

**AN EVALUATION OF A GROUP THERAPY
PROGRAMME FOR VULNERABLE CHILDREN**

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Submitted in partial fulfilment of the requirements for the degree of:

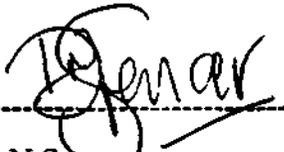
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DECLARATION

I declare that unless specifically indicated to the contrary that this research dissertation is my own work. It is being submitted for the degree of Master of Arts (Clinical Psychology) at the University of Natal, Pietermaritzburg. It has not been submitted for any other degree or examination at any other university.



D.N Spencer

7th day of June 2004

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ABSTRACT

HIV/AIDS is the biggest challenge facing humankind today and can no longer be compared to other health disasters. One of the greatest challenges it presents is that of nurturing healthy children to become competent, adaptive adults despite the numerous negative effects of the pandemic. Of concern is the lack of interventions that address the psychosocial needs of children affected by HIV/AIDS, poverty and violence. The present research study aims to evaluate a group therapy programme that has been developed to address this lack.

The therapy programme used in this study is embedded in Bronfenbrenner's (1979) ecological model, which focuses on the interaction between person and environment. The model proposes that this interaction is two directional and reciprocal. It also draws on the literature concerning risk and resilience in children, which aims to understand personal, familial and social factors that create and sustain resilience in children. Thus, the programme aims to intervene on many levels and to give the children the opportunity to deal with and gain mastery over their past experiences and feelings. In addition, it aims to develop resilience, self-esteem and internal coping resources and enables them to access external support systems in the future.

In order to evaluate the programme, a sample of 43 vulnerable children was drawn from a peri-urban community in Pietermaritzburg, KwaZulu-Natal. The sample was randomly divided into a control group and two experimental groups, that later merged into one experimental group. Pre-test data was collected from all the participants in the form of a questionnaire consisting of 4 quantitative tools: the Trauma Symptom Checklist for Children (TSCC), the Culture Free Self Esteem Inventory (CFSEI), the Reynolds Child Depression Scale (RCDS) and a Social Support Scale (SSS).

The group therapy programme, consisting of 15 sessions was then run with the experimental group. The control group engaged in 15 sessions involving games, singing,

drawing and other activities. Post-test data using the same questionnaire was collected from all the participants.

The data was analysed quantitatively. No statistically significant differences were noted between any of the overall pre- and post-test data, except that of the TSCC. The graphical representations of the results showed a reduction in trauma symptoms and depression, and a raise in self-esteem, however the p-values were not significant. This is thought to be the result of the small sample size. The result also indicated that the CFSEI cannot be considered a reliable tool in this study.

This study emphasises the need for further research in the field of vulnerable children in South Africa and the development, implementation and evaluation of interventions for this subgroup.

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Rationale for the study

Children affected by HIV/AIDS, poverty and violence are faced with an enormous and unique set of challenges, and the need for effective child based programmes for these vulnerable children is evident and urgent. “We are aware of the significance of the psychosocial problem” says Dr Isaye Ndombi, UNICEF Chief of Health Division in Dar Es Salaam, “ but we have no material or method as yet” (cited in Madörin, 2002). Furthermore, the number of vulnerable children in South Africa is increasing and there is a necessity for an effective intervention that addresses the immediate and future psychological, social and community oriented problems caused by AIDS, poverty and violence in South Africa. As Foster and Williamson (2000) point out, little attention has been paid to the psychological needs of children affected by HIV/AIDS. These authors call for a greater understanding of the impact of HIV/AIDS on children, in order to assist them effectively.

Since July 1997, Madörin (2002) has been investigating how psychosocial support can be developed for AIDS orphans in Tanzania and other parts of Africa. He has developed a multi-faceted programme, based within the ecological framework, which considers the individual as existing in a multi-systemic environment (Bronfenbrenner, 1979). The programme has been declared the UNAIDS best practice model for vulnerable children (Madörin, 2002). The first part of the 15-session programme aims to investigate the children’s past experiences and the emotions such as anger and grief that are connected to these experiences. The second part of the programme addresses the future, and aims to develop and instil resilience in the children. The programme, which has been successfully implemented in Tanzania, is intended to be holistic and includes community based workers from the children’s community. Thus it addresses the child’s psychosocial needs within the child’s context.

Recognising the immense need for a similar programme in South Africa, Madörin's group psychotherapy programme has been adapted to the South African context (Killian, 2002). This research project undertakes to evaluate the effectiveness of the adapted programme and assess whether it meets the needs of vulnerable children in South Africa. The empirical evaluation of the programme is important in terms of programme development and future implementation of the programme countrywide.

Introduction

This chapter focuses on the HIV/AIDS pandemic, its prevalence and manifestation around the world, especially in Africa, as well as exploring the effect and affects of HIV/AIDS on children, with reference to parental illness, disclosure, childhood bereavement and orphanhood.

HIV and AIDS

HIV/AIDS is an illness like no other and its effects are felt all over the world (Whiteside & Sunter, 2000). The acronym AIDS, stands for Acquired Immune Deficiency Syndrome, and it is caused by a virus, the Human Immunodeficiency Virus or HIV (van Dyk, 1999). HIV, like all viruses, can only reproduce itself inside another living cell. What makes the HI virus unique is that it is a retrovirus, meaning it can transcribe DNA from an RNA template (Whiteside & Sunter, 2000). The virus uses the T-cells of the immune system for this purpose. It enters this specific and vital cell of the immune system to reproduce and destroys the T-cell in the process (Boyle & Olscheid, 2000). As a result, the virus disrupts the entire immune system and a person loses their ability to fight off infections, thus rendering them helpless to opportunistic infection and disease (van Dyk, 1999). Therefore, it's a spectrum of immunodeficiency that occurs and as the patient's T-cells or CD4 count falls, the person is at risk for various infections and certain cancers (Boyle & Olscheid, 2000). When the patient's CD4 count falls roughly below 200, they become defined as having AIDS (Whiteside & Sunter, 2000). Therefore, AIDS is not a specific illness but many conditions (including pneumonia, TB and other infections) that the immune system infected by HIV cannot fight (van Dyk, 1999).

There are many theories as to the origins of HIV. The most widely accepted theory is that HIV crossed over from primates to humans through infected blood entering the wounds of those who killed the primates for food (van Dyk, 1999; Whiteside & Sunter, 2000).

HIV is present in all body fluids, but the concentration is especially high in blood, semen and vaginal fluid (van Dyk, 1999). Hence, HIV is transmitted through blood and body fluids, such as contaminated blood and blood products in transfusions or sharing blood-contaminated needles or syringes (Boyle & Olscheid, 2000; Whiteside & Sunter, 2000). HIV can also be transmitted from infected mother to child during pregnancy, childbirth or breastfeeding (Brown & Lourie, 2000). However, the most common mode of transmission is through sex, where the virus is transmitted from one person to another in vaginal fluid and semen (Boyle & Olscheid, 2000).

More than 60 million people world-wide have been infected with HIV since the virus was discovered. In 2002, 42 million people around the world were living with HIV/AIDS, with an estimated 28.9 million people having died from AIDS since the beginning of the pandemic (USAID, 2003). With almost 14,000 new infections per day, AIDS is the fourth leading cause of death globally and the leading cause of death in sub-Saharan Africa (USAID, 2003).

HIV/AIDS in Africa

Approximately 95% of people living with HIV/AIDS live in developing countries (USAID, 2003). Parts of Asia and Latin America are experiencing severe HIV/AIDS epidemics at a national level with Eastern Europe and Central Asia being the regions with the fastest growing AIDS epidemics (USAID, 2003). However, 70% of HIV positive people in the world live in Africa (Guest, 2001), with sub-Saharan Africa being the most severely affected region (HSRC, 2003). Sub-Saharan Africa has been described as the epicentre of the virus, with 23,3 million people estimated to have HIV or AIDS (Whiteside & Sunter, 2000). For Africa, HIV/AIDS is deadlier than war, tyranny, malaria or any other disease and it is sweeping through the continent tearing apart households and leaving millions dead (Guest, 2001).

South Africa has recently surpassed India as the nation with the greatest number of people living with HIV/AIDS, and it is clear that South Africa is among the worst

affected countries in the world (USAID, 2002). An estimated 13% of South African adults are infected and there are 1,700 new infections every day in South Africa (Guest, 2001). In 2001 a prevalence of 2.34 million women and 1.71 million men living with HIV was recorded (Rehle & Shisana, 2003). This figure is expected to fall slightly until 2010 and then remain stable until 2020 (Rehle & Shisana, 2003). Other models of projections suggest that infection is on the increase, with researchers estimating that AIDS deaths will rise from 120,000 in 2000 to as many as 383,000 in 2005 and 635,000 in 2010 (Women's International Network News, 2001). The differences in prediction centres around difficulties with sampling (Whiteside & Sunter, 2000) as well as differences in the estimation of the impact of prevention programmes (Rehle & Shisana, 2003). However, despite differences in projections, KwaZulu-Natal (KZN) consistently has the highest recorded prevalence of HIV (Whiteside & Sunter, 2000). Figure 1 shows the number of AIDS deaths predicted in KZN in the years to come. The prevalence of AIDS deaths is expected to rise until 2008, when it will level off. This figure may change, as treatment becomes available to HIV positive people.

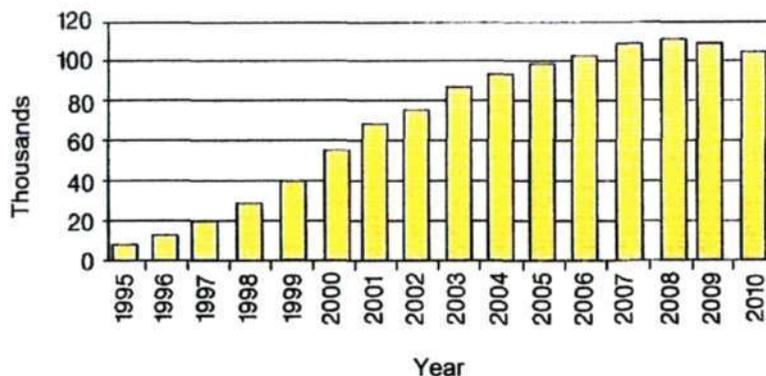


Figure 1: Projected AIDS deaths in KwaZulu-Natal, taken from Whiteside and Sunter (2000).

Furthermore, Africa is home to 95% of the entire world AIDS orphans (Guest, 2001) and according to Kamali et al. (1996) orphan rates in Africa have increased by 50% in the last two decades. Even if HIV infections are beginning to level off and the annual number of

deaths peaks, sub-Saharan Africa will have an unusually high rate of orphans for years to come, as shown in figure 2 below.

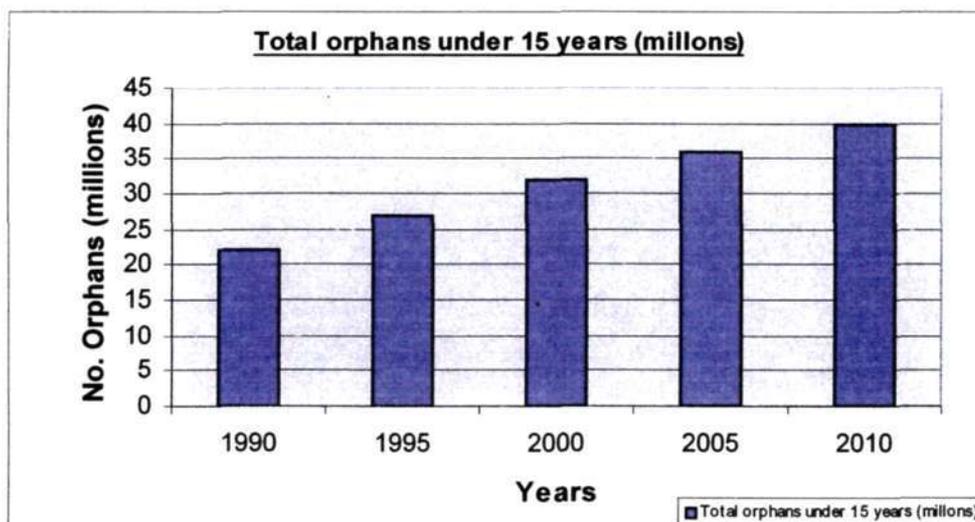


Figure 2: Graph of cumulative estimated total number of orphans for 19 African countries, adapted from Foster & Williamson (2000).

Reports predict that South Africa will have 1 million AIDS orphans under the age 15 by 2005 (Women's International Network News, 2001), and the number of AIDS orphans in South Africa is forecast to reach 2.5 million by 2010 (Whiteside & Sunter, 2000). Most estimates of the number of AIDS orphans define an orphan as a child whose mother has died since it is easier to obtain information about the child's biological mother than the biological father (Foster & Williamson, 2000). However, projections of the number of children expected to be orphaned in the future include children who will lose either their mother or their father or both, as predictions are made based on the number of already existing infections. Figure 3 shows the projection of orphan for KZN (Whiteside & Sunter, 2000). It is clear that the number of orphans in KZN is on the increase and the province will face an immense challenge with regard to meeting the needs of these vulnerable children.

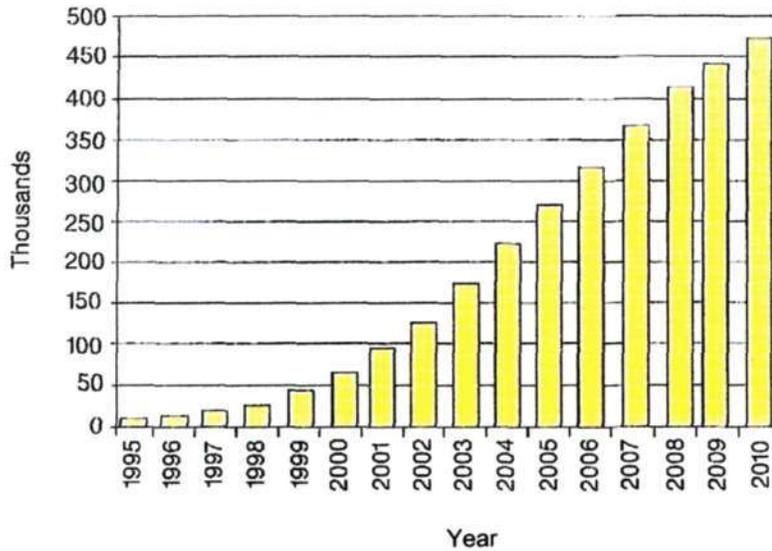


Figure 3: Projected number of AIDS orphan for KwaZulu-Natal, taken from Whiteside and Sunter (2000)

The statistics paint a grim future for Africa and the question that is frequently asked is: why are so many people living in Africa infected? (Guest, 2001). The answer is complex and multi-factorial. Ignorance about the transmission of HIV plays a role (Serpa, 2002). Generally, education has been inadequate and the government's effort to curtail the virus has been largely insufficient. Most people believe they will not contract the virus, thinking that AIDS only happens to members of other groups such as gay men, drug addicts and prostitutes (Guest, 2001). Many South Africans still do not know the facts about HIV/AIDS and the government's initial denial of the link between HIV and AIDS has resulted in further confusion (Guest, 2001). Educational campaigns focusing on the use of condoms have not been effective. This is due to the fact that in some areas there are difficulties in obtaining and using condoms and men generally dislike this method of contraception (Barnett & Blaik, 1992). Additionally, customs make it difficult for the distribution and use of condoms and myths about witchcraft and curses increase confusion and undermine preventive campaigns (Guest, 2001).

Africa's overwhelming poverty has also accelerated the spread of the virus and many cannot afford antibiotics for sexually transmitted diseases, which increase the risk of transmission (Guest, 2001; Whiteside & Sunter, 2000). Poverty has also forced

individuals into dangerous jobs like prostitution. Labour migration, mobility and relocation also contribute to the spread of HIV (HSRC, 2003). Many South African men (such as truck drivers and mine workers) travel far from home to seek work and are separated from their wives for long periods of time and tend to turn to prostitutes to meet their sexual needs, thus spreading the virus (Guest, 2001). A survey in Carltonville, a gold mining area near Johannesburg, revealed that 60 percent of the 88,000 miners had come from other parts of South Africa or from the neighbouring countries of Lesotho, Malawi and Mozambique (USAID, 2002). One-fifth of miners were HIV-positive, and 75% of the 400 to 500 sex workers who serviced the miners were HIV-positive (USAID, 2002).

Other factors that contribute to the prevalence of HIV/AIDS in Africa include cultural and social elements. The tendency to avoid talking about sex, ambivalent attitudes towards sex, the disintegration of traditional values and an increase in promiscuity in African communities assists in the spread of the virus (Serpa, 2002; Baylies & Bujra, 2000). A UNAIDS report (2000, in Guest, 2001) revealed that people living in Africa tend to become sexually active at a younger age and asking individuals to abstain or remain monogamous is unrealistic in terms of social norms. Traditionally, male promiscuity is accepted in African communities, with men tending to have more than one partner before and during marriage (Baylies & Bujra, 2000). Furthermore, the subservient position of women in the African culture results in women having little say in protection during sex, leaving them unable to protect themselves and their families (Baylies & Bujra, 2000). Additionally, rape and gang rape, which is on the increase in Africa, has become a potent method of spreading the virus (Whiteside & Sunter, 2000).

Furthermore, practices such as circumcisions and the cutting of ritual scars with razors that have not been sterilised aids the spread of the virus (Guest, 2001). In parts of rural South Africa, traditional healers have told infected patients that injecting someone with their blood will rid them of the disease (Serpa, 2002). In addition, superstitions, such as believing that sex with a virgin will cure HIV, have caused an increase in child rapes (Serpa, 2002). Sexual practices common in African communities such as 'dry sex', which

increase the risk of abrasions and tears making the transmission easier, also increase the transmission rate (Whiteside & Sunter, 2000).

Finally, Africa has minimal resources to cope with the results of this growing pandemic. Health care resources, drug therapy and good nutrition, which are accessible to many Westerners, are often unavailable to the overwhelming number of Africans with HIV/AIDS. Much research and development has gone into the development of a vaccine and a cure. To date neither is fully developed, resulting in a steady increase in the number of those infected (Whiteside & Sunter, 2000; Barnett & Blaik, 1992). As a result, very few South African communities, families and children can claim to be unaffected by the HIV/AIDS pandemic (Guest, 2001).

Definition of children affected by HIV/AIDS

HIV/AIDS can affect children in numerous different ways besides that of being orphaned by the illness. Many South African children are in fact HIV-positive. The 2002 Nelson Mandela/HSRC study of HIV/AIDS (HSRC, 2003) found that 5.6% of South African children between the ages 2-14 years old are HIV positive. Most of these children are infected through mother to child transmission (Brown & Lourie, 2000). A number of children are also infected through sexual abuse and rape (Stolar & Fernandez, 1997).

Furthermore, many children live in an AIDS afflicted household, i.e., households where the impact of the epidemic has been direct. In some of these households a family member is ill or has died from the illness (Barnett & Blaik, 1992) or the household has lost income, labour or support due to illness and stigmatisation or because an orphan has joined the family (Sherr, 1995). However, no matter the association between HIV/AIDS and a child, the effects of HIV/AIDS are far reaching and leave many children with unmet social, educational and health needs (Sherr, 1995).

Parental illness

One of the more direct and palpable ways that the HIV/AIDS epidemic has affected children is by impacting directly on the effectiveness of parenting (Miller & Murray, 1999). Approximately 85% of women with AIDS are of reproductive age at the time of diagnosis and the majority of these women already have children (Forsyth, Damour, Nagler & Adnopo, 1996). Thus, many parents are contracting the virus either before or whilst having their children and often fall ill while their children are still young.

The course of the illness is unpredictable, resulting in parents oscillating between prolonged periods of illness or absence due to hospitalisation and periods of wellness. This makes it difficult for them to meet the emotional and physical needs of their children consistently (Wild, 2001). A parent's poor health and lack of energy, as well as having to deal with the side effects of drug therapy, may result in children missing out on usual child and family activities (Miller & Murray, 1999). In some families, children may miss developmental milestones due to the lack of supervision and stimulation that results from parental illness (Miller & Murray, 1999). Not only are these parents unable to care for their children, they are unable to watch them grow to maturity (Wilfert et al., 1999). Likewise, many of these children never know their parents as healthy and able role models and some may have been deprived of the opportunity to form a strong attachment to their parent because of the illness. A strong mother-child attachment is often jeopardised very early in the relationship as infected mothers are often advised not to breast feed, depriving an infant and mother of that close physical and emotional bond (Miller & Murray, 1999).

Children with HIV positive parents are faced with the unique situation of watching their parents or siblings get ill, follow the distressing and uncertain clinical course of the illness and then die (Miller & Murray, 1999). Siegel et al. (1992) looked at the psychosocial adjustment of school-aged children of terminally ill parents. They found

that children of terminally ill parents had significantly higher levels of depression, anxiety and lower self-esteem. Parents reported higher rates of behavioural problems and lower social competence in these children. Children in a Ugandan study felt hopeless, scared and angry when their parent became ill (Sengendo & Nambi, 1997, in Foster & Williamson, 2000) and in a Zambian study, behavioural changes such as sadness, worry and less motivation to play were noted (Poulter, 1997, in Foster & Williamson, 2000). These children became solitary, miserable, distressed and fearful of new situations. Children of infected parents have also been noted to be more withdrawn and exhibit more difficulties with attention (Forsyth et al., 1996). They also tend to internalise their difficulties, becoming unlikely to display their distress externally through aggressive and difficult behaviour and were therefore, less likely to gain the attention of teachers and other professionals (Forsyth et al., 1996).

Coping with the emotional stress of being ill and dying places a tremendous burden on a parent. A parent's feelings of guilt, remorse and anger may complicate the parent-child relationship (Miller & Murray, 1999). These feelings, which are often difficult for young children to understand, are particularly prevalent if a child is HIV positive due to vertical transmission (Miller & Murray, 1999). Other parents feel extremely guilty at the prospect of abandoning their children when they die and they may become overprotective or distance themselves in an attempt to protect their children in the long-term (Wild, 2001). The complex emotions these parents experience not only complicate their role as a parent in the present, but many of these parents find it difficult to plan for their children's future. Their reluctance to plan for the future is often due to a denial of the seriousness of their illness or fear that others might discover their diagnosis (Wilfert et al., 1999).

Parental illness disrupts the entire family, often imposing new dynamics and exacerbating previously unresolved issues (Johnston & Martin, 1992). HIV places major stress on a couple's relationship and many couples become overwhelmed with their household, work and social commitments as the illness progresses (Wilfert et al., 1999). In some cases, parents have no support from their partners who may be dead or unavailable, leaving them feeling isolated and overburdened (Wilfert et al., 1999). It is clear that children of ill

parents struggle to make sense of their situation and as Nicholas and Abrams (1992, in Sherr, 1995) pointed out, many children from HIV afflicted households are in effect orphaned prior to a parent's death because of parental illness.

Disclosure

A common dilemma facing the HIV positive parent is the question of disclosing their HIV status to their children (Armistead, Tannenbaum, Forehand, Morse & Morse, 2001). Children are often not told about their parent's illness even during the last stages of the illness or after their parents die. This lack of knowledge and understanding serves to intensify children's fears and concerns regarding their parent's illness (Forsyth et al., 1996). In many ways, disclosure may be very beneficial to the family as it may lessen maternal anxiety and open up communication between parent and child about the illness and its consequences (Armistead et al., 2001). Disclosure not only provides parents with an opportunity to explain their illness to their children and prepare them for their death, it also mobilises informal and formal social support for the child (Strode & Barret Grant, 2001). Less secrecy about a parent's HIV status also lessens a child's feelings of shame and promotes family intimacy (Siegel & Gorey, 1994). However, even though many South African adults would like to speak to their children about their status, few do so as they feel disclosure will only lead to negative consequences and poor psychosocial adjustments on the part of the child (Strode & Barret Grant, 2001). Many parents living with HIV/AIDS fear potential stigmatisation and ostracisation by members of their family and community (Wilfert et al., 1999). Due to the destructive nature of the stigma and discrimination attached to HIV/AIDS many children who are aware of a parent or family member's status are often told to hide the information and experience tremendous anxiety guarding this weighty secret (Armistead & Forehand, 1995).

Whether or not parents disclose their status to their children is linked to the extent that parents discuss their affairs with their children in general, especially with regards to sexual matters (Antle, Wells, Goldie, DeMatteo & King, 2001). Cultural and family norms play a large part in this and many families avoid disclosure as it may be closely

linked to taboo subjects such as sex and illegal drugs (Lipson, 1994). In most African communities, it is considered taboo and disrespectful to discuss sexual issues between generations (Baylies & Bujra, 2000). This limits the opportunities for a parent and child to discuss a parent's status as well as educating the child in regards to sex, HIV and risk (Baylies & Bujra, 2000). As Faithful (1997) points out, the question of disclosure is often a dilemma for parents who find themselves caught between wanting to forget and deny their status and having to face the reality of the illness.

Another complicated issue facing some parents with HIV positive children is whether to disclose the child's HIV status to the child. In a study of disclosure of a child's status, it was found that only 43% of the sample group had been told their diagnosis (Lester et al., 2002). As in parental disclosure, the most common reason for non-disclosure was a concern about the emotional distress disclosure could cause. HIV positive children have significantly high distress associated with disclosure, fears of death and the deterioration of their health (Trad, Kentros, Solomon & Greenblatt, 1994). Many factors influence a parent's decision to disclose a child's status, this including parental communication style, the parents own status and illness, as well as the questions the child asked (Lester et al., 2002). Most often when parents do disclose the child's status, they omit information about the stages of the disease and death, leaving children feeling confused and fearful about the future (Pivnick & Villegas, 2000).

It seems that disclosure of a child's or a parent's status is a complicated task that is rarely completed. For most families, deception is based on a desire to protect their children from the hardships that the knowledge of a positive status will bring (Antle et al., 2001). However, the secrecy surrounding HIV prevents families from seeking help, denying them the emotional and practical support that is vital, especially to a bereaved child (Strode & Barret Grant, 2001).

