AN EVALUATION OF A THEORY-BASED SUPPORT GROUP INTERVENTION FOR CHILDREN AFFECTED BY MATERNAL HIV/AIDS

by

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In loving memory of my dad,

David Finestone.

When someone you love becomes a memory,

the memory becomes a treasure.

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Declaration of Authorship

I, Michelle Finestone, declare that

AN EVALUATION OF A THEORY-BASED SUPPORT GROUP INTERVENTION

FOR CHILDREN AFFECTED BY MATERNAL HIV/AIDS

is my own work and that all sources and citations from literature

have been acknowledged in-text and referenced in full.

Signature: ....

Date: 30 August 2013

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ABSTRACT

The aim of this study was to evaluate a 24-week support group intervention programme which was designed to enhance adaptive behaviour of latent-phase children affected by maternal HIV/Aids. The meta-theoretical paradigms underlying the study were pragmatism and realism. The study was embedded in a concurrent nested (QUALquan) mixed-method design. The quantitative approach in the main study followed a quasi-experimental research design whereas the qualitative approach in this study, contributing to the largest part of the analysis in the study, followed a nested multiple case study design. The theory-driven outcome programme evaluation model applied in this study was the integrative process/outcome evaluation approach. The participants (n=139) were purposefully selected from among previously identified HIV-positive women (n=220) with children between the ages of 6 and 10 years at clinics in the Tshwane region, South Africa. Data were collected over a period of five years in multiple waves of intervention implementation. Prolonged, in-depth engagement by the researcher with participants was prioritized. The data collection strategies comprised of mother-and-child psychological questionnaires, group process notes, careworker focus groups, quality assurance questionnaires and field notes. The data were quantitatively analysed by means of a paired-sample t-test for within-group comparisons and descriptive statistics were furthermore applied. The qualitative text and narration obtained through the interviews, documents and focus groups were coded and analysed for themes. The themes of the emergent concepts were re-coded to establish improved defined categories. The different data sampling strategies assisted the researcher in triangulating the data for increased evaluation reliability.

The PhD-study was conducted within a broader longitudinal study on resilience in South African mothers and children affected by HIV/Aids – the Promoting Resilience in Young Children Study. The findings of the Child Support Group Evaluation Study (e.g. PhD) showed that the content, methods and processes employed in the group-based sessions were effective and culturally sensitive. The intervention sessions enhanced the children's coping skills, internalised and externalised behaviour and daily living, communication and socialisation skills. The group provided a buffer for the children and supported them in coping with their mothers' illness.

The children displayed normative values through their religious coping styles, their quest for and display of respect and their unambiguous assertion of right and wrong. A specific finding of this study was that the children created a sphere or space in which to order their thoughts, behaviours and emotions within the intervention. This provided them with parameters in their adverse circumstances to display adaptive behaviour or resilience which they could use to function adequately. The study suggests that the use of support groups should be incorporated into intervention programmes dealing with latent-phase children affected by HIV/Aids.

Keywords:

Theory-based support group intervention programme

Programme evaluation

HIV/Aids

Resilience

Adaptive behaviour

Protective factors

Risk factors

HIV-affected child

Latent child

Careworker

CHAPTER 1

Introduction
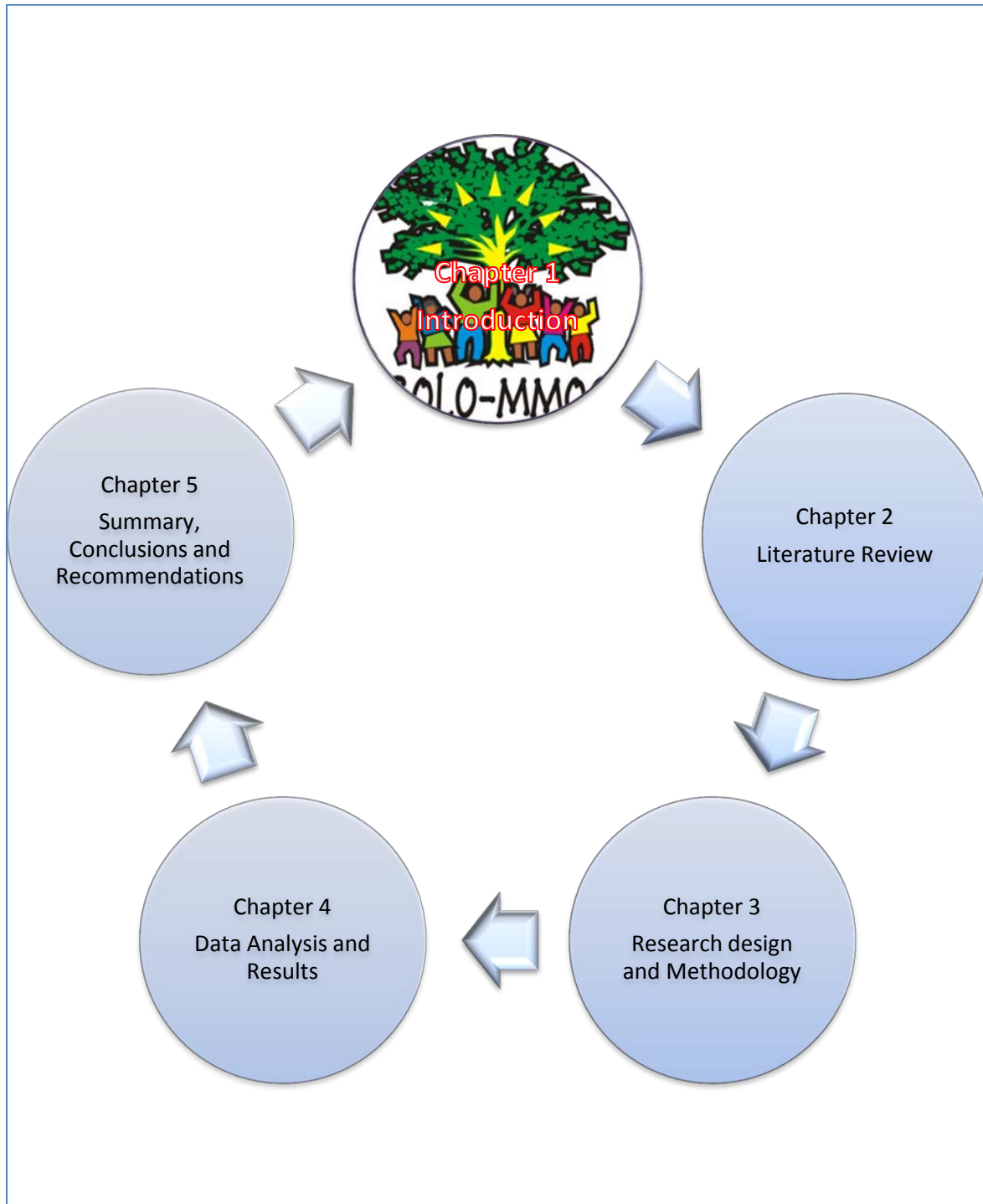
1. Introduction

> *"Childhood is a time for play, for experimentation, for fantasy, for exploration.*
> *Everything is curious. Few of us have been able to escape the fascination*
> *(and frustration) of watching a child explore. No place is too perilous, no object too*
> *valuable, no obstacle too insurmountable. They braille their way fearlessly over the world*
> *of seeing, listening, responding. The mystery the child is searching for, is itself"*
> (Buscaglia, 1982, p.34).

The childhood years are popularly perceived as a time where innocence and safety reign, but Goldman (2005) diminishes this myth when she describes childhood as a "*scary world where children experience trauma and difficulty*" (p.xvii). Adults believe that childhood should be a 'safe-haven' for children and therefore they are not willing to recognise 'pain and confusion' in children. According to Altschuler (1997) that is true for researchers as well.

Children are often required to grow up too fast, to imitate adult sophistication while they still secretly desire innocence (Elkind, 2001). The contemporary assault on childhood at home, at school and in the media is immense. In sub-Saharan Africa the HIV/Aids pandemic is placing an even greater strain on children. Sub-Saharan Africa has 10% of the global population but carries over 69% (nearly 1 in every 20 adults) of the HIV/Aids burden (UNAIDS report, 2012). Many children are thus in a vulnerable position. Researchers (Cluver & Gardner, 2007; Ebersöhn & Eloff, 2006; Fang et al., 2009; Forster & Williams, 2000) are in agreement that the impact of parental HIV on children is devastating. In the context of HIV/Aids, children have to take over adult responsibilities and drop out of school to provide for their families. They experience social isolation, poverty and may even have to migrate from their home environments to other family members.

In South Africa, as in many other developing countries, HIV initiatives initially focused on meeting the basic needs of children living in households affected by HIV. The reason behind this was that the children's immediate material needs were seen as more important than their need for long-term counselling. HIV/Aids research over the years has shifted focus to include the psychosocial needs of vulnerable children (Holmes & Debb, 2003).

HIV-affected children experience similar psychological reactions to parental illness as every other child whose parent has a life-threatening disease. Children affected by maternal HIV/Aids experience real-life concerns at an earlier age than most other children (Holmes & Debb, 2003). The psychosocial impact on these children is immense and could include grief, a lowered self-esteem, internalising behaviour problems (such as anxiety and depression) and externalising behaviour problems (such as aggression and hyperactivity). Children affected by parental HIV/Aids experience an added burden of stigma by association (Forster & Williams, 2000).

Not all children are able to cope adaptively with their adverse circumstances and levels of resilience during adversity can vary greatly. Resilience refers to the capability of a child to cope and rebound in the face of significant adversity. There are various definitions of the term 'resilience' but one that is accepted widely is the definition used by Luthar (2006) where resilience is described as positive adaptation despite adversity (Masten, 2001; Sroufe, 2005; Yates, Egeland, & Sroufe, 2003). For the purpose of this thesis study, resilience is described as a continuous process that consists of protective factors which buffer children exposed to adverse circumstances. Resilience can thus logically only exist when children have been challenged by or experienced adverse life circumstances. Resilience is an abstract concept made operational in the measurement of adaptive behaviour.

Research emphasises the need for rigorously researched theory-based programmes that are culturally appropriate for addressing the psychosocial needs of young children (King, De Silva, Stein, & Patel, 2009). Research, monitoring and evaluation of programmes focussing on the impact of HIV on families and communities, are important (Andrews, Skinner, & Zuma, 2006; King et al., 2009). In the South African context, research is critical to investigating the protective processes of children who are affected by HIV/Aids, as the 'disease burden' in South Africa is high. However, the activity of research in this field has been sorely neglected (Betancourt, Meyers-Okhi, Charrow, & Hansen, 2012).

Research into children's psychological well-being and adaptive behaviour affected by maternal HIV-Aids is 'extremely' sparse (Betancourt et al., 2012). Betancourt et al. (2012) indicate that the researchers were not able to find any research that could adequately explain on a quantitative level, the contribution of resilience factors at various ecological levels.

The aforementioned researchers suggest that a more comprehensive understanding of these resilience factors can contribute to a better targeted, 'strengths-based' intervention for children and their families affected by maternal HIV/Aids.

The Promoting Resilience in Young Children Study (PRYCS), in which this thesis study is nested, was a longitudinal study which aimed to enhance resilience of young children living in families affected by maternal HIV/Aids. This thesis is based on a secondary research study, the 'Child Support Group Evaluation Study' (CSGES). The Child Support Group Evaluation Study used a mixed-method approach to evaluate the efficaciousness of the Promoting Resilience in Young Children group-based intervention to enhance children's adaptive behaviour.

A concurrent nested (QUALquan) methods design was used. In this study, self-report child-focused psychological instruments were used to indicate if a theory-based group intervention had a significant influence on children's adaptive behaviour. A paired-sample t-test was conducted to compare the pre- and post-test behaviour of the children who attended the support group sessions. Concurrent with this data collection, qualitative group session notes, focus groups, observations and quality assurance questionnaires investigated the adaptive behaviour of the child participants. Both quantitative and qualitative data were collected to combine the strengths of both forms of research to corroborate the results. The study was implemented in two resource-poor communities in the Greater Tshwane district, South Africa. A pragmatic and critical realism worldview lens was used in the study. The study considered the cultural and developmental contexts of the children in the support groups. Theory-driven outcome evaluation guidelines furthermore directed the evaluation of the support group intervention.

The Promoting Resilience in Young Children Study, which encapsulates the Child Support Group Evaluation Study, adhered to the National Institutes of Health (NIH) ethical guidelines. Consequently, the Child Support Group Evaluation Study also adhered to these guidelines (Forsyth, 2005).

The study thesis is structured as follows: First, the extant literature on the latent child's experience of maternal illness, the psychosocial effects of HIV and Aids on children, resilience and adaptive behaviour of young children in the context of HIV and Aids and intervention groups for children are reviewed. This is followed by a description of the research methods and procedures used in the study. The results of the Child Support Group Evaluation Study are then discussed. Finally, the summary, conclusions and recommendations are presented.

2. Background to the Child Support Group Evaluation Study

2.1. The Promoting Resilience in Young Children Study (Kgolo Mmogo study)[1]

In order to set the background for and provide insight into the thesis study, the Promoting Resilience in Young Children Study randomised control trial methods (RCT) are synoptically introduced.

The title of the NIMH[2] grant study wherein the thesis study is nested is 'Promoting Resilience in Young Children', and was approved by the ethics committee of the Yale University as HIC #0510000726 in 2005. The Faculty of Health Sciences Research Committee of the University of Pretoria in South Africa approved the protocol in October 2005 as Protocol 144/2005.

The primary aims of this study were to indicate the psychosocial effects of parental HIV disease on young children in South Africa (three year-old and 6–10 year-old children); to assess the effectiveness of a theory-based support intervention for mothers and their children; and to identify maternal, medical and psychological factors and child-related mediating variables that contributed to adaptive functioning of children with HIV-infected mothers (Forsyth, 2005).

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[1] Kgolo Mmogo is translated in English from the African language Sepedi as "We grow together".
[2] NIMH is the National Institute for Mental Health in the USA and awarded the grant for the Promoting Resilience in Young Children Study (HIC #0510000726).

The hypotheses of the Promoting Resilience in Young Children Study were stated as:

> *"Hypothesis 1: Children of HIV-infected women have significantly decreased adaptive functioning when compared to children of mothers who are not HIV-infected.*
>
> *Hypothesis 2: A structured support intervention for HIV-infected mothers that includes support groups, home visiting for those who are ill, and parenting education that focuses on promoting resilience, results in improved adaptive functioning among children in both age groups.*
>
> *Hypothesis 3: Strengths of HIV-infected women, such as increased self-esteem and positive coping, promote more positive adaptive functioning among their children and this positive effect is most evident among pre-school-aged children. Furthermore, as a woman's medical condition improves following initiation of antiretroviral therapy, the adaptive functioning of her child also improves"* (Forsyth, 2005, p.7).

The conceptual model for the NIH intervention study was modelled on theory[3] and utilised components of interventions previously used in African communities. The theory-based conceptual model (refer to Fig. 2.4), as architected by Forsyth (2005), regards maternal HIV/Aids and unsafe social environments as risk factors for negative child behaviour outcomes. The intervention focused on two interrelated components: (1) the provision of support to mothers regarding the psychological effects of the disease, identified as decreased social support due to the stigma, increased rates of depression, poor self-esteem and avoidant coping and (2) improvement of the mother's ability to communicate and interact with her child in an age-appropriate manner to improve the child's adaptive functioning and to promote resilience.

The study was conducted as a randomised control trial (RTC) intervention. The participants were selected from a group of women who were enrolled in an earlier HIV-focused study[4] of children aged three and HIV-infected women with children in the age range of 6–10 years and who were referred to hospitals and clinics in the Atteridgeville and Mamelodi communities. The participants enrolled for the study included 32 mothers with children aged three years old and 429 mothers with children between the ages of 6–10 years.

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[3] The Promoting Resilience in Young Children Intervention was based on the resilience and coping theories of Baldwin, Baldwin & Cole (1990); Dutra et al. (2000); Garmezy (1984); Grotman (2003); Lazarus & Folkman (1984); Mallman (2003); Masten & Garmez (1985); Rutter (1990, 1993); Werner & Smith (1982).
[4] Serithi project.

The mothers and their children were randomly assigned to the treatment group or interview-only group. A comparison group of 118 age- and gender-matched children (three years and 6–10 years old) of non-HIV infected women were identified from the same sites in the same communities. In 2007 a pilot study of two mother and children groups preceded the main intervention study (Forsyth, 2005).

A randomised control trial of a six-month intervention period followed, where HIV-positive women and their children engaged in a structured support group intervention that focused on the enhancement of child resilience. The intervention was presented in a group format (Forsyth, 2005). In total, 12 groups or waves of mothers and children participated in the intervention support sessions. There were on average eight purposefully selected participants in each wave who attended the support groups.

The data were collected at baseline-, 6 month-, 12 month- and 18 month-intervals. The Promoting Resilience in Young Children randomised control trial is visually conceptualised and depicted in Figure 1.1.

The quantitative data collection was executed by a team of experienced research assistants, who received additional training in general interviewing methods, specialised child interviewing methods and ethical conduct. They received expert training in the specific requirements of each of the different questionnaires in the assessment battery. The training furthermore incorporated an introduction to the Promoting Resilience in Young Children Study's overall objectives and research questions; a detailed description and exploration of the specific items in the assessment battery; observation and DVD sessions for an in vivo learning experience of assessment procedures for each instrument; discussions relating to ethics, confidentiality and human rights issues; and several opportunities for the research assistants to practice their interview skills under supervision with immediate feedback from the trainers.

The research assistants received additional training in the narrative interview style and the scoring system of the Vineland- II instrument as it differed from the other measurements. The Vineland-II items are posed in a conversational manner and not in the conventional questionnaire-style approach. The research assistants also received training in the completion of child assent forms.

Most of the research assistants had previous experience in research activities focussing on adults and held a tertiary education degree in the health or psychology field. The research assistants were able to communicate in the participants' home languages, were aware of the cultural practices of the study participants and had expert knowledge about HIV/Aids.

Figure 1.1 Promoting Resilience in Young Children Study: randomised control trial

	Experimental groups				Comparison group	
Baseline	**HIV+ mothers and 6-10 year-old children** → Treatment	HIV+ mothers and 6-10 year-old children → ≠treatment	*Randomised*	HIV+ mothers and 3 year-old children → Treatment	HIV+ mothers and 3 year-old children → ≠treatment	*Randomised*	HIV - mothers and 6-10 year-old children	HIV - mothers and 3 year-old children
6 months	**HIV+ mothers and 6-10 year-old children** — Treatment	HIV+ mothers and 6-10 year-old children — ≠treatment	HIV+ mothers and 3 year-old children — Treatment	HIV+ mothers and 3 year-old children — ≠treatment		
12 months	HIV+ mothers and 6-10 year-old children — Treatment	HIV+ mothers and 6-10 year-old children — ≠treatment	HIV+ mothers and 3 year-old children — Treatment	HIV+ mothers and 3 year-old children — ≠treatment		
18 months	HIV+ mothers and 6-10 year-old children — Treatment	HIV+ mothers and 6-10 year-old children — ≠treatment	HIV+ mothers and 3 year-old children — Treatment	HIV+ mothers and 3 year-old children — ≠treatment	HIV+ mothers and 6-10 year-old children's care givers	HIV+ mothers and 6-10 year-old children's teachers

The quantitative data instruments for the mothers participating in the study, were purposefully selected to assess their socio-economic circumstances, physical health, psychological adjustment, parenting skills and perceived functioning of their children. The instruments to measure the aforementioned are summarised in Table 1.1 (Forsyth, 2005).

