising and hosting members of Organisation B to talk to his peers about HIV and AIDS.

Ek het met J ... die koördinator gepraat, hulle wil na onse skool toe kom.

"I spoke to J ... the coordinator; they want to visit our school."

Ek sal hulle verwelkom en introduce.

"I will welcome and introduce the members." (Meeting 8)

Camelot took his leadership role a step further by recruiting more of his peers to join Organisation B. This led to further involvement of the participant in other school projects of which he had not been a member.

Soms is my droom te groot om te beskryf maar dit is om aan die wêreld terug te gee.

"Sometimes my dream is too big to describe or explain, but it is, to give back to the world." (Participant's Journal)

Camelot was approached by other educators to become involved in school outreach programmes. The mobilisation and awareness of existing and new assets led to the following finding.

4.3.2 Presence of positive emotions

Presence of positive emotions were reported and observed by the participant, myself and others. These emotions, namely excitement, fun, enjoyment, pride and enthusiasm, were evident in the participant.

Ek is excited. Ek kannie wag om te vertel nie.

The participant reported: "I am excited. I can't wait to tell you what happened ..." (Meeting 4).

Hulle het gelag en hulself enjoy. Dit was lekker gewees, baie lekker gewees.

"They laughed and enjoyed themselves ... it was nice, very nice..." (Camelot about the workshop he presented).

Ek is vuurwarm.

"I am filled with enthusiasm."

"I observed that Camelot had a twinkle in his eye." (Facilitator's Journal).

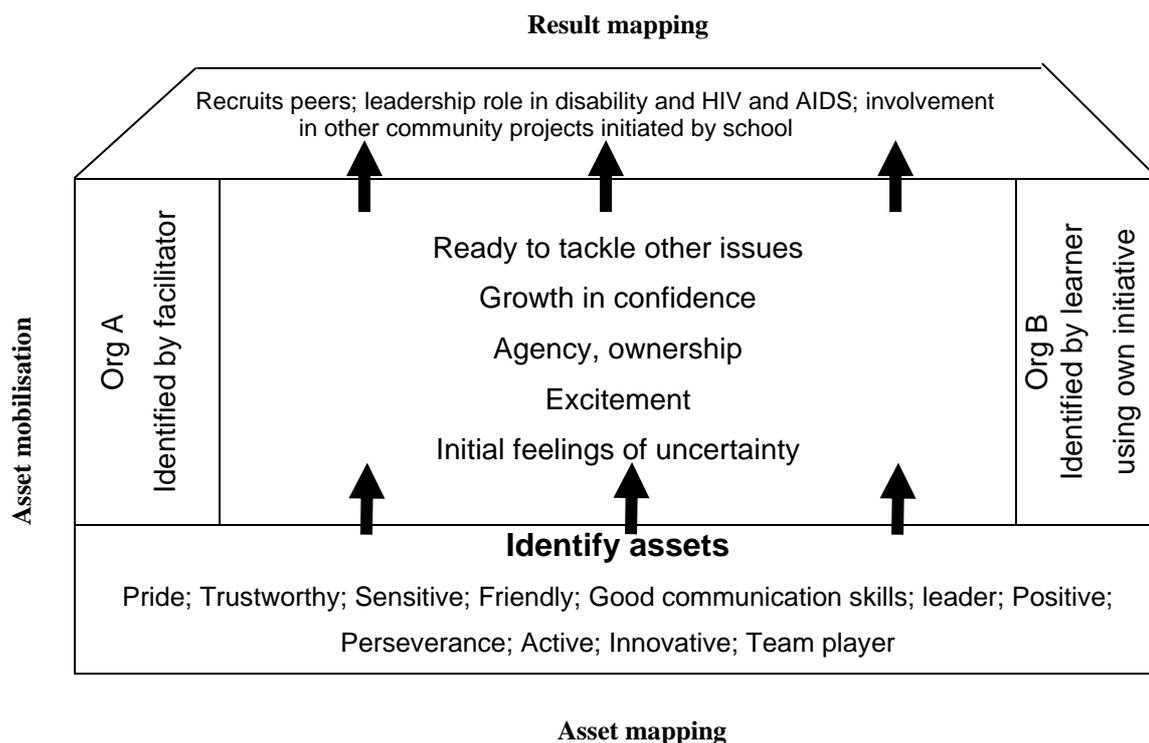
Remarks and observations by others:

"What happened to Camelot, he's so confident! (Bus driver).