Childhood bereavement

Children's conceptions of death

The death of an important person in a child's life is one of the most stressful events a child can experience (Committee on Psychological Aspects of Child and Family Health, 2000). Black (1996) suggests that even young children, with the help of adults can understand that death is permanent, universal, and irreversible and that dead people are different from people who are alive. However, a child's understanding of these facts depends largely on their cognitive development (Sherr, 1995). Moody and Moody (1991, in Sherr, 1995) suggest that a child's conception of death parallel Piaget's (1954) stages of cognitive development.

From birth to two years, Piaget's sensorimotor period, a child's concept is incomplete or non-existent. From two to six years, during Piaget's preoperational period, a child's thought processes revolve around magical thinking and egocentrism, and children of this age believe that death is avoidable and reversible (Moody & Moody, 1991, in Sherr, 1995). Children in this stage are preoccupied with bodily functions and often do not link the cessation of bodily functions with death, and they may be overly concerned with how the parent will eat and breath underground. The child's egocentrism at this age may cause the child to feel responsible for causing the parent's death, often resulting in feelings of guilt and shame (Moody & Moody, 1991, in Sherr, 1995).

From six to eleven years old, Piaget's concrete operational stage, children begin to realise that death is universal but they tend to view death as distant from them. Usually from about nine years old, a child will begin to understand death more clearly and realise that it is irreversible and that they will also die (Moody & Moody, 1991, in Sherr, 1995).

During Piaget's formal operational stage, from 12 years and above, children are able to form more complex cognitions and may explore thoughts around religious and philosophical ideas of death, life after death and heaven and hell.

Impact of parental death

The death of one or both parents is not something a child expects and is a crisis for children under a multitude of circumstances (Wild, 2001). For most children a parent's death means the loss of love, support, guidance, stability, security and a link with the past (Dane, 1997, in Wild, 2001). Dowdney (2000) suggests that children experience true grief and have the same range of feelings as bereaved adults.

However, children express their grief in different ways to adults since many children, especially very young children, do not have the means to express themselves verbally, thus making it less obvious to the observer (Skinner Cook & Dworkin, 1992). Regressive behaviours like thumb sucking and bed-wetting, separation anxiety and clingy, dependent behaviour are often evident (Wicks-Nelson & Israel, 1997). Anger, a common feature of grief for individuals of all ages, is often expressed through temper tantrums, discipline problems and aggressive behaviours. Concentration difficulties, irritability and decreased interest in play as well as physical symptoms including headaches, insomnia and loss of appetite are other ways children may exhibit their grief (Skinner Cook & Dworkin, 1992). Just like adults, children need the opportunity to express their feelings and in the absence of an opportunity to communicate, a pathological grief reaction may develop putting the individual at risk for negative long-term consequences (Siegel & Gorey, 1994).

Dowdney (2000) noted that one in five children develop a psychiatric disorder in the year following the bereavement, with a higher rate of disorders reported in boys. Many theorists, beginning with Freud, have linked childhood loss to anxiety or depression in adulthood (Saler & Skolnik, 1992). Saler and Skolnik (1992) note that a greater risk for depression later in life is associated with children who have less of an opportunity to

express and explore their feelings and thoughts about the loss and less opportunity to participate in the mourning process. Brown (1996, in Saler & Skolnik, 1992) suggested that mental illness following a death is more a consequence of how the bereavement is handled by the family and the cumulative stress of the multiple changes caused by the loss than the loss itself. Caregivers, who are able to provide and sustain stability, support and care for the child, encourage adjustment (Siegel et al., 1990, in Sherr, 1995). Similarly, families high in sharing, support and communication buffer the effects of the loss from their members (Committee on Psychological Aspects of Child and Family Health, 2000).

In the Western world the reaction to a parental death from AIDS is not dissimilar to that of other parental deaths (Sherr, 1995). However, a child may experience a prolonged period of anticipatory grief during their parent's long and disabling illness (Rosenberg, 1986, in Pivnick & Villegas, 2000). A loss due to an AIDS-related illness might also be complicated because of the social stigma attached to AIDS (Strode & Barret Grant, 2001). When working with children orphaned or affected by deaths due to AIDS, Pivnick and Villegas (2000) noted that their subjects experienced an early onset of mood disorders and depression. Along with disturbances in their mood, the subjects expressed a high degree of somatisation, suicidal thoughts, severe sleep difficulties, disturbance in appetite and recurrent nightmares (Pivnick & Villegas, 2000).

Summary

The number of HIV infections is escalating dramatically. Even if a solution to the HI virus was found immediately, the long-term impact of HIV/AIDS will linger in Africa for decades (Foster & Williamson, 2000). As a result of parental illness children experience disrupted routines, unscheduled parental absences, informal fostering, and the disturbance of witnessing their parents' suffering (Wild, 2001). Parental death and orphanhood further exposes the children of Africa to a complicated spectrum of difficulties. Burnett (2000, in Wild, 2001, p. 3) points out that the pandemic has aroused fears of a "lost generation" of dysfunctional and delinquent South African youth who have been

inadequately cared for, educated and socialised. These vulnerable children and the multiple risk factors they face will be discussed in the following chapter.

Introduction

Children in South Africa face a multitude of stresses related to the HIV/AIDS pandemic, which increase their vulnerability to further adversity, long-term negative effects, and physical and psychological illness (Wild, 2001). The interconnected and compounding multiple stresses these children are faced with (shown diagrammatically below, in Figure 4) are often difficult to separate from one another, thus making it difficult to quantify or counteract. Furthermore, many children, especially younger children, do not have the personal resources or the external support to deal with such compounding stress. Understanding the multitude of stresses these children face is vital in order to assist them appropriately.

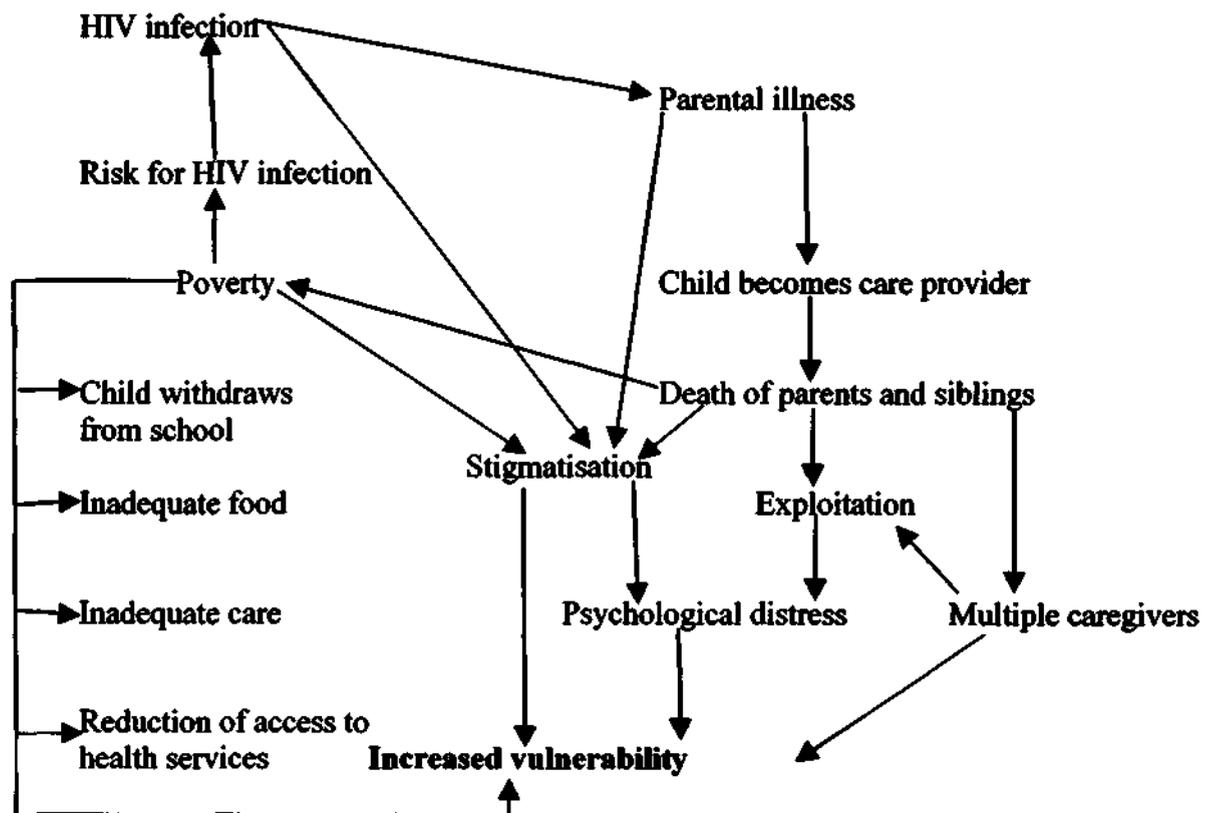


Figure 4: The multiple factors increasing vulnerability in children affected by HIV/AIDS. Adapted from Foster & Williamson (2000).

The majority of the children at risk for maladjustment in South Africa are bereaved, a factor which causes vulnerability (Ayyash-Abdo, 2001). However, a number of other negative factors such as stigmatisation, multiple losses, inadequate care and nutrition, lack of education, multiple caregivers and an increase in childhood responsibility complicate the grieving process. Additionally, many of these children face risk factors in their communities such as poverty and violence. All these factors play a significant role in increasing a child's vulnerability and decreasing their access to resilience building processes. This chapter explores these multiple risk factors, their causes, and consequences in terms of child's development.

Stigmatisation

The process of stigmatisation is described as the exclusion of certain individuals because they possess a particular characteristic or belong to a particular group (Kurzban & Leary, 2001). Stigma occurs during social interactions when the attributes an individual possesses do not meet the normative expectations of society (Kurzban & Leary, 2001). Richter (2001, in Strode & Barret Grant, 2001) explains that the root of stigma is fear, ignorance and an inability to accept any deviation from the norm. Individuals can be considered "spoilt" for numerous reasons, including personal characteristics, such as gender or race, lack of abilities, mental or physical illness or membership of a group, such as a religious group (Kurzban & Leary, 2001). Stigmatisation can manifest in many forms such as rejection, violence and hostility. Regardless of the context or form stigmatisation takes, it always involves discrimination, which is the behavioural element of stigmatisation.

Despite mass media campaigns in South Africa, faulty perceptions and lack of knowledge about HIV/AIDS and especially the transmission of HIV, remain and serve to increase stigma and discrimination against HIV-positive people (Strode & Barret Grant, 2001). Many people refuse to interact with HIV-positive people, even refusing to share crockery, toilets or touch an infected person (Foster & Williamson, 2000). Many people believe untruths such as that children whose parents are ill or who have died from AIDS can

infect others, or that if one person in a house is sick, everyone in that house is infected (Wild, 2001). Others believe that those who are infected have brought it on themselves, seeing them as promiscuous, dirty and not deserving of help and support (Strode & Barret Grant, 2001). The secrecy connected with HIV/AIDS is exacerbated in many communities by the traditional values, which discourage the open discussion of sex and death (Foster & Williamson, 2000). As a result of faulty beliefs and prejudice, people with HIV, including children, are being discriminated against in a variety of contexts including education, sporting, health and community settings.

For adults, discrimination has an immense effect on self worth and self-esteem, and it affects an individual's ability to parent effectively (Antle et al., 2001). Stigmatisation also affects the view children have of their parents and their ability to protect and provide for them (Strode & Barret Grant, 2001). Many children live with emotional distress related to social stigma caused by their own infection (Lewis, Haiken & Hoyt, 1994). However, it seems that children are more vulnerable to stigmatisation than adults since they may have to face the stigmatisation from their own status and that of their parents (Brown & Lourie, 2000). Others cope with compounding stigma from multiple sources including stigma associated with poverty, racial group or parental substance abuse (Pivnick & Villegas, 2000). Although these children require additional support and understanding, many of them are physically and emotionally isolated by their families and communities, receiving little instrumental or emotional support during and after their parents' illness (Brown & Lourie, 2000). Not only does stigmatisation results in children being deprived of basic social and educational services and less support, but children report having to work harder than other children and being the last in the household to have access to resources like food and money for school (HSRC, 2003). It seems that a child orphaned by AIDS serves as an unwelcome reminder of the overwhelming presence of HIV/AIDS.

Stigma and discrimination isolates children and forces them to resort to secrecy, causing them to withdraw from their community, promoting feelings of isolation and hindering healthy development (Fanos & Weiner, 1994). The persecution and social isolation due to stigmatisation and discrimination may last for years because of the nature of AIDS and

many parents die worrying about the future of their children and the effect discrimination and stigmatisation will have on them (Antle et al., 2001). Within communities where prejudice is high, children feel dirty, different and unacceptable. They are ignored, sworn at, teased and physically abused because of stigmatisation (Strode & Barret Grant, 2001). Teasing and social ostracisation damages children and leaves them feeling shamed, powerless and unwanted, which has an extremely negative effect on their emotional well-being and self esteem (Brown & Lourie, 2000). Often the emotions experienced due to stigmatisation are complicated and exacerbated by fear about their own futures (Strode & Barret Grant, 2001).

The stigma associated with AIDS increases the likelihood of persistent and unresolved grief (Pivnick & Villegas, 2000). Faithful (1997) discusses how discrimination can lead to disenfranchised grief, where a child's loss becomes unspeakable because of stigma and thus he or she is unable to resolve the grief. When the resolution of the psychological tasks of a child's grief is complicated by social stigma, it can result in anxiety and depressive symptoms (Knight, Mellins, Levenson, Arpadi & Kairam, 2000) and some children even consider suicide (Strode & Barret Grant, 2001). It is clear that stigma and discrimination is extremely damaging for children in that it diminishes their resilience and increases their vulnerability.

Multiple losses

Since HIV is a sexually transmitted disease, children who lose one parent are at risk of losing their other parent (Wild, 2001). Frequently, they may also lose younger siblings who were infected perinatally, resulting in some children losing multiple members of their immediate family, early in life (Roth, Siegel & Black, 1994). Losses of this multitude are unusual and traumatic for most children, but are becoming a common picture for children in families living with HIV/AIDS (Brown & Lourie, 2000). Many children in foster care may lose a second caregiver to illness or death and the loss of a foster parent may have as great an impact on a child as the death of a biological parent (Richter, 2003, in HSRC, 2003). These children may experience further losses including

members of their communities and extended families, either to AIDS or due to stigmatisation (Strode & Grant Barret, 2001).

The issue of loss is central for many individuals affected and infected by HIV/AIDS. Nord (1997) points out that for many the losses encompass much more than death. During a parent's illness the "normal" family processes, plans and dreams are lost, as is a sense of stability and security (Nord, 1997). Furthermore, children may lose peer relationships because of stigmatisation or if they are forced to move once their parents have died. Some children may lose contact with their siblings if they are separated after their parent's death in order for a family to share the burden of their care (Wild, 2001). Further losses that these children experience are the loss of hope, the loss of self-esteem and the loss of interest in life and formerly pleasurable activities (Nord, 1997). These overwhelming multiple losses leave children with a pervasive sense of helplessness, hopelessness and despair (Shrader, 1992, in Nord, 1997). For many children the multiple AIDS-related losses they experience can result in the most important and devastating loss of all, the loss of their childhood (Nord, 1997).

Multiple caregivers

For HIV/AIDS orphans, the extended family remains the first choice as caretakers (Foster & Williamson, 2000). In the African context the extended family consists of a large network of people, of all generations, related by varying degrees (Foster & Williamson, 2000). Aunts and uncles are a first choice for substitute childcare providers; however in South Africa the responsibility often falls on grandparents, as many of these young adults are sick themselves (Lindegger & Wood, 1995). Some families may be unable to care for an orphaned child as a result of being overburdened by their own children and that of other deceased relatives (Wild, 2001). This results in children being abandoned or moved between places of safety, children's homes and foster care (Richter, 2003, in HSRC, 2003). The care these children receive is fluctuating and dubious and often caregivers have little control over the children's actions, especially those of older children and

adolescents (Wild, 2001). Without supervision children are at risk for illness, malnutrition and early school termination (HSRC, 2003).

Some children go to a family member who is elderly, unsuitable or ill-prepared for them and only agree to take them because no one else would (Foster & Williamson, 2000). Often orphaned children find themselves living with a relative stranger or with someone with whom they have very little attachment. In many cases a child is relocated to a different town or province and some orphans are forced to move more than once if an elderly or sickly foster parent dies (Wild, 2001). The multiple caregivers that many AIDS orphans have results in a lack of consistency in their lives leading to problems including difficulties trusting and bonding with adults (Doka, 1992, in Nord, 1997).

Foster and Williamson (2000) point out that the role of the extended family and the community, when dealing with AIDS orphans, is currently undergoing changes. There is some doubt as to whether the full demands of caring for, teaching, disciplining and socialising these children can be met by the extended family (Barnett & Blaik, 1992). The “safety net” of the extended family (Foster & Williamson, 2000) seems to be stronger in rural areas where more traditional values are preserved. However, this safety net is eroding in more urban areas as the epidemic spreads and these family units are subjected to multiple stresses (Foster & Williamson, 2000). This leads to children slipping through the safety net and landing in a vulnerable position, where they are open to exploitation, sexual abuse, rape and an increased likelihood of engaging in antisocial behaviour (Foster & Williamson, 2000). Foster & Williamson (2000) suggest that intervention should aim at empowering these already existing structures within communities instead of placing children in institutions.

Disruption of attachment

As a result of multiple losses, abandonment and varying caregivers, many children affected by HIV/AIDS experience a disruption of their attachment to a single, stable caregiver. Bowlby (1973) emphasises the importance of attachment and suggests that a

secure attachment early in life is vital for later adjustment. Attachment is related to the consistency of a caregiver, as well as the caregiver's levels of responsiveness and sensitivity (Basic Behavioural Science Task Force [BBSTF], 1996). This special relationship between caregiver and infant serves many purposes beyond that of physical care, including soothing, stimulating, protection and helping the infant learn self and emotional regulation (Carlson & Sroufe, 1995, in Masten & Coatsworth, 1998). The more secure an infant feels in this relationship, the more likely they are to explore and interact with their environment (BBSTF, 1996). There are strong indications that a secure attachment correlates highly with successful adaptation, and fostering this relationship in interventions is key to instilling resilience in children (Masten & Coatsworth, 1998).

Bowlby's theory of attachment (1973) also indicates that the early bonding between mother (or primary caregiver) and infant is an essential foundation for all later social relationships and the disruption of this bond is one of the fundamental causes of psychopathology in children (Smith, 1986). A disturbed pattern of attachment comes in two forms: either children fail to attach or they attach in an indiscriminate manner (Kronenberger & Meyer, 1996; Louw, 1991). Children who fail to attach often present as inhibited and withdrawn. On the other hand, children who attach indiscriminately present as disinhibited (Kronenberger & Meyer, 1996; Smith, 1986). Children who have disrupted attachment often appear developmentally (especially in terms of language development) and socially delayed. Many manifest signs of nonorganic failure to thrive, lethargy, lack of interest in their environment and impaired social relationships (Kronenberger & Meyer, 1996; BBSTF, 1996). Other difficulties related to poor attachment includes anxiety, insecurity, overdependency and immaturity in childhood, as well as behavioural, marital and personality difficulties in adulthood (Smith 1986). However, children with secure attachments are more likely to be compliant, unconflicted and generally competent in their relationships with their peers and adults (BBSTF, 1996).

Children vary significantly as to whether the impact of early attachment has a lasting affect on them (Thompson, 2000). Attachment theorists seem to agree that the experience of early attachment is very important, but that it can be changed by later life experiences

(Sroufe, Carlson, Levy & Egeland, 1999, in Thompson, 2000). Many fluctuating factors such as the quality and style of parenting, living conditions, family interactions and circumstances, impact on the extent to which attachment impacts on later behaviour (Thompson, 2000). In their assessment of longitudinal studies, Belsky & Cassidy (1994, in Thompson, 2000) concluded that the relationship between attachment and later behaviour is “modest to weak”. However, researchers (e.g., Thompson, 1999; Belsky & Cassidy, 1994 in Thompson, 2000) acknowledged that attachment is an important developmental variable, even though its long-term predictive relations are relatively weak and vary for different individuals.

Disruption of attachment has been commonplace in South Africa before the HIV/AIDS pandemic. In the past, many mothers sent their young children to live with family members such as the maternal grandmother or maternal aunts in a different town or province (Hrdy, 2000). This was usually due to a lack of available caretakers in the towns or cities where parents were forced to seek work. The practice of exchanging children between households also has tribal roots and families see children as belonging to and the responsibility of the extended family (Barnett & Blaik, 1992). Many of these children moved several times depending on the availability of caretakers or because of the children’s changing educational needs (Hrdy, 2000). Little regard was given to the attachment process and children often lost their attachment figure numerous times. As a result of this social phenomenon, many black South African children present as unattached (Hrdy, 2000). Therefore, the loss attachment resulting from the HIV pandemic is not altogether a new pattern. Even though the problem is commonplace, it is dire and needs to be addressed.

Child headed households

In many cases, where the extended family or community is unable to support orphaned children, they will continue living in their home and heading their own household (Foster & Williamson, 2000). This is often the case when a parent has left more than one child and the extended family is unable to take on this extra burden or when the oldest child is

in his or her early or late adolescence (Desmond, Richter, Makiwane & Amoateng, 2003). In other cases, the formation of a child headed household is influenced by the desire of siblings to remain together in their own home (Foster & Williamson, 2000). Children who have little contact with their extended family due to migration or estrangement may have no choice but to look after themselves once orphaned (Wild, 2001). Some have elderly or nearby family members who check up on them regularly and provide them with as much assistance as possible (Strode & Barret Grant, 2001).

Nord (1997) noted that having a family member sick from AIDS causes the roles, tasks and functions of family members to shift. Older siblings often become surrogate parents to their younger siblings, taking on the parenting role and provide for the younger siblings on an instrumental and emotional level (Rotheram-Borus, Murphy, Miller & Draimin, 1997). These children are pushed into parenting roles and lose out on their own childhood and opportunities in the process (Strode & Barret Grant, 2001). Heading a household is a task that children are not fully equipped for and these children are often described as parentified children (Chase, 1999). Parentified children can be described as children who are compelled to perform the duties and responsibilities of a parent at the expense of their own development (Chase, 1999). In the long-term parentified children learn that their needs are less important than the needs of others. They have less motivation and fewer friends than do other children (Chase, 1999). They have little time to form their own autonomy, relationships and career plans and they are often suspicious, isolated, resentful and suffer from low self-esteem (Chase, 1999). Many children drop out of school in order to meet the demands of running a household (Foster & Williamson, 2000) despite the fact that children under 16 years of age are required by law to attend school, and should not be responsible for a household (Desmond et al., 2003).

In the 1999 October Household Survey (OHS) in South Africa, it was found that 0.25% of all households were child-headed, while 0.19% of households contained no adults and 0.22% of households contained only adults over 70 years olds and children under 18 (Desmond et al., 2003). Therefore, not all child-headed households are adult-less and children may gradually assume more responsibility, as the adults in the house are less

able to cope due to illness or old age (Desmond et al., 2003). Although many child-headed households maintain a link with extended family (Desmond et al., 2003) the emergence of large numbers of child-headed households confirms that the extended family system is under immense stress (Foster et al., 1995).

Health and nutrition

Since many AIDS orphans are cared for by ill parents, the elderly, unprepared relatives or other children, they are at risk for having inadequate access to food, shelter, clothing and health care (Wild, 2001). Their caregivers are likely to be uninformed about good nutrition, how to treat basic ailments and how to recognise more serious illness and malnutrition. In some cases, their caregivers are unable to maintain their household agricultural production because of illness and poverty, thus reducing the availability of fresh food and income for other food and medical necessities (Barnett & Blaik, 1992). After their parent's death, many orphaned children are unable to obtain food or money to buy food and they go to school hungry. As a result, they find it difficult to concentrate at school, they fall asleep or they spend their time worrying about where they will find food (Strode & Barret Grant, 2001). Therefore, children affected by HIV/AIDS and orphans in particular, are at risk for poor health because of neglect and malnutrition due to poverty (Foster & Williamson, 2000).

Good nutrition is vital for a child to develop healthily, especially in the first year of life, when rapid brain development is very sensitive to environmental factors. Inadequate nutrition intra-uterine or in the postnatal period severely interferes with development and leads to neurological and behavioural disorders (Drewett, Wolke, Asefa, Kaba & Tessema, 2001). Later on in life, malnutrition can lead to stunting, bad teeth, bowed legs, and vulnerability to infection and poor health (Biersteker & Robinson, 2000). Richter, Griesel and Rose (2000) noted that early school performance in inadequately fed children was poor and attention, concentration and ability to remember and learn in class could be improved by feeding schemes. Malnutrition also has an impact on the social and emotional development of the child, as children who are malnourished are more difficult

to care for, thus making caregiving less rewarding (Richter & Griesel, 1994, in Biersteker & Robinson, 2000). South Africa still has a significant problem with malnutrition with one in every four preschoolers reported being stunted and one in every ten under-weight for their age (Biersteker & Robinson, 2000). The highest rates of malnourished children are reported in the Eastern Cape, KwaZulu-Natal and the Northern Province (Biersteker & Robinson, 2000).

Similarly, basic hygiene and access to basic health care facilities are vital for a child's healthy development and the lack thereof can put a child at risk for future health problems and vulnerability to illness (Foster & Williamson, 2000). Nampanya-Serpell (1998, in Foster & Williamson, 2000) pointed out that orphans were more likely to have frequent illness than non-orphans were. Many children living in rural areas in South Africa do not have adequate access to water, sanitation and health services. Every day South African children, affected by poverty die from or suffer with illness, such as tuberculosis, measles, typhoid and diarrhoea, which are preventable with better conditions and greater access to health care services (Biersteker & Robinson, 2000). Although immunisation is high in South Africa (reported at 74.7 % of children in 1994), there is significant differences between provinces and children in urban areas have a far higher rate than those in rural areas, where many children remain unimmunised (Biersteker & Robinson, 2000).