Table 1.1 Instruments used to assess the mother participants

Construct measured	Instruments
Depression	Center for Epidemiologic Studies Depression (CESD)
Coping	Brief COPE Inventory, Brief Religious COPE
Parenting stress	Parenting Stress Index-Short Form (PSI)
Coping with children's negative emotions	Coping with Children's Negative emotions (CCNES)
Construct measured	Instruments
Child adaptive behaviour	Vineland Adaptive Behavior Scale Version II
Child behavioural/emotional problems	Child Behavior Checklist (CBCL)
Social environment	Socio-demographic data

The self-report child data instruments focused on the participants' psychological adjustment and the manner in which they approach adversity. The instruments utilised for the child participants are summarised in Table 1.2.

Table 1.2 Instruments used to assess the child participants

Construct measured	Instruments
Emotional intelligence	BarOn EQ-YV-i [TM]
Child coping skills	KidCope
Child spiritual coping skills	Children's Spiritual Coping Scale (CSCS)
Depression symptoms	Child Depression Inventory (CDI)
Anxiety symptoms	Revised Manifest Anxiety Scale (RCMAS)
Self-perceived competence and self-esteem	Self-Description Questionnaire (SDQ)

The child participants' teachers and assigned caregivers, as identified by the mother, were interviewed at the six-month and eighteen-month assessment intervals. The instruments utilised to assess the teachers' and caregivers' observations of the child participants are summarised in Table 1.3.

Table 1.3 Instruments used for the teachers and caregivers of the child participants

Teachers	Caregivers
Child Behavior Checklist (CBCL)	Child Behavior Checklist (CBCL)
	Vineland Adaptive Behavior Scale Version II

The Promoting Resilience in Young Children Study was specifically developed to be age appropriate for children 6–10 years old. The children attended the sessions with their mothers on a weekly basis for six months.

The child group intervention sessions followed a manual that was culturally tailored to fit the different cultures of the children who attended the groups. This theory-based manual was developed by psychologists with experience in intervention and child psychology (refer to Chapter 3, p.178). The Promoting Resilience in Young Children Study had additionally intended for volunteers from the community to facilitate the group process in order for the intervention to be sustainable in the community. The manual was developed to take this into account. Careworkers who facilitated the intervention groups received intensive training and weekly supervision from a psychologist and social worker. The careworkers were proficient in the languages the children spoke, namely Sepedi, Setswana, Isizulu and Sesotho.

The careworkers and social workers received training in data collection methods, ethical conduct, basic communication, counselling, and observation skills. The group session notes and observational notes prepared during and after each intervention session were discussed at weekly meetings and the careworkers received supervision during preparation for each intervention session with the project coordinator and social workers. Debriefing sessions were available to the careworkers and social workers. The social workers were responsible for collating and editing the support session notes the careworkers compiled, where necessary (refer to Chapter 3, p.190).

The study was implemented in two Greater Tshwane communities, Atteridgeville and Mamelodi. The Atteridgeville site intervention took place in a building that was converted from an old nurses' hostel to an office building with rooms specifically furnished to be used as intervention rooms for mothers and their children. This building is on the same grounds as a state hospital and clinic. The intervention had access to a fully-equipped outside play area for the children. The Mamelodi site intervention took place in a building that is currently under ownership of a community church. The building is situated in a safe area and on a main taxi route for the children and careworkers.

The site was renovated and upgraded to include an outside play area for the children and the rooms were decorated and furnished to accommodate the mothers and their children attending the sessions. Both sites have a fully-equipped kitchen to provide wholesome cooked lunches to the mothers and their children. The sites have three intervention rooms each, to accommodate the mother groups, the 6–10 year-old child groups and the three year-old child groups (refer to Chapter 3, p.172 for a comprehensive description of the intervention sites).

The thesis study or the "Child Support Group Evaluation Study" primarily focused on the qualitative evaluation of the support group intervention for the 6–10 year-old children who were randomised to receive the intervention treatment. The study purposely utilised the baseline and 6-month quantitative interview data of the aforementioned group (refer to Appendix 2). The mother participants' baseline and 6-month interview data referring to their children's behaviour was furthermore analysed.

3. Purpose of the study

The purpose of the Child Support Group Evaluation Study was to evaluate a six-month theory-based intervention programme for young children affected by maternal HIV/Aids that was implemented over a five year period in the Mamelodi and Atteridgeville areas. This study focused exclusively on the children groups who received treatment[5].

The aim of this study is essentially to contribute to the scarce body of literature describing group interventions with HIV-affected children. Betancourt et al. (2012) reviewed recent literature pertaining to the mental health and resilience of children and concluded that "*there is a clear need for rigorous research on mental health and resilience in HIV-affected children and adolescence*" and "*there is a particular need for intervention research that promotes resilience and positive outcomes across all ecological levels*" (p.n.).

This study aspires to contribute to future study designs pertaining to child interventions that focus on the enhancement of resilience on different bio-ecological system levels as measured operationally through adaptive behaviour indicators.

4. Rationale of the study

King et al. (2009) systematically reviewed electronic databases in 2008 with the aim to assess if any of the various programs and interventions focusing on the improvement of the psychosocial well-being of children affected by HIV/Aids demonstrated to be effective. They came to the conclusion that no study could be found that rigorously assessed the effectiveness of such interventions.

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[5] Treatment refers in this study to the six-month group intervention support sessions for children aged 6–10 years.

Not only are these interventions seldom rigorously assessed but little investigation in general has been done to assess the resilience of young children affected by HIV/Aids (Murphy & Marelich, 2008). This study concurs with Luthar and Brown (2007) that future research agendas must acquire the 'critical ingredients' of an effective intervention and proactively disseminate the findings of resilient adaptations across diverse at-risk groups over time.

The Child Support Group Evaluation Study focuses on the evaluation of an intervention programme for young children affected by maternal HIV/Aids and is based on a mixed-method design that includes elements obtained from both a quantitative analysis and a qualitative approach. This qualitative design allowed the researcher in this study to investigate the resilience phenomenon from an in-depth perspective and to capture a rich and nuanced dimension of the programme and experiences of the participants. Lieber and Weisner (2010) propose that the social sciences could benefit from addressing difficult problems using an integration of different research methods and that "*mixed-methods encourage and support holism, which is more richly, authentically, and appropriately represents the true complexity of behaviours as they occur in natural social contexts*" (Lieber & Weisner, p.560). The use of qualitative and quantitative data strands fortifies and increases the understanding of the adaptive behaviour enhancement phenomenon under study.

The study differs from previous child resilience studies in that most previous studies focused on the study of resilience *per se*. The aim of the thesis study is to qualitatively and quantitatively evaluate and rigorously assess the efficaciousness of a group-based intervention programme with the aim to enhance adaptive behaviour of children who are affected by maternal HIV/Aids.

The Promoting Resilience in Young Children Study in which the Child Support Group Evaluation Study is nested has focused on the quantitative impact of the group-based intervention on the resilience of children. The thesis study aims to evaluate the same group-based intervention for children of HIV-positive mothers, utilising qualitative methods to offer an additional explanation to or corroborate the findings of the Promoting Resilience in Young Children Study. The Child Support Group Evaluation Study specifically focused only on the children participants who received the intervention and furthermore explored the content, methods and process of the intervention.

5. Research questions

For this study the guiding research question is:

> **How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?**

In order to answer the main research question the following quantitative sub-question is explored:

A. To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?

The following qualitative sub-questions are examined to elucidate the critical aspects of this research:

B. What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?

C. What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child?

6. Clarification of key concepts

The concepts 'theory-based support group intervention programme', 'programme evaluation', 'HIV/Aids', 'resilience', 'adaptive behaviour', 'protective factors', risk factors', 'HIV-affected children', 'the latent child' and 'careworker' were identified in the present study for further clarification.

- **Theory-based support group intervention programme:**

A group intervention or treatment is any activity of a programme aiming to modify a determinant/s in the context of a group (Bauer, Sterba, & Hallfors, 2008). The intervention framework proposes an interaction between two major parties, the participants in the intervention programme and the research team. A programme refers to a collective intervention as disparate to individual intervention support (Sechrest & Figueredo, 1993).

The group intervention programme that was based on resilience theory allowed for group assessment of adaptive behaviour in this study. The theory-based support group intervention programme as developed in the Promoting Resilience in Young Children Study is evaluated in the Child Support Group Evaluation Study.

- **Programme evaluation:**

Programme evaluation is, according to Grinnell and Unrau (2008) "*a form of appraisal, using valid and reliable research methods, that examines the processes or outcomes of an organisation that exists to fulfil some social work*" (p.553). Programme evaluation and basic research display many similarities in the logical, orderly way of investigation (Royse, Thyer, & Padgett, 2010). In this study a theory-driven outcome evaluation process was followed. This evaluation method refers to the complex relationships between the context, content, application and outcomes of an intervention. As a result, these relationships produce a reliant and situational understanding of the efficaciousness of the intervention under investigation (Walshe, 2007).

- **HIV/Aids:**

Acquired immune deficiency syndrome (AIDS) is an infectious disease and is caused by the human immunodeficiency virus (HIV). The Aids disease damages major organ systems in the human body and destroys the immune system cells. The $CD4^+$ T-lymphocyte is the main target for HIV-infection. As the $CD4^+$ T-lymphocyte number count declines, the risk and severity for opportunistic infections increases (Castro et al., 1993). There are medical treatments (anti-retroviral medicine or ARM) available that can reduce the rate at which the HIV weakens the immune system (Dieffenbach & Fauci, 2011). In this study the acronyms Aids and HIV are used alternatively as the mother participants in the study were either HIV-positive or experienced Aids symptoms.

- **Resilience:**

Resilience is a positive adaptation despite adversity (Luthar, 2006). Resilience is an active process that entails the manifestation of positive functioning despite vulnerabilities or presence of high risk (Grigorenko et al., 2007).

Resilience in this study is seen as a complex set of concepts, traits and processes in adapting to adversity; it is reached in multiple ways, is embedded in culture, has development and history; and is a transactional process as suggested by Masten and Obradović (2006). In this study resilience is postulated as the umbrella concept of adaptive behaviour and is evaluated according to the bioecological systems theory.

- **Adaptive behaviour:**

Luthar (2003) describes resilience as "*the manifestation of positive adaptation despite significant life adversity. Resilience is not a child attribute that can be directly measured; rather, it is a process or phenomenon that is inferred from the dual coexisting conditions of high adversity and relatively positive adaptation in spite of this*" (p.xxix). For the purpose of this study adaptive behaviour is defined as a measurement to investigate the phenomena and processes underlying risk and protective factors. Garmezy (1991) has defined resilience as "*the capacity for recovery and maintained adaptive behaviour that may follow initial retreat or incapacity upon initiating a stressful event*" (p.459). Resilience is made operational and concrete in adaptive behaviour or, stated otherwise, adaptive behaviour converges in resilience.

- **Protective factors:**

Protective factors are factors that protect the child from adversity. In this study a protective factor is seen as "*specific attributes or situations that are necessary for the process of resilience to occur*" as defined by Earvolino-Ramirez (2007, p.75). Carr (2006) distinguishes between personal protective factors and contextual protective factors. Personal protective factors include biological (e.g., health, gender, age) and psychological protective factors (e.g., easy temperament, intellectual ability, high self-esteem, internal locus of control, optimistic attribution styles, humour, adaptive defences). Contextual protective factors encompass the wider social network of the child and his/her[6] family (i.e. school system, peer group membership). Close relationships with caring adults, effective schools and relationships with competent, prosocial adults in the wider community are three important protective factors (Luthar & Cicchetti, 2000).

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[6] A near even number of boys and girls were randomised to the Child Support Group Evaluation Study and therefore both of the sexes are referred to in the text e.g., he/she, his/her, him/her.

An intervention offers protective support to children in providing a meaningful relationship with at least one caring adult as suggested by Goldman (2005) and Luthar and Cicchetti, (2000). In this study the group facilitator or careworker fulfilled this role and was a protective factor in the children's lives.

- **Risk factors:**

Risk factors indicate the "*heightened possibility of negative outcomes among children who have certain vulnerabilities or are exposed to certain adverse conditions*" (Grigorenko et al., 2007, p.759). In this study risk factors are individual and/or environmental hazards or processes that increase the vulnerability of the latent-phase child to experience negative developmental outcomes (Engle, Castle, & Menon, 1996; Mcknight & Loper, 2002).

- **HIV-affected child:**

In this study the term 'HIV-affected child' refers to a child who has an HIV-positive mother and who is not HIV-positive him/herself.

- **Latent child:**

Latency or middle childhood is defined in this study as the ages of six to ten years. Carr (2006) describes middle childhood as a stage where children "*prefer to autonomously regulate their emotional states rather than involving caregivers in the process*" and strategies of distancing are used to "*manage emotions if children have little control over emotionally demanding situations*" (p.24). Changes in the middle-childhood years are slow, but children acquire many new skills during this phase (Collins, Madsen, & Susman-Stillman, 2008).

- **Careworker:**

Child careworkers have preferably to possess specific nurturing personal characteristics, communication skills, problem-solving skills, flexibility in presenting the group sessions, ability to work with children on their level and the ability to work in a team. They additionally have to be able to identify problematic behaviour and to refer to the appropriate agencies according to the Alberta Occupational Profiles (2009).

Rose (1990) mentions that it is difficult to define specific characteristics and roles of careworkers. She provides a working definition to encapsulate the myriad of responsibilities of a careworker by referring to child carework as the provision of therapeutic care for children in their environment.

The careworkers in the Child Support Group Evaluation Study were volunteers from the Atteridgeville community. They had knowledge of HIV/Aids and were mothers themselves. The careworkers were able to speak two or more of the regional languages. They received additional formal and in-service training to fulfil the role as group facilitator during the support group sessions.

7. Assumptions

In terms of the preceding orientation, the theoretical assumptions of the intervention evaluation study can be stated as follows:

- Children experience psychosocial distress related to a mother's illness (Spath, 2007).
- Interventions to support children in situations of maternal illness can impact positively on the psychological resilience of children (Spath, 2007).
- Children affected by HIV are at risk for physical, emotional and cognitive delays (Foster & Williams, 2000).
- Intervention programmes that focus on child resilience may help young children affected by HIV to develop optimally (Murphy & Marelich, 2008).
- In a low-resource context, an intervention programme for mothers and children affected by HIV can be implemented by careworkers (instead of highly qualified health careworkers).
- A structured, theory-based intervention that focuses on psychological resilience in mothers and children affected by HIV can utilise accessible, low-cost materials to support activities during sessions.

- Separate children sessions and combined sessions with the mothers can be a productive design format for the intervention[7].
- Group sizes should remain between 8–10 group members for optimal group intervention efficacy (Geldard & Geldard, 2001).
- Matters of serious psychological distress should be supported by means of an active referral process outside the group intervention (Eloff, Forsyth, Finestone, Boeving, & Sikkema, 2011).
- This study's role of the researcher as project coordinator for the Promoting Resilience in Young Children Study is clarified in an attempt to avoid bias. The data utilised in this study were extracted from different qualitative data sources e.g. eight careworkers, two social workers and the children in the group and their mothers. Quantitative strategies and data were furthermore applied to corroborate the study findings.

8. Limitations

The limitations for this study are as follows:

- The study was exclusively confined to the Atteridgeville and Mamelodi areas.
- The data were gathered in and during the Promoting Resilience in Young Children Study and further enquiry was thus not possible to elucidate vague responses.
- The study focused on the child support groups of the Promoting Resilience in Young Children Study as the field of specialisation of the researcher in this study lay in the area of child psychology.
- The Promoting Resilience in Young Children Study comparison group was not included in the quantitative phase of the evaluation study since the research methodology of the Child Support Group Evaluation Study was pre-defined as a pre- and post-treatment quasi-experimental design. Caution was taken not to replicate the NIH-sponsored Promoting Resilience in Young Children Study's, quantitative data findings.

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[7] The support group programme was divided into two distinctive parts. The first 14 sessions were sessions where the children and their mothers attended the group separately. Sessions 15-24 incorporated joint sessions where the mother and child participants had the opportunity to share their life worlds with each other.

9. Significance of the Child Support Group Evaluation Study

Despite limitations, the study intends to place emphasis on the evaluation of a group-based intervention programme that focuses on the enhancement of adaptive behaviour of latent-phase children in the context of maternal HIV/Aids. The mixed-method approach of this study may prove significant in contributing to the underdeveloped area of research related to the evaluation of an intervention to enhance adaptive behaviour (resilience) of latent-phase children affected by maternal HIV/Aids across ecological levels. This study furthermore investigated the contextual complexities in a low-resource setting and rigorously assessed the intervention content, methods and processes followed.

10. Literature review

According to Wiersma (1995), "*The review of literature provides the background and context for the research problem. It should establish the need for the research and indicate that the writer is knowledgeable about the area*" (p.406). Beyond the primary focus, the study subsequently focuses on the latent child's experience of maternal illness, the psychological effects of maternal HIV/Aids on children, resilience of young children in the context of HIV/Aids and broadly on support group intervention for children.

10.1. The latent child's experience of maternal illness

Children who experience stress, change and anxiety relating to uncertainty and caregiving tasks due to maternal illness are well documented in research (Armistead, Klein, & Forehand, 1995; Spath, 2007; Steele, Forehand, & Armistead, 1995). These findings indicate that parental illness is related to psychological distress that can subsequently manifest in internalised and externalised behaviour problems. Korneluk and Lee (1998) and Johnston, Martin, Martin and Gumaer (1992) identified individual factors such as age, gender, child and parenting coping styles and protective variables as factors that may influence a child's adjustment to parental illness.

The middle-childhood years are a relatively dormant phase and a period of developmental stability where children have the opportunity to develop and practice their physical, cognitive, emotional and social skills (Collins, Madsen, & Susman-Stillman, 2008). From a resilience perspective a child's most significant developmental task is the development of protective factors (Baruth & Carroll, 2002). Latent-phase children do not develop in isolation and the importance of children's interactions with their family, friends, school, community, society and culture demand attention. Lerner's developmental contextual model provides a constructive framework to assess and evaluate children's development in their specific contexts (Ford & Lerner, 1992). Children in the middle-childhood years may experience maternal illness in particular as difficult and even more so for children living in single-parent families (Annunziato, Rakotomihamina, & Rubacka, 2007; Helseth & Ulfsaet, 2003).

The risk factor of maternal illness heightens the probability that children may experience poor psychological outcomes. Strengthening the protective factors of children and their families may buffer them and increase the likelihood of a positive outcome. In this study particular attention was given to the latent children's developmental age and related adaptive behaviour. Resilience and related resilience processes have, according to Cicchetti (2010), a strong relationship with a child's age and his/her exposure to changing life circumstances.

10.2. The psychosocial effects of maternal HIV/Aids on children

The devastating effects of HIV/Aids cannot be denied although there is a current view of HIV being a chronic disease, but to some extent manageable. HIV is especially devastating for young children in the context of poverty where issues of crime, violence and lack of opportunity are additional factors of distress (Cicchetti & Garmezy, 1993; DeMatteo, Wells, Salter Goldie, & King, 2002). Anxiety, depression, social withdrawal, learning problems and attention deficits are some of the disorders that children affected by parental HIV may experience. The future wellbeing of children in South Africa is threatened because of the many stressors that play a role in a family with HIV. By increasing children's resilience and support in their environment, the positive outcomes for these children could be enhanced (Drimie & Casale, 2009).

This study utilises the ecological systems theory as theoretical lens to explore the effects of HIV/Aids on the multiple life contexts of the child.

The possible psychosocial and socio-economic effects of maternal HIV/Aids on children's psychological functioning and behaviour are given attention to in the study. Mothers infected with the HIV virus are exposed to their own psychological distress of dealing with a life-threatening illness. They additionally are exposed to discrimination because of the associated HIV/Aids stigma. It is assumed that the mother's parenting role subsequently changes in light of these factors. Children may as a result of this be expected to take over certain of the caregiving roles and this could be an extra burden on the child. It must be indicated that some children do however display positive adaptation despite the maternal HIV/Aids stressor in their lives. In Chapter 2, the literature regarding support structures and proposed interventions to support children living in families affected by maternal HIV/Aids are furthermore investigated in an effort to provide a holistic picture of children who are affected by HIV/Aids.