"I want the boy to take part in one of my projects. He has changed so much ..." (Science teacher).

These positive emotions motivated the participant to greater control and ownership.

Camelot's transformation can be illustrated through the diagram below



4.3.3 Agency and ownership

As mentioned in Chapter 3, the participant initially refused to involve his family. The resurfacing of the problems that he presented in meetings 1, 4 and 6 encouraged him to ask his mom directly about the future, her wishes regarding funeral arrangements, the house and what would happen to him and his siblings. Camelot seemed to have experienced sufficient growth to give him the **confidence** to address some of his unpleasant and daunting thoughts and concerns.

The participant exhibited increased ownership and agency in "taking charge" in terms of the realities of poverty, disability and HIV and AIDS. He decided that:

Ek will gesels oor die dinge wat my worry.

"I want to speak about things that bother me." (Meeting 4)

Ons moet met my ma praat oor wat sy eendag wil hê.

"We have to speak to my mom about what she wants eventually ..."

Ons moet haar gaan sien en dinge uitpraat.

"We have to go and visit her to talk things through."

I observed urgency in Camelot to find answers to his questions (Facilitator's Journal).

There was a noticeable change from "being the victim" to directing independence and empowerment and taking the lead in his life. The following table presents the process of taking ownership on which he embarked.

| Questions | Assets | Answers |
|---|---|---|
| What about me and the children? Will we be split? | Sensitivity, communication skills, planning, caring for others, trustworthy | I would like you to stay together |
| What will happen to our house? | Taking responsibility, planning, problem solving | I do not want you to sell the house. The house is on your name. |
| What about the funeral? | Sensitive but persevere, communication, plan for the future | It is taken care of. I have a funeral policy |

4.3.4 Incidences of school and community engagement

Incidents of community engagement were evident in the participant's decision to become a member of Organisation B. He became involved in a training workshop, distributing pamphlets and raising awareness about HIV and AIDS over weekends.

Ons loop van huis tot huis en vertel die mense van Vigs.

"We walked from door to door and told people about HIV." (Meeting 7).

Camelot is 'n belangrike member van ons.

"Camelot is a valuable member of our team." (Organisation Coordinator).

The participant expanded his participation and involvement within his community to other systems, namely the school and his peers. He decided to share his knowledge and experience with other learners with disabilities and encouraged them to become involved within their respective communities.

"This thing (HIV and AIDS) will affect all of us, our brothers, sisters, families, communities, our country, our world ..." (Participant addressing peers at

school) and he continued, "There's so much to do in our land. Somebody must start ..." *Want daar is baie om te doen in ons land, iemand moet begin* (Participant Journal).

4.4 DISCUSSION OF FINDINGS

The identification and mobilisation of new assets were preceded by learning to focus and gain awareness of assets. In this study, as mentioned previously, this stage was attempted through various activities *viz.* the introduction of the "half-full, half empty" glass analogy, the capacity inventory and the making of the collage. This, in my opinion, was an important step in setting the stage and preparing the participant for the next phase. This process of laying the groundwork was particularly important in lieu of the participant's history of being marginalised and labelled by the previous political system of apartheid, which resulted in segregation, exclusion and the stigmatisation of people with disabilities. Mbeki (1997), Tire (2003), Loebenstein (2005) and Strydom (2005) agree that the medical model located disability within an individual as a problem and encouraged the belief of dependency and the need to be looked after. I agree with Kretzman and McKnight (1993) that, given the history and background of disability and HIV and AIDS, it is an important step, when working with previously marginalised groups, to create awareness of assets within every individual.