Another major health concern is that AIDS orphans are at a higher risk for HIV infection (Pivnick & Villegas, 2000). This may be due to early onset of sexual activity and due to some orphans being forced to seek employment as commercial sex workers (Foster & Williamson, 2000). Infection through sexual abuse (Stolar & Fernandez, 1997) or maternal transmission (Brown & Lourie, 200) is also common. HIV infection is an increasing health problem for South African children, with child infections forming 10.7% of all new infections (Biersteker & Robinson, 2000). In these cases children have to cope with missing school, social activities and even developmental milestones due to failing health and frequent hospital visits (Sherr, 1995). Even though HIV-positive children may remain asymptomatic for several years (Fishkin et al., 2000), when their

symptoms do appear they directly impact on neurological development. Neuroimaging studies have demonstrated a high incidence of structural brain abnormalities in children with HIV, including cortical atrophy, white matter abnormalities and calcification (DeCarli, Civitello, Brouwers & Pizzo, 1993). Although it is difficult to establish causal relationships between HIV and cognitive impairment given the multitude of environmental risk factors, cognitive deficits directly related to the effects that HIV has on the central nervous system have been noted (Corscia et al., 2001). These neurological deficits have been associated with several dysfunctions, including intellectual decline, loss of previously gained developmental milestones and changes in muscle tone (Fishkin, et al., 2000), as well as language deficits, attentional deficit and delayed motor milestones (Knight et al., 2000).

Education

For many children affected by HIV/AIDS, education is often already disrupted or prematurely ended by parental illness and an increase in their responsibilities. Some children miss so much school while caring for their parent that they are struck off the register or miss too much work to return with their contemporaries and would rather not go back (Strode & Barret Grant, 2001). Ill parents are also unable to supervise homework or motivate their children to continue with their education (Wild, 2001). Furthermore, children affected by HIV/AIDS are preoccupied with fears about parental illness and death and struggle with worries and questions and are thus less successful in the classroom (Pivnick & Villegas, 2000). Some children report being too worried to go to school when their parents are ill, fearing that their parent will die while they are away (Strode & Barret Grant, 2001). Others compromise their learning because of acting out or behavioural problems connected to grief and these learners struggle to keep up and often drop out (Pivnick & Villegas, 2000). Some children cope well at school but are forced to change schools when they are orphaned and relocated to their extended family (Wild, 2001). Sometimes these children are educated in their second or third language in their new schools making it difficult for them to cope in the classroom and leaving gaps in their education (Wild, 2001).

Other children affected by HIV/AIDS are forced to discontinue their schooling because of poverty. Parents often struggle to pay the fees or provide uniforms and books for their children and school becomes unaffordable for many families as medical expenses increase and income declines due to ill health (Wild, 2001). Many impoverished children are discriminated against at school for being poor. They are often teased, bullied or excluded if they do not have the correct uniform and book, or they are forced to wear uniforms that are old and torn (Strode & Barret Grant, 2001). Other children report being denied access to education by teachers and principals because they do not have the correct exercise books or uniforms and are unable to afford the correct ones (Strode and Barret Grant, 2001). These children may choose to leave school feeling embarrassed about their poverty and their parent's inability to provide for them.

In South Africa it is estimated that 5% of poor children between the ages of 10 and 18 are not in school and only between 10 and 16% of children have access to preschool programmes (Biersteker & Robinson, 2000). For South African children, the reasons for their education being interrupted or insufficient are numerous and are often beyond the control of the child or parents. Firstly, there is shortage of more than 57,000 classrooms in schools across South Africa (Biersteker & Robinson, 2000). There is a shortage of 27,000 toilets, 17,000 telephones, 15,000 electrical connections and 10,000 borehole in schools countrywide. There is also a shortage of teachers and 36% of those teaching in South African schools do not have the officially required level of training (Biersteker & Robinson, 2000).

Barnett & Blaik (1992) note that professionals dealing with children affected by HIV/AIDS should see their education as priority. They note that the difficulty lies in getting the younger children to school and keeping the older children in school. The content and quality of the education that orphans receive is also important (Barnett & Blaik, 1992). The current reality in South Africa is that many children affected by HIV/AIDS are for various reasons, left with no education and no skills for the future,

limiting their chances of breaking the cycle of poverty. Most remain poor with few opportunities for the future (Strode & Barret Grant, 2001).

Effects of poverty on children

Throughout the world poverty is a barrier to the prevention and treatment of HIV infection (Brown & Lourie, 2000). In South Africa, the Apartheid policies have left racial, geographical and socio-economic discrepancies that are still evident today, resulting in unevenly distributed resources (Biersteker & Robinson, 2000). Terreblanche (2002, in Guthrie, 2003) suggests that even though South Africa has undergone significant political changes, there have not been parallel socio-economic changes. Consequently, out of every ten South African children, six still live in poverty (Biersteker & Robinson, 2000). The Labour Force Survey indicated that South African unemployment rates rose from 33% in 1996 to 37% in 2001 and it is assumed that with this increase, there is an increase in poverty (Guthrie, 2003). The survey estimates that 45% of South Africans live in poverty, that is, on less than \$2 (R8) per day (Guthrie, 2003). About 27% of the population (11 million people) live in the poorest 20% of households in South Africa and 70% of poor people live in rural areas (Whiteside & Sunter, 2000). Poor South African households are generally characterised by unemployment, low education (less than secondary), race (all black groups having a higher probability of being poorer than whites), being female headed and having a large number of young children (Biersteker & Robinson, 2000). Guthrie (2003) points out that poverty encompasses more than an insufficient or lack of income, it includes a lack of opportunities, less access to goods, services and social exclusion.

As the rate of deaths of productive young adults increases exponentially, South Africa's economy is negatively affected (Lindegger & Woods, 1995). In many cases HIV/AIDS is affecting families and communities that are already subjected to extensive poverty, poor infrastructure and limited services (Wild, 2001). Most South African families are poor before HIV infection, their poverty made worse by the crisis of AIDS, but for others poverty is a direct result of HIV/AIDS (Strode & Barret Grant, 2001). Many

breadwinners lose their job because of the illness or stigmatisation and treatment and care is expensive (Wild, 2001). Families are frequently left destitute by the illness and funeral costs, and many children are left with no inheritance (McKerrow, 1995, in Wild, 2001). Minors are vulnerable to relatives who want to cheat them out of their inheritance or divert the money to the needs of their own children (Barnett & Blaik, 1992). Foster & Williamson (2000) report that only 2% of Zimbabwean families write wills and taboos around discussing death in African cultures prevents adequate financial arrangements to be made for orphans. Many orphans seek relief and financial help from neighbours and community members, but as the epidemic spreads and the needs are becoming greater than the available resources, the amount of relief available to destitute families and children is decreasing (Foster & Williamson, 2000). Often economic factors determine the response of a family or community to providing care for an orphan who will be an added financial strain on an already poor household (Wild, 2001).

Chronic poverty has many negative effects on the development of a child. In many instances these begin with poor maternal health, inadequate nutrition and obstetrical supervision during pregnancy (Garmezzy, 1993). This is often followed by low birth weight and inadequate nutrition and medical care for the baby (Duncan & Brooks-Gunn, 2000), causing failure to thrive in infancy, which has detrimental effects on cognitive development in childhood (Mackner, Black & Starr, 2003). Poor children are also 6.8 times more likely to be abused or neglected, and 2.2 times more likely to experience a violent crime (Duncan & Brooks-Gunn, 2000). Economically disadvantaged mothers are also more likely than other women to experience psychological problems, especially depression, which affects their ability to parent competently (Pettersson & Burke Albers, 2001). Poor children are also likely to be forced to work, with girls becoming child carers, domestic workers or carers for female relatives, whereas boys may go and seek employment in towns or as labourers (Foster & Williamson, 2000). As it is illegal for children to work, they are often forced into abusive and exploitative employment situations (Desmond et al., 2003).

Effects of violence on children

Violence, like HIV/AIDS, negatively affects a child's development and increases his/her vulnerability, and for many South African communities violence has become an everyday occurrence. Children may either witness violence or are directly exposed to or involved in violence. There are many different forms of violence including family violence, physical or sexual abuse and community violence (Flower, Lanclos & Kelley, 2002). Family violence is common in South Africa, with physical violence found in one third of 1,615 homes sampled in Soweto, Johannesburg (Richter, 1996). Similarly sexual and physical abuse of children in South Africa is rife, with as many as 1,800 cases of sex crimes against children being reported to the Child Protection Unit in a single month (Biersteker & Robinson, 2000). Additionally, with crime on the increase children are increasingly becoming victims and witnesses of violence in their communities, schools and homes (Fitzpatrick & Boldizar, 1993). Other children are exposed to violence through tribal and political fighting that often continues even when agreements are reached (Wessells & Monterio, 2000).

Children affected by violence show signs of posttraumatic stress, with symptoms such as flashbacks, nightmares and difficulties sleeping, concentration problems, hypervigilance and avoidance of reminders of the violence (Wessells & Monterio, 2000). They are also likely to suffer from a range of emotional problems including low self-esteem, learned helplessness, anger, aggression and problems relating to peers and family members (Fitzpatrick & Boldizar, 1993).

There are many similarities between HIV/AIDS and violence. Both erode families and communities and create widespread social disruption (Machel, 2001). Both shatter a child's support structures, damage them physically and psychologically and deny them their basic rights (Wessells & Monterio, 2000). Both cause children to lose parents and siblings, resulting in an increasing number of orphans, street children and child headed households. Both dislocate families and expose them to risk factors such as malnutrition, loss of education and sexual exploitation and abuse. Furthermore, both HIV and conflict

are compounded by poverty and gender issues and a child affected by either violence or HIV/AIDS is more vulnerable to the negative effects of the other (Machel, 2001).

Summary

The instrumental needs of children often overshadow their psychological needs and are the focus for many interventions for AIDS orphans (Foster & Williamson, 2000). However, the combination of parental illness and death, the stress of stigmatisation, multiple losses and an increase in responsibility creates an immense psychological strain for children affected by HIV/AIDS (Foster & Williamson, 2000). Within the ecological framework, which will be discussed in a chapter below, children interact with multiple levels of the ecological system in which they live. These complex interactions can result in an accumulation of risk when environmental stresses, such as poverty, violence and HIV infection co-occur. However, despite these multiple risk factors and adverse environments, some children are able to develop healthily and others may thrive and become adaptive individuals (Strode & Barret Grant, 2001). The ability to rise above adversity and develop competence or resilience is an area of interest and debate for many researchers and clinicians and these ideas and theories will be explored in the following chapter.

Introduction

Masten, Best and Garmezy (1990) noted that risk factors such as low socio-economic status, birth complications, parental illness, marital discord, and schizophrenia in a biological mother, to name but a few, correlate statistically with negative outcomes and have been associated with more emotional and behavioural problems. While many children do develop behavioural and psychological difficulties in these adverse settings, some children are resilient and are able to overcome adverse factors and develop into healthy, well-rounded, independent individuals (Luthar & Zigler, 1991). This chapter explores the concept of resilience, looking specifically at the three broad sets of variables that are considered central in resilience, namely personal characteristics, family characteristics, and the availability of an external support system. The consequences of cumulated risks as well as the protective process of resilience will also be discussed.

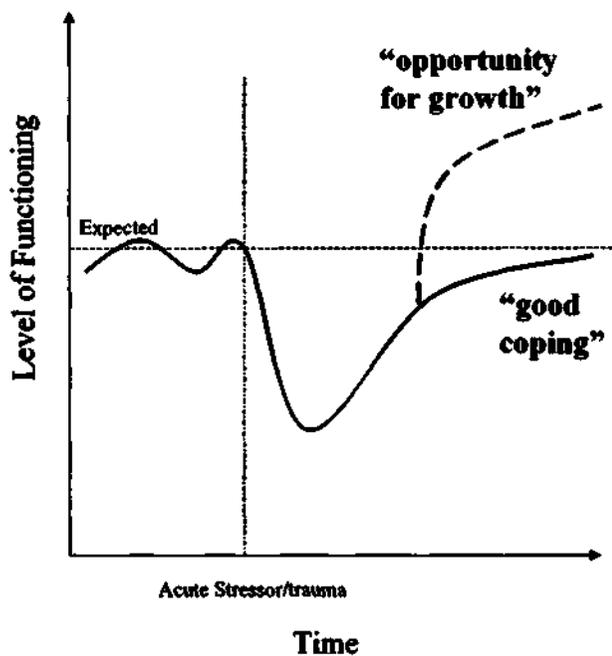
Resilience

Resilience has been defined as the development of competence despite severe or pervasive adversity (Egeland, Carlson & Sroufe, 1993, in Birkerts, 2000). Werner (1995, in Strode & Barret Grant, 2001) describes individuals as remaining invincible despite exposure to numerous damaging factors including poverty, biological risk factors and family factors including parental mental illness, lack of skills or education and family instability. For some, it is not only the absence of adverse effects such as maladjustment and psychopathology, but also indication of health and competence that have been favoured as indicators of resilience (Luthar & Zigler, 1991). This shift has been useful in turning the focus away from illness, to concentrate on health (Ungar, 2003).

Psychological resilience focuses on behavioural adaptations, in terms of internal states of well-being or competent functioning in the environment or both (Masten et al., 1990). Masten and her colleagues (1990) define three resilience phenomena, namely: good

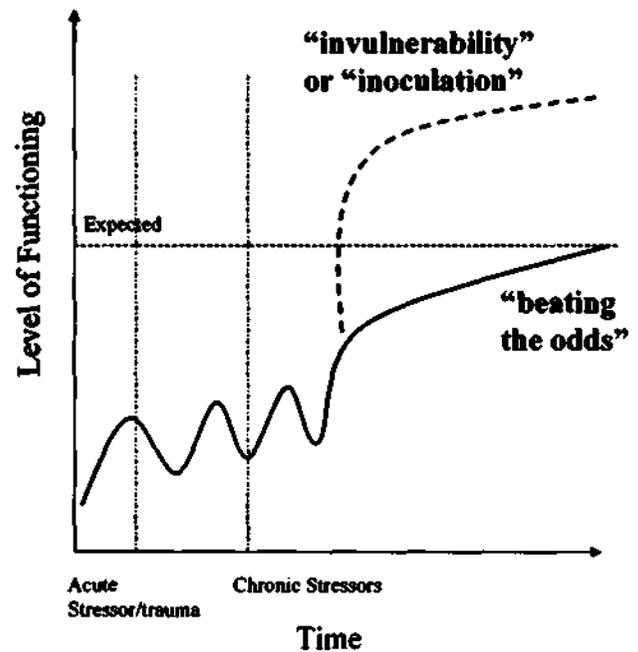
outcomes in high-risk children, sustained competence in children under stress, and recovery from trauma. These phenomena are represented diagrammatically in figure 5 (Ungar, 2003). Even in a low risk environment, as shown in the first graph, an individual may become vulnerable when faced with a situation of acute stress or trauma. Recovery or good coping is seen in some individuals, especially with assistance; however, growing beyond the expected level of functioning is seen only in resilient individuals. In high-risk environments, shown in the second graph, chronic stress makes it difficult for an individual to achieve and sustain the expected level of functioning. Achieving the expected level of functioning for these children is not only “beating the odds”, but also a form of resilience. Growing beyond this point is indicative of invulnerability, characterised by resilience.

Adaptation in a LOW Risk Environment



Graph 1

Adaptation in a HIGH Risk Environment



Graph 2

Figure 5: Adaptation in high and low risk environments, from Ungar (2003).

Thus, for resilience to occur two factors must be present (Masten & Coatsworth, 1998). Firstly, the presence of risk factors, for example poverty, war, psychopathology in the family, low socio-economic status, low parental education or premature birth, death of a parent, to name a few. Secondly, development must be effective (Masten & Coatsworth, 1998).

In the last ten years there has been an explosion of research into the understanding and conceptualising of risk and resilience (Birkerts, 2000). Understanding why some individuals collapse under life pressures and others mature into normal successful adults is pivotal (BBSTF, 1996). It is generally accepted that there is no single source of resilience. Instead, studies to date point to an interaction of factors, (BBSTF, 1996) generally based on the three broad sets of variables identified by Garmezy (1985). These are personal characteristics, family characteristics, such as warmth and cohesion, and the availability and use of an external support system by parents and children. These three categories of variables, which provide an individual with protection or promote risk, will be explored in more detail below.

Personal characteristics

A wide variety of personal characteristics have been noted to play an enormous role in resilience. These unique and complex factors are often difficult to separate and quantify. Most theorists agree that a combination of these individual characteristics can serve to either protect or put an individual at risk (Rutter, 1997; Masten et al., 1990; Luthar & Zigler, 1991; BBSTF, 1996). At the base of this is genetic predisposition, which plays an important role in the internal, individual factors that have bearing on vulnerability or resilience (BBSTF, 1996). Genetic research shows that there may be some genetic differences in term of sensitivity to certain environmental phenomena (Rutter, 1997). Similarly, an individual's genetic predisposition may place them at risk for certain pathologies. For example, researchers noted that children with schizophrenic mothers have ten times more chance of developing schizophrenia than the general population

(Masten et al., 1990). However, 90% of these children do not develop the disorder, suggesting that genes alone do not account for the risk of pathology.

On the other hand, environmental factors create risk for children. However, one's biological predisposition strengthens the probability that particular behaviours will be learned, thus social experiences can be influenced by genes (BBSTF, 1996). It seems that individuals seem to select and shape their environments according to their genetic predisposition (Rutter, 1997). In terms of risk for pathology, Rutter (1997) noted that the risk was highest when both environmental and genetic factors are present. For example, in his study of petty crime he noted that children are at a 6% risk of petty crime if there are environmental but no genetic risks, 12% if there is just a genetic risk and 40% if there is both a genetic and environmental risk present (Rutter, 1997).

Genetic predisposition may be expressed in aspects such as temperament and personality. At times, these qualities are protective with some individuals inheriting certain innate qualities that make it easier for them to negotiate difficult circumstances (BBSTF, 1996). Temperament is evident very early in life in terms of an infant's sociability, emotionality and activity (BBSTF, 1996). Emotionality, in particular, is an aspect of temperament that is involved in making a child resilient or vulnerable (Lengua, 2002). Children with high levels of negative emotionality are easily frustrated, fearful and sensitive to negative cues, whereas children with high levels of positive emotionality tend towards laughter, pleasure, and are sensitive to positive cues (Lengua, 2002). In terms of this, children's temperaments seems to moderate the quality and quantity of affection and attention they gain (Patterson, Reid & Dishion, 1992, in Masten 2001). Children with difficult temperaments are more likely to be the targets of parental hostility, criticism and irritability. They tend to be less susceptible to maternal control and receive more negative attention especially when their parents are stressed (Rolf, Masten, Cicchetti, Nuechterlein & Weintraub, 1989). Accordingly, children with difficult temperaments are less resilient and are prone to multiple risks in high-risk environments, whereas easy-going children demonstrate more resilience and lower adjustment problems (Lengua, 2002).

Furthermore, individuals who are resilient exhibit certain personality factors later on in infancy and childhood (Strode & Barret Grant, 2001). These include possessing effective communication skills, problem solving-skills, strong interpersonal skills and having a sense of hope and direction (Strode & Barret Grant, 2001). Stress-resilient children are also noted to have higher levels of empathy, a sense of efficacy, high self-esteem and are characterised as being outgoing, responsive and independent (Cowen, Wyman, Work, & Parker, 1990). Masten and Coatsworth (1998) include having an appealing sociable disposition, self-confidence, talents and faith to the list of individual characteristics that promote resilience. Humour has also been noted to be a protective personality factor and studies have shown that highly stressed but competent children score more highly on humour generation than less competent children (Luthar & Zigler, 1991). Similarly, intellectual ability, as well as curiosity are protective (Luthar & Zigler, 1991). However, the way in which intelligence interacts with stress is not fully understood (Luthar & Zigler, 1991). It seems that possessing the personal characteristic to acquire and maintain an identity increases resilience in children (Ungar, 2003).

Other innate, personal factors that play a role in risk and resilience are gender and age (Rutter 1990, in Rolf et al., 1989, Masten et al., 1990). It seems that resilience fluctuates with development. For example, very young babies do not show as strong a reaction to separation as older babies do. However, older children and adolescents report stronger and longer lasting reactions to disasters than younger children, as older children are more aware of the wide implications of the situation (Masten et al., 1990). Additionally, gender can influence whether a child will be vulnerable to maladjustment during different development stages. Boys are noted to be more likely to show emotional and behavioural disturbances when exposed to marked family discord (Hetherington & Stanley-Hagan, 1999). Furthermore, there is a greater prevalence of psychopathology in early and middle childhood in boys, such as ADHD and conduct disorder (Masten et al., 1990). However, there is a greater prevalence of some disorders in adolescence for many girls, for example, anorexia nervosa and depression (Masten et al., 1990). It seems that although childhood is more difficult for boys, the expectations of society, body changes and sexual

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ages for girls during adolescence (Rutter, 1989 in Masten

risk has on children it is important to consider a child's
e play an important role in the way he or she understands
engua, 2002). However, children do not exist in isolation
their immediate environment, that is, the family into which

A caring, stable and supportive family is essential to produce a well-adapted individual (Strode & Barret Grant, 2001). In fact, a caring relationship with one primary caregiver in infancy and early childhood is central and considered the most consistent protective factor for children in stressful environments (Dutra, Forehand, Armistead, Brody, Morse, Morse, Clark, 1999). An effective bond with a caring parent is related to better outcomes in children from homes where marital conflict is high, (Rutter, 1990, in Masten & Coatsworth, 1998), where child maltreatment or abuse is present (Luthar & Zigler, 1991), and where exposure to trauma is severe (Masten & Coatsworth, 1998). It is the quality of the parent-child relationship, especially in terms of early attachment, that is important in terms of adaptive child development (Bowlby, 1973). Poorly attached children are found to be more dependent, less socially competent and have lower levels of self-esteem and resilience (BBSTF, 1996).

The quality of the interaction between child and caregiver throughout childhood is vital and has implications in terms of a child developing behavioural problems, substance abuse, peer difficulties, depression, anxiety and antisocial behaviours (Leinonen, Solantaus & Punamaki, 2003). However, it is not only the quality of the interaction between child and caregiver that is important, the style of parenting plays an important role in adjustment (Masten & Coatsworth, 1998). Generally, authoritative parenting, that is, parenting high in warmth, guidance and goal setting, is more likely to result in social

competence than non-involved or punitive parenting (Leinonen et al., 2003). However, it has been noted that different parenting styles are effective for high-risk families (Baldwin et al., 1989, in Rolf et al., 1989). Where openness, mutual communication and more freedom seemed to benefit children of low-risk families, these authors suggest that parenting styles that are more restrictive, authoritarian and vigilant in supervision are better for children from high risk families (Baldwin et al., 1989, in Rolf et al., 1989). This style of parenting is related to higher competency in children and results in less risk in terms of early pregnancy, drug use, and antisocial behaviour (Masten, Hubbard, Gest, Tellegen, Gamezy, & Ramirez, 1999, in Masten, 2001). However, good quality parenting depends on numerous factors and not only does good parenting produce more competent children, but more competent children can produce positive changes in the quality of parenting (Masten et al., 1999, in Masten, 2001). This highlights the systemic nature of the family

On an everyday level, encouraging parents who help their children to become competent at school and in other community activities enhances a child's resilience by promoting mastery (Strode & Barret Grant, 2001). Parents or caregivers who pass along a strong set of values and morals to their children also promote resilience (Strode & Barret Grant, 2001). These cohesive and coherent sets of principle, which are often based in religious principles, provide structure and predictability for children (Strode & Barret Grant, 2001). Parents and other caregivers are the first environmental protectors of development; they nurture physical growth, self-esteem and provide information and learning experiences (Masten et al., 1990). They are also role models for behaviour, either adaptive or maladaptive (Masten et al., 1990).

A good marital relationship between parents is another familial factor that has been found to be a protective factor for children. This seems to go hand-in-hand with parenting as a good marital relationship is a predictor for a high quality of parenting, whereas a marriage characterised by conflict negatively influence parenting (Leinonen et al., 2003). Marital conflict, however, is associated with low self-esteem in children, difficulties at school, and negative images of selves and body (Rolf et al., 1989). The presence of a

close, confiding, warm relationship between parents seemed to buffer the effects of risk factors for the entire family, whereas divorce often brings financial strain and emotional distress, thus increasing vulnerability of the whole family (Rolf et al., 1989). During a divorce, children suffer immediately because of disruptions and parental hostility and violence, and in the long-term, from the stigma of divorce, the loss or blemishing of a parent and having to be prematurely self-sufficient (Leinonen et al., 2003). However, Hetherington and Stanley-Hagan (1999) note that children from divorced parents are initially vulnerable to the development of more emotional, social, behavioural and academic difficulties, but may eventually emerge as competent individuals, since reactions to divorce vary according to individual characteristics and other familial and extrafamilial factors.

Early parental loss, through divorce, separation or parental death has a significant impact on a child's resilience. Loss is indicative of an increase in helplessness, low self-esteem and an increased vulnerability to psychiatric disorders (Rolf et al., 1989). Saler and Skolnik (1992) noted that the effects of parental death on a child, especially in terms of risk for depression in adulthood, are influenced by the interactions of the child with the surviving parent and the family environment. Surviving parents described as empathetic, warm and those who promoted autonomy are protective and individuals from these families are less likely to report depression in adulthood (Saler and Skolnik, 1992).

Another factor that places a child at risk for maladjustment is parental psychopathology (Beardslee, Versage & Gladstone, 1998, in Leinonen et al., 2003). Parental mental illness compromises the quality of parenting available to a child and increases the likelihood of marital discord within the family (Leinonen et al., 2003). Parents with severe mental disorders have difficulty meeting their children's emotional and physical needs and often lack consistency in the care they provide because of their symptoms and periods of hospitalisation (Masten et al., 1990). Depressed parents may appear hostile and negative to their children because of their lack of energy, irritability and inability to engage with their children (Leinonen et al., 2003). Similarly, schizophrenic mothers find it difficult to provide a stable environment, which promotes resilience, thus placing their children at

risk, not only genetically, but also environmentally (Masten et al., 1990). The greatest buffer for children living with parents with mental illness is a warm, relationship with adults in and/or outside the family. In terms of this, Birkerts (2000), in her study with children of depressed parents, found that a family's ability to process the emotions related to the parental illness is vital in promoting resilience.