10.3. Resilience of young children in the context of HIV/Aids

Resilience is an adaptive process and multidimensional, rather than a single measurable outcome and is grounded in the knowledge of culture and context (Condly, 2006; Ungar, 2005). A resilient child is able to 'bounce back' from and effectively deal with adverse life events or situations. The process includes the child's ability to understand the event and to give a deeper meaning to it. This understanding may lead to an increased sense of competency, a belief of being able to cope and being in control. The more resilient child experiences fewer psychological and behaviour consequences and enhanced adaptive behaviour (Forsyth, 2005). The study of risks and protective factors enables social scientists to understand the factors that influence a child's adaptive development (Killian, 2005).

Resilience research has evolved over the years and moved away from merely identifying protective and risk factors to discovering the processes underlying resilience (Cicchetti, 2010). Resilience is, according to this viewpoint, strongly related to the child's age and his/her exposure to changing life circumstances. The developmental progression subsequently leads to new vulnerabilities and strengths. The identification of the resilience processes contributes to the design of effective preventive and intervention strategies that are developmentally appropriated to promote resilience in children who experience adversity (Cicchetti, 2010).

Masten et al. (1999) state that "*investigators must specify the threat to development, the criteria by which adaptation is judged to be successful, and the features of the individual or the environment that may help to explain the resilient outcomes*" (p.144). In this study, cumulative exposure to maternal illness is considered a threat to development; adaptation success is defined with respect to the outcomes set by the Promoting Resilience in Young Children Study (refer to par. 2.1, p.5) and the features of both the child participant and his/her environment are explored.

Adaptive behaviour indicator measurements were obtained from the child participants in the study before the 6-month intervention commenced and these findings were compared to the adaptive behaviour outcomes after completion of the intervention sessions. The child participant's adaptive behaviour was furthermore qualitatively described as it transpired during the intervention support sessions.

Resilience is an abstract, complex and multidimensional concept (Ungar, 2005). Resilience is therefore made operational in this study in adaptive behaviour. Adaptation is broadly defined as "*responses to the demands of the environment*" (Gilgun & Abrams, 2005, p.59). Resilience is hereby described as a continuous process that consists of protective factors which buffer children exposed to adversity and provided a helpful theoretical background to this study.

10.4. Support group intervention for children

The Promoting Resilience of Young Children Study is grounded in a systematic review of accrued evidence on compelling vulnerability and protective processes that tend to modify the effects of maternal HIV infection. The intervention was developed to improve possible maladaptive patterns as well as to build child participants' strengths. "*The resilience framework serves to direct interventionists to empirical knowledge regarding the salience of particular vulnerability and protective processes within the context of specific adversities*" (Luthar & Cicchetti, 2000, p.860). A resilience-focused intervention implies a focus on positive and negative outcomes with an implicit emphasis on primary prevention. Where problems have already surfaced, the resilience framework focuses on the deficits and the areas of strength (Luthar & Cicchetti, 2000).

The advantages, limitations and types of group-based interventions for children are discussed in this study. The practical considerations in support group planning and the principles underlying the design of a group-based intervention programme are examined in detail to provide a framework against which the content of the Promoting Resilience in Young Children Study intervention programme can be evaluated.

The literature on counselling and facilitation skills required from a group facilitator is used to scrutinise the training and facilitation skills of the careworkers who facilitated the group sessions in this study. General group-based intervention programmes for children to improve adaptive behaviour and specifically the characteristics of support groups for HIV-affected children, are alluded to in this sub-section of the literature review.

11. Methodology and procedures

11.1. Research paradigms

The meta-theoretical paradigms underlying the study are pragmatism and realism. The methodological paradigm utilised in the Child Support Group Evaluation Study is a concurrent nested (QUALquan) mixed-method strategy.

11.1.1. Methodological paradigm

The mixed-method research design is a legitimate and autonomous research design and is defined by Creswell (2006) as:

"Mixed-methods research is a research design with philosophical assumptions as well as methods of enquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone" (p.144).

A concurrent nested mixed-method design with the main emphasis on the qualitative data are utilised in this study. The data were extracted from the population using qualitative and quantitative measures and was analysed separately before it was theoretically integrated through an interpretative integration process.

11.1.2. Meta-theoretical design

A paradigm is a "*loose collection of logically related assumptions, concepts, or propositions that orient thinking and research*" (p.24) according to Bogdon and Biklen (2007) and impacts the way knowledge is studied and interpreted. In this study the pragmatic and realism paradigms were identified to orient the research process. The pragmatic paradigm is not dedicated to one specific system of philosophy or reality but places 'the research problem' as central. Different approaches are utilised to understand the problem under investigation. The 'central' research question has the effect that the data collection and data analysis methods are chosen specifically to answer the research questions (Mackenzie & Knipe, 2006). According to Imas and Rist (2009) realist evaluation is a "*theory-driven evaluation that provides a coherent and consistent framework for the way evaluations engage programs, treats stakeholders as fallible experts, and draws on other approaches to evaluation*" (p.204). The pragmatic and realistic paradigms guided the research evaluation activities where "*data sources or resources are limited – to try to find out whether specific expected programme footprints can be identified in light of available data and data types*" (Pawson & Tilley, 2004, p.23).

11.2. Research design

The nested multiple case study and the quasi-experimental designs were chosen to answer the qualitative and quantitative questions and is aligned with the pragmatic and critical realism paradigms. The use of both a quantitative and qualitative design provided the opportunity for a holistic evaluation of the Child Support Group Evaluation Study.

11.2.1. Nested multiple case study design

Case studies provide an opportunity to explore a programme in-depth (Creswell, 2003). A case study analysis makes use of a detailed description of the case and its setting to establish patterns and to develop naturalistic generalisations from analysing the data (Creswell, 1998). The case study design followed in the evaluation of the child intervention group provides an opportunity to study child participants bounded by time and activity. A variety of data collection methods are used that enables an in-depth study of the participants in the intervention programme. Multiple cases broadened the coverage of this study.

11.2.2. Quasi-experimental design

The efficaciousness of a support group intervention, also referred to as 'treatment' in this study, was assessed by implementing a quasi-experimental design. The treatment effect is estimated by making a comparison between different cases before and after the treatment implementation (Mark & Reichardt, 2009). A one-group pretest-posttest design is applied, where comparisons of the baseline and six-month instrument data are made to assess if the six-month support group intervention had an effect on the study participant's adaptive behaviour.

11.2.3. Theory-driven outcome evaluation

Programme evaluation is a specialised form of social research and based on certain underlying philosophical assumptions that refer to the nature of reality and the design and conduct of the research investigation. It is not possible to prove that an assumption of an objective reality is true, but certain assumptions are needed to construct practical changes in the world. The assumption of an objective reality does not negate the participant's subjective construct of his/her own life, but it does assert that there is an element of the participant's world that exists objectively. Objective changes in a participant's life are thus an important construct to evaluate. The assessment of an intervention includes both the objective and subjective impact of the programme to present a more accurate image of the programme (Royse, Thyer, & Padgett, 2010). The most pertinent goal for an evaluation, according to Paulsen and Dailey (2002), is to determine whether or not an intervention has improved the problem or situation it was intended to change.

A priori specification of essential intervention effects is important to indicate which intervention effects had an impact on the effectiveness of the programme. Different types of indicators are proposed to assess the outcomes and to minimise validity problems (Sechrest & Figueredo, 1993). The theory-driven outcome evaluation endeavours to map out the programme theory underlying the intervention and to design a research evaluation method to test that specific theory. The aim of the theory-driven evaluation is not to find out whether a programme is effective, but rather to establish, how, when and why the intervention is effective (Walshe, 2007). The conceptual framework of Chen's theory-driven outcome evaluation programme rationale and programme plan guides the programme evaluation in this study (refer to Fig.3.4). Chen (1989) explains this evaluation approach by emphasising that "*the study of the complex treatment implementation processes, causal mechanisms underlying a program, and generalization processes will strengthen the evaluation so that it better serves the purpose of enlightenment in decision making*" (p. 396).

11.3. Participant selection and sampling procedure

Creswell (2003) indicates the importance of identifying the sampling strategies and the approaches that were used to establish data validity. The Child Support Group Evaluation Study sample was purposefully selected from the complete sample of the Promoting Resilience in Young Children Study population (refer to par. 2.1, p.5). The data of the children who received treatment and attended the intervention sessions were identified for the study. The Promoting Resilience in Young Children Study sample was purposefully selected (refer to Figure 1.1) from the clinic and hospital population in Atteridgeville and Mamelodi.

11.4. Data-collection

In addition to the different types of sampling strategies it is essential to specify the types of data that were collected for the purpose of studying a specific phenomenon (Creswell, 2003). The quantitative and qualitative data were collected concurrently. The specific secondary documentation data that were collected for the Child Support Group Evaluation Study to assess children's adaptive behaviour after they completed a six month intervention, is summarised in Appendix 2.

The study focuses on the qualitative data as gathered from:

- Group session process notes.
- Focus groups with the careworkers.
- Child group quality evaluation questionnaires.
- Mother group quality evaluation questionnaires.
- Careworker evaluations of the individual children in the different groups.
- Careworker and project coordinator observational notes.

The qualitative data analysis explores in-depth the perceptions of the children, mothers and careworkers of their intervention experience and the possible observed behaviour changes in the children who attended the intervention sessions.

The quantitative assessment instruments used in the Child Support Group Evaluation Study were selected on the basis of their ability to measure adaptive behaviour (refer to Table 1.4). Sechrest and Figueredo (1993) support the notion of purposefully selecting instruments. Instruments have to be able to measure outcomes effectively and provide outcome criteria with strong theoretical links to the desired outcomes.

Table 1.4   Assessment instruments used in the Child Support Group Evaluation Study

Construct measured	Instruments
Child behaviour and adaptive functioning	**Mother participant instruments**
Child adaptive behaviour (communication, daily living and socialisation skills)	Vineland Adaptive Behavior Scale Version II
Child internalised and externalised behaviour problems	Child Behavior Checklist (CBCL)
Social environment	Socio-demographic data
Child self-report on psychological adjustment and the manner in which s/he approach adversity	**Child participant instruments**
Emotional intelligence	BarOn EQ-YV-i ^{TM}
Child coping skills	Kidcope
Child spiritual coping skills	Children's Spiritual Coping Scale (CSCS)
Depression symptoms	Child Depression Inventory (CDI)
Anxiety symptoms	Revised Manifest Anxiety Scale (RCMAS)
Self-perceived competence and self-esteem	Self-Description Questionnaire (SDQ)

11.5. Data analysis and validation procedures

The quantitative data analysis and the qualitative data analyses were completed in two phases although the data sets were concurrently collected. The data were then interpretively integrated to generate the final conclusions in this study.

In the first phase of the data analysis the quantitative data were investigated. The six-month post-intervention interview data were compared with the pre-intervention baseline interview data to determine whether the independent variable (treatment) had an effect on the dependent (adaptive behaviour) variable. The inferential statistical method identified for testing the research question and related hypotheses was the paired-samples t-test (Dawson & Trapp, 2004). The series of steps that were taken to verify the validity of the quantitative data findings are described in the study by referring to the validity and reliability of the scores of the instruments utilised in previous studies (refer to Chapter 3, p.153).

In the second phase, the qualitative data analysis followed a two-tier process where specific identified individual group member data were analysed and thereafter the group session data were enumerated and themes identified. The group session data were furthermore explored in-depth in an effort to evaluate the efficaciousness of the intervention programme. Data transformation of enumeration is a process where a researcher is permitted to qualify the quantitative data in an effort to create factors or themes that can be compared with the factors and themes of the qualitative database (Creswell, 2003). In the qualitative data analysis credibility is established by scrutinising the qualitative data for accuracy and adhering to triangulation and rich detailed descriptions of the phenomenon under investigation. In this qualitative design, credibility was sought by using general strategies to enhance trustworthiness

The intervention group-based support sessions are furthermore evaluated and suggestions for possible improvement are offered for the future development of group-based interventions to enhance adaptive behaviour of children who are affected by maternal HIV/Aids.

12. Outline of chapters

The outline of the rest of the chapters in the research thesis is indicated in Table 1.5

Table 1.5 Outline of chapters in the Child Support Group Evaluation Study

CHAPTER	DESCRIPTION
2 Literature Review	**LITERATURE REVIEW** This chapter provides a literature review and conceptual framework for the evaluation of a support group intervention for young children affected by maternal HIV/Aids: • The latent child's experience of maternal illness • The psychosocial effects of maternal HIV/Aids on children • Resilience of young children in the context of HIV/Aids • Support group intervention for children
3 Research design and Methodo-logy	**RESEARCH DESIGN AND METHODOLOGY** This chapter provides an in-depth description of *inter alia:* • Research paradigm • Research design • Theory-driven outcome evaluation of an intervention programme • Participant selection and sampling procedure • Data collection methods • Data analysis and validation process • Intervention setting • Design and content of intervention programme • Facilitator training process • Cost of group sessions • Ethical issues
4 Data Analysis and Results	**DATA ANALYSIS AND RESULTS** This chapter offers the findings and interpretation of the Child Support Group Evaluation Study for children affected by maternal HIV/Aids
5 Summary, Conclusions and Recommen-dations	**SUMMARY, CONCLUSIONS AND RECOMMENDATIONS** This chapter concludes the research and provides a final evaluation of the Child Support Group Evaluation Study. The following information is presented: • Summary • Limitations of the study • Conclusions • Recommendations • Future research

CHAPTER 2

Literature Review

Figure 2.1 Summarised outline of the literature review

Evaluation of an intervention programme for young children affected by maternal HIV/Aids

The latent child's experience of maternal illness

- The continuity and discontinuity of middle childhood developmental models across cultures
- Lerner's developmental contextual model
- Developmental domains of the middle-childhood years
- The latent's child's development in the context of maternal illness

The psychosocial effects of HIV and Aids on children

- An overview of the ecological systems theory and other theoretical models to explain the impact of illness on families
- The psychosocial effects of maternal HIV/Aids on children
- The socio-economic effects of maternal HIV/Aids on families
- Maternal psychological distress
- Parenting under special circumstances
- Maternal HIV disclosure to children
- Stigma and discrimination associated with maternal HIV/Aids
- The care giving role of children in families affected by maternal HIV/Aids
- Support for children living in families affected by maternal HIV/Aids

Resilience and adaptive behaviour of young children in the context of HIV and Aids

- The establishment and progress of resilience research
- Working definition of resilience
- Advantages in applying the ecosystemic resilience paradigm
- Risk factors for children affected by maternal HIV/Aids
- Protective resilience factors
- Domains for resilience enhancement in children affected by maternal HIV/Aids
- Principles underlying the development of interventions aimed at resilience

Intervention groups for children

- Advantages of intervention group work
- Limitations of intervention group work
- Different types of support groups for children
- Practical considerations in planning for a children's support group
- Principles in designing a group intervention programme
- Counselling and facilitation skills required in children's groups
- Group intervention programmes to enhance adaptive behaviour
- Support group intervention programmes for HIV-affected children

1. Introduction

Chapter 2 aims to provide the background to the evaluation of the Promoting Resilience in Young Children Study for latent-phase children of HIV-infected mothers, subject to the scope and limitations as presented in the literature. To accomplish this, the latent child's experience of maternal illness and the specific psychosocial effects of maternal HIV/Aids are discussed. Furthermore, reviews of the body of knowledge referring to resilience and adaptive behaviour of children in the context of HIV/Aids are presented. Finally, reviews of the literature pertaining to the planning, content and process of group-based intervention programmes for HIV-affected children is included. The literature research forms an integral part of the research process and provides the underlying theoretical assumptions for the evaluation of the theory-driven group-based intervention for children affected by maternal HIV/Aids. A summarised outline of the literature review is presented in Figure 2.1.

2. The latent child's experience of maternal illness

2.1. Introduction

The middle-childhood years[1] are also referred to as the latent-phase and spans from the ages of 6–10 years. Huston and Ripke (2006) assert that the middle-childhood years are marked by changes in competences and distinctive behaviours which have long-term implications for adolescent and adult patterns. This transitional phase leading to adolescence is not solely defined by age, according to Zembar and Blume (2009) and Bronfenbrenner (1979), but also by culture and context. The context of the child, in which development occurs and interaction take place, is thus of significance in understanding the latent-phase. Maternal illness therefore has a possible traumatic impact (positive and/or negative) on children's development (Stein, 2003). The context of maternal illness comprises of both material and psychosocial stressors. According to Pederson and Revenson (2005) and Stein (2003), social science researchers have given limited attention to children's experience of maternal illness.

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[1] In this study the terminology of middle-childhood years and latent child phase are used interchangeably and refers to the childhood years spanning from 6–10 years.

2.2. The continuity and discontinuity of middle-childhood developmental milestones across cultures

Zembar and Blume (2009) juxtapose the positivist and postmodernist perspectives of development by indicating that the central theme of both perspectives is the importance of cultural influences. They presuppose that the latent child constructs a sense of identity in relation to his/her family, peer group and school culture. Children's developmental transitions may be different in different cultures where certain cognitive and social skills are more cultural (emic) than general (etic). Within the different cultures there are also different contexts that may have an impact on the latent child's development and subsequent experience of maternal illness.

Traditional ideas in Africa are important and have an influence on children's developmental outcomes, according to Jackson and Abosi (2006). They further elaborate on this viewpoint by referring to certain cultural-wide and cultural-specific values attached to marriage, family, sexuality and the status of women across Africa. These values have to be taken in consideration when assessing physical and social development. Jackson and Abosi (2006) refer to a number of important cultural factors that have a significant influence on the development of school-aged children. They indicate that school-aged children in Africa are generally closely connected to their social group although they show independency early in life. They display a desire to help their peers in order to ensure the well-being of their in-group and discriminate against out-groups for this reason. They would rather work in cooperation with one another than in competition. They display enhanced skills development through observation coupled with verbal instruction and the learning experience is enhanced if the child sees the practical need thereof. They furthermore demonstrate a moderate expression of emotions, respect for their elders and a predisposition to believe in gender differences.

Jean Piaget's child development research ideas dictated the scholarly understanding of how children developed until the early 1980s. He posed that all children developed in the same way and focused on the ways that an individual child makes sense of his/her 'generic' world. This Piagetian model focuses on children's experience of the world, but negates to take their diverse cultural contexts into consideration (Boyden & Mann, 2005; Kerig, Ludlow, & Wenar, 2012).

Lev Vygotsky and other social-cultural theorists subsequently proposed that all psychological experiences originate through interpersonal interaction and that notion has led scholars to look more closely at children's cultural and social contexts. Caregivers and other people in a child's learning environment thus have an immense impact on the child's acquisition of knowledge, abilities and experiences to function successfully in his/her community. Identifying the risks in a community is not a straightforward process. Diverse maturity levels, skills and experiences impact the way a child makes sense of his/her situation. Therefore it is imperative for researchers to understand the context of the child before aiming to assess a child's development and well-being (Boyden & Mann, 2005; Kerig, Ludlow, & Wenar, 2012).

Certain general milestones that span across cultures are necessary for a child to reach in the middle-childhood years. These milestones are referred to as 'domains' and are divided into physical, cognitive, affective and social developmental domains by Zembar and Blume (2009) and Huston and Ripke (2006). The developmentally-appropriate principles underlying the different domains of children's behaviour are closely related, according to Berry (2008). Development therefore in one domain has an impact on the other domains as well. The sequencing of this skills and abilities acquisition takes place in a relatively orderly fashion. Development happens at different rates for different children and is influenced by the multiple social and cultural contexts of the developing child. Children are not passive in their learning and actively take part in making sense of the world around them. The bioecological system of the child has a definite impact on his/her development.