Despite the background of being marginalised, the participant exhibited perseverance, commitment and initiative in identifying and mobilising assets in the community previously unknown to him. He used his existing assets to ignite or mobilise new assets that he may not have been aware of. This strengthening and developing of awareness of existing and new assets motivated the participant to challenge perceptions and stigmas within Organisation A regarding disability. He was not intimidated by the person in "authority" when questioned about being a person with disability, but used his assets to impart, educate and share knowledge about people with disability. In this study, this transformation from disempowerment to empowerment to become a voice for people with disability embraces the beliefs of the social model. This transformation, in my opinion, results in a shift from being a

"victim" of the medical model to being an advocate of disability. The social model promotes advocacy and the ability of people with disabilities to have agency in their world (Tire, 2003; Loebenstein, (2005). Camelot, through his voice and advocacy, addresses the "power" that was given to able-bodied persons and professionals to think, care and decide for people with disabilities in the past. This shift of power from the professional to persons with disabilities and their representative organisations is recommended and encouraged by the social model (Mbeki, 1997; Frieg & Hardy, 2001; Loebenstein, 2005). I support Curtin and Clarke (2005), who encourage people to listen to the voices of young people with disabilities.

The assets identified by the participant *viz.* aspects like trustworthiness and a positive attitude were discovered through using an "asset map", a capacity inventory and a collage presenting these assets. By using different approaches to highlight assets, I as the researcher wanted to ensure that the participant focused on and gained awareness of his assets. This was an important start for Camelot in that that he recognised his capabilities, gifts and skills, particularly due to the basic truth that persons who find themselves marginalised or labelled as "disabled", "handicapped" or "too young" should be made aware of every individual's giftedness (Kretzman & McKnight, 1993).

The participant, despite having been introduced to the asset-based approach and identifying his individual assets, insisted that he was faced with particular problems as a learner with disability and affected by HIV and AIDS. He listed the problems alongside a list of his assets. The participant was referred to a special school via the medical model during the apartheid years when people with disabilities were discriminated against and isolated. Kretzman and McKnight (1993) remind us that the asset-based approach does not deny the existence of needs, but the main effort of participants in an asset-based intervention are devoted to identifying assets, accessing assets and mobilising such assets for sustainable support. While identification of problems is an integral part of this model, it takes the "half-full" rather than "half-empty" approach (Ammerman & Parks, 1998).

The information obtained in an asset assessment is not useful unless it enables the individuals, organisations and leaders to mobilise capacities

(Kretzman & McKnight, 1993; Ammerman & Parks, 1998; Ebersöhn & Eloff, 2003). The participant mobilised his assets in going out into his community (unknown to him) to investigate an organisation. The initial list of assets that were identified and used led to the identification and mobilisation of more assets. In this study, the practical application of using assets led to the strengthening and enhancement of existing assets. The use of assets motivated the learner to use and identify other new assets, *viz.* initiative, advocacy for disability, recruitment of peers and further school and community involvement. He used his own initiative to identify other assets and Organisation B in the asset mobilisation process.

When Camelot visited Organisation A, he demonstrated great **perseverance**, **courage** and **initiative** in deciding to address the lack of knowledge about people with disability and volunteering to educate the youth of Organisation A. He demonstrated that he was **confident** and **capable** of acting as an advocate for disability. The success of this exercise motivated him even further and caused him to grow in confidence. He moved from the label of dependency, encouraged by the previous political system (Mbeki, 1997; Tire, 2003) to being empowered, enabled and able to interact on an equal level with other people in society. This study shows that, when given the opportunity to use and mobilise assets, the participant is not just capable and competent to interact on an equal level with others, but also to share knowledge and educate them. Growth in confidence and achievement encouraged the participant to share knowledge about different organisations with his peers. This was evident in his actions when he organised the awareness campaign concerning HIV and AIDS for the school. I observed a distinct movement from the participant's initial focus on "my problems" to an out reach and service to others. The previously disempowered, disabled and dependent became empowered, enabled and independent.