The socio-economic status (SES) of a family is an additional variable that affects resilience (Cowen, Wyman, Work, & Parker, 1990). This may be due to fact that low SES increases the likelihood of a family being exposed to multiple risk factors such as violence, marital discord, low parent education, parental stress and family violence and abuse (Repetti, Taylor & Seeman, 2002). In terms of this, mothers from families with a lower SES may need to work and are more likely to be tired, overburdened and irritable and thus, less available for their children (Baldwin and Cole, 1989, in Rolf et al., 1989). Families from lower SES are also more likely to lack warmth and support and are more likely to live in impoverished, high crime neighbourhoods. They are also less likely to provide their children with books and other resources than more prosperous families (Repetti, Taylor & Seeman, 2002). Low SES is also related to early mortality, negative physical health and a higher rate of psychological difficulties in children (Lengua, 2002). However, as Luthar & Zigler (1991) point out, research is moving towards what parents do in their interactions with their children and away from a parent's status in terms of occupation, income and other demographics.

Parenting, divorce, parental psychopathology or death and a family's SES can place a child at risk. Thus, the family environment lays the foundation for the way the child views himself, his environment and his competence within that environment. In the same way that a supportive family mediates risk factor, so too does a family require social support systems outside the family unit. These systems play an important role in a child's resilience.

External support systems

Social, cultural and other environmental factors, external to the family system, play a defining role in a child's development (Pianta, Egeland & Sroufe, 1989, in Rolf et al., 1989). In terms of this, the availability and use of an external support system by parents and children is the last of the three variables that Garmezy (1985) identified as protective and promoting resilience. The emphasis is on the quality and quantity of social, emotional and cognitive support available to both the individual and the entire family system. A good quality support system for parents can strongly affect coping skills among high-risk families (Luthar & Zigler, 1991). African communities have been known to be cohesive and interdependent, and these qualities can serve as protective factors for these communities and the individuals in them (Foster & Williamson, 2000).

Strode and Barret Grant (2001) suggest that adult role models beyond the family such as teachers and ministers are important to provide children with a supportive refuge. In terms of this, resilient children are skilled at choosing and identifying with positive models and sources of support (Masten & Coatsworth, 1998). For children whose family systems have failed them, social connections and communities at school or local churches may provide them with much needed security, nurturance and guidance. Instead of seeking professional help, these children tend to have a network of informal friendships, including friends of the same age, older friends, members of church youth organisations, ministers, teachers and principals. From this nurturing support system the children learn the skills and resources they need to negotiate the risky environments in which they find themselves (Masten et al., 1990). Other extrafamilial factors that provide external social support and promote resilience include connections to prosocial organisations and attending effective schools (Masten & Coatsworth, 1998).

Often positive peer relations play a protective role in providing social support and help during times of adjustment and in some cases peers and close friends become more important when other protective factors, such parents, are not available (Masten &

Coatsworth, 1998). For children, a strong peer network is important in helping them form their identities and in gaining social acceptance and a sense of values (Strode & Barret Grant, 2001). Peer relationships influence the choices children make and children tend to find a peer group which reinforce their behaviour, for example, competent children will choose peers who are a positive influences on them, while aggressive children will choose friends who exacerbate their negative behaviour (Masten & Coatsworth, 1998).

A child's competency or perceived competency within their environment can be bolstered by the presence of support systems available to the child or the family. However, the nature of the risk is important to consider as some children are faced with numerous stress factors creating cumulated risk.

Cumulated risk

Masten, Best and Garmezy (1990) noted that in most risky environments multiple risk factors co-occur. These risk factors are often difficult to separate and create exponential risk for an individual (Masten et al., 1990). Rutter (1979 in Garmezy, 1993) studied the effects of cumulated risk factors in a study of impoverished families in England. He identified six family-linked variables that when cumulated were significantly associated with an increased likelihood of psychiatric disorders in children. The factors were severe marital discord, low SES, overcrowding or large family size, paternal criminality, maternal psychiatric disorder, and foster home placement for the children of the family. He found that a single stressor produced a 1% increment in psychiatric disorders in children, while two stressors produced a 5% increment. Three risk factors produced a 6% increase and four or more risk factors accounted for a 21% increment in the rate of psychiatric disorders. Thus, in this study, the culminated presence of stressors accounted for a 33% psychiatric rate.

Kolvin (1988, in Garmezy, 1993) used similar culminated risk factors in his longitudinal study examining the relationship between risk factors and the development of later criminality. He looked at marital discord, parental illness, poor domestic and physical

care of the children and home, dependence on the state or community for subsistence, overcrowded housing, and poor mothering ability. He noted a marked relationship between culminated risk and the rates of offending. Similarly, Sameroff, Seifer and Zax (1982, in Gamerzy, 1993) examined the exposure to multiple risk factors in children born to schizophrenic mothers. They included ten risk factors in their research; namely maternal mental illness, high maternal anxiety, maternal rigidity in attitudes, beliefs and values regarding her child's development, few positive interactions between mother and child, unskilled occupational status of the head of the household, minimal maternal education, disadvantage minority status, reduced family support, stressful life events in the family and large family size. They noted that these risk factors, especially when co-occurring, had a severe effect on a child's cognitive, social and emotional development. Furthermore, they suggested that each risk factor equated to a child losing four IQ points.

However, Gamerzy (1993) noted that even though most of the participants in these studies showed negative long-term outcomes, there were always a few participants from these settings who had positive outcomes. Researchers have always been interested in the protective factors, or the protective process that compensated for these risk factors and made these children resilient despite cumulated risk.

Protective processes

It has been suggested that researchers need to look not only at protective factors but also at the protective process (Masten, 2001). In fact, instead of identifying a protective process, it has been suggested that there may be patterns of behaviour and responses that are more or less adaptive (Rolf et al., 1989). Rutter (1990) sees vulnerability and protection at opposite ends of the same continuum and it seems that as risk factors shift and alter, so too does resilience. Therefore, the protective process is dynamic and changing. Masten and Coatsworth (1998) point out that all children possess protective systems and high-risk children who are resilient do not possess any extraordinary ability. Instead, despite their adversity they are able to maintain these protective systems. Therefore, resilience arises out of ordinary human adaptive process, and the greatest

threats to development are factors that place the systems underlying these processes at risk (Masten, 2001).

Summary

Children are inherently vulnerable and at the same time they are strong and determined to survive and grow (Rolf et al., 1989). These contradictions have been the focus of many debates as researchers strive to understand the physical and psychological development of children under stress. Central to this is the work of Garmezy (1985) who theorised that three broad sets of variables are considered to be pivotal in resilience, namely personal characteristics, family characteristics, and the availability of external support systems. The understanding of these factors, as well as competence, protective factors, risks and vulnerability can only enhance efforts to help children in adversity.

Many protective factors have been removed from the lives of children affected by HIV/AIDS due to loss of parents, stigmatisation and poverty. HIV is placing millions of children, who do not have the personal capacity and social support to adapt to their aversive situations, at risk for maladjustment. Many of these children have not been taught the skills to overcome the immense burdens and trauma they face, leaving them at risk for emotional and behavioural difficulties.

It is clear when considering development and resilience that both external factors (such as the quality of the environment), as well as internal factors (such as the meaning given to events) play a role in risk and resilience (Masten, 2001). This dynamic interaction within and between organism and environment needs to be understood, in order to create interventions that promote the already existing systems of adaptation (Masten, 2001). Bronfenbrenner's ecological model, which will be discussed below, provides a framework, which considers the individual and his or her environment as multi-systemic, with each system impacting upon the individual in a multitude of ways.

Introduction

This chapter aims to examine Bronfenbrenner's theoretical perspective on child development. The advantages and disadvantages of his orientation, as well as its usefulness for clinical practice and research will be discussed. Furthermore, the format and aims of the group therapy, which is embedded in Bronfenbrenner's theory, will be put forward. Since this study aims to evaluate this structured group therapy, programme evaluation will also be discussed. Additionally, the political nature of research will be explored.

The ecological model: Bronfenbrenner

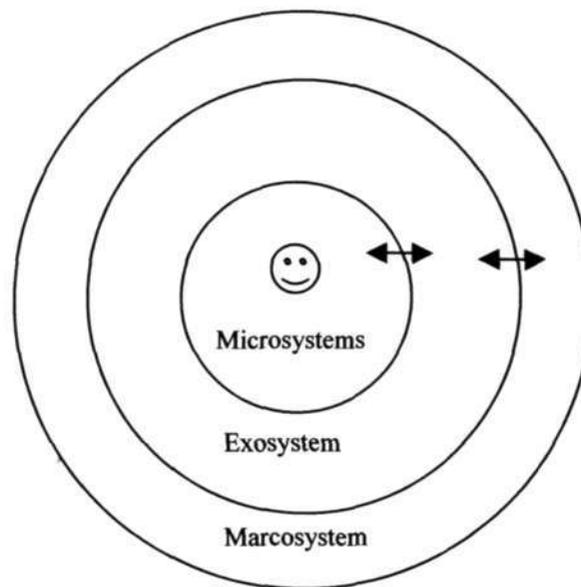
Numerous authors (e.g. Belsky, 1980, Cicchetti & Lynch, 1995, in Stockhammer, Salzinger, Feldman, Mojica & Primavera, 2001) have discussed the role of a human ecological framework for understanding the impact of adversity on child development. Such a framework is generally based on Bronfenbrenner's (1979) pioneering work. Bronfenbrenner developed a theoretical perspective that looked at the developing person and his or her environment, particularly focusing on the interaction between person and environment, which he proposes is two-directional and reciprocal (Bronfenbrenner, 1979). He termed this view transactional, with transactionality being one of the key features of the ecological model (Bronfenbrenner, 1979). For Bronfenbrenner (1979), the growing person is always seen as a dynamic entity, actively involved in development, and not just a *tabula rasa* waiting to be written upon (Bronfenbrenner, 1979). Equally, for Bronfenbrenner, the environment encompasses much more than just the immediate setting (Stockhammer et al., 2001). He describes the ecology of human development as: "the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings,

and by the larger contexts in which the settings are embedded.” Bronfenbrenner (1979, p. 21.).

Many theories of human development focus exclusively on the individual and their abilities, personality and behaviour, other theories focus on the environment looking at modelling, reinforcement and social learning. Bronfenbrenner’s theory, however, focuses on how the environment influences behaviour (Bronfenbrenner, 1979). Although many theorists acknowledge the individual’s environment, most only focus on the immediate environment and few theorists focus on how events and conditions outside the individual’s immediate setting can influence them and their development (Bronfenbrenner, 1979). Bronfenbrenner, on the other hand, looks at the individual in more than one setting, as well as the relationship between settings. He aimed at studying development embedded in context, turning away from the period during which the study of child development focused on the individual and rarely looked at context (Bronfenbrenner, 1989). For Bronfenbrenner (1979) human development requires the examination of a number of multi-person systems, the interaction between them and the effect these systems have on an individual’s development and behaviour.

Bronfenbrenner conceptualises the individual as existing in an ecological environment, made up of structures within themselves, similar to the rings of an onion (Bronfenbrenner, 1979). The first or innermost level is the immediate environment occupied by the developing person, such as the home or the school. The connections between other people within these settings, and the nature of these links are as important as the environment itself. This interrelated, immediate setting is called the microsystem (Bronfenbrenner, 1979). Bronfenbrenner (1979) highlights the principle of interconnectedness and emphasises that it does not only apply within a setting but with equal importance between settings in which the developing person exists. He calls this interconnectedness the mesosystem (Bronfenbrenner, 1979). Similarly, the developing person’s immediate environment is linked to and affected by settings he or she may never enter, such as a parent’s place of work. This system Bronfenbrenner (1979) calls the exosystem. Finally, this complex system is surrounded by the macrosystem, which refers

to overriding “ideology and organisation of social institutions common to a particular culture or subculture,” Bronfenbrenner (1979, p. 43).



Key:

☺ The developing individual

↔ The Mesosystem

Figure 6: Illustration of Bronfenbrenner’s ecological model.

Development involves a change in the person and takes place in both perception and action (Bronfenbrenner, 1979). Bronfenbrenner points out that very few external influences can be described in terms of their physical characteristic and events, instead what is essential to development is the meaning an individual gives the situation or setting (Bronfenbrenner, 1979). It is how the person perceives their environment, what meaning they attribute to events and how they make sense of their role in it, that is important. For example, it is not just the presence of stressors that will result in maladjustment, but rather the individual interpretation of those stressors that is important. In terms of this, Smith (1986) in examining the relationship between marital discord and child behavioural adjustments, showed that it is not simply the presence of parental stressors that result in maladjustment, rather it is the quality of the relationship between parent and child that is important. She found that the child’s perception of the parent-

child interaction influences the child's behaviour and that a child's perception of parental rejection is a predictor of childhood behavioural problems (Smith, 1986).

It is important when examining a developmental theory, to consider whether or not the theory is teleological. This refers to the idea that development moves towards a specific goal or outcome (Aldridge & Sexton, 1997). Piaget's (1977) theory of development, for example, is teleological in that he advocated that all children develop towards moral development and formal operation. Bronfenbrenner discards teleological thinking and suggests that all individuals are unique depending on individual context and characteristics and he suggests that multiple outcomes are possible (Aldridge & Sexton, 1997). Similarly, Bronfenbrenner's theory is not sequential like many theories of development (Thomas, 1992). The sequential nature of theories such as that put forward by Erikson and Piaget has been criticised for being narrow and exclusive. Piaget (1977) focuses on universals, that is, what all children have in common, which is useful when addressing developmental issues common to all children (Beifin, 1992). However, Bronfenbrenner is not focused on the commonalities between individuals nor does he address individual differences in great detail, instead he focuses on contextual factors to which other theorists may have paid less attention (Beilin, 1992). Thus, Bronfenbrenner's theory encompasses more of the individual's uniqueness and allows for natural fluctuations in development.

An advantage of Bronfenbrenner's theory of development is that it looks at most areas of development, as well as how systems develop simultaneously (Aldridge & Sexton, 1997). Some theorists tend to focus on one area of development such as cognitive development, language development etc. Bronfenbrenner does not focus on one element of a child's development; instead he focuses on intracontextual and intercontextual development. His main research question being: how do intracontextual and intercontextual variables interact and change over time to produce an individual's development (Aldridge & Sexton, 1997). Another factor that makes Bronfenbrenner's theory useful is that, instead of concentrating on infancy and childhood like most developmental theories, he focuses

on ongoing child and family systems, thus looking at the whole lifespan (Thomas, 1992). Hence, he focuses on how a child develops over time, across contexts.

In terms of research, Bronfenbrenner (1979) stressed the importance of using developmentally sensitive research and the idea of development in context has implications for research. Bronfenbrenner created the term ecological validity, which refers to the extent to which the environment experienced by an individual during research has the elements that the researcher assumes it does (Bronfenbrenner, 1979). Bronfenbrenner (1979) regards research as ecologically valid when it is carried out in a natural setting involving aspects of everyday life. He suggests that the observer needs to participate in the setting in roles similar to those of the participants and become a member of the subculture experienced by the participants. This reduces the likelihood of misinterpretations and errors based on misperception. Ecological research looks at the developing individual, the structure of the setting and the interactions between the two and his theory has played an important part in research and the development of interventions.

In terms of this, Aldridge and Sexton (1997) point out that theories of child development form a foundation for childhood education and early intervention. When one evaluates a theory of development it is useful to consider how useful the theory is in practice. Malley, Beck and Adoro (2001) used Bronfenbrenner's framework in addressing the practicalities of making the school setting non-violent. The ecological framework encourages parental involvement in education, family-driven early interventions and empowerment of families, teachers and children in education, and served to be a useful model (Malley et al., 2001). Likewise, Fantuzzo and his colleagues (1998) found Bronfenbrenner's theory of ecological development useful when examining the psychosocial adjustment and peer social competencies of maltreated children. Stockhammer et al. (2001) also focused on maltreatment in children and used Bronfenbrenner's theory in clarifying issues in the assessment of maltreated children. Stockhammer et al. (2001) discovered that information about the adversities facing a child and the context in which it occurs predicts functioning more strongly than just

information about the adversity. They noted that Bronfenbrenner's theory was useful in terms of looking at the child's entire context and used his stance to develop interventions for protecting children.

One also needs to consider whether Bronfenbrenner's theory holds true to the needs of children in the 21st century. In the post-modern era, social and feminist theories make an impact on some developmental theories, but Bronfenbrenner's theory has increased in popularity because it addresses the salience of context (Aldridge & Sexton, 1997). Similarly, other theories have been criticised for being Westernised, which is not the case with Bronfenbrenner, as his theory focuses on how context interacts with the child, regardless of the nature of the context. Therefore, it may be argued that Bronfenbrenner's theory holds true in all cultures and on all continents, including Africa.

Bronfenbrenner's theory is flexible, generalisable, cross-cultural, all-encompassing and non-goal directed, making it useful both in research and clinical practice. Thus, his principles were central in the creating the group therapy programme aimed at assisting vulnerable children. The programme acknowledges the multiple settings and systems in which children live and interact, as well as seeing children as dynamic and active participants of their development. The aims and format of this programme will be discussed below.

Aims of the Group Therapy Programme to assist Vulnerable Children

The group therapy programme, which is embedded in Bronfenbrenner's theory, was developed by Madörin and adapted by Killian to assist vulnerable children in a culturally appropriate and effective manner (Madörin, 2002; Killian, 2002). The authors aimed at creating a community-based and self-sustaining programme. This allows the community in which the children live to be trained, empowered and supported, thereby enabling them to take responsibility for their children and offer them ongoing support (Killian, 2002). The central aim of the therapy programme is to address the psychosocial needs of

children affected by poverty, violence and HIV/AIDS in South Africa. As Killian (2002) explains in the programme manual, it does so by:

- Addressing the psychological consequences of the adverse circumstances facing these children
- Increasing their resilience and therefore enhancing their ability to cope with their life circumstances
- Increasing their self-esteem
- Sensitising caregivers to the needs of children living in adversity by including community members in the programme
- Offering ongoing support and development to the children
- Forming links between children at risk and community health workers
- Community mobilisation, in terms of acknowledging and addressing HIV related issues

Format of the group therapy programme to assist vulnerable children

The programme consists of 15 sessions and is divided into two parts (Killian, 2002):

1. **Looking back-** giving the children the opportunity to deal with and gain mastery over their past experiences and the feeling of loss, grief, anger and turmoil associated with the past. This consists of eight sessions.
2. **Looking forward-** enabling the children to develop their resilience, self-esteem and internal coping resources as well as teaching them how to access external support systems in the future. The second part is made up of the remaining seven sessions.

The programme creates a framework, which the children fill with their own experiences, stories and questions (Madörin, 2002). This not only creates a cathartic process but also increases the children's and the community's knowledge and understanding of HIV/AIDS and the adversities connected with the virus. This ultimately empowers the

children and the community. The programme is also based in theories of risk and resilience, and therefore aims to boost the children's resilience and enable them to cope in their risky environments.

Even though this group therapy programme was a success in Tanzania (Madörin, 2002), the suitability and effectiveness of this programme in South Africa needed to be addressed. Thus, programme evaluation will be discussed.

Programme evaluation

According to Potter (1999), programme evaluation in research is used to establish whether or not a programme is needed, effective and likely to be useful in the context for which it was developed. Patton (1997, p.23) defines programme evaluation as "the systematic collection of information about the activities, characteristics and outcomes of a programme to make judgements about the programme's effectiveness, and/or inform decisions about future programming". This type of evaluation is often ongoing and the programme's implementation, quality and outcomes are normally the focus. Programme evaluation is thus useful and necessary for accountability purposes, as well as for the development of social programmes (Potter, 1999).

The central goal of programme evaluation is to establish whether the programme in question is effective in helping the people it was developed for without producing negative side effects (Cook & Shadish, 1986). Not only should an evaluation determine whether the social programme meets the specific needs identified in a certain population, it should evaluate whether the service has been offered as it was originally planned (Potter, 1999). In order to evaluate a programme it must have clear aims and goals. Goal attainment is often quantitatively measured, thus reliability, validity, generalisability and measurability are stressed in programme evaluation (Patton, 1997).

However, in the real world programme evaluation is not so straightforward. Social programmes, although intended to be well-implemented interventions are often

inadequate, producing little change and having vague goals and objectives (Cook & Shadish, 1986). At times, programme evaluation can seem little more than a political act where power and ideology is more important than feedback. Change or the discontinuation of a social programme after an evaluation is rare. As a result, more recent programme evaluations are used to identify problems of implementation and generate practical solutions for improvements (Patton, 1997). Cook and Shadish (1986) note how important it is to make incremental changes to existing programmes in order to make them more effective.

Patton (1997) points out that programme evaluation differs from other research. Instead of undertaking to discover new knowledge and test theories as basic research does, programme evaluation provides information about programmes within certain settings, thus informing decisions, identifying options and clarifying improvements. Therefore, where research aims to produce knowledge, a useful evaluation supports action and the usefulness of an evaluation should extend beyond collecting data and publishing articles.

A programme can be evaluated by means of assessing the individuals involved in the programme by measuring the outcomes or by assessing the procedures of the programme (Cook & Shadish, 1986). Potter (1999) points out there is no single correct way but rather there are multiple methodologies available to evaluate a social programme depending on the context, assumptions of the programme and the requirements of the evaluators. The evaluation of the group therapy developed by Madörin and adapted by Killian (2002) was an important step in the development and implementation of the programme. The method in which this programme evaluation took place will be discussed in detail in the following chapter.

The political nature of research

It is important to note that all research is political in nature (Durrheim & Wassenaar, 1999). Research does not exist in isolation; instead values, beliefs and societal issues influence it. Similarly, research will influence society so that there is a two-way flow of

knowledge. Thus, by studying reality, new realities are created in the individual and society (Terre Blanche & Durrheim, 1999). Researchers also acknowledge the political nature of programme evaluation (Patton, 1997). Numerous issues make programme evaluation political. Firstly, the fact that people are involved in evaluations means that the results will be influenced by their personal perspectives and politics (Patton, 1997). Furthermore, the fact that evaluations require classifying and categorising and that data is interpreted make evaluations political. This is because only a part of interpretation is logical and deductive and the rest is heavily influenced by the values and perspectives of the researchers (Patton, 1997). Lastly, the fact that organisations are involved in evaluations and the fact that the results will influence actions and decisions, including the allocation of resources, status and power, make evaluations political (Patton, 1997).

Patton (1997) suggests that when planning an evaluation, a researcher should understand and anticipate the various different positions or interests of the varying stakeholders in the research, in order to curtail possible attempts of any group to bias or misuse the results. The researcher must also consider the reason for the programme evaluation, as well as considering the decisions that will be made from the result (Patton, 1997). Failing to recognise that the research involves politics and power reduces the evaluator's options and increases the likelihood that the evaluator and the results will be manipulated and used to the advantage of a stakeholder (Patton, 1997).

The political nature of evaluations was evident in this research and manifested in numerous ways. When researching children affected by AIDS, poverty and violence, my own values and my ideas of children, HIV/AIDS and community work influenced the research. These included seeing children as fragile and in need of help and viewing the community intervention as a positive programme that would be welcomed by the children and community. These ideas and many other beliefs and perceptions had to be suspended throughout the running of the programme, as well as during the interpretation of the data. It was also important to explore my personal agenda for being involved in the research, which was to complete my Masters thesis, thus completing my degree.

Introduction

This chapter outlines the aims of the study, the design and procedure of the research, as well as the research questions. The process of data collection, sampling, as well as the instruments used and how they were translated, will be discussed.

Aims of the research

The central aim of this study was to empirically evaluate the effectiveness of the structured group therapy programme for vulnerable children developed by Madörin (2002) and Killian (2002). The evaluation aimed at examining whether the programme caters to the psychosocial needs of South African children affected by violence, poverty and HIV/AIDS. Essentially, the research aimed at investigating whether it is possible, through group psychotherapy, to address the effects of past adversities experienced by these children, as well as increasing their level of resilience and developing coping skills useful to them. The efficacy of the programme was measured in terms of quantifiable measures of trauma symptoms, levels of self-esteem, depression and ability to access social support. These provided a comparable measure useful in a between and within subjects design.

Research questions and hypotheses

The following hypothesis were tested:

Hypothesis 1:

Ho: There is no statistically significant difference in terms of trauma symptoms between the experimental and control groups after the programme is completed

Ha: There is a statistically significant difference in terms of trauma symptoms between the experimental and control groups after the programme is completed, with the children in the experimental group scoring lower on the Trauma Symptom Checklist for Children than the children in the control group.

Hypothesis 2:

Ho: There is no statistically significant difference in terms of trauma symptoms between the pre- and post-test scores of the experimental group.

Ha: There is a statistically significant difference in terms of trauma symptoms between the pre- and post-test scores of the experimental group, with the children scoring lower on the Trauma Symptom Checklist for Children in the post-test data.

Hypothesis 3:

Ho: There is no statistically significant difference in terms of depressive symptoms between the experimental and control groups after the programme is completed

Ha: There is a statistically significant difference in terms of depressive symptoms between the experimental and control groups after the programme is completed, with the children in the experimental group scoring lower on the Reynolds Child Depression Scale than the children in the control group.

Hypothesis 4:

Ho: There is no statistically significant difference in terms of depressive symptoms between the pre- and post-test scores of the experimental group.

Ha: There is a statistically significant difference in terms of depressive symptoms between the pre- and post-test scores of the experimental group, with the children scoring lower on the Reynolds Child Depression Scale in the post-test data.

Hypothesis 5:

Ho: There is no statistically significant difference in terms of self-esteem between the experimental and control groups after the programme is completed

Ha: There is a statistically significant difference in terms of self-esteem between the experimental and control groups after the programme is completed, with the children in the experimental group scoring higher on the Culture Free Self Esteem Inventory than the children in the control group.

Hypothesis 6:

Ho: There is no statistically significant difference in terms of self-esteem between the pre- and post-test scores of the experimental group.