The physical developmental domain in the middle-childhood phase refers to biological and neuro-physiological changes, improved perceptual and motor skills, growth spurts, weight gain and increased athletic abilities. The cognitive developmental domain includes an increase in logical reasoning where concrete examples are utilised, memory and learning take place, and important academic skills, such as reading and writing, are acquired. A child's cognitive development has a direct impact on his/her social adjustment. The cognitive schemas children forms have an influence on how they process information and how they pay attention to certain events. Children are more able to recall information that is congruent with the schemas they actively form. These schemas form the basis for children's perceptions of events and become more permeable as the child develops and experiences different situations (Huston & Ripke, 2006; Zembar & Blume, 2009).

These experiences permit perception adaptations to specific and different conditions he/she encounters. Schemas develop through interactions with parents and significant others and are later influenced by the broader community and the cultural context of the child. Adverse social experiences, such as violence, may lead to the formation of maladaptive schemas. This experience of the world as hostile may as a result be projected in externalised behaviour towards the outside world. Choe, Zimmerman and Devnarain (2012) refer in their study to the effect of victimisation and witnessing violence on a child's behaviour. They pose that "*victimization, witnessing violence and friends' violent behaviour contributed directly to violent behaviour. Only family conflict and friends' violence influenced violent attitudes*" (p.166). Positive peer and adult relationships are protective factors for children experiencing violence, according to the study of Jain, Buka, Subramanian and Molnar (2012). They indicate that "*positive peers and supportive relationships with parents and other adults had significant effects. Positive peers and family support were particularly protective of witnesses and victims*" (p.107). Experiences such as chronic illness in the family may result in the formation of a schema equating family life to anxiety (internalised behaviour). The affective development phase entails the enhancement of personal competencies through participation in social and scholastic activities and attachments with significant others. Children's emotions and feelings mediate their attributions and behaviour. The social and moral developmental domains refer to the children's ability to understand others and to act appropriately in social situations. They achieve this developmental goal in forming close relationships with others where they place a high regard on same-sex friendships and fairness (Huston & Ripke, 2006; Lochman, Holmes, & Wojnaroski, 2008; Zembar & Blume, 2009).

Differences or discontinuity may exist in the interpretation of children's developmental milestones across cultures. It is therefore important to make provision for possible dissimilarities by incorporating the differences (or discontinuity) and the similarities (or continuity) of expected milestones as described in current literature. Lerner's developmental contextual model (Ford & Lerner, 1992) is helpful in ensuring that the culture and contexts of children, for instance experiencing stigmatisation in the context of maternal illness, are taken into consideration.

2.3. Lerner's developmental contextual model

A holistic view of the middle-childhood years is provided by means of the developmental contextual model of Lerner (Ford & Lerner, 1992) as illustrated in Figure 2.1. This model not only describes the dynamic interaction of children and their environments on biological, psychological, socio-cultural and historical levels but also indicates development across all domains while interaction takes place within multiple environments across time. The latent child is thus not a mere passive bystander in relation to his/her context but also plays a part in his/her own development. Development in all domains and interaction within multiple environments take place simultaneously. As individuals change and develop over time, their communities, societies and cultures change as well. It is probable that these changes will also affect the child's life on other levels. The relationships between developing children and their ever-changing contexts change and these changes take place within a specific historical place and time. Social practices and interventions could therefore have an effect on the development of the latent child (Zembar & Blume, 2009).

Zembar and Blume (2009) indicate that the most salient contexts that protect and/or put a latent-phase child at risk are the family, school, peer group and local neighbourhood contexts. Certain changes in a family may have important developmental effects on a child, for example, if the socio-economic status of the family changes, the family relocates, the parent is ill or if the mother has a new partner. Families are important buffers for stressful life events and provide safe boundaries. Family support, positive communication patterns and modelling of prosocial behaviour are developmental assets for the latent-phase child.

The school environment plays an important role in the middle-childhood years as this is the place where the child spends most of his/her time during the day. The teacher is a significant person in the child's life. In the school context the child acquires new academic skills and is challenged on many levels. The child is also exposed to a new peer group where socialisation skills are needed and subsequently developed or not (Zembar & Blume, 2009). In South Africa the child in primary school may be exposed to an unsafe school environment. The majority of schools in South Africa are plagued by violence, bullying and substance abuse, according to a report from the South African Council for Educators (2011). The report further indicates that the school environment is a reflection of what is taking place in the broader social context.

Ward, Martin, Theron and Distiller (2007) posit that South African children are exposed to extreme levels of violence. The exposure to violence puts a child at risk for developing internalising and externalising problems such as depression, anxiety, substance abuse and conduct problems (Ward, Martin, Theron, & Distiller, 2007).

The child is furthermore expected to interact with peers in his/her neighbourhood or community. The latent-phase child usually prefers friends of the same age and sex. The neighbourhood plays an important part in developing a child's interaction skills with peer group interaction and the establishment of socialisation skills. If the neighbourhood is deemed dangerous, parents would tend to be over-protective of their children and may thus limit the child's opportunities to socialise with peers. Children in this age group may also partake in community organisation activities, such as church-related activities, which are important for the child to develop a sense of belonging and integration (Zembar & Blume, 2009). Barbarin, Richter and De Wet (2001) highlight the effect of violence on a child's psychosocial life. Children in South Africa are exposed to explicit and ambient political, family and community violence on a daily basis. Adverse psychosocial adjustment is a result of living in a constantly violent and threatening environment. Children may present with diverse behaviour, emotional, social and scholastic problems. Attention problems, aggression, anxiety and depression were indicated as the most prevalent effects of violence in South African youth. Barbarin et al. (2001) indicate that mothers in South Africa are just as exposed to the violence in their communities as their children, but their ability to regulate their distress has important implications for their children's response to the experienced violence. Coping resources such as family support, individual resilience, maternal coping and spirituality may modify the adverse effects experienced by the children.

The middle childhood years can be viewed as a period of opportunity, according to Huston and Ripke (2006). Children in this age group experience increased cognitive abilities, physical abilities and self-awareness without the pressures of adolescence. Huston and Ripke (2006) describes this developmental level as *"…a good time to maximize the potential for positive growth and to introduce supports and opportunities that help children along successful pathways to adulthood"* (p.7).

The latent-phase is therefore physically a relatively quiet period where the child is presented the opportunity to acquire essential new life skills on different developmental levels.

Literature (Huston & Ripke, 2006) proposes interventions in this developmental phase where vulnerable children are supported to reach their full potential. Children exposed to maternal illness are especially vulnerable in this phase as they are developmentally in need of support and guidance to reach their expected developmental goals.

Figure 2.2 Lerner's developmental contextual model as adapted for children in the latent developmental phase with HIV-infected mothers

Culture

Society

Community

School network
Teachers
Classmates

Social network
Parents' peers
Child's peers

LATENT CHILD
-Attitudes
-Behaviour
-Temperament
-Personality
-Health
-Biology
-Developmental levels
-Cognition

Time

Time

MOTHER
-Attitudes
-Behaviour
-Temperament
-Personality
-Health (HIV+)
-Biology
-Developmental levels
-Cognition

Work network/ unemployment
Immediate prof. associates

Marriage network
Non-nuclear familly
Siblings/other children
Other Parent/Spouse /partner

Community

Society

Culture

(Adapted from Ford & Lerner, 1992, p.77).

2.4. Developmental domains of the middle-childhood years

The question of 'How do we know a child is doing well?' is reflected in knowledge of child development, including certain well-documented and researched general developmental tasks.

Masten and Coatsworth (1998) caution researchers to evaluate competency (developmental tasks) by also taking the child's community and environment into account. A child living in an unsafe area may exhibit, for instance, elevated survival skills. The same survival skills may be viewed as inappropriate in other communities with less violence. Competency in the middle school years includes social competence with peers, socially appropriate conduct and academic achievement. The protective factors in children's lives buffer them, to a certain extent, against adverse circumstances and assist in the development of appropriate developmental skills. Bailey (2004) associates the development of age-appropriate tasks to the development of protective factors. He states that "*developmental psychopathology perspective emphasises the importance of successful adaptation for a given developmental period. Given that developmental tasks vary with age, it follows that the protective factors may also differ with age*" (Bailey, 2004, p.411). The protective factors for children may therefore differ in the latency phase from other developmental phases.

The physical, cognitive, affective, social and moral development of children in the latent-phase may provide important clues to how a child experiences his/her relationships with other people and their environment. Changes in the middle-childhood years are slow, but children acquire many new skills during this phase (Collins, Madsen, & Susman-Stillman, 2008; Jackson & Abosi, 2006). The general developmental tasks that a latent-phase child is expected to reach according to developmentalists, are summarised in Table 2.1.

Table 2.1 Normative developmental trends of the latent-phase child

Developmental domains	Normative developmental trends of the latent-phase child
Physical development	- Height and weight increase gradually. Girls develop sooner and more quickly than boys. Environmental factors also have an effect for example, diet. - Girls may show secondary sex characteristics. Early maturation may lead to adjustment difficulties. Children in middle childhood may engage in interactive sexual activities with other children. - Physical development in relation to the onset of puberty and development of sexual identity.

Developmental domains	Normative developmental trends of the latent-phase child
Physical development	• Dendritic pruning and increased myelination of the brain take place. • Mostly high-levels of physical activity. Rapid shifts of attention and high activity levels are normal in this age group. • Specific motor movements are refined and integrated such as running, jumping, throwing and balancing. Fine-motor skill improvement is important for fine motor movements such as writing and cutting. Perceptual-motor skills develop where the sensory system and the motor system become more integrated.
Cognitive development	• Constructivist perspective (Piaget): Concrete operational stage where the child develops internalised representations of concrete objects. Children learn more easily if concepts are presented concretely. • Children in this phase can understand casual relationships and asks questions such as 'Why?' and 'How come?' Both maturation and environment play a role in development. • Latency children are concrete in their experiences and they find it difficult to verbalise their opinions and feelings. • Socio-cultural perspective (Vygotsky): Learning ensues through interaction with culture and contexts. • Information-processing perspective: increased short-term storage capacity (5-6 items), speed of processing quicker, improved attention, and mnemonic strategies (can sort and cluster items) and improved meta-cognition. • Improved speaking and reading skills. • Understand differences of opinion, but sees world in 'black and white' terms. • Shift from egocentrism to understanding others (understanding how others think and feel). • Own behaviour, feelings and ideas are seen as separate from other people and it is accepted that other people may differ in behaviour, feelings and ideas. • Have difficulty handling criticism. • Display magical thinking and may think they are the cause of something happening. • Exposure to violence may affect neurological development.
Affective development	• Includes self-understanding, emotional development, self-control and motivation. Obtain personal competencies through participation in activities. • Make use of emotional expression to regulate relationships. Has the awareness that a person may have multiple emotions about the same person. • Distancing self is used as a strategy to cope with emotions in situations which the child has little control over. • Psychosocial theory (Erikson): Industry vs. Inferiority. The task of the latent-phase child is to do work on a skill/project and to follow through for some time. Contributes to sense of identity. If the child does not receive adequate support or help, he/she may develop a sense of inferiority. • Child strives for positive regard from others (parents, teachers, peers). • Child prefers autonomous regulation of emotions to involving caregivers. • A need for self-actualisation. • Child differentiates between components of self-competence (for example, academic, social, physical appearance) and engages in social comparisons that contribute to sense of self-esteem. Body image develops. • Understand own emotional states and can control emotions. • Common fears in this age group are darkness, injury, being alone and animals. Fears are replaced by anxieties and worries. • The child might daydream in this phase to reduce daily stressors which may lead to denial of real-life events. They may fantasise without reality testing to verify fantasies.

Developmental domains	Normative developmental trends of the latent-phase child
Affective development	- The child does not have the ability in this phase to handle intense emotions for long periods of time. He/she needs an adult supervision to feel safe and to make choices. - Can distinguish social appropriateness of emotional expressions and can mask emotional reactions if not appropriate according to social circumstances.
Social and moral development	- Acquiring social skills and social stress escalates during this phase. They want to feel they belong. - Transition to independence; begin to think independently from parents. - Focus emotional energy on competent relationships. Increased interpersonal understanding. - Social comparison takes place and the child evaluates him/herself according to academic, physical and social areas of competence. - Friendship refinement. Can have strong friendships and 'enemies'. They negotiate and differentiate themselves from others in concrete ways (for instance eyes, skin, and strengths). If the child does not feel a sense of belonging because of the lack of similarities, the child may feel ostracised. Peer relationships are important to the child. - Enforce rules and critical of self and others. - Sometimes overconfident of own abilities. - Use moral reasoning to guide social interactions. Understand the perspectives of others and make judgements based on shared expectation in relationship or on obligations to others. Absolutist and inflexible, there is no midway. They see right as right and wrong as wrong with no mitigating considerations. They conform to some type of moral higher power, for instance religion. - Faith: express and explain faith through stories shared with family/ culture/community. Believe God can be influenced through promises/prayers/ deeds. - Rules followed for own interest. - Aggression is more often verbal or relational than physical. - May engage in stereotyping. - Concept of death: Children younger than eight years may feel guilty if a parent dies and can experience the parent's death as something that is not permanent. A child older than eight years experiences a parent's death as final and universal. He/she may also fear mortality. Anger is often an associated feeling. A child in this phase may think that he/she did something wrong or is the reason that his/her parent/s died (magical thinking). Adapted from Akos (2000); Becvar (2001); Boyce et al. (2002); Carr (2006); Collins, Madsen & Susman-Stillman (2008); Di Ciacco (2008); Kerig, Ludlow, & Wenar (2012); Papalia, Olds, & Feldman (2006); Robinson, (2008); Visser (2007); Wenar & Kerig (2006); Worden (1996); Zembar & Blume (2009).

In this study attention is directed to the summarised table of normative developmental trends for the middle childhood years (refer to Table 2.1). Maternal illness is a traumatic life event and places extra ordinary demands on a family. The development of children in the context of maternal illness necessitates a detailed explanation for a more comprehensive understanding of the children's development and subsequent adaptation.

2.5. The latent child's development in the context of maternal illness

The middle-childhood years are described by developmentalists (Collins, Madsen, & Susman-Stillman, 2008) as a dormant phase where the child experiences relative stability in his/her development before entering the sometimes tumultuous adolescent phase. Children in this phase are nonetheless more vulnerable to stressors than children of other age groups, according to Collins, Madsen and Susman-Stillman (2008). A child in the latent-phase who is exposed to illness in the family and/or has to take over the role as caregiver is vulnerable to educational, social, and emotional problems (Aldridge & Becker, 1999).

The impact of parental illness on a child depends on several factors (Armistead, Klein, & Forehand, 1995). Variables that are pointed out by Spath (2007) to be specifically important are developmental age, gender of the child and the ill parent, the amount of parental systematology, parent/sibling response to illness and family characteristics. Mother-child relationships generally differ from father-child relationships as the mother typically spends more time with the child. Maternal illness in a single-parent family thus has a remarkable impact on a child's development (Annunziato, Rakotomihamina, & Rubacka, 2007; Helseth, & Ulfsæt, 2003). Factors that play a role in maternal illness are noticeably depression, physical incapability of being with her child and episodes of intense pain (Johnston et al., 1992). Research focussing on children in families where the mother is depressed indicates emotional and behavioural difficulties, attachment and academic problems, self-regulation difficulties, problematic peer relationships and sleep disturbances, according to Collins, Madsen and Susman-Stillman (2008) and Spath (2007). Children may experience stress and anxiety relating to the uncertainty regarding their future (Helseth & Ulfsæt, 2003; Spath, 2007). These findings indicate that parental illness is related to psychological distress and is manifested in problematic behaviour (internalised and/or externalised behaviour problems). Separation from a caregiver due to hospitalisation, role changes in the family, increased tasks and responsibilities are stressors, as indicated by Spath (2007) and Korneluk and Lee (1998), that may have a negative psychological effect on a child. Internalising problems include anxiety, rumination, social isolation, depression, low-self-esteem and survivor guilt whereas externalising problems include behaviour problems such as bullying and aggressiveness, according to Van der Heijden and Swartz (2010). If the child doesn't actively cope with the parent's illness it may result in psychological dysfunction.

Problematic parent-child relationships, sibling-child relationships and an overall feeling of family instability are, according to Spath (2007), present in families with parental illness. Steele et al. (1995) conclude that the severity of a parent's illness can be correlated with the amount of disruption in a family. These disruptions may cause the child in this situation to use more internalising coping strategies, which is predicative of increased internalised problems. The researchers furthermore direct attention to the importance of the child's relationship with his/her healthy (not ill) parent where this relationship may ameliorate the child's experience of the stress caused by the illness in the family. The healthy parent is an important asset in the child's life. Warm supportive relationships with a parent before the parent got ill is another buffer for the child to cope with the parental illness stressors. Children with parental relationship problems will thus present with more avoidant coping strategies and internalising problems. Internalising problems are strongly related to problems associated with parental illness and child adjustment.

Korneluk and Lee (1998) indicate that perceptions of the impact of parental illness on children depend on the source of information. Children will often report more symptoms on a questionnaire than they would admit to their parents or caregivers. One reason that is offered for this discrepancy is that the children may want to spare the sick parent from further distress by concealing their own distress. Korneluk and Lee (1998) conclude that the presence of parental illness *per se* does not inescapably lead to psychopathology in children. Distress in the context of parental illness may be part of the clinical profile of children, but that does not necessarily result in adjustment problems. Annunziato et al. (2007) mention that maternal optimism and positive parenting are protective mechanisms for a child in a single-parent family with a chronic illness. These mechanisms also contribute to a lowering of externalising and internalising problems.

Individual factors such as age, gender, child and parental coping styles and protective variables/resilience are further identified by Korneluk and Lee (1998) and Johnston et al. (1992) as factors that may influence a child's adjustment to parental illness. Age and gender differences may be ascribed to the child's perception of his/her increased household responsibilities. Coping skills become more complex as children develop and their problem-solving skills improve with age. Older children also have a more developed cognitive repertoire they can utilise in their coping with the parent's illness.

The different coping styles of children and parents are furthermore possible mediators in the children's experience of their parents' illness. Children may not be able to change anything regarding their parent's illness, but they may feel that they have slight control by negotiating, for instance, over additional household chores. Korneluk and Lee (1998) therefore caution that researchers have to examine coping efforts aimed at particular stressors and not only assess global coping scales when they investigate children's responses to parental illness.

Korneluk and Lee (1998) and Helseth and Ulfsæt (2003) state that it is important to explore the coping skills of children, but the parent's style of coping has a more significant effect on how a child adjusts to the illness. Parents who display avoidant coping themselves often complain about their children's internalising and externalising behaviour. A link is indicated between the parent's own coping strategies and their children's strategies for coping with their illness. Parental illness is a stressful life event for a child and may lead to physical, mental health and normative developmental threats (Pederson & Revenson, 2005; Visser, 2007). Steele et al. (1995) propose that parental emotional distress and the parent-child relationship are affected by parental illness. They further elaborate on Billings and Moos' (1981) model on childhood coping, stating that a child can use active or avoidant coping. Active coping strategies are used in an attempt to actively focus on the stressor whereas avoidant coping is where cognition and behaviour are used to draw the child's attention away from the stressor. Avoidant coping is more closely linked with child adjustment problems.

Helseth and Ulfsæt (2003) additionally refer to three different kinds of coping strategies that children use. The first coping strategy is problem-focused coping where a child aims to change or do something about their parent's illness. The second coping strategy is emotion-focused coping where the child tries to deal with his/her feelings about his/her parent's illness and the third coping strategy is a dual-focused coping strategy where the child attempts to achieve both goals. Although children use all three strategies they mainly use the emotion-focused coping where they try to avoid or distract their attention from their parent's illness. They take part in pleasurable activities such as playing and watching television in order to cope with the situation. Helseth and Ulfsæt (2003) report that children struggle on their own with their parent's illness and the parents seldom know how to approach their children and how their children are really coping in the context of their illness. The researchers concur with Korneluk and Lee (1998) that children attempt to hide their own distress in an effort to protect their parents from seeing how much they are hurting.