The presence of positive emotions observed and reported in this study motivated and encouraged the participant to further success and achievements. The feelings of fun, excitement, confidence, pride and enjoyment replaced previous reports (from the learner) of hopelessness, dependency and helplessness. Reports of increased positive emotions have

also been recorded in previous research (Viljoen, 2005; Ferreira, 2005; Loots, 2005 in Ebersöhn & Eloff, 2006). These studies, against the backdrop of reports on vulnerable children and HIV and AIDS), report an increase in positive psychology constructs such as pride, confidence, self-worth, hope, optimism and enthusiasm. I agree with Viljoen (2005) that resilience also has to be mentioned when talking about the asset-based approach, because the basic premise of building, developing and strengthening resilience (Hunter, 2003; Pharoah, 2004) states that children can display extreme resilience when their lives are changed through illness or the loss of a parent. In this study it was too early to report on whether this process has built resilience, but time will tell.

The presence of positive emotions in this study transpired into increased agency and ownership. As mentioned earlier, the participant had specific questions or problems that he wanted to address through focusing on assets. Camelot took ownership and decided to confront these issues. His questions and concerns in planning for the future of his siblings and himself correlates with studies (Richter, 2004; Viljoen, 2005; Karim & Karim, 2005) regarding the importance of psychosocial support for children affected by HIV and AIDS. The participant took ownership of his life and future by directly addressing the problems through the utilisation of his assets. In the study, this showed increased agency developing from "waiting for other people to think and decide for me", dependency on others, to independence. Briedennhann (2003); Ferreira (2005) and Loots (2005) in Ebersöhn and Eloff (2006) have also reported increased involvement and ownership and agency by individuals and communities in their studies. This increase in agency and ownership is significant in this study, given that the participant was accustomed to having decisions made on his behalf by other people.

The increase in agency and ownership led to the participant's engagement in school and community activities. Camelot, who did not know his community before the research process began due to his being a hostel resident at the special school, decided to share his newfound knowledge and assets with his peers at school and the community. He became a member of Organisation B and took part in community outreach projects at the school. Camelot's

involvement in the community and school was a catalyst for other learners and communities to become more involved in addressing community issues. He built a bridge between different systems (peers, school and community) that did not exist previously. The participant in this study became an asset in building, creating and strengthening other people, resources and systems.

This change or transformation did not only manifest a change in behaviour but also in attitude and in the language used by the participant. What he had previously reported through "I feel unsafe, a little scared about what I must do, I feel strange when they look at me" was replaced by "I'm so excited, I am fired up. They laughed and participated. It was nice, very nice...". The transformation in Camelot was observed by myself and spoken of by other people, i.e. the driver of the school bus and science teacher who were not aware of or involved in the research process. The bus driver commented "The boy is so confident!" and the science teacher said "I want him to take part in one of my projects. The boy has changed so much!" I observed that the participant was bursting with excitement, talked non-stop about his experience in the community and had a twinkle in his eye. I found in this study that awareness of assets and application thereof in practice resulted in feelings of confidence, empowerment and competence. These feelings of empowerment encouraged the participant to tackle and confront other challenges in his life that he had avoided in the past.

In my study I noticed that, as asset awareness developed, the participant became aware of more assets and of abilities that he never thought he had. He developed a certain confidence in himself and this, in turn, brought about the awareness and mobilisation of other assets that may otherwise have remained dormant or underutilised. Camelot's focus shifted from an inward focus expressed in "I have things that fill my thoughts" to an outward one of "I believe that others can benefit from my stories. There is a lot that needs to be done in our country, somebody must make a start". Camelot further expressed his aspirations in his journal as follows, "Sometimes my dream is too big to describe, but it is to give back to the world". The awareness and mobilisation of assets increased the participant's feelings of empowerment and control over his own life. The initial feelings of powerlessness and

helplessness in the context of disability and HIV and AIDS changed to increased feelings of agency, empowerment and competence.

4.5 CONCLUSION

This study shows that knowledge, skills and asset awareness empowers a learner with disability who is affected by HIV and AIDS. The practical application and implementation of raising asset awareness by applying the asset-based approach was beneficial to the learner and yielded positive outcomes of empowerment, confidence and independence. There is no doubt in my mind that the use or consumption of assets that were identified and subsequently mobilised in the earlier phases of the study fuelled the process and led to the identification and mobilisation of further assets. This is supported by Camelot's initial reluctance to discuss issues relating to his mother's illness. He could easily have become a "victim" of labels attached by the medical model and yet this study has brought out latent assets and abilities that may have remained dormant. In a society that is easily deceived by labels and physical appearance, he has shown resilience and a desire to take charge of his own destination and aspires to share his story and gifts with others.