Ha: There is a statistically significant difference in terms of self-esteem between the pre- and post-test scores of the experimental group, with the children scoring higher on the Culture Free Self Esteem Inventory in the post-test data

Hypothesis 7:

Ho: There is no statistically significant difference in terms of perceived social support between the experimental and control groups after the programme is completed

Ha: There is a statistically significant difference in terms of perceived social support between the experimental and control groups after the programme is completed, with the children in the experimental group scoring higher on the Social Support Scale than the children in the control group.

Hypothesis 8:

Ho: There is no statistically significant difference in terms of perceived social support between the pre- and post-test scores of the experimental group.

Ha: There is a statistically significant difference in terms of perceived social support between the pre- and post-test scores of the experimental group, with the children scoring higher on the Social Support Scale in the post-test data.

Sample

A sample of 43 children was drawn from a primary school in a peri-urban community in Pietermaritzburg, KwaZulu-Natal. This community is severely poverty-stricken and HIV/AIDS is rife. Community members and teachers at the school identified these 43 children as being vulnerable children. The children were all affected by HIV/AIDS and had all lost mothers, fathers or both parents to the virus. The children were aged between eight to twelve years old. Two experimental groups and one control group were formed through random assignment. Randomisation ensured that subject's characteristics that may affect the outcomes were evenly distributed between the control and experimental group. Thus, any differences between the groups would be due to chance and would not be systematic. Furthermore, a control group was used to demonstrate any differences between the two groups that may be attributed to the therapy (Schweigert, 1994). The two experimental groups consisted of 12 and 15 respectively, children and the control group consisted of 16 children.

Research design

The research design used for this study was a programme evaluation using repeated measure design based on pre-test and post-test data. The sample group, consisting of 43 children from a primary school was randomly assigned to either the experimental or control groups. Only the experimental groups underwent the structured group therapy programme being evaluated, while the control group engaged in activities, including games, colouring in and singing songs. Pre- and post-test information was collected from all the participant. The information was collected in the form of a questionnaire (see Appendix B) consisting of Trauma Symptom Checklist for Children (TSCC), the Culture Free Self Esteem Inventory (CFSEI), the Reynolds Child Depression Scale (RCDS) and a

Social Support Scale (SSS), all of which had been translated into Zulu (this process will be discussed in more detail). Later, the data obtained was analysed using SPSS-11 and the pre- and post-test outcome measures on the four instruments were compared. A comparison of the outcomes between the experimental groups and the control group was also made.

Research procedure

Contact was made with community workers in the peri-urban community outside Pietermaritzburg, in KZN. In order to intervene effectively and increase the likelihood of sustainability, the 15-session programme was run using the assistance of volunteers based in the community from which the sample was drawn. The concept of considering and working with the entire system and intervening on many levels is in line with Bronfenbrenner's ecological framework (1979). The volunteers were identified as being interested in working with children and underwent a two-week training programme to equip them to assist vulnerable children. Contact was also made with the principal of the school. The research study and the group therapy programme were explained to her and she consented to allow the research to be conducted in her primary school.

With the help of the teachers, 43 vulnerable children between the ages of eight to twelve years old from the surrounding community were identified. Trained data collectors met with the caregivers of these identified children in their homes. The aims and procedure of the research were explained to the caregivers and potential participants. Questions and discussion were encouraged and informed consent was obtained from the legal guardian of each child (this process will be discussed in more detail below). Assent was obtained from the children.

Once informed consent had been obtained, the data collectors filled in the children's questionnaire with each child (see Appendix A). Once the pre-test data was collected, the children were randomly divided into a control group of 16 children and two experimental groups of 15 and 12 children. The experimental groups participated in the full 15-session

therapy programme, participating in two sessions a week for eight weeks. The control group simultaneously engaged in the same number of sessions where they played games and undertook activities such as drawing, reading stories, colouring in, dancing and singing. If the therapy was deemed useful, the control group would have the option of undergoing the therapy later in the year, as per usual ethical protocols. Initially the children in the experimental group were divided into two groups according to age. The groups were combined for the second half of the therapy programme due to the decline in the number of group participants, as well as some difficulties experienced by the facilitators in running two separate groups.

Once the therapy sessions were completed, which took two months, follow up data using the same questionnaire was collected from each participant.

Ethical dilemmas of doing research with children

During the course of this research the ethical dilemmas of working with children were examined. One of the main ethical concerns that always needs to be considered during research is that of gaining informed consent (Gregory, 2003). Informed consent was gained from the legal guardians and assent was obtained from the participants of the study. When gaining informed consent from the legal guardians of the children, all efforts were made to contact the legal guardians of the participants. A small percentage of the participants were staying with caregivers that were not their legal guardians. Where this was the case and the legal guardian was unable to be located, the child was not included in the study.

In terms of the process of gaining legal consent from the guardians, a data collector visited each guardian at home. The data collectors were members of the community who were involved with the programme and specifically trained to collect data. All of the participants and their caregivers are Zulu speaking; thus it was necessary to use Zulu speaking people to assist with data collection. This would ensure that the participant and their caregivers understood the information about the programme before signing the

consent or assent forms. The data collectors explained that the treatment being offered was part of a research programme and clearly outlined the aims and procedure of the research. The format and aim of the group therapy programme were also explained. Care was taken to explain random assignment and that their child may initially be placed in the control group, but that all the children would eventually receive the group therapy if it were deemed beneficial. It was also explained that a child may chose to leave the research at any stage and that they would suffer no prejudice if they decided not to join or to leave the project. This was explained in clear, simple lay language until all the relevant information was understood. The possible risks as well as the benefits (which will be discussed below) were outlined. The responsibilities of the participants, as well as the expected duration of the study were also clarified. Discussion and questions were encouraged. The caregivers were then asked to read and sign the consent form (see Appendix C), which was witnessed by the data collector. Similarly, the research process and group therapy process was explained to the children who were potential participants using simple language and age appropriate terms. The assent forms (see Appendix D) were then read to them, and they signed if they wished to participate.

Confidentiality is another important ethical issue to consider during research (Gregory, 2003). The facilitator and volunteers maintained confidentiality of the participants' identity and status at all times. At the beginning of the group sessions confidentiality was clearly explained to the children. Issues of confidentiality were also covered during the informed consent process, during which it was explained that the content of the sessions would be private. Confidentiality, in terms of the data collected from the children, was maintained by using codes instead of names on the questionnaires and by securely storing the data.

The issues of non-maleficance and beneficence were also considered. Non-maleficance is the duty to do no harm and beneficence is the duty to minimise the potential harms and maximise the potential benefits for the participants (Kaplan & Sadock, 1998). Few potential risks were noted to be involved in this research. The risks for the experimental groups included that of distress and vicarious traumatisation. The group therapy

programme focuses on the children's past experiences of adversity and the emotions that are connected with these experiences. It was considered that some children might find it distressing to talk about these experiences or suffer some vicarious traumatisation when hearing about the experiences of others. These risks were minimised, as the therapy is structured in a way that these experiences and feelings can be expressed in a useful and cathartic manner. Furthermore, the facilitator is experienced in assessing and intervening with children and received supervision from a psychologist who is experienced in the programme. Similarly, the volunteers are sensitive to and trained for the needs of vulnerable children. As a result, distress and vicarious traumatisation was kept at a minimum. In addition, individual therapy was available at the Child and Family Centre, on the campus of the University of KwaZulu-Natal, in the event that a child did experience extreme distress. No risks were foreseen for the control group.

In terms of foreseen benefits of the therapy, a nutritious snack consisting of a sandwich, a piece of fruit and a drink was provided. This benefited the health and nutrition of the children. The volunteers involved in the therapy also benefited as they were provided with an opportunity to work with children and to expand their skills and knowledge about children and HIV/AIDS. Providing the structure group therapy also resulted in the children from that community receiving help that is more holistic in nature. Although a great deal was being done for these children in terms of their instrumental and medical care, their psychological well-being had been largely overlooked. Another benefit was that of instilling resilience and coping skills in the children involved in the therapy. By addressing already existing psychopathology and psychosocial problems early on, the intervention aims to prevent the difficulties experienced by the vulnerable children being exacerbated. This prevents individuals from having to seek mental health assistance, thus preventing resources being spent on them later on in life and reduces possible hospital admissions. Lastly, communities countrywide may benefit from the programme, as the evaluation of the programme was a step towards making it available for implementation in other communities affected by HIV/AIDS.

There are many ethical dilemmas to be faced when considering research with children and vulnerable children in particular. It was important not only to consider these factors, but also to actively take steps to ensure ethical standards were maintained throughout the study.

Instruments

Quantitative measures were used in assessing the therapeutic value of the programme. Four instruments measuring different constructs were selected in order to attain a wide and varied amount of information concerning the children's psychosocial adjustment before and after the programme. The instruments used were:

1. Trauma Symptom Checklist for Children (TSCC)
2. The Culture Free Self Esteem Inventory (CFSEI)
3. Reynolds Child Depression Scale (RCDS)
4. Social Support Scale (SSS)

When selecting instruments for this study, many tools were considered. The above-mentioned tools were selected, as they were appropriate for children between the ages of eight to twelve years and they measure constructs that would be useful in terms of evaluating the programme. Furthermore, they are considered to be valid and reliable tools and they are easy to administer and score. These instruments are discussed in more detail below.

Trauma Symptom Checklist for Children

Vulnerable children are exposed to a multitude of stress factors and face a number of situations outside of normal human experiences. These traumatic events have an impact on a child's emotional well-being and development (Townsend, 2002). Even though there are many varying traumas, which may produce negative psychological effects on children, there are few tests for childhood post-traumatic symptomology and none that

have been standardised on large samples of boys and girls from the general population (Townsend, 2002). The Trauma Symptom Checklist for Children (TSCC) was designed by John Biere in 1996 to address this lack. The TSCC is a self reporting measure for children aged 8-16 years old, evaluating trauma related symptoms, including the effects of child abuse, neglect, interpersonal violence, the witnessing of trauma and the effects of major accidents and disasters (Biere & Elliot, 1997).

The 54-item instrument consists of six clinical scales of anxiety, depression, posttraumatic stress, dissociation (with two sub-scales of overt dissociation and fantasy), anger and sexual concerns. This instrument allowed for the identification of these symptoms in the vulnerable children participating in this study, and monitored whether or not the programme lessened these symptoms. Unlike most tests for children, the TSCC yields two validity scales. Underresponse (UND), which measures abnormally low endorsement of common symptoms and Hyperresponse (HYP), which measures the excessive endorsement of rare symptoms (Biere & Elliot, 1997). The items are explicitly written at the level thought to be understood by children of eight years and older (Biere & Elliot, 1997).

The TSCC scales are internally consistent (alpha coefficient for clinical scales range from .77 to .89 in the standardisation sample) and exhibit reasonable convergent, discriminative and predictive validity in normative and clinical samples. The TSCC was standardised on a group of over 3,000 inner city, urban and suburban children and adolescents in America (Biere & Elliot, 1997). The TSCC takes 15-20 minutes for most children to complete and is suitable for individual and group administration. It was selected for this research study, as it would aid in the gathering of rich information before and after the therapy sessions.

The TSCC has been found to be a reliable and valid tool in numerous other studies. Scott (1998) used the TSCC in examining the relationship between exposure to violence, symptomology and parental support. Mok (1997) also found the tool useful in gender comparisons of child sexual abuse victims. He used it to assess 452 abused children aged

3-17 years old, in order to compare their symptomology. Similarly, Shaw, Lewis, Loels, Rosado and Rodriguez (2000) used the TSCC in assess the difference in symptoms in sexual abuse victim of child perpetrator as compared with adult perpetrators. Gorman, Kennedy and Hamilton (1998) used the TSCC in a study of self-perception, self-esteem and depression in children with spinal cord injuries. They, like Brady and Caraway (2002), who used the TSCC to measure trauma symptoms in 41 children seven to twelve years old who had been removed from their homes, found the tool to be useful and reliable. These authors noted that the TSCC has high construct validity, that is, the TSCC is a valid measure of trauma symptoms in children.

Culture Free Self Esteem Inventory

Self-esteem, believed to be a major aspect of self-concept, may be considered to be an individual's global positive or negative feelings towards him/herself (Rosenberg, 1979, in Marini, Roger, Slate, Vines, 2002). A person's self-esteem affects the manner in which he or she deals with their environment. People with low self-esteem tend to view their environment as threatening and may have difficulty interacting with it (Roy, 1976, in Marini et al., 2002). Battle (1992) indicated that self-esteem, which he described as a person's perception of his or her own worth, is constantly evolving. He also believed it is a culmination of inherent composition influenced by interactions with significant others and various personal life experiences (Battle, 1992). Battle (1992) sees the self as a combination of factors including a person's feelings, hopes, fears, thoughts and views of what s/he is, has been and will become.

The Culture Free Self Esteem Inventory (CFSEI) was designed by Battle (1992) to evaluate attitudes towards the self and personal judgements. The items in the test are divided into two groups: those that indicated high self-esteem and those that indicate low self-esteem. The Form B of the CFSEI-2 containing 30 items was used. It consists of ten items measuring general self-esteem, referring to the individuals' overall perceptions of self worth, five items measuring social/peer related self-esteem, aimed at measuring an individuals' perception of the quality of their peer relationship. Five items measure

academic/school related self-esteem, i.e., the individuals' perception of their academic ability and five measuring parental/home related self-esteem. This refers to their perception of their status at home, including a subjective view of how their parents/caregivers view them. A five-item lie sub-scale is included to indicate defensiveness. The CFSEI can be administered in less than ten minutes and responses are of the forced-choice variety with the child choosing either yes or no for each item.

Children referred for emotional problems score significantly lower on all aspects of self-esteem when compared with children never referred for psychological intervention (Battle, 1992). In assessing the psychosocial impact that HIV/AIDS, poverty and violence have on children, a measure of self-esteem was considered useful in providing an assessment of how the children view themselves and their abilities in various contexts. Being a measure that yields quantitative scores, the CFSEI permitted easy comparison of data, which was useful in the evaluation of this programme. Standardised inventories such as the CFSEI were used in this research because it lessened the extent the examiner influences the data and they could be administered by someone with little training.

In a study of the construct validity of the CFSEI, Battle (1992) compared the results of the CFSEI with data obtained using the Coppersmith's Self-Esteem Inventory and found a strong correlation between the two instruments for all grade levels and for both genders. The instrument also correlates favourably with other measures of personality including A.T Beck's Depression Inventory and the Minnesota Multiphasic Personality Inventory (Battle, 1992). The structure of the CFSEI was investigated using 117 boys and girls from Grades 7, 8 and 9. The scores were subjected to a varimax-rotated matrix that revealed five sub-tests. When the scores were subjected to an alpha (α) analysis of internal consistency. The alpha coefficients were as follows: General .71; Social .66; Academic .67; Parents .76; Lie (defensiveness) .70. Thereafter, test-retest reliability was tested in numerous studies with boys and girls enrolled in grades one to eight in American schools. The data indicated that the correlation for standardised samples were significant for all 5 sub-tests.

The CFSEI has been found to be a reliable and valid tool in numerous studies. Hurt, Malmud, Brodsky, and Gianmetta (2001) used the CFSEI in their study of the psychological and academic correlates in child witnesses of violence. They used the CFSEI to assess 119 children of seven years old who had been exposed to violence, to evaluate their distress and the relationship between exposure to violence and school performance, behaviour and self-esteem. In a study by Rawson and McIntosh (1991) the CFSEI was used to assess the effects of a structured and intensive camping programme and specific behaviour modification techniques on children's self-esteem with 121 boys and girls aged six to twelve years old. As well as using the TSCC in their study of self-perception, self-esteem and depression in children with spinal cord injuries, Gorman et al. (1998) found the CFSEI a useful tool in this study. Bynum and Durm (1996) investigated the relationship between parental divorce and self-esteem in children using the CFSEI and found the tool to be effective, valid and reliable.

Reynolds Child Depression Scale

Depression is an all encompassing mood disorder that influences most areas of functioning including behavioural, emotional, somatic and cognitive operation (Reynolds, 1989). As with depression in adulthood, depression in childhood is not expressed in a single symptom. Instead multiple symptoms manifest, including social withdrawal, somatic complaints, low self-esteem, problems with concentration and a loss of enjoyment of previously pleasurable activities (Wicks-Nelson & Israel, 1997). As Reynolds (1989) points out, depressive symptoms are not a part of normal child development and depression needs to be assessed and treated, otherwise it may persist and have life threatening consequences.

Some theorists consider separation and loss (real or imagined) to be the foundation of childhood depression (Wicks-Nelson & Israel, 1997). Others link stressful life events and trauma, leading to a perception of a lack of control and a certain style of thinking and behaviour, with childhood depression (Wicks-Nelson & Israel, 1997). Many vulnerable children in South Africa will experience one or many losses in childhood and may have

an overwhelming sense of helplessness due to the extreme adversities of their environment. Maternal depression appears to be related to childhood dysfunction. Although childhood depression is not an inevitable consequence of having a parent with depression, the individual does have a predisposition to depression (Wicks-Nelson & Israel, 1997). In terms of this, many vulnerable children may be exposed to a parent or caregiver who suffers from depression due to their own sense of helplessness at their HIV status and the stress factors associated with the virus. These children are at high risk for developing depressive symptomology in childhood.

In order to understand, evaluate and treat childhood depression, accurate measurements of depression are important (Reynolds, 1989). The Reynolds Child Depression Scale (RCDS) was designed to assess depression in children, aged eight to twelve years old, providing researchers and clinicians with useful information for making decisions about the mental health of children (Reynolds, 1989). It is a self-reporting measure that can be administered individually or to groups. Items are written at a second-grade level, the instrument can be completed in less than ten minutes and the test is quickly hand-scorable. The RCDS consists of 30 items; assessing symptoms of depression from the criteria listed for major depression and dysthymia in the Diagnostic and Statistical Manual of Mental Disorders –3rd ed., revised (1980). The first 29 items are symptom related, asking children how often they have experienced certain symptoms. The children choose their responses from a four-point Likert-type scale range from 0="almost never" to 3="all the time". The last item consists of five "smiley" faces ranging from sad to happy. The thirty items possess good reliability-high Cronbach's alpha (Reynolds, 1989). Based on over eight years of research and clinical data on over 1,600 children, RCDS exhibits test-related reliability of .82 and .85 for studies of two-week and four-week intervals (Reynolds, 1989). Validity has been consistently demonstrated through extensive content, construct, and criterion-related studies.

The RCDS has been found to be a reliable and valid tool when working with children aged eight to twelve years and it has been used in numerous studies. The RCDS was used by Schick and Runyan (2003) to provide immediate screening evaluations on all children

entering state custody. This quantitative, objective analysis estimated each child's functioning in order to better match children to services and placements. The authors considered the tool to have high construct validity and to be a valid measure of childhood depression (Schick & Runyan, 2003). Thus, the RCDS was considered a useful tool for this research project.

Social Support Scale

Schrover, Ranchor and Sander (2003) describe social support as the perceived availability of emotional support as well as the lack of negative interactions and problem-focused emotional support. This type of social support is characterised by reassurance, comfort, problem solving and advice (Schrover et al., 2003). Schrover and his colleagues (2003) focused on cancer patients and social support and they showed that low levels of social support were associated with higher levels of depressive symptoms in cancer patients. Similarly, Wertlieb, Weigel, Springer and Feldstein (1989) found that social support from intrafamilial and extrafamilial sources moderate the relationship between life stresses and illness.

Battles and Wiener (2002) found that social support along with open communication concerning an HIV diagnosis are vital for positive psychosocial adjustment in children. These authors used a social support scale to examine the psychosocial factors associated with the long-term survival of children with paediatric HIV infection (Battle & Wiener 2002). The average age of the study was 11 years old and the authors used a child social support scale to assess the amount of support these children received. The authors found the tool to be effective, valid and reliable and noted social support correlated negatively with problem behaviour.

Similarly, Cauce, Felner and Primvera (1982, in Luthar & Zigler, 1991) explored the protective function of three dimensions of social support for children aged seven to twelve years old; namely family support (parents and relatives), formal support (counsellors, teacher and clergy), and informal support (other adults and peers). The

social support scale used in this research measured support gained from these three sources. The researchers noted that social support was protective and that perceived helpfulness of these support structures differed according to sex, age and background.

Luthar and Zigler (1991) indicate that positive school experiences serve as a protective function in children and the availability of supportive parents strongly affects coping skills among high-risk families. It was also noted that intervention programmes that offer social support systems to high-risk families provide protection and promote positive outcomes (Luthar & Zigler, 1991). In fact, Hunter and Kilstrom (1979, in Luthar & Zigler, 1991) suggest that the presence of social support is among the factors that determine whether parents repeat intergenerational cycles of child abuse.

Social support is a vital protective factor in high-risk situations and children who perceive their social support as high fare well under stressful situations. Additionally, resilient youths appear more skilful in choosing and identifying positive role models and useful sources of support (Luthar and Zigler, 1991). Thus, resilience goes hand-in-hand with social support. This made it an important variable to quantify in the vulnerable children participating in this study and a valid measure for the evaluation of the group therapy programme.

Translating the questionnaires

Translating the questionnaires to be used in this study was a lengthy and arduous process aimed at making the data collection more reliable and relevant to the South African context. The translation of the questionnaires intended to put the test items in the first language of the participants, as well as converting terms and ideas into those that would be understood by the participants in the context in which they live. The translators used words that were easy to understand and relevant to rural Zulu-speaking children without losing the original meaning and content of the tests.

The initial step was to translate the questionnaires and the instructions for the questionnaires into Zulu. A psychology masters student, whose first language was Zulu, did this step of the translating procedure. The aim was to have the translation done by a Zulu speaker with a sophisticated knowledge of psychology, so as to avoid the content of the questions and instructions changing. The items were then translated back into English by a Zulu speaker of a lower educational standard to ensure the translation would be accessible to the rural children it was intended for. The sentences resulting from this step were then compared to the original English items. Where there were discrepancies between the two versions the procedure was repeated until the results matched the original items.

The four tests were then formatted into one questionnaire including instructions for each test and questions pertaining to demographic information (see Appendix B).

Introduction

In this chapter the analysis of the collected data, which was done using the Statistical Package for the Social Sciences-11 (SPSS-11), is presented. Firstly, the demographics of the sample will be explored, followed by the descriptive statistics and the reliability of the tools. The results of the statistical procedures used to examine the relationships between the pre- and post-test data and the control and experimental groups will then be presented.

Characteristics of the sample

Table 1 reflects the age composition, while table 2 looks at the gender distribution of the whole sample group and table 3 shows the level of education of the participants.

Table 1: Age distribution of the sample of vulnerable children

Age	Frequency	Percentage
8 year olds	10	24%
9 year olds	9	20.9%
10 year olds	5	11.6%
11 year olds	6	14%
12 year olds	13	30.2%
Total	43	100%

The mean of the age of the participants is 10 years old

Table 2: Gender composition of the sample.

Gender	Frequency	Percentage
Male	22	51.1%
Female	21	48.8%
Total	43	100%

Even though the sample was selected without making allowances for gender, there was a fairly even distribution of male and female participants of 22 males and 21 females.

Table 3: Composition of the level of education of the children in the sample group.

Grade	Frequency	Percentage
Grade 1	2	4.6%
Grade 2	5	11.6%
Grade 3	10	23.2%
Grade 4	7	16.2%
Grade 5	5	11.6%
Grade 6	12	27.9%
Grade 7	2	4.6%
Total	43	100%

Attendance

When implementing a community based intervention the attendance by the participants can be sporadic and problematic. The attendance of the programmes by both the experimental and control group members is represented below in figure 7 and figure 8.

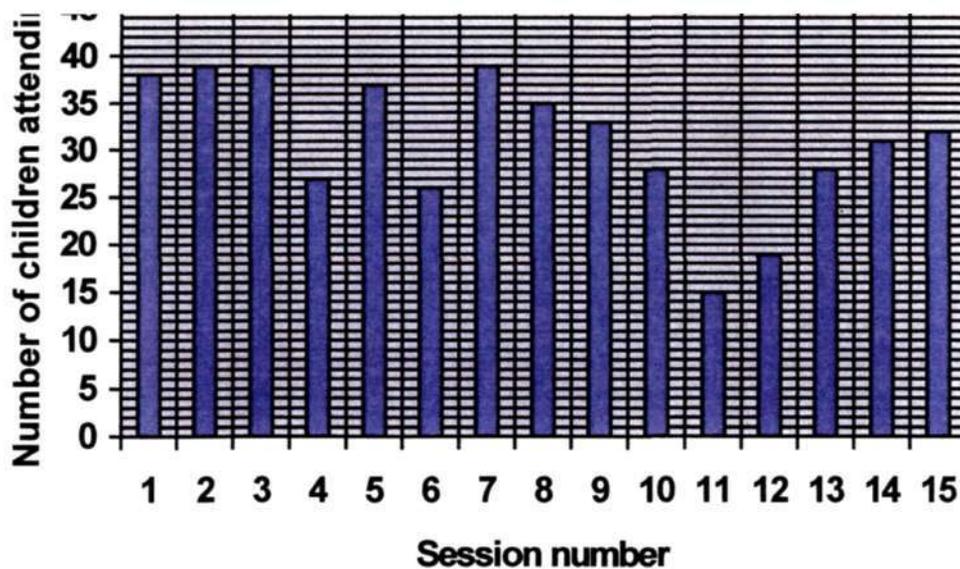


Figure 7: The number of children at each session

Generally, the attendance of the sessions was good, with the average number of children per session being 31 children. Sessions 11 and 12 were poorly attended as they fell during a school holiday and some of the participants were unable to come to these sessions. Figure 8 represents the number of sessions attended by the each child. There were 15 sessions and the average number of sessions attended by each child was 12.