Helseth and Ulfsæt (2003) indicate that they are unsure whether avoidant coping is an appropriate coping mechanism. Avoidant coping may be a technique where a child acquires some time to deal with the situation and his/her emotions. There is a point where a child's strategies to maintain well-being is sufficient, but then the burden may also become too strenuous and they may experience extreme stress levels. Researchers have to be especially aware of these extreme points such as at the time of diagnosis, when a situation changes or where a mother's illness progresses.

Compas, Connor-Smith, Saltzman, Thomsen and Wadsworth (2001) and Johnston et al. (1992) propose that problem-solving strategies are acquired through adult modelling of behaviour. Korneluk and Lee (1998) state that if a child is not told about the parent's illness, the child is deprived of the opportunity to learn adequate problem-solving (and emotion-focused skills) as modelled by the parent. Children may display more immediate distress upon being told about the illness of the parent, but they may have a better chance of coping if they are exposed to their parents' coping skills.

Spath (2007) asserts that intervention strategies for children in families with parental illness often lack empirical methodology and/or statistical analysis of effectiveness. Sparse and dated literature is available to describe the relationship between maternal illness and child development (Armistead, et al. 1995; Pederson & Revenson, 2005; Siegel, 1992; Steele et al., 1995). The existing research that focuses on the effect of parental illness on child functioning and normal development has yielded mixed results (Annunziato et al., 2007; Korneluk & Lee, 1998). Annunziato et al. (2007) furthermore direct attention to the importance of research focussing on the effect of illness in a single parent family and states that "*the specific burden of illness on single parents and how their children might be affected has not been studied to date*" (p.389). Individual behaviour cannot be understood without paying attention to the individual's social contexts and other variables such as culture and family composition (Pederson & Revenson, 2005).

2.6. Summary

The middle-childhood years are thus a period of relative developmental stability where children have the opportunity to develop and practice their physical, cognitive, emotional and social skills. These life skills are important for adjustment in later developmental phases.

Latent-phase children are not developing in isolation and the importance of children's interactions with their family, friends, school, community, society and culture demand attention. Lerner's developmental contextual model provides a constructive framework to assess and evaluate children's development in their specific contexts. Children in the middle-childhood years may experience maternal illness in particular as difficult and even more so for children living in single parent families. The risk factor of maternal illness heightens the probability that children may experience poor psychological outcomes. Strengthening the protective factors of children and their families may buffer them and increase the likelihood of a positive outcome. Positive adult modelling of constructive coping skills has a salient effect on children's behaviour and coping skills. Children whose mothers are infected with HIV have to cope with added stressors. They have to cope with both maternal illness and the difficulties associated with the disease. The psychosocial effects of maternal HIV/Aids on children are discussed in the following section of Chapter 2.

3. The psychosocial effects of maternal HIV/Aids on children

3.1. Introduction

Taylor and Kvalsvig (2008) refer to the Bill of Rights in the Constitution of South Africa where in theory all children in South Africa have the right to "*basic nutrition, shelter, health care, social services, protection from neglect and abuse and the right to equality, dignity and a basic education*" (p.61). The government has, according to this Bill of Rights, a statutory obligation towards children affected by HIV/Aids. In theory this is a noble endeavour, but in practice it seems to be very difficult to achieve. Women are more likely than men to be infected by HIV and they tend to be infected at an earlier age (UNAIDS, 2004). According to Andrews et al. (2006), Armistead et al. (1995) and Stein (2003), HIV/Aids is not just another unique terminal illness, but it is a complicated disease with added economical and psychosocial stressors. HIV/Aids is a progressive illness where the family members must cope with the changing nature of the disease as the parent becomes more ill. Parental depression is a possibility during the course of the illness that may disrupt parenting and this could have an additional influence on a child's functioning. HIV/Aids may also, in some instances, result in the decline of parental cognitive functioning and as a result have an array of negative consequences for the whole family (Armistead, Klein, & Forehand, 1995; Korneluk & Lee, 1998).

Specific potential mechanisms that may be predicative of the relationship between parental physical illness and child functioning are identified by Armistead, Klein and Forehand (1995): disruption of parenting that include less parental support to the child, fewer discipline efforts, neglect of the child, changes in family routines, parental absence, parental depression, inter-parental conflict and parental divorce.

Drimie and Casale (2009) highlight the fact that children in South Africa living in families with HIV are vulnerable and fear for their future security. They conclude that the future wellbeing of children in South Africa is threatened because of the many stressors that play a role in a family affected with HIV. They propose that by increasing the children's resilience capacities and protective factors, the positive outcomes for children could be optimised.

The bioecological systems theory of Bronfenbrenner is used in the study as a framework to explain the phenomenon of maternal illness and aims to provide insight into the impact of maternal HIV/Aids on children's adaptive behaviour and development.

3.2. An overview of the bioecological systems theory and other theoretical models to explain the impact of illness on families

"Aids has introduced an unprecedented challenge to families and communities throughout sub-Saharan Africa, threatening the survival and development of children who have been orphaned and rendered vulnerable by individual, household or community circumstances" (Schenk, 2009, p.918)

Guba and Lincoln (1994) and Tudge, Mokrova, Hatfield and Karnik. (2009) recommend a close relationship between the chosen theory, the methods used and the analytic strategy employed in a study. Theory is used to *"provide a framework within which to explain connections among the phenomena under study and to provide insights leading to the discovery of new connections"* (Tudge et al., 2009, p.198). Theory provides clarity and integrity of scientific thought and gives researchers the opportunity to compare finding across studies.

Therefore, the bioecological systems theory of Bronfenbrenner is discussed in detail in the literature review and references are additionally made to the family systems health model, the family coping with maternal illness model and the adjustment to parental illness model to provide a framework for investigating the impact of maternal illness on children's adaptive behaviour (refer to Figure 2.3).

The Bronfenbrenner ecological theory of human development and socialisation has been renamed to 'the bioecological systems theory' in order to place the child's own biology as the 'primary micro-environment'. Bronfenbrenner's theory originated from Kurt Lewin's 1935 classical field theory as evidenced in his 'human behaviour'-formula where B=f(PE). Lewin's formula states that "*behaviour (B) [is] the result (f) of interaction between person (P) and the environment (E)*" (Härkönen, 2007, p.4).

Bronfenbrenner's theory is used by numerous researchers to describe different environmental factors and persons in different relationships, roles, actions and processes. It makes a contribution to the understanding of the child's role and behaviour in relation to different contexts the child lives in. This theory perceives a person as an active role-player in his/her environment where the environment requires that the person adapts to its conditions and restrictions. The environment is portrayed as different-sized circles placed inside each other with a reciprocal relationship between the micro-, meso-, exo- and macro-systems. (Bronfenbrenner, 1994; Christensen, 2010; Härkönen, 2007).

Two propositions are generally referred to, for defining the bioecological model. The first proposition states that human development occurs in progressively complex reciprocal relationships between a person and other human organisms and their immediate environment. These interactions have to take place on a regular basis for it to be effective. Enduring patterns of interaction is referred to as '*proximal processes*' and examples of proximal processes are parent-child and group activities. The second proposition states that "*the form, power, content and direction of proximal processes*" affect development of a person (Bronfenbrenner, 1994, p. 38). The two propositions are theoretically interdependent. In order to measure a child's development, a research design measuring the two propositions simultaneously is imperative. Bronfenbrenner (1994) alludes to studies indicating that the proximal processes are more powerful than the environment within which they occur.

Proximal processes refer to any long-term interaction between a person and his/her immediate environment where development is made possible. These interactions could be supportive or destructive. For optimum development the interaction must happen on a regular basis over long periods of time, for example parents' play interaction with children and children taking part in peer group activities. The children's interaction in the activities gives them the opportunity to make sense of their world (Tudge et al., 2009). Bronfenbrenner (1979) positions proximal development as central to his theory. The "*form, power, content and direction*" (p.198) of the proximal development depends largely on the child's personality traits, the characteristics of the immediate environment, the nature of the developmental outcomes, the changes that take place over a time period and the historical context of the child (Tudge et al., 2009).

A study focussing on children's behaviour in the context of maternal HIV/Aids that is guided by the bioecological systems theory therefore has to focus on the developing child, the environment, the nature of the developmental outcomes (processes) and changes over time to preserve the integrity of the theory.

The developing child's biological and genetic composition is acknowledged in the bioecological systems theory, but the **personal characteristics** of a child that accompanies him/her to a social situation is of more significance. A child has 'demand', 'resource' and 'force' characteristics according to the bioecological systems theory. A demand characteristic refers to the immediate reactions of other people to the child because of his/her age, gender and physical appearance. The resource characteristics are not based on immediate reactions to appearance but rely on mental and emotional resources such as past experiences, skills and material resources (for example, access to good food, caring parents and educational opportunities). Force characteristics refer to traits such as character traits, motivation and perseverance. The development pathway may be different for two children with the same resources as one child may display more resilience than another because he/she is more motivated to succeed. Temperamental, biological, intellectual and personality characteristics of the child and his/her significant others (for example, parents or siblings) are further examples of personal characteristics as described by Tudge et al. (2009).

Figure 2.3 Graphic representation of Bronfenbrenner's bioecological system theory
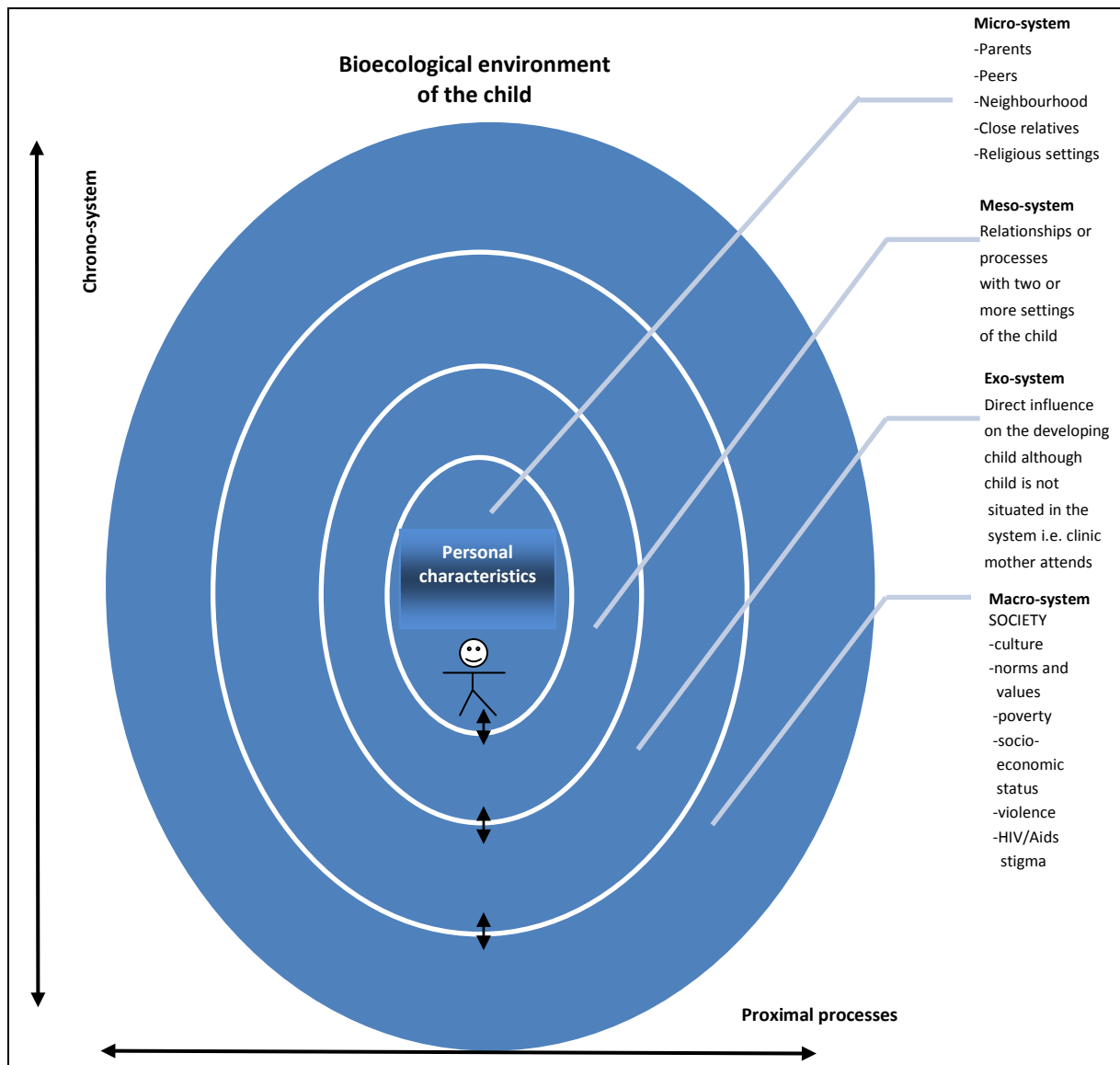
(As adapted from Bronfenbrenner, 1994).

The **environment** or context refers to four interrelated systems (refer to Figure 2.3). The first system is the micro-system that includes the relationships closest to the child and includes, for example, the child's parents, classmates at school and close relatives. Religious settings and the child's neighbourhood are also referred to as the child's micro-system. The reciprocal nature of the theory makes provision for interpreting relationships as a two-way system where both systems influence each other and is called a bi-directional interaction. The second meso-system refers to the relationships and processes between two or more settings of the developing child (Bronfenbrenner, 1994; Christensen, 2010; Tudge et al., 2009).

The meso-system is thus a system of micro-systems, for example, a child without a close relationship with his/her mother may experience difficulties forming positive relationships with his/her teacher or form an even stronger bond due to the lack of the mother-child relationship. The meso-systems can support or oppose each other. The third exo-system does have a direct influence on the developing child although the child is not situated in the system. The mother may for instance experience a particular long day at the clinic to receive her anti-retroviral medication and then she behaves more irritable than usual towards her child when she arrives home. The child is not part of the clinic system, but he/she experiences the mother's irritability associated with the clinic experience. The final macro-system spans across all the systems and refers to the society the child lives in which include elements such as culture, poverty and socio-economic status. It influences and is influenced by all of the systems (Bronfenbrenner, 1994; Christensen, 2010; Tudge et al., 2009).

The **time variable** could be subdivided in micro-time, meso-time and macro-time. Micro-time refers to what is happening in a specific activity whereas meso-time refers to the extent and consistency to which a specific activity takes place in a child's life. Macro-time refers to a more global concept of time and is referred to as the chrono-system. The chrono-system is the change or stability over a time period in the characteristics of the child and the environment in which he/she grows up in. The changes that occur over time are described with this variable (Bronfenbrenner, 1994; Tudge et al.*,* 2009).

Bronfenbrenner (1990) proposes five critical processes for the positive development of a child. The core of these five propositions is the child's emotional, physical, intellectual and social need "*for ongoing, mutual interaction with a caring adult--and preferably with many adults*" (Bronfenbrenner, 1990, p.1). A child requires participation in reciprocal relationships on a regular basis over an extended life period with one or more caring adults who are committed to the child's well-being. The establishment of interpersonal relationships with strong mutual attachments enhances a child's responsiveness to the physical, social, and symbolic environment. These attachments open the door to exploration and imagination that may assist a child's psychological growth. The relationship between the caring adult and the child depends to a large degree on another adult (third party) who encourages and gives status to the reciprocal relationship. Trust, information exchange and good communication are necessary for effective relationships (Bronfenbrenner, 1990).

Effective child-rearing processes involve the child's bioecological system as a whole. Parents, family, teachers, friends, neighbours and social economic circumstances are components of this system.

The bioecological systems theory provides a framework to evaluate child support groups, focussing on the enhancement of behaviour of children affected by maternal HIV/Aids. The overarching framework has the capability to comment on children's personality traits, characteristics of the immediate environment, nature of the developmental outcomes, changes that take place over a time period and the historical context of the child. The theory consequently supports the evaluation of the complexities related to maternal HIV/Aids. Knowledge of how a child reacts to a chronic illness is important in order to support children affected by maternal HIV/Aids. Korneluk and Lee (1998) provide theoretical models to explain a child's reaction to a chronic illness in his/her family.

Korneluk and Lee (1998) identify three theoretical models to assist in explaining a child's reaction to a chronic illness in his/her family. The researchers do, however, focus attention on the importance of the integration of developmental levels in a bid for an overarching theory. Rolland's family systems health model views illness as a normal part of life and a family can either display enhanced functioning or problematic functioning, dealing with the illness at hand. Rolland (1987) identifies three dimensions to appraise illness in a family: a) illness characteristics (acute vs. gradual, progressive/stable vs. episodic/relapsing, outcome and extent of debility), b) major phases in the natural history of the illness, the individual and family life cycle (crisis, chronic or terminal phase of illness and the developmental phase of the individual and family), and c) family systems variables (style of communication, adaptability and cohesion). Lewis, Woods, Hough and Bensley (1989) developed a family-coping-with-maternal-illness model. This model is entirely family focused and places emphasis on illness factors and time frames of diagnosis. The researchers direct attention to the impact of various illnesses. They also investigate the effect of specific family characteristics and relationships within a family. The impact of the socio-economic status of the family and the support from significant others play an important role in family functioning according to Lewis et al. (1989). Armistead and his colleagues place emphasis on how the child functions during parental illness. The adjustment-to-parental-illness model focuses on disrupted parenting and the marital relationship between the spouses (Korneluk & Lee, 1998).

In this study the overarching bioecological systems theory was used to select appropriate research methods and subsequent analytic strategies. HIV/Aids influences a multitude of systems and therefore the study focused on the support groups where the children interacted with each other, but also with their mothers and other external factors (for example culture and stigma). The effects of maternal HIV/Aids on the latent child were examined on multiple bioecological levels, but emphasis was placed on the micro-level impact and changes over a timeframe of six months. The effect of maternal HIV/Aids on children was studied by analysing the developmental level of the children, the characteristics of HIV/Aids, the family system variables (for example socio-economic status and support) and the children's reactions to the illness.

3.3. The psychosocial effects of maternal HIV/Aids on children

Elevated levels of psychological distress, depression, loneliness, negative self-esteem, anxiety and withdrawal are identified by Betancourt et al. (2012); Forehand et al. (1998); Forehand et al. (2002) and Forsyth, Damour, Nagler and Adnopoz (1996) as internalising problems having a major impact on the psychological development of children whose mothers are HIV-infected.

The latent child additionally has to cope with feelings such as helplessness and fear associated with the impact of HIV/Aids on the family. The range of emotions, which may include anger towards the sick parent or feeling guilty about being angry, may make it difficult for the child to express his/her feelings. HIV/Aids have the added burden of shame and embarrassment that accompanies the stigmatisation faced by families affected by HIV/Aids (Johnston et al., 1992). The child may feel that he/she has to grow up fast and accept increased responsibility in the family. Children may start to act out, their scholastic performance may drop, and they may display social withdrawal. Social promiscuity and substance abuse are associated risk factors for children living in a family affected by HIV/Aids (Family Health Project Research Group, 1998; Johnston et al., 1992).

Children of HIV-infected mothers are thus vulnerable for developing emotional and psychological problems. They are particularly prone to developing depression and anxiety disorders (Forehand et al., 2002).

They display more depressive symptoms and show less warm and supportive relationships with their mothers, according to Forehand et al. (2002), than children whose mothers are not infected. According to Brandt (2005) and Hough, Brumitt, Templin, Saltz and Mood (2003) clinical research focussing on the psychological health of HIV-affected children indicates that they are extremely vulnerable and at great risk for developing psychopathology. HIV-infected mothers report that their children display heightened levels of externalising behaviour and internalising problems. Pelton and Forehand (2005) hypothesise that the children of HIV-infected mothers display problematic behaviour in the borderline clinical range before their mother's death and these continue for at least two years after her death.