It seems, from the above-mentioned findings, that the learner in the study is confronted by challenges that are very similar to those reported in other research (Save the Children, 2001; Giese et al., 2003; Richter et al., 2004; Karim & Karim, 2005). The process of becoming aware of his assets (asset-awareness) brought with it initial feelings of uncertainty that changed into feelings of confidence, excitement and the desire to challenge issues that were avoided in the past. The mobilisation and utilisation of assets is crucial to building capacity and strengthening of existing assets and to ignite dormant or new assets. When I use the term "**asset awareness**" I refer to the activities of asset mapping combined with the process of mobilising assets in practice. The aim is to bring theory and practice together to strengthen existing assets and identify or bring to the surface new, latent gifts and talents. I propose the use of this term with learners in the school context as a more user-friendly term. I propose that the asset-based approach and "**asset awareness**" be

incorporated in the life-orientation curriculum to shift the focus from needs to assets within our schools and other places of learning. I believe that the asset-based approach is one way by which to address the influence and impact of the medical model that is still evident in our homes, schools, communities and society.

4.6 RECOMMENDATIONS FOR FURTHER RESEARCH AND TRAINING

Following from this research project, I want to make various recommendations with a view to further research and training.

4.6.1 Recommendations for further research

1. Duplication of this study with larger groups of participants and using similar aims in order to compare the findings of this study.
2. Qualitative research studies with persons with different (dis)abilities and affected by HIV and AIDS.
3. Studies involving the whole family, including siblings, to give voice to their narratives about being infected or affected.
4. Doing research with persons with a disability and HIV and AIDS.
5. Investigating the influence of culture within a community in child-headed households.

4.6.2 Recommendations for training

1. The asset-based approach to be taught to learners at school as part of the Life-Orientation curriculum.
2. The asset-based approach to be presented to undergraduate students.
3. Workshops to be presented to principals, educators, therapists and support staff in schools.
4. Parents to be involved in the raising of asset awareness in order to reinforce this approach with their children.
5. Implementation of asset identification and mobilisation as part of whole school development.

4.7 REFLECTIONS

On finally coming to the end of this exhausting and sometimes stressful research journey, I feel a sense of sadness cloaked in excitement; sadness because I have reached the end of the study, but excitement because of the results. Raising asset awareness and the mobilisation of the assets in an individual is a rewarding experience in its own right. I have to remind myself that this is not about me, but rather about sharing Camelot and his family's story. At the same time I must admit that I have gained a tremendous amount in my personal capacity. I have grown as a person. Visiting Camelot's mother at their home was a humbling experience. His circumstances served to greatly amplify in my mind his assets and what he had achieved up to that point in the study. Camelot amazed me with his excitement and passion. He kept me on my toes with gems of wisdom that were advanced for his age. He is living testimony to what Ebersöhn and Eloff (2003; 2006) have to say about "the unanticipated outcomes; be prepared to be surprised". I felt honoured to have shared this research journey with him. In some ways I feel like a mother about to show off her newborn baby for the first time, proud and hopeful that the study will provide greater momentum to the adoption of the asset-based approach. In Camelot's own words, "I want to share with the world, maybe others can learn from my story".

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ADDENDUM A
Letter from WCED

ADDENDUM B
Letter of Consent - Learner

ADDENDUM C
Letter of Consent - Parent

ADDENDUM D
Capacity Inventory
(Kretzman & McKnight, 1993)

ADDENDUM E
Participant's Collage

ADDENDUM F
Example of Data Analysis

ADDENDUM G

Narrative description of intervention

ADDENDUM H
Information about Cerebral Palsy
(Western Cape Cerebral Palsy Association
Prospectus)

ADDENDUM I

Examples of visual data

ADDENDUM J
Participant update