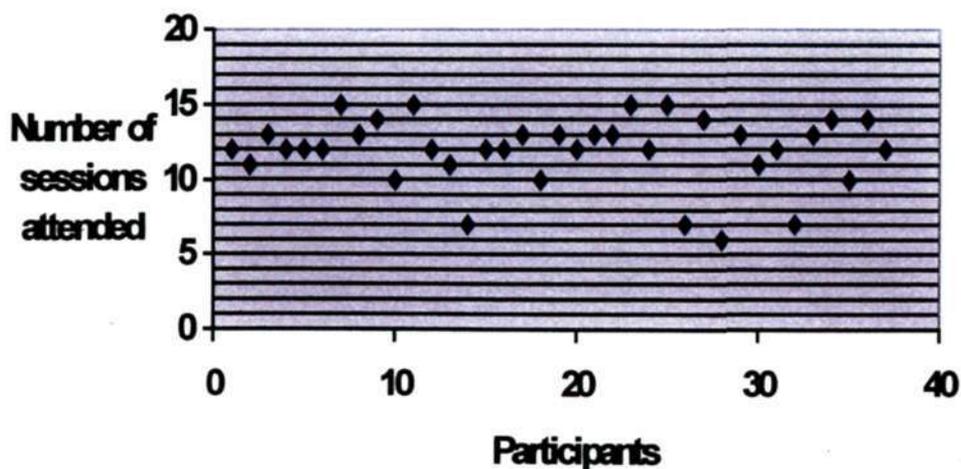


Figure 8: The number of sessions attended by each child (experimental and control).

Originally, data was collected from 43 children. During the running of the group therapy programme six children, two children from each group, dropped out of the study leaving 37 children. The children dropped out for a variety of reasons, but usually for reasons

beyond their control, such as their grandmother wanting them home earlier to complete their chores. The effects of the attrition of the sample will be discussed in more detail below. Of the 37 children who attended the sessions post-test data was obtained from 35, as two children left the community after the intervention and post-test data could not be obtained for them. When running the statistics the scores of the two experimental groups were combined in order to create one score that could be compared to the control group's score.

Descriptive statistics

Descriptive statistics were calculated for the pre- and post-test data on each of the sub-scales of the CFSEI (general self-esteem, social self-esteem, academic self-esteem, parental self-esteem, and the lie scale), the sub-scales of the TSCC (anxiety, depression, posttraumatic stress disorder, anger, dissociation, both overt and fantasy) and the RCDS. The mean, standard deviation, maximum and minimum scores of each sub-scale and the test as a whole are represented in the tables below.

Table 4: The means and standard deviations of the CFSEI and its sub-scale for the pre- and post-test data of the whole sample.

Sub-scale	N	Minimum	Maximum	Mean	Std. Deviation
General-pre-test	40	13.00	20.00	16.7250	1.63280
General-post-test	35	14.00	20.00	16.7429	1.63316
Social-pre-test	43	5.00	10.00	7.6744	1.22903
Social-post-test	35	6.00	9.00	7.4857	1.06747
Academic-pre-test	42	6.00	10.00	8.8095	.99359
Academic-post-test	35	7.00	10.00	9.3429	.72529
Parental-pre-test	42	6.00	10.00	9.2619	1.08334

Parental-post-test	35	7.00	10.00	9.5429	.81684
Lie-pre-test	43	5.00	9.00	7.3023	.96449
Lie-post-test	35	5.00	10.00	7.5714	1.11897
CFSEI-total pre-test	43	43.00	54.00	49.8140	2.94599
CFSEI- total post-test	35	43.00	55.00	51.0000	3.12485

Table 5: The means and standard deviations of the TSCC for the pre- and post-test data of the whole sample.

Sub-scale	N	Minimum	Maximum	Mean	Std. Deviation
Anxiety-pre-test	36	5.00	28.00	13.0556	5.36627
Anxiety-post-test	32	3.00	22.00	10.4375	4.77856
Depression-pre-test	38	53.00	71.00	60.8421	4.68769
Depression-post-test	31	53.00	71.00	58.8065	3.39037
PTSD-pre-test	37	2.00	27.00	12.1892	6.63676
PTSD-post-test	32	3.00	18.00	9.6250	4.34593
Dissociation/overt-pre-test	41	.00	9.00	3.7073	2.42120
Dissociation/overt-post-test	34	.00	9.00	3.0588	1.89002
Dissociation/fantasy-pre-test	40	48.00	52.00	49.3250	1.20655
Dissociation/fantasy-post-test	34	48.00	54.00	49.2647	1.37750
Dissociation/total-	40	48.00	60.00	52.9750	3.18238

pre-test					
Dissociation/total -post-test	33	49.00	63.00	52.2121	2.49697
Anger-pre-test	38	.00	14.00	5.0263	3.13211
Anger-post-test	32	.00	19.00	3.4375	3.90977
Dissociation/total -pre-test	40	.00	16.00	5.3250	4.20249
Dissociation/total -post-test	33	.00	11.00	5.0303	3.60108
TSCC-total pre- test	43	3.00	74.00	37.5814	16.68080
TSCC-total post- test	35	14.00	62.00	32.6857	12.46589

Table 6: The means and standard of the RCDS for the pre- and post-test data of the whole sample.

	N	Minimum	Maximum	Mean	Std. Deviation
RCDS-pre-test	43	8.00	51.00	23.7674	8.53240
RCDS- post- test	35	9.00	50.00	21.9714	7.10628

The structure of the SSS did not produce score equivalent to those in the above tables.

Reliability of the tools

Using SPSS-11, the reliability of each test was checked using the data collected from the whole sample. Reliability checks were run for both the pre- and post-test data. The (alpha) reliability coefficients are displayed in the tables below.

Table 7: The (alpha) reliability of the CFSEI.

Sub-scale	Pre-test data	Post-test data
General self-esteem	.3580	.3522
Social self-esteem	.3547	.1051
Academic self-esteem	.1926	-.0998
Parental self-esteem	.5863	.4660
Lie scale	-.1042	.2081

Table 7 shows that none of the sub-scales of the CFSEI are reliable, with all the reliability coefficients falling below .6. Since none of the score are considered reliable the results from this instrument must be viewed with caution.

Table 8: The (alpha) reliability coefficients of the TSCC.

Sub-scale	Pre-test data	Post-test data
Anxiety	.6649	.6123
Depression	.7441	.7367
Posttraumatic stress	.7960	.6479
Dissociation-overt	.4042	.3668
Dissociation-fantasy	.4642	.4132
Dissociation-total	.5964	.5000
Anger	.4766	.7971
Sexual concerns	.6328	.4768
Total for TSCC	.8470	.8392

The (alpha) reliability coefficients of the sub-scales of the TSCC shown in the table above were mostly high enough to be considered reliable. Correlation matrixes of all the TSCC sub-scales were computed for both pre- and post-test scores (see Appendix E1). All the sub-scales of the TSCC correlated except for the anger sub-scale, which does not overlap with the other sub-scales. Furthermore, it is only in the pre-test data that the

anger sub-scale does not correlate with the other sub-scales. However, since there is a high correlation between the remaining sub-scales of the test, the reliability of the TSCC as a whole was calculated. The overall reliability of the tool was .8470 for the pre-test and .8392 for the post-test. This (alpha) reliability coefficient is acceptable and thus, the results from this tool are considered worth analysing. Reliability of this tool could be improved by excluding a few items (such as item number 19), which correlated negatively between the pre- and post-test.

Table 9: The (alpha) reliability coefficients of the RCDS.

Pre-test data	Post-test data
.6997	.7260

The RCDS showed reliability coefficients of .6997 and .7260, which allow this tool to be considered reliable.

Due to the format of the SSS, a reliability test was not run on the test.

Choice of statistical procedures

The design of the experiment is that of a 2-way layout, with most interest falling on the interactions or changes between or within the groups. Thus, it was decided that 2-way ANOVAs would be run on each of the pre- and post score pairs. The 2-way ANOVA allows one to test the variability between the factors and the interaction among the factors (Schweigert, 1994). The 2-way ANOVA was appropriate for the data from the CFSEI, the TSCC and the RCDS; however, due to the very coarse scores of the SSS a 2-way ANOVA could not be run on the data from this test. Instead Mann-Whitney tests were run on the differences between the pre- and post-test data of the SSS. Bradley (1968) notes that testing the differences between the pre- and post-test scores using the Mann-Whitney test is in effect looking at the interaction in an ordinary 2-way ANOVA. SPSS-11 offers a wide range of statistical output, particularly for the 2-way ANOVA with

repeated measures; however more in-depth statistical analysis was not felt to be warranted with this data due to the insignificance of the results from the 2-way ANOVAs or Mann-Whitney tests. It was also noted that some of the insignificant scores would become significant, purely by chance if ANOVAs were run enough times. The following discussion will focus on the relevant results; however, the full statistical output is available on a disk in the School of Psychology, Pietermaritzburg.

Trauma Symptom Checklist for Children

A 2-way ANOVA was used on the results of the TSCC to calculate if there was a significant difference between the pre- and post-test data as well as between the control and experimental. The three f-tests that arise from any 2-way ANOVA are the main effects of (1) combined experimental and control groups for pre-minus post-test changes; (2) combining pre- and post-test scores for each group, to test overall differences, and (3) the interaction. Abstracting from the lengthy SPSS output for the TSCC, it was noted that the p-values ($p=.306$ and $p=.177$) for both the main effects are not statistically significant; however there was a significant interaction of $p=0.040$ (see Appendix E2 for the complete table). This significant interaction is represented in figure 9 below.

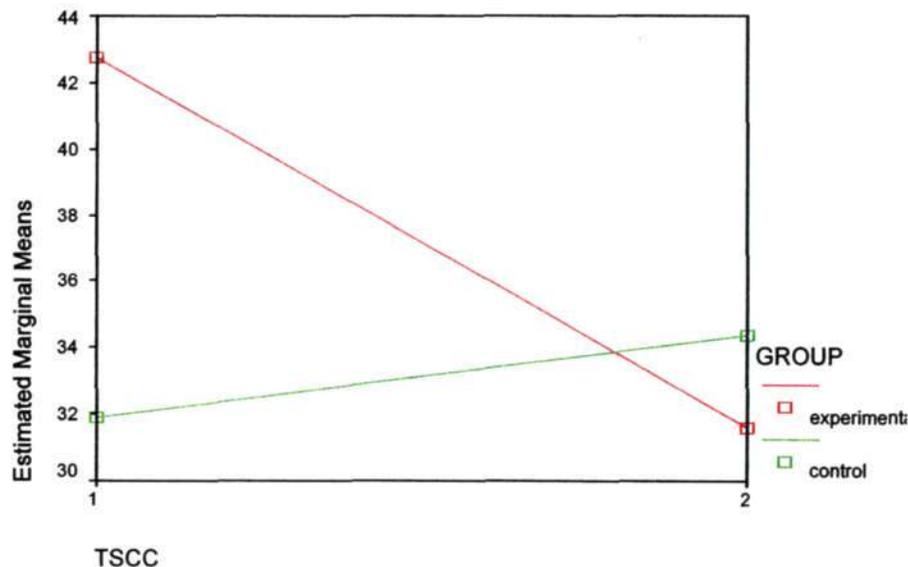


Figure 9: Representation of the results of the 2-way ANOVA of the TSCC.

The fact that the pre-test data for the control and experimental data differs so much is surprising considering the sample was randomised. The trauma symptom measure for the experimental group shows a large drop, whereas the control group show a minimal increase over the two months that the intervention was implemented. Thus, one can theorise that the trauma symptoms of the experimental group reduced significantly due to the therapy programme. Perhaps the control group's symptoms showed a minor increase

due to the fact that these children are predisposed to a range of symptoms including those measured by the TSCC, because they all live in a community where violence is an everyday occurrence and poverty and HIV/AIDS is common.

2-way ANOVAs were run on all of the sub-scales of the TSCC, namely anxiety, depression, posttraumatic stress, dissociation and anger. No significant difference was noted on either the anxiety or depression sub-scales for any three of the f-tests. The results from the depression sub-scale reiterate those of the Reynolds Child Depression Scale (to be discussed below). Both the posttraumatic stress disorder and the anger sub-scale approached significance with p-values of .070 and .022 respectively for a change between the pre- and post-test data (see Appendix E3 and Appendix E4 for the complete tables). This suggests that the symptoms of posttraumatic stress and anger of all children (experimental and control) attending the sessions reduced significantly. Furthermore, the dissociation sub-scale of the TSCC shows a significant interaction, which is represented in figure 10 below.

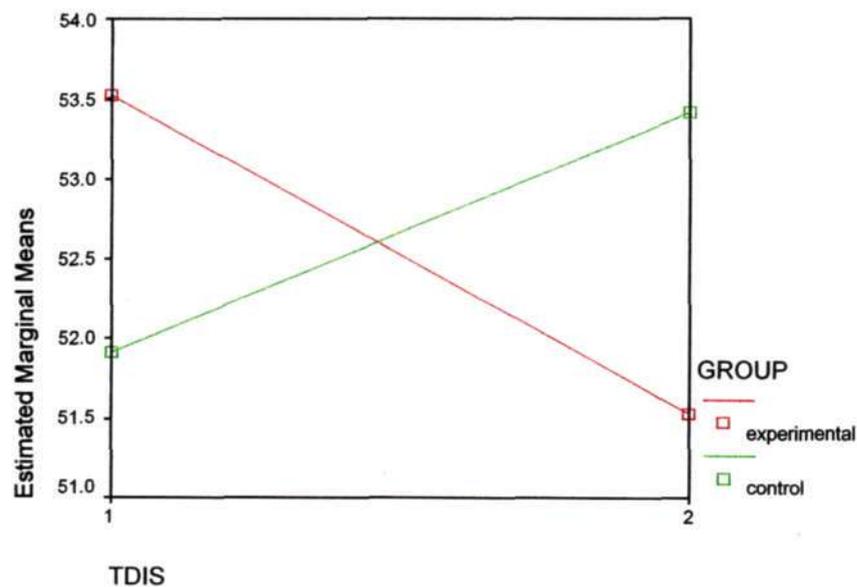


Figure 10: Representation of the 2-way ANOVA results for the dissociation sub-scale.

This interaction is significant but difficult to interpret. This score consists of both sub-scales of dissociation, namely overt dissociation and fantasy. It seems that the symptoms

of the control group increased, even though the experimental groups symptoms has decreased. Items on this sub-scale include question such as: *pretending I'm somewhere else; going away in my mind, trying not to think and feeling like things aren't real*. Dissociation, both overt and fantasy, seems to be a coping skill increasingly used by these vulnerable children and the group therapy programme seems to offer the children an opportunity to express their feeling, resulting in these symptoms decreasing.

Culture Free Self Esteem Inventory

The 2-way ANOVA was also used with the CFSEI to examine the difference between the pre- and post-test scores and the difference between the scores of the control and experimental groups. However, due to the unreliability of this tool, significant outcomes were not expected and as predicted no significant differences between either the pre-or post-test scores or the control and experimental groups were noted (see Appendix E5).

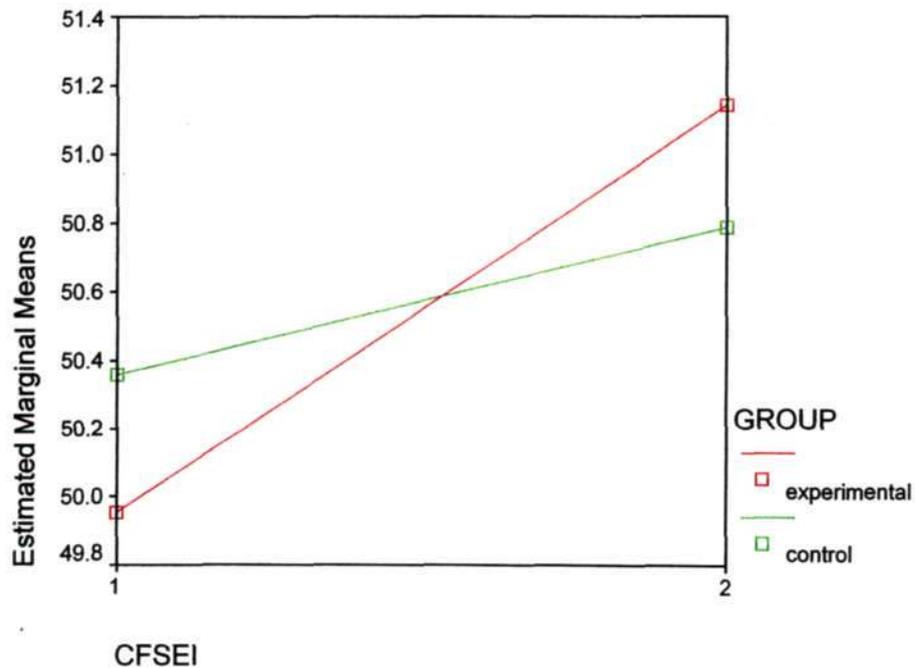


Figure 11: Representation of the results of the 2-way ANOVA of the CFSEI.

The graph in figure 11, which represents the results of the 2-way ANOVA of the CFSEI, shows that the self-esteem of the children in the both groups rises; however the p-values are not significant. This may be due to the small sample size as well as the unreliability of the CFSEI. Two-way ANOVAs were run on the five sub-scales of the CFSEI, namely general self-esteem, social self-esteem, academic self-esteem, parental self-esteem and the lie scale. None of these sub-scales showed a significant difference between the pre- and post or control or experimental scores.

Reynolds Child Depression Scale

The 2-way ANOVA run on the data collected from the RCDS showed that there was no significant difference between either the pre- and post-test data or between the control and experimental groups. The graph in figure 12, which represents the results, shows that depressive symptoms of the children in the both groups, decreases. However the p-values of .112 and .390 are not significant (see Appendix E6). This may be due to the small sample size. This finding is confirmed in the depression sub-scale of the TSCC, which shows no significant difference between the pre- and post-test or control or experimental scores on this sub-scale.

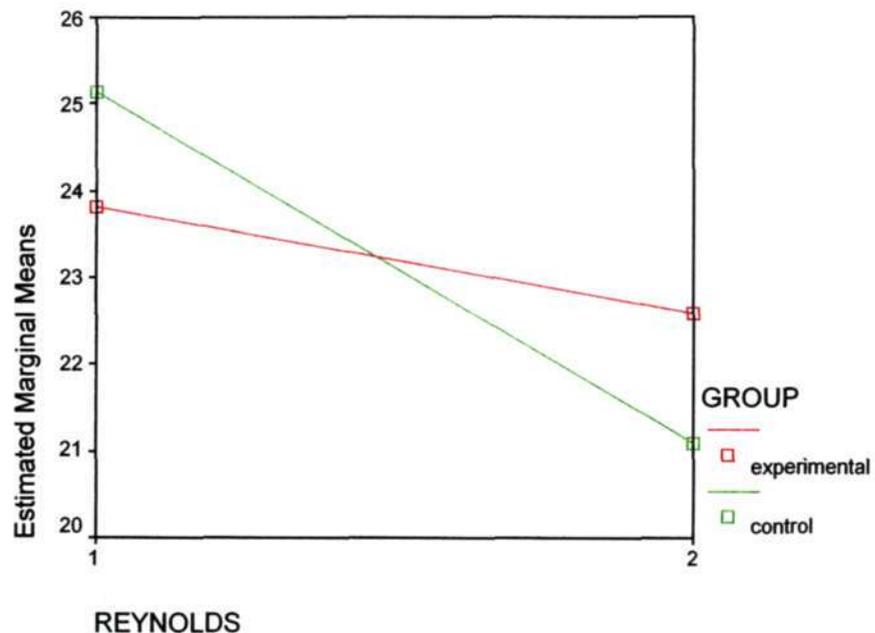


Figure 12: Representation of the results of the 2-way ANOVA of the RCDS.

Social Support Scale

As mentioned above the coarse score categories of the SSS seemed inappropriate for ANOVA methods. Therefore, Mann-Whitney tests were run on the differences between the pre- and the post-test scores, since testing the differences between two groups using the Mann-Whitney test, is in effect like looking at the interaction in an ordinary 2-way

ANOVA (Bradley, 1968). The Mann-Whitney test revealed that there was no significant difference between the pre- and the post-test data.

Summary

In summary, the TSCC was the only test that showed any significant difference between pre- and post-test data. The CFSEI shows an increase in self-esteem in the control and experimental groups from the pre- and post-test data graphically; however the p-values are not significant, which may be due to the small sample size and the unreliability of the instrument. Similarly, the graph of the RCDS shows a decrease in depressive symptoms in the control and experimental groups from the pre- and post-test data. However, the changes are not statistically significant. Furthermore, the Mann-Whitney test revealed that the differences between the pre- and post-test scores of the experimental versus the control groups on the SSS are not significant enough to indicate an increase in access to social support. Nevertheless, the trends are all in a positive direction in terms of improved level of functioning.

Introduction

This research has focused on the evaluation of the group psychotherapy for vulnerable children in South Africa. The discussion will involve assessing the question as to whether the therapy programme has reduced the symptoms of the participants (in terms of depression and trauma symptoms) and raised their resilience (in terms of self-esteem and access to social support). This discussion will centre on the results from the Trauma Symptom Checklist for Children, the Culture Free Self Esteem Inventory, the Reynolds Child Depression Scale, and the Social Support Scale that were set out in the chapter above. The findings will be discussed in terms of rejecting or accepting the null hypotheses. Furthermore, programme evaluation will be discussed with special reference to the strengths of the programme.

The hypotheses

The null hypothesis of hypothesis 1 states that there is no statistically significant difference in terms of trauma symptoms between the experimental and control groups after the programme is completed. The analysis of the data shows that the null hypothesis can be rejected, as there is a statistically significant difference in terms of trauma symptoms between the experimental and control groups after the programme was completed. This interesting interaction, displayed above in figure 9, shows a steady drop of the experimental group's trauma symptoms. This suggests that the group therapy programme reduces trauma symptoms in vulnerable children. However, there is no statistically significant difference in the results from the pre- and post-test scores of the experimental group on the TSCC, which leads to the acceptance of the null hypothesis of hypothesis 2.

What is of interest on the TSCC results is the interaction between the control and experimental groups. Figure 9 shows how the symptoms of the control seem to increase

over the two months that the intervention was run. It seems that the participant's trauma symptoms are increasing, which may be due to the fact that they are living in a community where HIV/AIDS and violence are rife. The TSCC assesses symptoms such as anxiety, depression, anger, dissociation and the symptoms of posttraumatic stress disorder. The literature points out that many aspects of HIV/AIDS, poverty and violence lead to an increase in these symptoms. For example the stigmatisation connected to HIV/AIDS causes emotional distress in children in terms of their own status (Lewis et al., 1994) and that of their parents (Brown & Lourie, 2000). Stigma is very destructive, causing isolation, shame, powerlessness (Brown & Lourie, 2000) and hinder healthy emotional development, resulting in anxiety and depressive symptoms (Fanos & Weiner, 1994).

Similarly, bereavement is one of the most stressful events a child can experience (Committee on Psychological Aspects of Child and Family Health, 2000). The multiple losses these children experience, which are common for children in families living with AIDS or HIV, are unusual and traumatic for most children (Brown & Lourie, 2000). Furthermore, the lack of stable or consistent care and the multiple caregivers that the children find themselves with make them vulnerable to exploitation and abuse (Foster & Williamson, 2000). Some of the questions of the TSCC explore abuse or exploitation. For example, item 24: *feeling scared of men* and item 26: *washing myself because I feel dirty inside*. The community workers reported that many of the children from the area are sexually and physically abused and the children identified for the programme were particularly vulnerable due to their circumstance. Thus, without intervention the trauma symptoms of vulnerable children will increase, as seen in the control group.

It is clear that all the children in the sample are at immense risk for an increase in trauma symptoms. However, the reduction of the trauma symptoms of the experimental group demonstrates that the therapy programme aids to alleviate some of the symptoms of the children. Reducing these symptoms is one of the central aims of the therapy programme (Killian, 2002). The first part (the first eight sessions) of the therapy programme in particular, gives the children the opportunity to deal with and gain mastery over their

feelings of loss, grief, anger and turmoil associated with their past (Killian, 2002). Specifically, session six deals with feelings of anger and frustration and session seven focuses on feelings of stigmatisation and discrimination. Furthermore, session D, called “yes-no”, aims to increase a children’s ability to defend themselves against abuse and expand their knowledge about their rights, in the hope of preventing future trauma.

The TSCC was proven to be a reliable tool, with an alpha reliability coefficient of .8470 for the pre-test data and .8392 for the post-test data. However, it seems that one of the greatest factors affecting the results is that of an insufficient sample size. The small sample size reduces the chance of reaching significance.

This factor also affected the results of the RCDS and the SSS. The graphs for the RCDS (figure 12) shows a decrease in depressive symptoms from pre-to post-test, however, the p-values are not statistically significant. Thus, the null hypotheses of hypotheses 3 and 4 with regard to the Reynolds Child Depression Scale have to be accepted. The null hypothesis of hypothesis 3 states that there is no statistically significant difference in terms of depressive symptoms between the experimental and control groups after the programme was completed. The null hypothesis of hypothesis 4 states that there is no statistically significant difference in terms of depressive symptoms between the pre- and post-test scores of the experimental group.

In terms of the literature, it is clear that vulnerable children are at risk for developing depressive symptoms. Most of the children had been faced with having to cope with the illness of one or both parents, which is a distressing situation for any child (Miller & Murray, 1999). Children of terminally ill parents have been noted to have significantly higher levels of depression, anxiety and lower self-esteem (Siegel et al., 1992). Behavioural changes such as sadness, hopelessness, worry and less motivation to play have been noted in children of terminally ill parents and they tend to become solitary, miserable, distressed and fearful of new situations (Poulter, 1997, in Foster & Williamson, 2000). Children of infected parents have also been noted to be more withdrawn and have more difficulties with attention (Forsyth et al., 1996). Depressive

symptoms may also be related to the stigma associated with AIDS, which increases the likelihood of persistent and unresolved grief (Pivnick & Villegas, 2000). Furthermore, an increase in bereaved children's responsibility leaves them with little time to form their own autonomy and relationships, lowers their self-esteem and enjoyment of life and can lead to depressive symptoms (Chase, 1999).