In an attempt to explain why some children affected by HIV develop psychological problems and other children not, Hough et al. (2003) refer to factors having a profound effect on children with HIV-infected mothers. The social support structures of the mother, the socio-demographic characteristics of the family, the child's social support structures, the HIV-associated maternal stressors, the mother's coping strategies, the child's coping strategies and the quality of the mother-child relationship are factors ultimately effecting the child's psychosocial adjustment.

The Family Health Project Research Group (1998) considers the following factors as important in the study of psychosocial adjustment of children affected by HIV/Aids:

- Stage of illness.
- Social-emotional support.
- Economic and material resources.
- Environmental stressors.
- Mother's psychological functioning.
- Mother's coping strategies.
- Parenting.
- Child's required self-sufficiency.
- Child's knowledge of the mother's illness.
- Child's coping strategies.

A child with an HIV-infected mother will have periods where he/she will be without his/her primary caregiver if she is hospitalised.

The psychosocial adjustment of a child having a mother that is still in the early stage of HIV-infection may differ from a child's psychosocial adjustment having a mother who is showing with more pronounced symptoms of Aids. The child faces anxiety and distress with the knowledge of their mother's illness. This anxiety places the child in chronic trauma as the child in the latent-phase understands the irreversibility of death (Dorsey et al., 1999; Willemsen & Anscombe, 2001).

Doku (2009) postulates that children whose parents died of Aids, children whose parents died of factors other than Aids and children living with HIV and Aids-infected parents display greater symptoms of depression and anxiety. Grieving is, according to Stein (2003), more difficult for a child living with a parent with HIV/Aids and for Aids orphans than for children in families with other terminal illnesses. The material and psycho-social stressors involved are more complicated and severe than in the instance of other terminal illnesses. Van der Heijden and Swartz (2010) emphasise that the experience of grief may be complicated by social conditions and cultural practices. Even though grief is a personal experience with some universal traits, the social and cultural environment of the child will have a direct influence on the child's grief process. In all circumstances of parental illness the family structure changes, the parent-child relationship changes and there may also be socio-economic changes involved. Children living with parents infected by HIV/Aids are exposed to a heightened risk for psychological disorders including conduct, peer and emotional problems. Children in South Africa living in families with parental HIV-infection are exposed to numerous Aids-related deaths in their families and communities (Theron & Theron, 2010).

Van der Heijden and Swartz (2010) estimate that 15% of children in South Africa under the age of 15 years, are directly affected by HIV/Aids. Parents, family members, friends of the family and even friends may die because of Aids and children are thus exposed to multiple bereavements. Social-economic burdens and stigmatisation accompany the grief. Adverse psychosocial development, health and survival needs sketch an unsure future for these children where there is a loss of role-models, nurturers and bonds with family members. Not all children develop psychological problems because of their loss. The support, coping skills and resilience of a child dictate how he/she will cope with her/his grief.

Children react differently to stressful life events, according to Eloff and Ebersöhn (2002). Children do not have the ability to verbalise their feelings in the same way as adults do and their behaviour may be viewed as inappropriate by outsiders, as they have a tendency to act out their anxiety and fears. A child could react with internalising stress responses (depression and/or anxiety), externalising stress responses (acting out and difficult behaviour) and/or with somatising stress responses, where the child exhibits with bodily aches and pains in a way to cope with the stressful life event. Korneluk and Lee (1998) stress that the manner in which children cope with difficult life situations changes as the child grows older. Children's coping skills develop in the middle childhood phase to more sophisticated cognitive and problem-focused strategies. A parent's coping style has an impact on the child's coping style as the child models the parent's technique of coping with illness. Avoidant coping may result in increased internalising and externalising problems. Korneluk and Lee (1998) support the notion of a relationship between the coping of the parent with his/her illness and the child's coping with the parent's illness. A parent who attempts to protect his/her child by not telling him/her about the illness may unintentionally be denying the child the opportunity to model problem-solving and/or emotion-focused coping. The parent has a "*buffering role providing emotional scaffolding for their children"* (Korneluk & Lee, 1998, p.188). Parental illness has the natural effect of distress on children, but the majority of children do not display clinically-significant psychopathology, according to Korneluk and Lee (1998).

Armstrong, Birnie-Lefcovitch and Ungar (2005) refer to coping as a "*complex interaction between the individual and the environment, with the goal of management of stress rather than mastery"* (p.270). The coping strategies of adults and children may differ. What may be beneficial for an adult may be totally inappropriate for a child. Hough et al. (2003) argues that avoidance coping might be seen as a negative coping skill in adults, but in children it may provide an internal locus of control and also increases a child's social adaptability. Children have a tendency to seek out help in their immediate social environment and this type of behaviour is associated with positive adaptation to difficult situations. The opposite is true when the social networks of the child are depleted which is the case in many situations where children are affected by maternal HIV/Aids.

Murphy and Marelich (2008) further point to the effects of a mother's HIV status on a young child's resilience. Maternal illness has a direct impact on a young child's resilience. A child's resilience may decrease as the viral load of the mother increases.

Resilient children, however, display fewer depression symptoms and higher self-efficacy, according to the researchers (Murphy & Marelich, 2008).

Children growing up in a home with a chronic illness are at risk for developing an array of problems and scholastic difficulties. They may even display delayed development. Parent-child relationships that are awry because of a debilitating illness, coupled with others stressors such as poverty and stigmatisation, have an impact on the child's ability for future adjustment. A large group of HIV-infected mothers experience depression and the children may as a result experience their mother's coping (or not coping) with the disease as a lack of interest in their (children's) own lives (Letteney, 2010; Lichtenstein, Sturdevant & Mujumdar, 2010). The psychological and physiological needs of children affected by HIV are rarely met by the school and surrounding mental health systems. Children living in households of HIV-infected households are thus vulnerable on social, behavioural and emotional levels.

For the purpose of this study the children's general and religious coping skills were measured to determine how they coped in difficult situations. Instruments that measure adaptive behaviour, internal and external behaviour problems, anxiety, depression and emotional intelligence were used to assess the possible effects of maternal HIV/Aids on children. The children's behaviour was furthermore observed in a support group setting and the socio-economic circumstances of the families were reported. The viral load of the mothers did not feature in this study, but cognisance was taken of the possible effects thereof on the children.

3.4. The socio-economic effects of maternal HIV/Aids on families

Najman et al. (2004) indicate that children living in poverty are exposed to outcomes which may have compromising effects on their short- and long-term health, well-being and achievements. Low family income and the socio-economic status of the mother of the child may be important indicators of a child's mental health and cognitive development. Najman et al. (2004) therefore indicate that interventions are necessary to redress inequalities and "*must begin early in life, must be extensive in their impact and be implemented over a significant period of the life course*" (p.1157).

HIV is disproportionately present in families living in poor social and economic circumstances, which exacerbates the difficulty of managing their health (Deacon & Stephney, 2007; Letteney, 2010). Poverty as a psychological stressor plays an important role in the context of HIV/Aids. The course of HIV-disease progression is more often than not drawn out and in the process the children usually are neglected and there are no or limited funds available for children to receive counselling or other forms of support. As a result of the poverty, the family experiences material needs such as healthy food, clothing, school fees and money for extracurricular activities. The question is posed whether children in HIV-infected families are vulnerable and in distress because of Aids or because of general vulnerability caused by poverty and related socio-economic factors (Stein, 2003).

Letteney (2010) highlights the fact that newer medical treatments are leading to parents who are living longer with HIV and with its advanced stage, Aids. The benefits of the recent generation anti-retroviral treatments (ART) are so effective that doctors estimate that a "*20-year-old diagnosed with HIV today who takes his or her medicine exactly as prescribed and who does not have other pre-existing health issues will likely have a near-normal life expectancy*" (Hosein, 2012). HIV-infection changed from a life-threatening condition to a chronic disease. Letteney (2010) argues that as the number of HIV-infected families is thus likely to grow, it places urgency on research focussing on the daily stressors of low-income HIV-infected families with children in elementary school. Mothers infected with HIV are more frequently staying with their children in low socio-economic surroundings (Letteney, 2010). Brackis-Cott, Mellins, Dolezal and Spiegel (2007) disagree with the assertion, claiming HIV-infected mothers and their affected children exhibit similar mental health risks as mothers and children not affected by HIV living in poverty. HIV-affected families present with more depressive symptomatology than families without HIV, living in the same circumstances.

HIV/Aids dramatically increase the expenditure rate and decrease the financial income of the family. Medical expenditures are high even though the HIV-infected parent may receive his/her anti-retroviral medicine for free in South Africa. Travelling costs to the clinic or the hospital and importance for the HIV-infected patient to eat healthy and drink extra vitamins and minerals are just some of the extra costs incurred by HIV/Aids.

In addition, the parent infected by HIV may not be able to contribute to the family income anymore, whereas the carer could also lose her income taking care of the family member infected by HIV. Disability grants are available, but the amount is small and in many instances the recipients are unaware of them (Smit, 2007).

In this study the mothers reported on the socio-economic questionnaire that most of the children lived in single-parent families and extreme poverty. The low socio-economic surroundings the children were exposed to enhanced their vulnerability. The mothers were mostly unemployed and the families were not able to afford the extra costs brought on by HIV. Subsequently, money was not available to send children with behavioural and/or emotional problems for appropriate therapeutical interventions. The Promoting Resilience in Young Children Study aimed to enhance children's resilience despite their difficult socio-economic circumstances and the Child Support Group Evaluation Study aimed to assess the efficaciousness of this intervention.

3.5. Maternal psychological distress

Mothers infected with HIV face numerous challenges on a physical level but also on a parental level. They are not only experiencing physical discomfort, pain and lethargy, but in addition to their dealing with the disease they have to be parents for their children. The bereavement analogy of 'chronic sorrow' best describes the response of the mothers and their family to the positive diagnosis of HIV. A chronic illness is experienced as a loss and the loss is equated to the loss of a loved one. This 'chronic sorrow' leads to a persistent feeling of sadness. Mothers diagnosed with HIV, in many instances, display depression, anxiety, suicidal ideation, suicidal attempts, substance abuse, despondence, anger, guilt and other psychological problems (Antle, Wells, Goldie, DeMatteo, & King, 2001; Beardslee, Gladstone, Wright & Cooper, 2003; Betancourt et al., 2012; Brackis-Cott et al., 2007; Letteney, 2010; Smit, 2007).

HIV-related stress is mediated through two different types of coping styles, according to Hough et al. (2003). A mother displaying a detachment coping style will avoid dealing with the situation and feelings at hand. She would rather distance herself from it and keep her feelings to herself whereas a mother with an involvement (active) coping style will use problem-solving skills and seek help (Hough et al., 2003).

Avoidant coping is associated with psychological distress such as depression and anxiety. An active style of coping with the HIV diagnosis is significant in predicting better psychological adjustment and better parenting (Hough et al., 2003). Stigmatisation is pointed out as the main reason why mothers with HIV do not seek assistance and rather opt for an avoidant coping style.

A diagnosis of HIV is life-changing for the mother and her family. Hough et al. (2003) indicate that the distress experienced by women diagnosed with HIV heightens as symptoms appear and the illness becomes more severe. HIV-infected mothers may experience even greater restrain in their ability to perform daily tasks and take care of their children, if they experience depression. Degnan, Henderson, Fox and Rubin (2008) link the impact of maternal depression on children to inhibited child behaviour and social anxiety. Although there is widespread concurrence that maternal depression has a major impact on children, little research has been done to measure the effect of maternal illness, according to Korneluk and Lee (1998) and Hough et al. (2003).

The Child Support Group Evaluation Study set out to study the behaviour of HIV/Aids-affected children. Therefore, the instruments measuring depression and coping in the mothers were not reported on. The possible influence of maternal psychological distress on children's behaviour as described in the literature is recognised and viewed as significant in this study.

3.6. Parenting under special circumstances

The 2011 census survey conducted in South Africa indicates the traditional ideal of a nuclear family consisting of a mother, father and children is only for the privileged minority (one third of the South African family population) and the *'typical child'* in South Africa is raised by his/her mother in a single-parent household (Holborn & Eddy, 2011; Statistics South Africa, 2012). The effect of HIV/Aids on South African families is reflected in the increasing numbers of single-parent families with absent fathers and child-headed households. Paternal absence is alarmingly high in South Africa according to Andrews, Skinner and Zuma (2006), taking into consideration that the presence of and relationship with a father are associated with higher adaptive coping in children affected by maternal HIV/Aids (Betancourt et al., 2012).

HIV/Aids is a contributing factor to the large number of single-parent families in South Africa. The stigma associated with HIV/Aids exacerbates the occurrence. Spouses in the first instance may desert their families because they blame their partners, and in the second instance, the high adult mortality rate leaves only one parent available to take care of the children (Smit, 2007). In South Africa the *ubuntu* principle establishes the family as the centre of support and therefore a sense of responsibility for the collective rearing of children exists between families. Although it is often the tradition for extended family members outside the nuclear family to take care of their family in need, it is suggested by Smit (2007) that the extended family is becoming 'over-extended'. The poverty and unemployment rates are high in South Africa and more individuals are becoming dependent on fewer family members that are employed. Households often have more to cope with than they can handle. This situation and the added effect of parental illness have implications for the socio-economic and emotional well-being of a family.

The impact of parental illness on children is well documented in cancer literature, according to Letteney (2010) and Visser (2007). In these studies it is indicated that children may experience a multitude of difficulties because of their mother's illness. The mothers have less time to take care of the needs of their children because they have to focus on their own health. Disrupted parenting can result and this may include neglect, parental absence and fewer parental efforts towards discipline. A parent diagnosed with a chronic illness is a major stressor for the entire family. Parents may experience psychological distress when diagnosed with a life-threatening disease and this may have a limiting effect on their response repertoires. Family routines and parent-child relationships may be disrupted as a result. Although anti-retroviral medicine is helping mothers to stay healthier for a longer time, they still experience the stressors of having to cope with a chronic disease on a daily basis (Murphy, Marelich, Armistead, Herbeck, & Payne, 2010).

HIV/Aids is a chronic, debilitating illness that affects the entire family. It is not an episode but an ongoing challenge. If the mother does not have adequate support she may feel overwhelmed by her HIV diagnosis. The parents infected with HIV are exposed to stigmatising, they are in the predicament of whether to tell their child about their illness, and they have to make arrangements for their child after their death (Johnson et al., 1992).

Families who have functioned on the borderline before the HIV-diagnosis could become dysfunctional when faced with the added burden of HIV/Aids parental infection, according to Johnston et al. (1992). Families who live in poverty and experience parental HIV-infection are thus facing double jeopardy. These families may experience more difficulties than other families facing other types of chronic illnesses. A person with HIV may experience symptoms throughout the course of the disease that include night sweats, fatigue, swollen glands and physical debilitation (Deacon & Stephney, 2007; Letteney, 2010).

As the illness progresses to Aids the symptoms worsen in severity and type. The anti-retroviral medications also cause side-effects for many women that range from fatigue to psychological distress. The mother may furthermore be in need of frequent visits to the clinic and in some instances hospitalisation is required. As the HIV disease progresses parenting become an even bigger endeavour where the mother has less energy and is spending more time in healthcare facilities. Children often either have to accompany their mothers to the clinic or be left unattended at home. Mothers also report feeling guilty for not being able to complete chores and needing assistance with childcare (Letteney, 2010). Bauman, Camacho, Silver, Hudis and Draimin (2002) indicate that there is a direct relationship between an HIV-infected mother's psychological distress and the behavioural problems of her child. Higher emotional distress and physical health problems in the mothers correlate with higher behavioural problems in their children.

Armstrong et al. (2005) point to the important relationship between the quality of parenting and a child's ability to cope during adversity. Good parenting has the effect that many risk factors in a child's life can be mediated, taking into consideration the child's characteristics and behaviour. Willemsen and Anscombe (2001) support the view that maternal HIV and Aids have a definite impact on parent-child relationships and the quality of parenting. The threat of certain death, daily struggles with the illness and the side-effects of the anti-retroviral medicine not only have a physical effect on the parent, but also an emotional effect.

Murphy et al. (2010) postulate that maternal stress may have an added negative impact on parenting and negative parenting skills may have an effect on the behaviour of children. Mothers, who are over-anxious about their health and functioning, experience their parenting role as more stressful. Research (Murphy et al., 2010) indicates that HIV-infected mothers experience increased conflict with their children and they get more easily annoyed with them.

An HIV diagnosis may have the effect that her parenting deteriorates while she is in the process of coping with her own mortality. She may be overly aggressive in disciplining her child and her communication with her child may be less than optimal during this time. Mothers report problems in school, unsuitable friends and substance abuse as their major concerns (Betancourt et al. 2012; Hough et al., 2003). Poor mother-child relationships are, according to Hough et al. (2003), a predictor of possible internalising, poor academic performance and other related problems. HIV-infected mothers have a difficult task to maintain mother-child relationships as they experience emotional distress and little support in general due to stigmatisation and other restraints. Jones et al. (2008) focused, in a longitudinal study', on the effect of parenting and children displaying aggressiveness. The researchers highlight the central role of warmth and support in a mother-child relationship. Jones et al. (2008) indicate that children display less aggressive behaviour in a mother-child relationship where the mother is positively involved. The study additionally proposes that a positive relationship between a mother and child has a salutary effect on a child's internalised behaviour.

The complicated stigma issues in the community surrounding HIV/Aids further obscure the parenting role. The parent has the difficult decision to make whether he/she will disclose his/her HIV status to his/her child. The burden of the knowledge of the illness is immense for children as they have to keep a secret in fear of discrimination against the family. Children are also very observant and an older child in many instances will know that the parent is ill even if he/she was not told about the illness (Deacon & Stephney, 2007). This knowledge that something is wrong in the family and not knowing exactly what the problem is, causes anxiety or other expressions of psychological distress. The silence and secrecy surrounding their parent's illness make it more difficult for children to discuss their anxiety with other people. In addition the 'HIV-secret' compels the mother who has not disclosed her secret to the community, to keep her family boundaries closed to outsiders. The mothers may discourage her children from interacting with other people in an effort to keep the 'HIV-secret' safe. The isolation has an impact on a child's social life and social skills. The result is less social support for the family in desperate need (Corona et al., 2006).

Selected research findings (Antle et al., 2001), however, are indicating that mothers infected with HIV/Aids may show more compassion, tolerance and nurturance towards their children. The mother may realise that she has a potentially short life-span and thus will aim to protect and prepare her child for possible loss. The challenge for a family living with a positive HIV-diagnosis is to maintain a balance between a sense of hope and dealing with the unpredictable health issues of HIV/Aids. Good parenting, where the parent seeks out creative ways to cope with a positive diagnosis of HIV and displays an active coping style, lessens the negative effects of HIV/Aids (Hough et al., 2003).

Dutra et al. (2000) refer to family variables that might be predictable of resilience in children affected by maternal HIV living in low income communities. The parent-child relationship is an important factor and is described by Dutra et al. (2000) where *"…maternal facilitation of a dependable and positive parent-child relationship provides resources that enable a child to adapt well in spite of a stigmatizing maternal illness"* (p.483). The researchers conclude that parental monitoring is an important aspect in the promotion of a child's resilience but caution that the impact of high-risk environments cannot be negated and requires serious consideration when resilience and parenting are studied.

Richter et al. (2009) and Earls, Raviola and Carlson (2008) also place emphasis on the importance of families. A family buffers a child and gives him/her emotional and material help to overcome the effects of the disease. They propose interventions supporting distressed and fractured families, focussing specifically on home visits and child development. Murphy et al. (2010) indicate that there is an intervention need for mothers and their school-aged children other than medicine adherence and prevention interventions. The main areas identified to be addressed through intervention programmes are: information on how psychological distress can affect child outcomes, how to deal with stress, how to implement family routines and how mother-child communication can be improved.

In this study the relationships between the mothers and children were qualitatively observed in a support group setting. The mother-and-child joint sessions aimed to improve the resilience of the children by enhancing the mother-child relationship. The joint sessions focused mainly on emotions, communication and sharing between the children and their mothers.

3.7. Maternal HIV-disclosure to children

Maternal HIV-disclosure to children is a complicated process and research is reporting mixed results. Letteney (2010) and Corona et al. (2006) refer to the reason why mothers are reluctant to disclose their status to their children, as fear for stigmatisation. HIV/Aids is still stigmatised in the South African society due to the sexual nature associated with the transmission of the disease. If the mother decides not to disclose her status to her child, it may lead to even greater feelings of anxiety and depression in the mother. The mothers who disclose their HIV-positive status experience significantly higher levels of perceived stigma according to Letteney (2010) and also receive less help with childcare. Brackis-Cott et al. (2007) indicate that children of mothers who disclosed their status to their children in their study displayed more depression symptoms than children who were not told. Whereas Forehand et al. (2002) report that children in their study whose mothers disclosed their HIV status to them did not report more internalising symptoms on the Child Depression Inventory (CDI) self-report questionnaire than children whose mothers did not disclose it to them. The children of HIV-infected mothers did, however, display a more negative relationship with their mothers.

Corona et al. (2006) additionally refer to the detrimental effect on a child's well-being if a child is uncertain about an illness in a family. They witness the effects of the illness, but do not have any background or information regarding the illness. The researchers further refer to studies that conclude that children display less aggressiveness and a higher self-esteem if they do know their mother's HIV-positive status. A child also displays better adjustment after the death of a parent if he/she was informed about the parent's illness, according to the researchers.

The disclosure rate in South Africa is low, according to Deacon and Stephney (2007). Corona et al. (2006) and Armistead et al. (2001) corroborate this finding with international statistics indicating the same trend. A negative effect of disclosing a parent's HIV status to a child is that the child is burdened with a secret. The child in most instances will not be able to share this secret with other people as the family may be ostracised or discriminated against. Many HIV-infected mothers are apprehensive to disclose to their children because they are worried about the emotional impact it may have on their children. The biggest concern for parents is if they should disclose their status to the community and how to do it.

Many families choose to keep their HIV status a secret because of the possible discrimination they and their children may face. Mothers may worry that their children do not have the skill to keep the 'family secret' and they may lack judgment when confiding in others, according to Antle et al. (2001). Research is additionally indicating that a mother's income level and severity or physical symptoms impact her decision to disclose her status to her child (Armistead et al., 2001).

The decision of a mother to disclose her HIV-positive status to her child is a difficult decision to make. Corona et al. (2006) and Letteney (2010) indicate that both disclosure and non-disclosure to children have positive and negative effects on the child and the mother. The family needs support and guidance to cope adequately with the disclosure process. The WHO guidelines (WHO, 2011) indicate that a child of school age should be told about the HIV status of his/her parent(s) guided by the intent to improve the child's welfare.

In this study the data, regarding the mothers' disclosure of their HIV status to their children, were reported. A small number of mothers indicated that they disclosed their status to their children and this is in accordance with the assertion of Deacon and Stephney (2007) that the disclosure rate in South Africa is very low.

3.8. Stigma and discrimination associated with maternal HIV/Aids

Stigma refers to " … *negative meanings that are attached to a discrediting trait, such as HIV/AIDS, result[ing] in avoidance, less than full acceptance, and discrimination of people with that trait*", according to Bogart et al. (2008, p.245). Bogart et al. (2008) distinguish between three forms of stigma – felt, enacted and courtesy stigma. Felt stigma refers to the fear of being discriminated against, whereas enacted stigma is the physical expression of stigmatisation. Enacted stigmatisation could also refer to structural discrimination such as healthcare discrimination. Courtesy stigma refers to the discrimination and prejudice that is experienced by individuals who are associated with the stigmatised person. This type of stigmatisation is experienced by HIV-affected children as young as seven years of age and may affect their willingness to disclose their parent's HIV status to their friends. Felt stigma is the main reason why parents find it difficult to disclose their status to their children. Bogart et al. (2008) conclude that young children are profoundly influenced by their parent's HIV status and felt stigma.

If they are forbidden to discuss their parent's HIV status they are isolated and it may result in emotional suffering (Bogart et al., 2008). An effective intervention where HIV-affected children can share their experiences with their parents and peers may provide them with emotional support.

HIV/Aids has one common denominator and that is stigma, according to Ostrom, Serovich, Lim, and Mason (2006). The stigma attached to HIV/Aids is associated with drug use and sexual promiscuity. The bearer of the HIV-virus is also seen as a possible transmitter of the virus and therefore this person is shunned from the community (Ostrom, Serovich, Lim & Mason, 2006). In the African culture the HIV-virus also carries the additional burden of being viewed as a product of witchcraft (Van Dyk, 2008).

The stigma associated with HIV has an impact on the HIV-infected person's choice to disclose his/her status. The positive outcome of disclosure may be the support from friends and family, but disclosure may also leave a person vulnerable to rejection (Ostrom et al., 2006). A mother disclosing her status to her child is thus in a particularly vulnerable situation. If a child tells another person about his/her mother's status, the child and mother may be subjected to possible violence, isolation and stigmatisation. Mothers infected with HIV who indicate high levels of HIV-related stigma, also display significantly lower levels of physical, psychological and social functioning. They exhibit higher levels of depression than mothers who report lower stigmatisation. High stigmatisation also results in poorer psychosocial adjustment and a bigger chance of delinquent behaviour among children with HIV-infected mothers (Bogart et al., 2008).

Stigma associated with HIV/Aids has, according to Deacon and Stephney (2007), a potentially detrimental effect on various aspects of a child's life. The researchers mention the effect on access to education, well-being, direct care (including vulnerability for abuse, denial of care, child labour, loss of inheritance) and indirect care (children avoiding possible situations where discrimination may occur for instance social interaction, schooling and healthcare). The stigma surrounding HIV/Aids intensifies the silence between parents and children. Children living in HIV-infected families are seldom offered the opportunity to discuss their emotions and grief with their parents. There is an imposed silence surrounding death in many African cultures and children are in most instances excluded from the funeral ritual (Van der Heijden & Swartz, 2010).

Research is confirming that HIV/Aids related stigma and discrimination is aggravating the effects of maternal HIV and Aids for children (Deacon & Stephney, 2007; Dorsey et al., 1999). Visser et al. (2009) indicate that stigma (specifically moral judgement) is a factor in the South African community that has had a harmful effect on prevention and treatment of HIV.

This study recognised the possible negative effects of stigma on the children's behaviour, as indicated in the literature review. However, the effects of stigma on the child participants in the study could not be quantitatively measured due to ethical constraints. Most of the children were unaware of their mother's HIV-status.

3.9. The caregiving role of children in families affected by maternal HIV/Aids

The act of children taking over parental role behaviour is referred to in the literature as 'parentification' (Deacon & Stephney, 2007). Families affected by HIV have a heightened risk for parentification. HIV/Aids not only involve stringent medical intervention to prolong life, but the medicine also has an array of side effects that may interfere with daily family life. Stigma and secrecy surrounding the disease further complicate the effects on the family (Deacon & Stephney, 2007; Tompkins, 2007). Betancourt et al. (2012) and Johnston et al. (1992) allude to the negative impact of HIV on family processes. HIV is a chronic and lengthy illness where parenting, roles, power, routines and relationships are changed. The family is challenged with coping in the midst of the parental illness in a way that is most beneficial for the family.

Children who experience stress, change and anxiety relating to uncertainty and caregiving tasks due to a caregiver's illness, are well documented in research (Eloff & Ebersöhn, 2002; Johnston et al., 1992; Spath, 2007; Antle et al., 2001). These findings indicate that parental illness is related to psychological distress that is manifested in difficult behaviour. Separation from a caregiver due to hospitalisation, role changes in the family, increased tasks and responsibilities and uncertainty regarding the future are stressors indicated by Spath (2007) that may have a negative psychological effect on a child. Parent-child relationships, sibling-child relationships and an overall feeling of family instability are, according to Spath's review (2007), present in families with parental illness.

Variables that are pointed out by Spath (2007) and Tompkins (2007) to be specifically important in parentification are developmental age, gender, the amount of parental systematology, parent/sibling response to illness, degree and duration of caregiving, availability of support and family characteristics. Families who have coped with stressful situations prior to the parental HIV-infection tend to cope more effectively with the illness and its demands (Johnston & Martin, 1992).

Tompkins (2007) and Johnston et al. (1992) challenge the perception held by researchers that parentification is '*predominantly pathological in nature*' where the child is exposed to family dysfunction and other pathological disorders. The researchers refer to the positive effects of parentification on the whole family. When the child takes over certain parental roles, the positive results may be a higher self-esteem, lower levels of depression, an altruistic lifestyle, acceptance of responsibility, sense of accomplishment and enhancement of coping skills. Mothers who are in a situation of parental role reversal also report that they develop a closer relationship with their child. Tompkins (2007) cautions though, that in the event of parents displaying serious Aids-related symptoms, the parentified behaviour becomes more maladaptive and the children may revert to an overt coping style and display difficult behaviour. Research in the understanding of the complex process of parentification is still limited and it is unclear whether this phenomenon will have the same beneficial impact in the long-term as it has in the short-term.

In this study the children's behaviour and responses during the separate and joint group sessions were qualitatively observed. These observations were of particular importance in describing the participants' caregiving behaviour and assessing subsequent effects on adaptive behaviour.

3.10. Support for children living in families affected by maternal HIV/Aids

Armistead et al., (1995) emphasise the importance of research in the area of parental HIV-infection and the effect of the disease on children. Children in families with HIV-infection are exposed to years of physical illness and the looming threat of death.

Spath (2007) directs attention to the significance of empirically-tested interventions for children with HIV-infected mothers in order to improve their behaviour and emotional outcomes. Only a few systematic empirical studies to date examined the effectiveness of intervention strategies for children confronted with a parent's illness and, specifically, parental HIV/Aids. Spath (2007) and Korneluk and Lee (1998) furthermore accentuate the benefits of psycho-educational programmes for children coping with parental illness.

Psycho-education programmes could present opportunities for children to express their concerns regarding their parent's illness; they could prevent the development of psychopathology; enhance development and positive developmental characteristics such as resilience and improve formative strategies for dealing with adversity. Groups provide support to children in that they can share their fears and questions with others in the same situation. The therapeutic components and psycho-educational aspects of the intervention have to be approached from a developmental perspective. Interventions involving more than one family member have the added benefit of improving communication in the family (Korneluk & Lee, 1998; Spath, 2007). Richter, Beyrer, Kippax and Heidari (2010) suggest that interventions have to build on the strengths of the family and provide support for the entire family to have a long-lasting effect on a child affected by HIV. Murphy and Marelich (2008) additionally propose that children will benefit from interventions specifically designed to improve their resilience. Literature reviews indicate that there is a strong correlation between coping strategies, mental health and resilience in HIV-affected children. Positive child and parent relationships and monitoring have a positive effect on the resilience of children (Betancourt et al., 2012).

Korneluk and Lee (1998) and Stein (2003) advise that the mother's illness has to be viewed systematically and the focus has to shift from the individual to the family. Families play an important role in how children cope with maternal illness. High cohesiveness, communication and little conflict in a family ameliorate the effect of maternal illness for a child. According to Melvin and Lukeman (2000) young children's comprehension of the world around them, their behaviour and their coping styles are influenced and processed through their family. The family has an immense influence in how a child will experience loss, conflict and illness. The way in which a family experiences these events and how it is communicated to the child has an influence on the child's behaviour.

Interventions should take heed not to further stigmatise children affected by HIV/Aids and be constructed in a holistic manner. Interventions should encapsulate broader life-skills and health education programmes rather than just focussing on themes such as stigma and discrimination (Melvin & Lukeman, 2000).

Stein (2003) emphasises the importance of the effect of poverty on the psycho-social support for children. Psychological interventions for children in order to alleviate psycho-social stress are imperative, but equally important are the material and physical needs of the child. A child cannot benefit optimally from a psychological intervention when he/she is hungry. Psychological interventions should focus on the children's social, physical and emotional needs, as presented on all the bioecological levels, in order to have an impact on the children's lives (Stein, 2003).

L'Etang and Theron (2011) indicate that South Africa, in particular, is lacking indigenous HIV counselling interventions that are specifically focused on the psychosocial needs of children living with HIV/Aids. The African traditions, practices and beliefs differ from other countries and therefore psychosocial interventions for children living with HIV/Aids have to be tailor-made for the South African population.

The Child Support Group Evaluation Study intended to empirically test the Promoting Resilience in Young Children Study intervention, which was aimed at improving the behavioural and emotional outcomes of the children affected by maternal HIV/Aids. The group support sessions were designed to holistically support and build on the strengths of the children and their mothers. The group support sessions were tailor-made for the South African population as it used different culturally-appropriate methods and indigenous games (for example, the 'masekitlana' and 'morabaraba' games).

3.11. Summary

Children are made materially, emotionally and socially vulnerable by maternal HIV/Aids. Material vulnerabilities include not only the availability of money, food and clothing, but also access to healthcare and education. Emotional vulnerability refers to the availability of support, care and love. It also refers to support in the grieving process.

Children affected by HIV/Aids are most probably exposed to poverty and troubled by the prospect of parental illness and death. Anxiety, depression, social withdrawal, learning problems and attention deficit are some of the disorders that they may experience in their lives. Social problems may impact vulnerable children because of a lack of supportive peer groups and role-models. The structure of families affected with HIV/Aids in South Africa changed because of the exposure to the related stressful circumstances. As a result there is an increase of maternal single-parent households (Andrews, Skinner, & Zuma, 2006).

Richter et al. (2010) place the spotlight on the millions of children in South Africa who are affected by HIV/Aids and where families and communities are shattered by its devastating effects. Increased poverty, interrupted education, family problems and caregiving tasks are some of the effects children affected by HIV experience. Psychosocial problems, discrimination and ostracism of families lead to further difficulty. The already strained support mechanisms such as extended families and the community cannot comply with the ever-growing need of these children, due to factors such as stigmatisation, poverty and personal health issues. Family support is recognised as an important intervention for children affected by HIV. Not all children develop behavioural problems when they experience adversity. Resilient children are able to cope and in some instances thrive in spite of their adverse circumstances. Resilience and consequently adaptive behaviour is furthermore explored in order to evaluate the impact of children's support groups on adaptive behaviour.

4. Resilience of young children in the context of HIV/Aids

4.1. Introduction

Intervention in vulnerable children's lives and comprehension of children's resilience growing up in a developing country such as South Africa, are emphasised by Grigorenko et al. (2007). The researchers place specific importance on the significance of understanding the risk factors encountered by children on a daily basis (for example, poverty, HIV/Aids) and to enhance resilience indicators and mechanisms that may help children to overcome these challenging life situations. The importance of resilience research in developing countries is furthermore supported by the notion that the majority of children and thus future labour force contributing to the global economy, reside in developing countries.

Condly (2006) attempts to summarise the plethora of resilience definitions by indicating that there could be disagreements on the particular situations where resilience occur, but emphasising that agreement does exist across the spectrum of child resilience research that resilience entails the interaction between genetic predispositions and support received. Two important individual resilience characteristics mentioned by Condly (2006) are easy temperament and cognitive ability. Children with a high intelligence and an easy temperament tend to understand situations better and use adaptive coping skills in an attempt to survive the adverse situation.

In Condly's (2006) review of the literature a child with a positive feeling towards his/her parent and where the parent is part of the child's daily life, reacts better to trauma. Direct mediators influencing children's resilience are, according to this review a caregiver's positive future expectation of the child, limited separation during infancy, positive and stable discipline practices and paternal involvement. Maternal depression did however have a negative impact on resilience. Furthermore it appears that a family's role in the early childhood years is extremely important for the development of resilience, but it becomes less important as the child becomes older.

According to Condly (2006), Klimes-Dougan and Kendziora (2004) and Urbis (2011), risks and resilience are multifaceted and expressed in different behaviours. Childhood resilience is observed in the competence displayed by the child in the school, social and behavioural arenas. Luthar and Brown (2007) refer to this traditional focus of researchers to concentrate on overt behaviour where adaptive behaviour is observed by others and used to judge how resilient a child is. The approach is queried by Luthar and Brown (2007) where they state "*sometimes considered are children's psychological symptoms but no attempts [are made], to our knowledge, to ask them about their own feelings of happiness or psychological well-being*" (p.941). Resilience is furthermore described by Bailey (2004) as something that cannot be ascribed to a child if he/she has not experienced significant stress nor is it a pre-existing condition such as having a good temperament or supportive family. Resilience is not an 'all or nothing' characteristic but rather a situation where a child can deal with some adversities and have difficulties dealing with others. It is implausible that children will show resilience across all adverse situations.

Masten and Obradović (2006) caution researchers to take into account that some risks and adversities are so overwhelming for a child's development that resilience is not possible. Every child experiences adversities that they struggle with somewhere in their development.

Resilience is thus a multifaceted concept that must be viewed within the adverse situation in which it occurs, but the children observed have to be given the opportunity to comment on their own well-being for a more holistic view of resilience. It is postulated that resilience skills are teachable, because it is not a fixed attribute of a child, it is not universal across domains and it is changeable over time as the child develops. Resilience requires a child to learn new skills and to be exposed to different problems according to Bailey (2004) and Urbis (2011).

4.2. The establishment and progress of resilience research

Studies searching for protective factors in the presence of adversity are well-documented (Luthar, Cicchetti, & Becker, 2000; Masten, 1994; Werner, 1995). Studies that refer to children of schizophrenic mothers are important to establish childhood resilience as a theory (Luthar et al., 2000). Emmy Werner is described as a pioneer in the modern resilience field where she started to move beyond looking at pathology to studying resilience in the 1970s. Her innovative resilience study on Hawaiian children incorporated multiple adverse conditions in a systematic search for protective factors. In the 1980s, North American researchers explored the phenomenon where vulnerable children succeeded despite experiencing adversities. These researchers redirected their research aims from focussing mainly on individual risks to focussing on protective factors (Condly, 2006; Luthar et al., 2000). Consequently, resilience research was established (Theron & Theron, 2010).

Richardson (2002) provides a historical framework to ground research and interventions *vis-à-vis* resilience and resilience theory. The history of resilience research entails three waves of inquiry, according to the researcher. The first wave mentioned is where the resilient qualities of individuals and support systems are phenomenologically described. The **individual protective factors** or qualities that predict success were the main focus of the research.

Theron and Theron (2010) elaborate on this early phase of resilience research to describe protective factors as encompassing of personality traits (e.g. flexibility), dispositional characteristics (e.g. easy temperament) and biological factors (e.g. intelligence). The paradigm shift from looking at risk factors to identifying positive strengths in individuals gave resilience theory a solid background (Luthar et al., 2000; Richardson, 2002).

In the second wave of resilience research, also described as the **resilience process**, the focus is redirected to the process of coping with adversity and the manner in which protective factors are enhanced (Richardson, 2002). Hereby the protective factors of the child's family (for example, supportive parents) and the child's community (for example, mentoring adults) were taken in consideration collectively with the child's own protective assets (Theron & Theron, 2010). This approach highlighted the fact that resilience has to be researched holistically, taking into account all the protective factors and processes involved in a child's life.

The third wave or **transactional process** is where researchers began to place emphasis on the eco-systemic transactions that transpire between an individual and his/her surrounding systems. The child negotiates with his/her community and family for support and these systems can or cannot reciprocate this request. Bronfenbrenner's bioecological systems theory is particularly helpful in understanding the mutual interaction processes that enhance or stifle adaptive behaviour (Bronfenbrenner, 1990). This ecosystemic understanding of resilience evolved to include the individual's context and culture in resilience research (Theron & Theron, 2010). Resilience research, according to Luthar et al. (2000), advanced from the empirical identification of risk or protective factors to an investigation of *processes* underlying their effects. The first level of research is the identification of constructs linked to positive and negative outcomes of a specific vulnerable group and the next phase is an attempt to understand the underlying systems that provide and explain the effects of the outcomes. The shifted focus to include transactional processes is helpful to describe and identify the motivational forces within individuals and groups, according to Masten (2007) and Richardson (2002). In therapy and by implication intervention sessions, it will thus be possible to help children to discover and apply this knowledge in an effort to overcome adversity.