Furthermore, these children are faced with parental death, which places them at risk for developing depressive symptoms in childhood (Skinner Cook & Dworkin, 1992) and anxiety or depression in adulthood (Saler & Skolnik, 1992). Saler & Skolnik (1992) noted greater risk for depression later in life was associated with children who had less of an opportunity to express and explore their feelings and thoughts about the loss. It is clear that it is necessary to address the depressive symptoms of vulnerable children. Thus, the therapy programme offers the children the opportunity to explore and express these feelings. In fact, the therapy aims to address these symptoms directly, as session three looks at feelings associated with the loss of a loved one and session five deals with feelings of sadness and helplessness. Even though the p-values are insignificant, due to the small sample size, it is positive that the graph of the results of the RCDS scale shows a reduction in the depressive suggesting the therapy does lessen the children's symptoms of depression.

In terms of trauma and depressive symptoms, verbal reports were received from members of the communities, the teachers from the primary school and the group participants (mainly the experimental group) concerning a reduction in symptoms particularly of anxiety, sadness, anger, difficulties in concentrating and sleeping. A difference was noted in the children's play and interactions between group members in terms of a lessening of aggression and isolation. Likewise, differences were noted in their drawings, which showed fewer signs of anger and insecurity, as well as in their written reports on how they were feeling.

In terms of the CFSEI, neither of the alternative hypotheses from hypothesis 5 or 6 could be accepted. Instead the null hypothesis of hypothesis 5, which states there is no

statistically significant difference in terms of self-esteem between the experimental and control groups after the therapy programme is accepted. Similarly, the null hypothesis of hypothesis 6, which states that there is no statistically significant difference in terms of self-esteem between the pre- and post-test scores of the experimental group is accepted. The major difficulty with the data from the CFSEI is that there is no way to verify the results as the tool itself was found to be unreliable. The reliability (alpha) coefficients of the sub-scales of the CFSEI were all below .6. The other tools were noted to be more reliable and even though they do not offer a reliability coefficient of .8, they are certainly more reliable than the CFSEI.

The translation process may have affected the reliability of this tool. Although this process was thorough and aimed at keeping the essence of the items, it may have interfered with the reliability of the tool. Although the basic translation procedure was followed (elaborated in chapter 5), perhaps this process could have been expanded upon with the translated test being tested and re-tested on further groups of uni- and bilingual people to ensure consistency. Moreover, a pilot test could have been run first. Some of the items of the CFSEI, for example, item 12: *I never take anything that does not belong to me*, may have been confusing for the children. Other items, such as item 25: *there are many times I would like to run away from home*, may be problematic in terms of measuring self-esteem, as running away may be caused by a range of factors having little to do with a child's self-esteem.

It is unfortunate that the results of the CFSEI are unreliable, as a measure of self-esteem is vital for gaining information about vulnerable children. Vulnerable children have been noted to have a low sense of worth and a low self-esteem (Strode & Barret Grant, 2001). Bereavement and multiple losses leave children with a pervasive sense of helplessness, hopelessness and despair, which negatively affects their self-esteem (Shrader, 1992, in Nord, 1997). Similarly, the stigma associated with HIV/AIDS impacts negatively on a child's self-esteem (Brown & Lourie, 2000). Acknowledging this, the second part of the therapy aims at developing the children's resilience, self-esteem and internal coping resources. For example, during session A, titled "I have changed and will continue to

change”, the children drew pictures of themselves, which they surround with positive adjectives about themselves. This exercise was noted to be very effective in enhancing their self-esteem. Similarly, sessions G and F, titled “I am a very special and precious person” and “keys for coping with the future”, involve exercises and tasks aimed at raising self-esteem and enhancing coping skills.

In terms of the SSS, the data reveals that the null hypothesis of hypotheses 7 and 8, which investigated the difference in terms of perceived social support, are accepted. The null hypothesis of hypothesis 7 states there is no statistically significant difference in terms of perceived social support between the experimental and control groups. The null hypothesis of hypothesis 8 states, there is no statistically significant difference in terms of perceived social support between the pre- and post-test scores of the experimental group.

The second part of the therapy programme aims at teaching the children how to access external support systems in the future. HIV/AIDS, especially the stigma associated with the virus, is causing a decrease in the social support available to the children from their communities and families (Strode & Barret Grant, 2001). Hence, children affected by HIV/AIDS are often physically and emotionally isolated (Brown & Lourie, 1994). Children often lose contact with community members and extended family when they lose the adults in their life (Strode & Barret Grant, 2001). Resilient children on the other hand, are skilled at choosing and identifying with positive models and sources of support (Masten & Coatsworth, 1998). From these nurturing support systems they learn the skills they need to negotiate the resources needed to sustain themselves and even thrive in their risky environments (Masten et al., 1990).

The therapy programme, especially session E, titled “friendship” and session C, which focuses on problem solving, aims to help the child identify sources of help and support from among their peers and within their community. Furthermore, there were qualitative reports of the children having increased access to social support during and after the programme was run. This was especially true in terms of the community workers, who were trained to assist vulnerable children and came from the children’s community. They

reported that the children, who were now familiar with them, were using them in the community as source of help and support.

Programme evaluation

Programme evaluation aims to establish whether or not a programme is needed, and likely to be useful in the context for which it was developed (Potter, 1999). It is clear from the literature that a community-based intervention focusing on the psychosocial needs of children affected by HIV/AIDS, poverty and violence is urgently required. The literature reiterates the lack of interventions that cater for the psychosocial needs of vulnerable children (Foster & Williamson, 2000). Furthermore, the literature highlights the significant increase of AIDS orphans (Whiteside & Sunter, 2000) and HIV infection rates in South Africa (Guest, 2001). Thus, it is clear that the programme is relevant and much needed in South Africa. Programme evaluation also looks at whether a programme targets the correct population and whether or not it is used in the context it was developed for (Cook & Shadish, 1986). The therapy programme meets these requirements positively as it was used in the context for which it was developed and on the subgroup it aimed to target.

Programme evaluation also focuses on the implementation and quality of the programme (Potter 1999). In the case of this programme, the quality and implementation of the programme were of a high standard, as the facilitators worked from the manual developed by Madörin (2002) and adapted by Killian (2002), which has been declared an UNAIDS best practice model for vulnerable children (Madörin, 2002). Additionally, all the community facilitators conducting the programme were carefully selected, underwent a training programme, and had supervision after each session, in order to ensure the programme would be correctly implemented and the therapy would be of a high calibre.

The main focus of programme evaluation is however, whether or not the programme is effective. This research project focused on the evaluation of the group therapy in terms of whether it meets the psychosocial needs of vulnerable children. In the case of this

evaluation, the effectiveness was measured in terms of the children's questionnaire, made up of the TSCC, the CFSEI, the RCDS and the SSS. The results reflect that the programme is not effective in these terms and the majority of the alternative hypotheses, set out in chapter 5, cannot be accepted. However, the instruments quantitatively measured only a few constructs, which seems an inadequate appraisal of the programme. By focusing on the outcomes of the programme in terms of a few measures rather than the process of the intervention, the evaluation loses a lot of rich data. Therefore, it is useful in terms of programme evaluation to look at other positive aspects of the programme and thus, the strengths of the programme will be discussed below

Strengths of the programme

One of the main strengths of the programme was the fact that it is community based. All the groups were held in the participants' community and used facilitators from the community. Thus, the children did not have the impracticality or expense of having to travel for therapy. Furthermore, the community-based nature of the project meant that the children were able to meet and bond with the facilitators who are based in their community and thus establish a support network. This makes the project sustainable and the care available to the vulnerable children long-term. The facilitators also benefited as they receive training and had the opportunity to expand their skills through the programme. As a result, the vulnerable children are incorporated into the community and the community is empowered to care for its children. Foster and Williamson (2000) noted that as the epidemic spreads, the strength of families and community systems to provide and protect these vulnerable children is dwindling and interventions should aim at empowering these already existing structures instead of placing children in institutions.

One of the key strengths of the programme is that it is based on Bronfenbrenner's (1979) ecological model. The intervention considers each child as a dynamic individual existing in, influenced by and influencing many systems. Masten (2001) suggested that when aiming to reduce risk or increasing resilience through intervention, one must focus on both the child and the system in which the child lives. The therapy programme considers

these systems and aims to enhance them, thus intervening in a more holistic and effective way.

Simultaneously, another strength of the programme is that it promotes awareness of vulnerable children. In many South African communities children affected by HIV/AIDS and AIDS orphans in particular have become numerous (Whiteside & Sunter, 2000) and the adversities facing these children have become too overwhelming for the communities to contemplate. Community-based interventions reawaken awareness of vulnerable children, highlighting their needs and mobilising assistance for them. An important factor of the programme is that it was run in a community-based school, thus promoting awareness of vulnerable children to the teachers and principal in the school and offering the staff support and contact with other professionals who are interested in and trained to assist vulnerable children.

Similarly, the programme raised awareness about HIV/AIDS in the community, thus breaking the silence surrounding the virus and helping to combat stigma. The programme offers the children an opportunity to speak about their experiences. By providing this forum to talk about HIV/AIDS, loss and stigma, the children and the community are educated about HIV/AIDS and the vast consequence of the virus. In turn education reduces fear and stigmatisation and helps lessen discrimination (Strode & Barret Grant, 2001).

Another strength of the programme is that it provides the profession of psychology with valuable information about vulnerable children and the difficulties that they face. Since the programme involves the children talking about, drawing and writing about their experiences and expressing their feelings connected with these experiences, a wealth of information about the reality these children face is gained. This is the reality for thousands of South African children countrywide (Guest, 2001) and it is important that they have the opportunity to tell their story. Furthermore, this enables us to develop other interventions and put structures, including policies, in place to assist them.

A great strength of the programme is that it incorporates play and it is fun. The group therapy programme allows the children the opportunity to relax, play and to be children again. Many of these children have taken on numerous burdens at home and have lost the important chance to play and be with other children. Play is a vital component of childhood, which facilitates mastery, self-healing and allows for the release of emotions and tension (Killian, 2002). Each session includes games and songs, which help teach the children fairness, conflict resolution, respect for other and themselves, responsibility and self-control (Killian, 2002). The therapy is also culturally enriching and the children play games and sing songs that are culturally appropriate. Some of the therapy tasks, such as making personal shields, are also culturally enriching, giving the children a sense of belonging and pride in their roots.

One of the central strengths of the programme is its group format. Group therapy is a model of therapy that is found to be useful and effective for a wide range of patients with a variety of difficulties or pathologies (Yalom, 1983). Yalom (1983) noted that the group experience offers a unique healing experience and certain factors inherent and specific to group therapy are therapeutic. Many of Yalom's principles were at work within the groups run at the school. Yalom discusses how the group process instils hope in group members (Yalom, 1983). Many of the vulnerable children felt hopeless and isolated by their adversity, assuming no one was available to them. The group process instilled a certain amount of hope and optimism for the future in them. Yalom's (1983) principle of universality was evident within the group process, that is, the feeling of relief when group members realised that they are not alone in their experience or adversity. Many of the children in the groups expressed that before they attended the group they felt different from other children because of their problems. This left them feeling shamed, unacceptable and very lonely. The group experience invalidated these feelings for many of the children, as they realised that their peers had similar experiences, thoughts and feelings. Similarly, Yalom's (1983) principle of cohesiveness existed in the group therapy as the members experienced a sense of belonging to a group, of sharing and of being valued and accepted. This was a positive and therapeutic experience for the children.

Yalom (1983) notes that group therapy often results in important information being imparted and this was true of the groups run at the primary school. The second half of the programme in particular, focuses on transferring information that will raise the participant's resilience and build their coping skills. Furthermore, there was an exchange of information between the participants as they shared skills and behaviours that had worked for them when facing difficult situations. Yalom (1983) also highlights the development of socialising techniques through group work, where members learn appropriate behaviours and adaptive skills including how to listen, how to be non-judgmental and responsive to others and how to empathise with others (Yalom, 1983). The children in the group wrote their own rules in one of the first sessions and many of the rules encouraged these sorts of skills. For example, the children made a rule to talk one at a time and that laughing at or teasing anyone because of what they were saying was not allowed. Thus, the children learned some appropriate social behaviour during the sessions. Additionally, Yalom (1983) notes that groups often provide an individual with the opportunity to learn new behaviour through imitation. The children were given the opportunity to learn from and model the behaviour of the facilitators and other group members. Yalom (1983) points out that even if the modelling is short-lived, the process of trying out new behaviours is therapeutic and valuable in the process of adjustment.

Yalom (1983) identified catharsis as a central and important element of group work. The children attending the groups were offered the opportunity and space to express their feelings related to their bereavements and the difficulties they had faced at home and in their communities. Group therapists have noted that children's grief can be positively affected by the group experience (Yalom, 1995, in Pivnick & Villegas, 2000) and Winnicott (1960, in Pivnick & Villegas, 2000) notes that grieving children need a supportive "holding environment", which group therapy provides. Consequently, the release of affect was an important step for them. Additionally, Yalom notes that group therapy often provides the chance to discuss existential factors such as death, isolation, loneliness etc. in an open and explicit way. This was particularly true of the programme as it focuses on issues such as bereavement, death, loss, loneliness, isolation and stigma,

which are infrequently spoken about in the community from which these children originate. As Yalom (1983) points out the group process has the ability to be extremely therapeutic, possessing elements unavailable in other therapeutic interventions.

Another strength of the programme is that it aims, not only to alleviate symptoms, but also to extend resilience. Therapy programmes for vulnerable children need to aid children in becoming self-protective and resilient by providing them with coping skills, encouraging competence and helping them create a network of support (Strode & Barret Grant, 2000). The group therapy programme aims to increase the participants' sense of worth and help them form a positive sense of self. It also helps them to learn to trust others and enables them to access resources both psychological and practical, on a personal level and within the community. All of these factors promote resilience in individuals, families and communities.

It is clear from the above mentioned strengths that the results from the data collected do not adequately or accurately represent the therapy programme and its consequences. This is partly due to the limitations of the research, which will be discussed in the chapter below.

The following discussion highlights the limitations of the study, as well as providing suggestions for the extension and improvement of further research in this field.

Limitations of the research

One of the central limitations of the research was that of the sample size. Initially a sample of 43 was chosen in order to have three groups of a workable size, i.e. not more than 15 children per group. Ideally, data should have been collected from more than one school; however other groups could not be run for this research project due to time constraints. Another problem with the sample size was the fact that it diminished during the intervention, making the post-test data sample smaller. Howell (1997) points out that an unequal number of subjects between the pre- and post-test does not always affect the results of an experiments. He notes that the reason for the subject leaving the study is important in terms of significance to the results. In terms of this, participants who choose to leave a research study for reasons innate to the study will affect the results, however participants who leave the study because of reasons beyond their control do not affect the results. In this experiment the participants who left the study, left for reasons beyond their control, such as caregivers wanting them home earlier or moving away from the community. Even though this is positive in light of Howell's theory of the attrition of a sample, the sample size did diminish which reduces the chance of the results reaching significance. This was a notable limitation of the study

Another limitation of the study is that the research was limited to KZN. The sample consisted of members of only one race from one community, which affects the generalisability of the results in other provinces and communities. Within this sample group, the participants had been exposed to a variety of different stressors, traumas and bereavements, thus the sample lacks consistency. This was useful in accessing the broad effects of bereavement and the usefulness of the group therapy programme on a more general level.

Another limitations of the study were that of the instruments used. Although the instruments were chosen because they were noted to be valid and reliable, none of the measures have been standardised for South African black children. Thus, the results from these all measures should be interpreted with caution. Furthermore, the translation of the instruments may have affected their reliability. As previously noted the CFSEI proved to be unreliable in this study, which is a significant limitation as it reduces the amount of information gathered about the programme. Perhaps the CFSEI was not as cultural free as its author claims it to be. This has been a shortcoming noted in other studies (Holaday, Callahan, Fabre & Hall, 1996).

Moreover, even though the measures selected were thought to be comprehensive in measuring the symptoms of the children, they were limiting in what was reported. The focus of the instruments was to report individual symptoms. While a focus on psychiatric symptoms is important and necessary in planning interventions, it may create a biomedical view of the difficulties and can result in children being labelled ill or disordered. Perhaps different instruments or qualitative research would yield entirely different difficulties and measure other variables. This research aimed at exploring resilience and how resilience can be enhanced; however the difficulty lies in quantifying resilience accurately (Masten, 2001).

Another limitation is in the lack of measurement of mediating variables. Various factors external to the programme, such as the quality of a child's relationship with his or her teacher or changes in his or her family circumstances, could either mediate or worsen the effects of the multiple stressors faced by vulnerable children. Within every study there are multiple confounding factors, which cannot be controlled, and perhaps these were not adequately explored in this study.

Recommendations and implications for further research

This study has highlighted the importance of understanding vulnerable children in South Africa and ways to assist them. This programme evaluation may be one of the many steps needed in designing and implementing an intervention that addresses the needs of vulnerable children. Therefore, the research should be viewed, not as an end in itself, but as part of a process of investigation. Further research to understanding the adversities facing vulnerable children in South Africa is necessary. Hand-in-hand with this, is a need for further research into understanding, accessing and increasing resilience in South African children. This form of research is significant in terms of guiding policy making regarding the children of South Africa.

In terms of the programme evaluation, Potter (1999) points out there is no single correct way to evaluate a programme, but rather there are multiple methodologies available. Further research is needed in the evaluation of the programme. For example, it would be useful to explore the consequences of the intervention on the family and the community, as well as exploring what sort of practical assistance is needed in these realms. Additionally, exploration of age and gender differences in terms of reduction of symptoms and raising resilience would also be useful for programme evaluation and development.

The aim of this study was to evaluate the programme and quantitative methods were used as a means of generating hypotheses for testing. However, it is recommended that programme evaluation using a qualitative method be undertaken. This will provide rich and varied information about the programme and insights into the adversities of vulnerable children. Looking beyond the clinical symptoms to consider the affects that HIV/AIDS, poverty and violence has on children, in terms of other constructs such as moral and social development, is implicated in future study.

Programme evaluation should be ongoing, which is useful and necessary for accountability purposes, as well as for the development of similar social programmes (Potter, 1999). Therefore, an exploration of the longitudinal effects of the programme is recommended in terms of addressing the psychosocial need of vulnerable children over time. Research should also look at the long-term effects of the programme with an aim to understand and reduce the link between childhood vulnerability and adulthood pathology, suicides and criminal behaviour.

Conclusion

HIV/AIDS can no longer be compared to other health disasters- it is the biggest challenge facing humankind today (Machel, 2001). One of the greatest challenges with which it presents us is that of nurturing healthy children in unhealthy settings, and it is critical to South Africa that her children become competent, adaptive adults and productive, responsible citizens despite the pandemic. Masten and Coatsworth (1998) point out that if we allow the known risk factors for development to rise while resources available to children fall, we can expect the competence of individual children and thus society at large, to suffer. Therefore, it is vital that we address the psychosocial needs of vulnerable children in South Africa and instil resilience in them. For Masten (2000) resilience arises out of ordinary human adaptive processes and interventions should focus on promoting, restoring, facilitating and protecting these systems of adaptation.

The group therapy programme is an attempt to cater for the increasing psychosocial needs of South Africa's vulnerable children and this research, despite the above-mentioned limitations, aims at providing information useful for the development of interventions for this subgroup.

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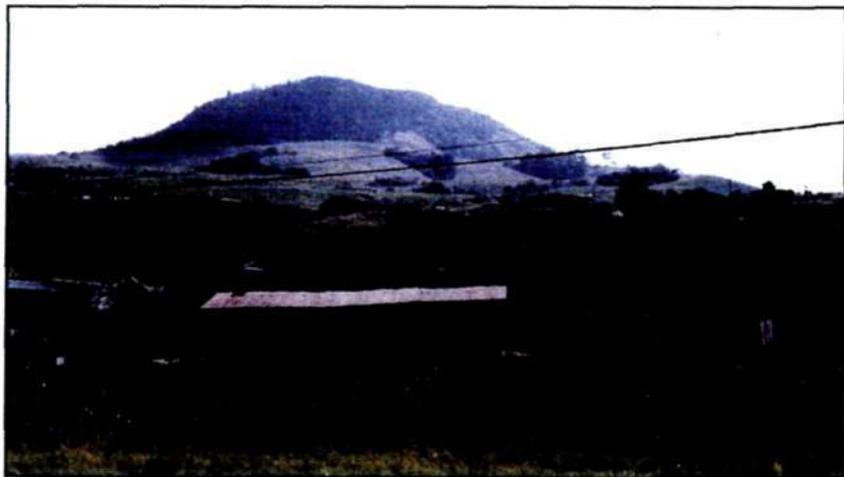
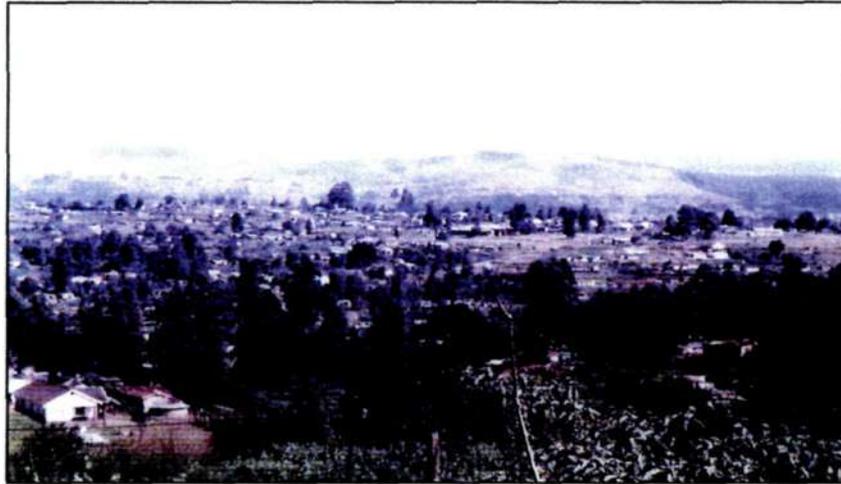
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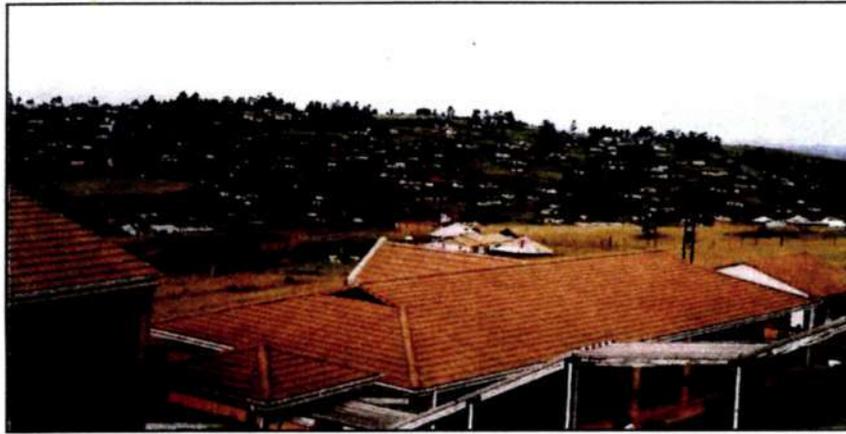
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APPENDICES

Appendix A: Photographs of the intervention



Views of the community where the programme was run



The school



The facilitators



The children doing the therapeutic task



The children playing a game during a session

Appendix B: Questionnaire for children

Subject code: _____

Date: _____

***Imibuzo yezingane
Questionnaire for children***



Igama: _____ Isibongo: _____

Name

Surname

Usuku lwakho lokuzalwa: _____ Iminyaka yakho: _____

Date of birth

Age

Ubulili: Intombazane/Umfana

Gender: Girl/boy

Nginikeza imvume yokuthi zonke izimpendulo engizinikezile lapha zisetshenziselwe ukwenziwa kocwaningo. Ngichazelwe kwacaca ukuthi yonke imininigwane yezimpendulo iyogcinwa iyimfihlo. Ngiyaqonda futhi ukuthi iminingwane eqondene nami ngqo ayisoze yatshelwa noma yanikezwa omunye umuntu nokuthi ngingayeka ukuzimbandakanya nalolucwaningo nanoma inini.

I give my consent for the information in this questionnaire to be used for research purposes. The issue of confidentiality regarding the information I reveal has been clearly explained to me. I understand that my personal details will remain anonymous and that I may withdraw my participation in this research at any point of the process.

Sayina lapha: _____

Sign here

Usuku: _____

Date

CFSEI-2

Phendula imibuzo elandelayo ngalendlela: Uma umbuzo uchaza indlela oyiyo noma ojwayele ukuphatheka ngaya beka umaka ebhokisini eliqondene no “Yebo”. Uma umbuzo ungasho indlela ophatheka ngayo beka umaka maqondana no “Cha”. Beka umaka esikhaleni esisodwa (yebo noma cha) umbuzo ngamunye. Lesi akusiso isivivinyo ngakho azikho izimpendulo ezilungileyo noma ezingalungile.

Please mark each question in the following way: If the question describes how you usually feel, make a check in the “Yes” column. If the question does not describe how you usually feel, make a check in the “No” column. Check only one column (either yes or no) for each question. This is not a test and there are no right or wrong answers.

		Yebo	Ch
1.	Ngifisa ukuba ngabe ngimncane <i>I wish I were younger</i>		
2.	Abafana kanye namantombazane bayathanda ukudlala nami <i>Boys and girls like to play with me</i>		
3.	Ngivamisile ukushiya esikoleni uma umsebsenzi wakhona usulikhuni kakhulu <i>I usually quit when my school work gets to hard for me</i>		
4.	Abazali bami abakaze bangithukuthelele <i>My parents never get angry with me</i>		
5.	Nginabagane abangabaningi <i>I only have a few friends</i>		
6.	Ngiba nokuthokoza okukhulu nabazali bami <i>I have lots of fun with my parents</i>		
7.	Ngiyathanda ukuba gumfana/ Ngiyathanda ukuba yintombazane <i>I like being a boy/ I like being a girl</i>		
8.	Ngiyisehluleki esikoleni <i>I am a failure at school</i>		
9.	Abazali bami bangenza ngizizwe ukuthi angiyinto yalutho <i>My parents make me feel like I'm not good enough</i>		
10.	Ngivame ukuhluleka uma ngizama ukwenza izinto ezibalulekile <i>I usually fail when I try to do important things</i>		
11.	Ngihlale ngithokozile esikhathini esininigi <i>I am happy most of the time</i>		
12.	Angikaze ngithathe into okungesiyona eyami <i>I have never taken anything that does not belong to me</i>		
13.	Ngivame ukuzizwa nginamahloni ngobumina <i>I often feel ashamed of myself</i>		
14.	Abafana abanengi kanye namantombazane badlala kancono imidlalo Kunami <i>Most boys and girls play games better than I do</i>		
15.	Imvamisa ngizizwa ngingento yalutho <i>I often feel that I am no good at all</i>		
16.	Abafana abanengi kanye namantombazane bahlakahiphile kunami <i>Most boys and girls are smarter than I am</i>		
17.	Abazali bami abangithandi ngoba angihlakaniphile kakhulu <i>My parents dislike me because I am not good enough</i>		

TSCC

Lezizinto ezingezansi zichaza izinto ezicatshangwa abantwana noma imizwa yabo noma izinto abazenzayo. Funda lezizinto ngayinye bese ukokolozela kuleyonamba etshengisa ukuthi kwenzeka kangakanani
The following items describe things that kids sometimes think, feel or do. Read each item, then mark how often it happens to you by drawing a circle around the correct number.

Kokolozela u 0 uma kungenzeki nhlobo <i>Circle if it never happens to you</i>	0	1	2	3
Kokolozela u 1 uma kuqabukela kwenzekile <i>Circle if it happens sometimes</i>	0	1	2	3
Kokolozela u 2 uma kwenzeka kaningana <i>Circle if it happens lots of times</i>	0	1	2	3
Kokolozela u 3 uma kwenzeka njalo <i>Circle if it happens almost all of the time</i>	0	1	2	3

Isibonelo uma kuqabukela ufika emuva kwesikhathi esikoleni uzokokolozela u 1
For example, if you are late for school sometimes you would circle the 1 for this item.

1. Ukufika ngemuva kwesikhathi esikoleni <i>Being late for school</i>	0	1	2	3
--	---	---	---	---

Uma wenze iphutha noma ufisa ukushintsha impendulo yakho ungakucimi ngerabha. Faka isiphambano phezu kwempundulo ofisa ukuyishintsha bese ukokolozela impendulo eyiyona.
If you make a mistake or want to change your answer, do not erase. Cross out the wrong answer with an X and then circle the correct answer, like this:
 Isibonelo

1. Ukufika ngemuva kwesikhathi esikoleni <i>Being late for school</i>	0	1	2	3
--	---	--------------	---	---

	Akwe- nzeke nhlobo	Kuke kwenze- ke	Kwen- zeka kanin- gana	Kwenz- eka njalonje
	<i>Never</i>	<i>Some- times</i>	<i>Lots of times</i>	<i>Almost all the time</i>
1. Amaphupho amabi <i>Bad dreams or nightmares</i>	0	1	2	3
2. Ngiyesaba ungathi kukhona into embi ezokwenzeka <i>Feeling afraid something bad might happen</i>	0	1	2	3
3. Ngicabanza imicabango esabekayo <i>Scary ideas or pictures pop into my head</i>	0	1	2	3
4. Ngifuna ukuhlambalaza <i>Wanting to say bad words</i>	0	1	2	3
5. Ngenze sengathi ngingomunye umuntu <i>Pretending I am someone else</i>	0	1	2	3
6. Ukudaza inkani ngokweqile <i>Arguing to much</i>	0	1	2	3
7. Ukuba nesizungu <i>Feeling lonely</i>	0	1	2	3
8. Ukuthinta izitho zami zangasese ngokweqile <i>Touching my private parts too much</i>	0	1	2	3
9. Ukuzizwa ngidabukile noma ngingajabule <i>Feeling unhappy or sad</i>	0	1	2	3
10. Ukukhumbula izinto ezenzeka <i>Rememebering things that happened that I didn't like</i>	0	1	2	3
11. Ukubalekela isimo esizongicabangisa <i>Going away in my mind, trying not to think</i>	0	1	2	3
12. Imicabango yezinto ezesabekayo <i>Remembering scary things</i>	0	1	2	3
13. Kuthi angihayize ngibulale izinto <i>Wanting to yell and break things</i>	0	1	2	3
14. Ukukhala <i>Crying</i>	0	1	2	3
15. Ukwesaba ubala <i>Getting scared all of a sudden and don't know why</i>	0	1	2	3
16. Ukuthukuthela ngigaxoli <i>Getting mad and can't calm down</i>	0	1	2	3
17. Ukucabanga ngokuya ocansini <i>Thinking about having sex</i>	0	1	2	3
18. Ukuba nenzululwane <i>Feeling dizzy</i>	0	1	2	3
19. Ukushawoda obantu <i>Wanting to yell at people</i>	0	1	2	3
20. Isifiso sokuzilimiza <i>Wanting to hurt myself</i>	0	1	2	3

21. Isifiso sokulimaza abanye abantu <i>Wanting to hurt other people</i>	0	1	2	3
22. Ukucabanga ngokuthinta izitho zangasese zabanye abantu <i>Thinking about touching other people's private parts</i>	0	1	2	3
23. Ukubeleselwa yimicabango yocansi <i>Thinking about sex when I don't want to</i>	0	1	2	3
24. Ukwesaba abantu besilisa <i>Feeling scared of men</i>	0	1	2	3
25. Ukwesaba abantu besifazane <i>Feeling scared of women</i>	0	1	2	3
26. Ukugeza ngoba ngizizwa ngingcolile ngaphakathi <i>Washing myself because I feel dirty on the inside</i>	0	1	2	3
27. Ukuzizwa ngiyisilima noma ngimubi <i>Feeling stupid or bad</i>	0	1	2	3
28. Ukuzwa sengathi ngenze into embi <i>Feeling like I did something wrong</i>	0	1	2	3
29. Ungathi ngiyaphupha ngibhekile <i>Feeling like things aren't real</i>	0	1	2	3
30. Ukukhohlwa izinto <i>Forgetting things, can't remember things</i>	0	1	2	3
31. Ukuzizwa sengathi angisimina <i>Feeling like I'm not in my body</i>	0	1	2	3
32. Ukuba novalo <i>Feeling nervous or jumpy inside</i>	0	1	2	3
33. Ukwesaba <i>Feeling afraid</i>	0	1	2	3
34. Ukungabathembi abantu ngoba ungathi bazofuna ucansi <i>Not trusting people because they might want sex</i>	0	1	2	3
35. Akuvumi ngiyeke ukucabanga ngento embi eyenzeka kimina <i>Can't stop thinking about something bad that happened to me</i>	0	1	2	3
36. Ukulwa <i>Getting into fights</i>	0	1	2	3
37. Ukuba nenhliziyo embi <i>Feeling mean</i>	0	1	2	3
38. Ukucabanga sengathi ngikwenye indawo <i>Pretending I'm somewhere else</i>	0	1	2	3
39. Ukwesaba ubumnyama <i>Being afraid of the dark</i>	0	1	2	3
40. Ukwesaba uma ngicabanga ngocansi <i>Getting scared or upset when I think about sex</i>	0	1	2	3
41. Ukukhathazeka ngezinto <i>Worrying about things</i>	0	1	2	3

42. Ukubona sengathi akukho muntu ongithandayo <i>Feeling like nobody likes me</i>	0	1	2	3
43. Ukukhumbula izinto engingazithandi ukuzikhumbula <i>Remembering things I don't want to remember</i>	0	1	2	3
44. Ukukhanukela ucansi <i>Having sex feelings in my body</i>	0	1	2	3
45. Inggondo yami iyama <i>My mind going empty or blank</i>	0	1	2	3
46. Ukuzizwa ngizonda abantu <i>Feeling like I hate people</i>	0	1	2	3
47. Akuvumi ngiyeke ukucabanza ngocansi <i>Can't stop thinking about sex</i>	0	1	2	3
48. Ukuzama ukungabi namizwa <i>Trying not to have any feelins</i>	0	1	2	3
49. Ukuzwa sengathi ngiyahlanya <i>Feeling mad</i>	0	1	2	3
50. Ngiyesaba sengathi kukhona ofuna ukungibulala <i>Feeling afraid that some will they to kill me</i>	0	1	2	3
51. Ngifisa sengathi izinto ezimbi ngabe azikaze zenzeka <i>Wishing bad things never happened</i>	0	1	2	3
52. Ngifuna ukuzibulala <i>Wanting to kill myself</i>	0	1	2	3
53. Ngiyandwaza <i>Daydreaming</i>	0	1	2	3
54. Ngiyacasuka uma abantu bekhuluma ngezocansi <i>Getting upset when people talk about sex</i>	0	1	2	3

RDS

Indlela yokwenza: Nansi imisho etshengisa imizwa yakho emasontweni amabili noma ngaphezulu adlule. Funda lemisho bese uthatha isinqumo ngokuthi lokhu kwenzeka kangakanani. Thatha isiqumo ngokuthi: Akwenzeki nhlobo kuke kwenzeke, kwenzeka kaningana noma kwenzeka njalo nje.

Directions: Here are some sentences about how you might have been feeling over the past two weeks or so. Read each sentence and decide how often you feel this way. Decide if you feel this way: Almost never, sometimes, a lot of the time or almost all the time. Tick the answer that describes how you really feel. There is no wrong or right answers.

	Akwenzeki nhlobo <i>Almost never</i>	Kuke kwenzeke <i>Sometimes</i>	Kwenzeka kaningana <i>A lot of the time</i>	Kwenzeka njalo nje <i>All the time</i>
1. Ngizizwa ngijabule <i>I feel happy</i>				
2. Ngiyakhathazeka ngesikole <i>I worry about school</i>				
3. Ngizizwa nginesizungu <i>I feel lonely</i>				
4. Ngizwa sengathi abazali bami abangithandi <i>I feel my parents don't like me</i>				
5. Ngizizwa ngisemqoka <i>I feel important</i>				
6. Engathi ngingacasha, ngicashela abanye abantu <i>I feel like hiding from other people</i>				
7. Ngizizwa ngidabukile <i>I feel sad</i>				
8. Engathi ngingakhala <i>I feel like crying</i>				
9. Ngibona engathi akekho onendaba nami <i>I feel that no one cares about me</i>				
10. Engathi ngingadlala nezinye izingane <i>I feel like playing with other children</i>				
11. Ngizizwa sengathi ngiyagula <i>I feel sick</i>				
12. Ngizizwa ngithandwa <i>I feel loved</i>				
13. Sengathi ngingabaleka <i>I feel like running away</i>				
14. Sengathi ngingazilimaza <i>I feel like hurting myself</i>				
15. Ngibona sengathi ezinye izingane azingithandi <i>I feel that other kids don't like me</i>				

16. Ngizizwa ngicasukile ngezinto ezithize <i>I feel upset about things</i>				
17. Ngibona sengathi alikho iqiniso emhlabeni <i>I feel life is not fair</i>				
18. Ngizizwa ngikhathele <i>I feel tired</i>				
19. Ngizibona ngingalungile <i>I feel I am bad</i>				
20. Ngizibona ngingento yalutho <i>I feel I am no good</i>				
21. Nginenkinga yokungazinzi ngengqondo uma kufundwa <i>I have trouble paying attention in class</i>				
22. Ngiyazidabukela <i>I feel sorry for myself</i>				
23. Engathi ngingaxoxa nezinye izingane <i>I feel like talking to other children</i>				
24. Ngiyaqwasha <i>I have trouble sleeping</i>				
25. Engathi ngigazijabulisa <i>I feel like having fun</i>				
26. Ngikhathazekile <i>I feel worried</i>				
27. Ngiphathwa isisu <i>I get stomach aches</i>				
28. Ngizizwa ngibhorekile <i>I feel bored</i>				
29. Ngibona sengathi ayikho into engiyenzayo <i>esizayo I feel nothing I do helps anyone</i>				
30. Khetha ibhokisi elikhombisa imizwa yakho <i>Tick the face that shows how you feel</i>				

Lapha nginohla lwabantu okungenzeka bangabi khona empilweni yakho, ngakho ngicela ungazise uma lo muntu ekhona empilweni yakho. Uma lo muntu ekhona beka uphawu ohleni oluqondene naye. Bese ungazise ukuthi uwusizo kangakanani lo muntu ezinkingeni zakho, uma kukhona okudingayo nokuthi ukujabulela kangakanani ukuba naye. Lokhu ukwenza ngokubeka uphawu ohleni oluchaza kahle lo muntu nobuhlobo: obukhona phakathi kwenu. Isibonelo: uma ungenaye umfowenu noma udadewenu beka uphawu luqondane nohla luka 'Cha' bese ubeka uphawu luqondane no 'Cha' kuzo zonke izinhla eziqondene naye. Uma unothisha okuthokozelayo ukuba naye futhi okusizayo uma unezinkinga kodwa engakuniki imali ungaphendula kanjengesibonelo esilandelayo:

(Below is a list of people, you may not have all of these people in your life, so please first tell me if you have this person in your life. If you have this person on your life, tick ("✓") in the yes column. Then let me know how helpful this person/people are for personal problems, when you need material things, and also how often you have fun with them. You do this by placing a tick in the column which best describes your relationship with this person in each column. For example, if you have no brothers or sisters, then you place a tick in the NO column for this person is in my life, and No in all of the other columns. If you have a teacher with whom you have a lot of fun, and who often helps you when you have a personal problem, but who does not help you with money or material things, you would answer:)

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	Yilomuntu osepilweni yami (This person is in my life)		Lomuntu uwusizo uma nginezinkinga (This person is helpful when I have a personal problem)			Lomuntu uyasiza uma ngidinga imali nezinye izinto (This person is helpful when I need money and other things)			Ngiyajabula uma nginalomuntu (I have fun with this person)		
	Cha	Yebo	Akwenzeki Not at all	Kuyenzeka Sort of	Kuvamile Very	Akwenzeki Not at all	Kuyenzeka Sort of	Kuvamile Very	Akwenzeki Not at all	Kuyenzeka Sort of	Kuvamile Very
Uthisha (Your teacher)		✓		✓		✓					✓

Appendix C: Consent form for caregivers

Consent Form to be signed by Caregivers:

I, (write in parent's/caregiver's name).....,

being the legal guardian or adult primarily responsible for the care and well-being of

(write in child's name).....

Whose date of birth is (write in child's birthdate)..... hereby

give my consent for (write in name child is usually called)

.....

● To participate in the structured group therapy programme being run by (write in facilitator's name).....

● The group sessions will take place on (write in venue)..... At (write in time and days).....

● I understand that it is important for (write in child's name)..... to be present at all 15 sessions.

● I understand that the group facilitators can not be held liable for any injury, loss, or damage to person or property, howsoever caused.

● I understand that the child's identity will not be disclosed to anyone outside of the group process and that any information shared by him or her will be dealt with professionally, ethically and with the utmost discretion.

Signed:..... Date:

Witness:..... Date:

Contact person:.....

Appendix D: Assent form for the participants

**ASSENT FORM TO BE SIGNED BY GROUP
PARTICIPANTS**

I, (write in your name).....

- Understand that the group that I will be a part of is going to have activities, games and tasks, which help children, think and talk about their lives and experiences and the feelings they have. I understand that at times this may be difficult and that at no time will I have to talk or join in.
- I understand that I can decide to leave the group at any time.
- I also understand that everything done and said in the groups will be private and all information about the children in the group will be kept private
- I understand that I must not share the things spoken about in the group with people outside of the group.
- I understand that the group will run over 15 session held at the Harriet Shezi Clinic two afternoons a week for 8 weeks, starting on.....

Signed:.....

Date:.....

Witness:.....

Date:.....

Appendix E: Statistical output

Appendix E1: Correlation matrixes of the sub-scale of the TSCC

Correlations

		ANXIETY	DEP	PTSD	DISOV	DISFAN	ANGER	SEX
ANXIETY	Pearson Correlation	1	.826(**)	.841(**)	.648(**)	.700(**)	.075	.493(**)
	Sig. (2-tailed)	.	.000	.000	.000	.000	.670	.003
	N	36	34	34	36	35	35	35
DEP	Pearson Correlation	.826(**)	1	.854(**)	.641(**)	.804(**)	.097	.263
	Sig. (2-tailed)	.000	.	.000	.000	.000	.579	.116
	N	34	38	36	38	37	35	37
PTSD	Pearson Correlation	.841(**)	.854(**)	1	.659(**)	.782(**)	.065	.481(**)
	Sig. (2-tailed)	.000	.000	.	.000	.000	.709	.003
	N	34	36	37	37	36	35	36
DISOV	Pearson Correlation	.648(**)	.641(**)	.659(**)	1	.478(**)	-.062	.139
	Sig. (2-tailed)	.000	.000	.000	.	.002	.712	.392
	N	36	38	37	41	40	38	40
DISFAN	Pearson Correlation	.700(**)	.804(**)	.782(**)	.478(**)	1	.152	.212
	Sig. (2-tailed)	.000	.000	.000	.002	.	.369	.195
	N	35	37	36	40	40	37	39
ANGER	Pearson Correlation	.075	.097	.065	-.062	.152	1	-.302
	Sig. (2-tailed)	.670	.579	.709	.712	.369	.	.069
	N	35	35	35	38	37	38	37
SEX	Pearson Correlation	.493(**)	.263	.481(**)	.139	.212	-.302	1
	Sig. (2-tailed)	.003	.116	.003	.392	.195	.069	.
	N	35	37	36	40	39	37	40

** Correlation is significant at the 0.01 level (2-tailed).

Correlations

		PANXIETY	PDEP	PPTSD	PDISOV	PDISFAN	PANGER	PSEX
PANXIETY	Pearson Correlation	1	.678(**)	.639(**)	.366(*)	.394(*)	.516(**)	.577(**)
	Sig. (2-tailed)	.	.000	.000	.039	.026	.004	.001
	N	32	29	31	32	32	30	31
PDEP	Pearson Correlation	.678(**)	1	.732(**)	.289	.175	.482(**)	.394(*)
	Sig. (2-tailed)	.000	.	.000	.115	.355	.006	.028
	N	29	31	30	31	30	31	31
PPTSD	Pearson Correlation	.639(**)	.732(**)	1	.271	.477(**)	.530(**)	.277
	Sig. (2-tailed)	.000	.000	.	.133	.006	.002	.132
	N	31	30	32	32	32	31	31
PDISOV	Pearson Correlation	.366(*)	.289	.271	1	.158	.515(**)	.161
	Sig. (2-tailed)	.039	.115	.133	.	.380	.003	.371

	N	32	31	32	34	33	32	33
PDISFAN	Pearson Correlation	.394(*)	.175	.477(**)	.158	1	.643(**)	.166
	Sig. (2-tailed)	.026	.355	.006	.380	.	.000	.363
	N	32	30	32	33	34	31	32
PANGER	Pearson Correlation	.516(**)	.482(**)	.530(**)	.515(**)	.643(**)	1	-.129
	Sig. (2-tailed)	.004	.006	.002	.003	.000	.	.483
	N	30	31	31	32	31	32	32
PSEX	Pearson Correlation	.577(**)	.394(*)	.277	.161	.166	-.129	1
	Sig. (2-tailed)	.001	.028	.132	.371	.363	.483	.
	N	31	31	31	33	32	32	33

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Appendix E2: Results of the 2-way ANOVA on the TSCC

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
TSCC	Sphericity Assumed	322.438	1	322.438	1.902	.177
	Greenhouse-Geisser	322.438	1.000	322.438	1.902	.177
	Huynh-Feldt	322.438	1.000	322.438	1.902	.177
	Lower-bound	322.438	1.000	322.438	1.902	.177
TSCC * GROUP	Sphericity Assumed	779.010	1	779.010	4.594	.040
	Greenhouse-Geisser	779.010	1.000	779.010	4.594	.040
	Huynh-Feldt	779.010	1.000	779.010	4.594	.040
	Lower-bound	779.010	1.000	779.010	4.594	.040
Error(TSCC)	Sphericity Assumed	5595.333	33	169.556		
	Greenhouse-Geisser	5595.333	33.000	169.556		
	Huynh-Feldt	5595.333	33.000	169.556		
	Lower-bound	5595.333	33.000	169.556		

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	TSCC	Type III Sum of Squares	df	Mean Square	F	Sig.
TSCC	Linear	322.438	1	322.438	1.902	.177
TSCC * GROUP	Linear	779.010	1	779.010	4.594	.040
Error(TSCC)	Linear	5595.333	33	169.556		

Tests of Between-Subjects Effects

Measure: MEASURE_1
Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	83049.610	1	83049.610	330.366	.000
GROUP	272.010	1	272.010	1.082	.306
Error	8295.762	33	251.387		

Appendix E3: Results of the 2-way ANOVA on the posttraumatic stress sub-scale of the TSCC

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
POSTTRAU	Sphericity Assumed	110.031	1	110.031	3.546	.070
	Greenhouse-Geisser	110.031	1.000	110.031	3.546	.070
	Huynh-Feldt	110.031	1.000	110.031	3.546	.070
	Lower-bound	110.031	1.000	110.031	3.546	.070
POSTTRAU * GROUP	Sphericity Assumed	2.031	1	2.031	.065	.800
	Greenhouse-Geisser	2.031	1.000	2.031	.065	.800
	Huynh-Feldt	2.031	1.000	2.031	.065	.800
	Lower-bound	2.031	1.000	2.031	.065	.800
Error(POSTTRAU)	Sphericity Assumed	837.694	27	31.026		
	Greenhouse-Geisser	837.694	27.000	31.026		
	Huynh-Feldt	837.694	27.000	31.026		
	Lower-bound	837.694	27.000	31.026		

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	POSTTRAU	Type III Sum of Squares	df	Mean Square	F	Sig.
POSTTRAU	Linear	110.031	1	110.031	3.546	.070
POSTTRAU * GROUP	Linear	2.031	1	2.031	.065	.800
Error(POSTTRAU)	Linear	837.694	27	31.026		

Tests of Between-Subjects Effects

Measure: MEASURE_1
Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	6711.116	1	6711.116	170.624	.000
GROUP	52.081	1	52.081	1.324	.260
Error	1061.988	27	39.333		

Appendix E4: Results of the 2-way ANOVA on the anger sub-scale of the TSCC

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
TANGER	Sphericity Assumed	62.323	1	62.323	5.882	.0
	Greenhouse-Geisser	62.323	1.000	62.323	5.882	.0
	Huynh-Feldt	62.323	1.000	62.323	5.882	.0
	Lower-bound	62.323	1.000	62.323	5.882	.0
TANGER * GROUP	Sphericity Assumed	.254	1	.254	.024	.8
	Greenhouse-Geisser	.254	1.000	.254	.024	.8
	Huynh-Feldt	.254	1.000	.254	.024	.8
	Lower-bound	.254	1.000	.254	.024	.8
Error(TANGER)	Sphericity Assumed	286.091	27	10.596		
	Greenhouse-Geisser	286.091	27.000	10.596		
	Huynh-Feldt	286.091	27.000	10.596		
	Lower-bound	286.091	27.000	10.596		

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	TANGER	Type III Sum of Squares	df	Mean Square	F	Sig.
TANGER	Linear	62.323	1	62.323	5.882	.022
TANGER * GROUP	Linear	.254	1	.254	.024	.878
Error(TANGER)	Linear	286.091	27	10.596		

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	941.392	1	941.392	128.964	.000
GROUP	.013	1	.013	.002	.967
Error	197.091	27	7.300		

Appendix E5: Results of the 2-way ANOVA on the CFSEI

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
CFSEI	Sphericity Assumed	11.010	1	11.010	2.015	.165
	Greenhouse-Geisser	11.010	1.000	11.010	2.015	.165
	Huynh-Feldt	11.010	1.000	11.010	2.015	.165
	Lower-bound	11.010	1.000	11.010	2.015	.165
CFSEI * GROUP	Sphericity Assumed	2.438	1	2.438	.446	.509
	Greenhouse-Geisser	2.438	1.000	2.438	.446	.509
	Huynh-Feldt	2.438	1.000	2.438	.446	.509
	Lower-bound	2.438	1.000	2.438	.446	.509
Error(CFSEI)	Sphericity Assumed	180.333	33	5.465		
	Greenhouse-Geisser	180.333	33.000	5.465		
	Huynh-Feldt	180.333	33.000	5.465		
	Lower-bound	180.333	33.000	5.465		

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	CFSEI	Type III Sum of Squares	df	Mean Square	F	Sig.
CFSEI	Linear	11.010	1	11.010	2.015	.165
CFSEI * GROUP	Linear	2.438	1	2.438	.446	.509
Error(CFSEI)	Linear	180.333	33	5.465		

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	171781.038	1	171781.038	13601.949	.000
GROUP	.010	1	.010	.001	.978
Error	416.762	33	12.629		

Appendix E6: Results of the 2-way ANOVA on the RDS

Tests of Within-Subjects Effects

Measure: MEASURE_1

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
	Sphericity Assumed	118.402	1	118.402	2.668	.112
	Greenhouse-Geisser	118.402	1.000	118.402	2.668	.112
	Huynh-Feldt	118.402	1.000	118.402	2.668	.112
	Lower-bound	118.402	1.000	118.402	2.668	.112
	Sphericity Assumed	33.717	1	33.717	.760	.390
	Greenhouse-Geisser	33.717	1.000	33.717	.760	.390
	Huynh-Feldt	33.717	1.000	33.717	.760	.390
	Lower-bound	33.717	1.000	33.717	.760	.390
	Sphericity Assumed	1464.369	33	44.375		
	Greenhouse-Geisser	1464.369	33.000	44.375		
	Huynh-Feldt	1464.369	33.000	44.375		
	Lower-bound	1464.369	33.000	44.375		

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	REYNOLDS	Type III Sum of Squares	df	Mean Square	F	Sig.
REYNOLDS	Linear	118.402	1	118.402	2.668	.112
REYNOLDS * GROUP	Linear	33.717	1	33.717	.760	.390
Error(REYNOLDS)	Linear	1464.369	33	44.375		

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	36010.288	1	36010.288	476.354	.000
GROUP	.117	1	.117	.002	.969
Error	2494.655	33	75.596		