The initial studies of resilience focussing on individual protective factors, evolved to include familial and contextual transactions. The transactional processes of the child, family and community further paved the way to include the culture and context of the child in current resilience research. The dynamic and flexible nature of recent resilience studies is the focal point of current resilience research, according to Theron and Theron (2010). Masten (2007) refers to the pragmatic mission of resilience research as "*learn[ing] better ways of preventing psychopathology and promoting healthy development among children at risk for problems*" (p.926).

4.3. Operational definition of resilience

An array of resilience definitions is offered in the resilience literature to describe resilient behaviour of children (Garmezy, 1991; Luthar, 2003; Masten, 2001). The definitions of prominent resilience scholars such as Garmezy, Luther and Masten are explored with the aim to establish a working definition of resilience for the Child Support Group Evaluation Study. The definitions of Theron and Theron (2010) and Mallman (2003) are furthermore investigated as it has specific relevance for the South African sample group.

Luthar and Brown (2007) view resilience as an applied science where scientific knowledge is used to maximise the well-being of people at risk. Garmezy (1991) defines resilience as "*the capacity for recovery and maintained adaptive behaviour that may follow initial retreat or incapacity upon initiating a stressful event*" (p.459). Theron and Theron (2010) describe resilience as a complex concept where the process and outcome are characterised by "*positive adaptation to adversity*" (p.1). Mallman (2003) additionally refers to resilience as "*the capacity to face, overcome and be strengthened – even transformed – by the adversities of life and bounce back after stressful and potentially traumatizing events*" (p.1).

Luther, et al. (2000) furthermore define resilience as "*a dynamic process encompassing positive adaptation within the context of significant adversity*" (p.453). According to Urbis (2011) most definitions of resilience contain these two elements "*... 'exposure to adverse or traumatic circumstances' and 'successful adaptation following exposure'. As such, a central theme within the definition of resiliency points to adversity being the stimuli that precedes the resiliency process*" (p.18).

This definition of resilience presupposes that there are two important conditions that have to be met for the definition to transpire. Firstly there must be exposure to severe adversity or threat and secondly, positive adaptation must be possible despite brutal onslaughts to developmental processes. The Child Support Group Evaluation Study focuses on young children affected by maternal HIV/Aids and emphasis is placed on these children's adaptation. The resilience definition as posed by Luther et al. (2000) and supported by Urbis (2011) is considered to be too cryptic and broad to explain adaptive behaviour in the Child Support Group Evaluation Study.

Masten and Obradović (2006) do caution that resilience is a complex phenomenon and therefore a well-developed conceptual and operational definition is important when studying it. There is not only one accepted pathway to study resilience, taking into account the many attributes and processes involved. Resilience is embedded in cultural, developmental and historical contexts and these contexts have to be made explicit.

Masten (1994) refers to resilience as incidences where children successfully adapt in spite of '*significant threats to development*'. Initially research on resilience focused on single-risk factors, but resilience research (Luthar, Sawyer, & Brown, 2006) has evolved to include indications of multiple risks. Masten et al. (1999) specify that in order for researchers to use the construct 'resilience', the following constructs have to be stated: the threats to development, the criteria by which adaptation is seen as successful and the traits of the individual and/or environment that help to explain the resilient outcomes. An operational definition is used as one method to attain precision and is the manner in which the variable(s) under investigation is defined and measured (Royse et al., 2010).

For the purpose of this Child Support Group Evaluation Study, resilience is postulated as the umbrella concept of adaptive behaviour. Resilience is made operational in adaptive behaviour or, stated otherwise, adaptive behaviour converges in resilience. Resilience is a continuous process that constitutes protective factors which buffer children exposed to adverse circumstances. Resilience can thus logically only exist when children have been challenged by or experienced adverse life circumstances –   in this instance maternal HIV/Aids and poverty.

The children's development and their bioecological systems are integrated in the evaluation, utilising a mixed-methods approach to incorporate the multiple perspectives of the group participants and relationships with other significant role-players (mothers, careworkers and other group members).

4.4. Advantages in applying an ecosystemic resilience framework

"The resilience framework serves to direct interventionists to empirical knowledge regarding the salience of particular vulnerability and protective processes within the context of specific adversities" (Luthar et al., 2000, p.860).

The ecosystemic resilience framework provides parameters for evaluating and predicting vulnerable children's adaptive behaviour in their environment following an adverse event. The identification and amelioration of both protective and risk factors may have a significant impact on children's resilience. Werner's longitudinal research in Kauai, Hawaii provides an example of the advantages of applying the ecosystemic resilience framework (Werner, 1995).

Werner (1995) found that the resilient children in her study had certain characteristics in common. She identified the following characteristics: they had an active approach in solving problems, a tendency to perceive their experiences constructively, the ability to gain the positive attention of other people, and used faith in order to attach a positive meaning to life. In another study conducted by Werner (2005) she furthermore identified sociability with a sense of independence as an important resilience factor among school-age children in their environments. The identified protective factors are helpful in designing an intervention programme focussing on resilience enhancement as it guides the programme developer in focussing on relevant (identified) resilience domains.

Resilience has to be studied in the specific context of the child to be able to describe the influence it has on a child's adaptive behaviour. Theron and Theron (2010) highlight the transactional process of resilience, whereby the ecosystemic transactions between a child and his/her environment play a role. To understand resilience from an ecosystemic perspective it is important that resilience researchers focus on the culturally and contextually bound transactions between role-players in the environment.

The protective factors in families identified in the Kauai study (Werner, 2005) indicate that despite poverty, most resilient children had the opportunity to form a close bond with at least one caregiver in their first year of life. Substitute caregivers also played an important part as positive role-models and resilient children actively sought out people to perform this important role. The identification of protective factors enabled Werner to recognise structure, rules and assigned household chores as important in enabling resilient children to cope well despite the adversities they experienced. She furthermore listed protective factors that are of importance for resilience and resides outside the immediate family. She directs attention to emotional support from outside the resilient child's immediate family (for example, friends), scholastic accomplishments, participation in extracurricular activities and acceptance in the classroom. Werner's observations and protective factor identification give direction to early childhood programmes that may act as a buffer against adversity in both the child's immediate family and at school. The study conducted by Masten and Coatsworth (1998) places emphasis on the importance of children becoming competent adults in society.

Competence is defined by them as *"a pattern of effective adaptation in the environment, either broadly defined in terms of reasonable success with major developmental tasks expected for a person of a given age and gender in the context of his or her culture, society, and time, or more narrowly defined in terms of specific domains of achievement, such as academics, peer acceptance or athletics"* (Masten & Coatsworth, 1998, p.206). Masten and Coatsworth's (1998) study and subsequent definition describe interactions as unstable and fluctuating with time. Both the child and the environment are thus subject to constant change. This knowledge may lead to the improvement of intervention strategies as the elements of context and time are seen as variables in the development of resilience.

The identification of risk factors, for instance children growing up in communities where poverty and violence are prevalent, lead Dutra et al. (2000) to postulate that these children have a larger predisposition for lower scholastic achievements and display more internal and external behavioural problems. Knowing the effect of risk factors on children's behaviour provides researchers with a deeper understanding of children displaying behavioural problems and gives them the opportunity to design/incorporate the necessary therapeutic intervention opportunities. Risk factors can also be removed or changed in an intervention setting to give a child the chance to learn adaptive behaviour skills.

Resilience research frameworks (Corcoran & Nichols-Casebolt, 2004; Lerner, 2006; Schoon, 2006; Toland & Carrigan, 2011) are able to direct attention to vulnerable populations and to identify important aspects (protective and risk factors) that need to be addressed in order for children to develop resilience. The ecosystemic resilience framework is all inclusive and provides a holistic view of a child's adaptive behaviour in his/her culture and environment.

4.5. Risk factors for children affected by maternal HIV/Aids

The three basic fundamental life assumptions as referred to by Condly (2006) encapsulate the importance of a child to feel safe and valued. He refers to the assumptions of the world being essentially a good place, life and life occurrences having meaning and purpose and the value and importance of a person's life, as posited by Janoff-Bulman. According to the researcher, some events in life are so traumatic that a child not only has to deal with the immediate danger, but also has to reassess his/her view of the self and the world. A child facing trauma is thus re-evaluating his/her position in the world and the child's reaction to the trauma reflects in the behaviour he/she displays. Trauma affects every person in a different manner and to a different extent. Some children are exposed to multiple stressors and hardships such as poverty, parental illness and violence and despite this some not only survive, but also thrive. These children are seen as resilient, according to Condly (2006). He describes resilience as a continuous phenomenon where the interaction of children with their environment must be seen in relation with his/ her abilities, motivations and social support systems. Resilience is hereby indicated as not a one-step process, but an ongoing process where the child is constantly negotiating his/her position in relation with the demands and risks of his/her environment.

Risk factors can be described as stressors in a child's life that may result in emotional, social or behavioural problems. The child's development is hereby placed under severe stress. Resilience literature has identified a range of risk factors and Urbis (2011) records it as biological risks that include the child's genetic make-up (including pre-and post natal factors); psychological risks including not having close relationships and social support; family risks involving single parenting and overcrowding, scholastic risks such as violence, lack of support and stressful life events such as parental death or illness.

As noted previously, children affected by maternal HIV/Aids are specifically vulnerable and at risk to develop psychosocial problems. The ecosystemic resilience framework guides researchers to identify populations at risk. Risk and resilience are shaped by a 'dynamic environment' according to Fleming and Ledogar (2008). The Forehand et al. (1998) study came to the conclusion after studying children in poor and violence prone communities that both children exposed to HIV and the children not exposed to HIV displayed impaired psychological functioning. The researchers also found that children exposed to HIV displayed higher external and internal behaviour problems than their peers not affected by HIV. The children affected by HIV in addition exhibited lower social skills and cognitive competence. Forehand et al. (2000) indicated with their study that it is important for future research to identify factors that may explain the relationship between children affected by maternal HIV and their problematic psychosocial adjustment.

Dutra et al. (2000) and Urbis (2011) further suggests that family variables have an additional impact on resilience of children living in high risks environments, as for instance children affected by maternal HIV/Aids. These variables include family structures, socio-economic status, marital status of the parents and the number of siblings living at home. The mother's mental health status and her activities have a particular effect on a child's coping ability. The activities include participation in church, parental support structures and parental distress. The parenting variables do not act independently but in combination with one another. Research indicates, according to Dutra et al. (2000), that the variables are not just correlated with one another, but the presence of one variable may enhance the presence of another as for instance a positive mother and child relationship motivates parental monitoring of their children's activities. The interaction of two or more variables thus has as effect on increased prediction of adaptive or non-adaptive behaviour.

Children exposed to maternal HIV/Aids live in a constantly stressful environment. Stress affects a child most if it is ongoing and enduring as in the case of maternal HIV/Aids. The stress is exacerbated if the child has no control or perceives no control over a situation, as for instance maternal illness. Stress is a risk factor for a myriad of psychological and health problems such as anxiety, depression, aggression, behavioural problems and substance abuse. Adequate coping skills modify stress and associated psychopathology (Kraag, Zeegers, Kok, Hosman, & Abu-Saad, 2006).

For the purpose of this study the quality of the mother-child relationship and the presence of single-parent families, poverty, limited support structures, stigmatisation, violence, external and internal behaviour problems and emotional problems are considered major risk factors for the participants in this study.

4.6. Protective resilience factors

Masten (1994) refers to protective factors as buffers or ameliorating factors assisting a child in adapting successfully to a stressful situation or chronic adversity. A protective factor is thus a moderator of risk and adversity. Developmentally-appropriate outcomes are a direct result of protective factors. Protective factors are, according to Werner (1986), "*those environmental context variables that buffer or mediated the negative impact of biological or psychosocial events over time*" (p.37).

Werner and Smith (1992) identify five different clusters of protective factors that have an impact on children's positive or negative long-term outcomes living in the same circumstances and experiencing the same risks. The child having an even temperament elicits more positive responses from caregivers and others, a caring relationship with at least one adult, having an external support system (church, school, youth group) providing a sense of belonging, having a disposition for setting goals and actively taking part in life and future planning and having an average intelligence seems to have a better resilience prognosis.

Masten (1994) adds to Werner and Smith's (1992) protective factor clusters the following protective factors: effective parenting, talents and other accomplishments of the child, a sense of self-worth and hopefulness, a supportive school and socio-economic advantages. Children of HIV-infected mothers have an array of risk factors to cope with and in many instances they live in a community burdened by violence, poverty, discrimination and related socio-economic difficulties. These factors play a role in the prognosis of children's mental health, according to Bauman et al. (2002). Children coping with their mothers' HIV-infection are coping with one more challenge in their already difficult circumstances. Bauman et al. (2002) and Werner (1990) however highlight the cases where children exposed to these stressors do not develop psychiatric disorders and instead show resilience.

The researchers indicate biological (for example, developmental stages, IQ), dispositional (for example, proactive coping styles, high self-esteem), family (for example, stable relationship with at least one adult, maternal competence, required helpfulness), community (for example, friends, school, teachers, mentors, church) and other related support systems as protective factors in helping a child to cope with his/her mother's HIV-infection (Bauman et al., 2002 & Werner, 1990). Bailey (2004) refers to the importance of hobbies and other extra-mural activities such as reading and sports as buffering factors from stressors a child may be exposed to. These activities provide a type of detachment for the child and he/she has a place to 'escape' to if the stressors are too overwhelming at certain stages. Another important protective resilience attribute is the ability of a child to take care of him- or herself. Self-care entails recognising and meeting personal needs. A resilient child would go beyond the realisation of self-care and take proactive steps to achieve this goal. He/she will reach out for help and will be able to protect him- or herself from dangerous situations (Williams, Lindsey, Kurtz, & Jarvis, 2001).

Research is indicating, according to Klimes-Dougan and Kendziora (2004), that a family displaying behavioural problems and a pattern of negative parent-child relationships concerning one sibling may actually be a protective factor for another child in the family. Werner (1986) also refers to research indicating that for girls who are raised in poverty a mother's steady employment is a protective factor. In this case the mothers may show resilience behaviour which the daughters observe and model. Protective factors are thus not always 'neat' and logical explanations for resilience. The researcher has to take the complete bioecological environment of the child into consideration in order to study the factors protecting a child.

Protective factors build resilience, according to Urbis (2011), by either preventing the occurrence of a risk factor, intervening in processes where the risk factors are operating, buffering and protecting against negative effects or promoting self-esteem/efficacy whereby the child can cope better with the risk at hand. Earvolino-Ramirez (2007) and Garmezy (1985) describe these protective factors as a specific attribute or situation necessary for the process of resilience to take place. These factors are situational and individual-specific and not so easily ascribed to specific characteristics or situations. The protective factors that may be beneficial for one child may not have the same effect for another child. Resilience is according to them a dynamic and developmental process.

Bailey (2004) indicates that protective factors are teachable and can be encouraged; it is not a static or pre-existing condition where the child is subjected to his/her genetic makeup. For a child to reach specific developmental milestones, he/she has to develop certain developmental skills and therefore a child's protective factors may also differ with age. Certain developmental aspects are normal at certain ages, as for instance fear and obsessive-behaviour in pre-schoolers, but develop into emotional and behavioural problems if the child keeps displaying the same tendencies in the middle childhood years. Risk factors have to be identified and ameliorated by protective factors to enhance a child's resilience. Resilience and subsequent adaptive behaviour are thus considered to be teachable and can be encouraged, taking into account the child's developmental level and his/her circumstances.

4.7. Identified domains for resilience and adaptive behaviour enhancement in latent children affected by maternal HIV/Aids

The double-burden position of children living with maternal HIV-infection in poor circumstances predisposes them to emotional, social and behavioural problems. The defining personal attributes or resilience characteristics of a child are listed in resilience literature (Condly, 2006; Corcoran & Nichols-Casebolt, 2004; Ungar, 2004) under multiple headings and are not 'protective factors' *per se*, according to Earvolino-Ramirez (2007). The resilience domains identified as important for enhancing the ability of these vulnerable children to cope with their stressful life circumstances, are sub-divided into the two main categories, namely the social-emotional well-being domain and the skills and knowledge domain. In this study, the domains are also referred to as indicators.

4.7.1. Social-emotional well-being domain (indicators)

The social-emotional domain encompasses social-emotional skills important for children to function adaptively in their world of being. Condly (2006) directs attention to the superior ability of resilient children to locate and maintain support from other children and adults. External support seems to be most useful for a child where the at-risk child and his/her family are supported as a whole. Earvolino-Ramirez (2007) additionally points to literature indicating that social support and meaningful relationships with at least one person are consistent with resilience outcomes. Positive social relationships with other people give the child an opportunity for communication and to feel they are listened to.

Not all types of social support are deemed positive where for instance children may find a sense of belonging in delinquent groups. A resilient child with positive social skills may be more willing to accept help and support from others. They may also be more receptive to professional help and guidance, having the experience of trust in previous social relationships (Earvolino-Ramirez, 2007). Building a trusting relationship is an important aspect of being resilient (Williams, et al. 2001). Anxious children are prone to avoid contact with other people and they seek and accept social support to a lesser extent. Although social support is a buffer for stress it seems that not all children have the ability to make use of this stress reductive factor (Enthoven & Van der Wolf, 2006).

The importance of social relationships is well captured by the National Scientific Council on the Developing Child (2004) where they describe relationships as: "*Stated simply, relationships are the 'active ingredients' of the environment's influence on healthy human development. They incorporate the qualities that best promote competence and well-being – individualized responsiveness, mutual action-and-interaction, and an emotional connection to another human being, be it a parent, peer, grandparent, uncle, neighbour, teacher, coach, or any other person who has an important impact on the child's early development*" (p.1). Luthar (2006) furthermore refers to relationships as key indicators for resilience. A critical aspect to mitigate environmental risks is therefore to understand and to improve children's relationships in their environments.

The social-emotional domain of children include the ability to identify and express own emotions as well as identifying and reacting appropriately to others' emotions (emotional intelligence), self-efficacy and a realistic self-esteem, a sense of humour, flexibility in different situations, self-determinism and a positive future perspective. The indicators or factors identified as important in the Child Support Group Evaluation Study are described in more detail in the following paragraphs.

Emotional intelligence is described by BarOn (2004) as "*an array of noncognitive capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures*" (p.14). According to BarOn (2001) emotional intelligence interacts with other determinants such as intellectual capabilities and the reality and limitations of the environment.

Emotional intelligence is furthermore sub-divided by the researcher in intrapersonal emotional intelligence (including assertiveness, self-regard, emotional self-awareness, independence, self-actualisation); interpersonal emotional intelligence (including empathy, interpersonal relationships with others, social responsibility); stress management (including reality testing, flexibility and problemsolving) and a child's general mood referring to hope, optimism and happiness (BarOn, 2001).

Self-efficacy is an attribute that can be innately present or mastered in previous situations (Earvolino-Ramirez, 2007) whereas Lochman, Holmes and Wojnaroski (2008) define **self-esteem** as "*an individual's evaluation of the self (that is, his or her feeling of worth)*" (p.36). Latent-phase children evaluate their competence or self-efficacy in several domains of their development, including their academic abilities, social abilities and physical attributes. This type of evaluation has an impact on the child's psychological adjustment and behaviour. Resilient children of HIV-positive mothers display better self-efficacy than non-resilient children, according to Murphy and Marelich (2008). The children cope better with their mothers' HIV-infection and they display enhanced interpersonal problem-solving skills. A high self-esteem because of positive self-efficacy evaluations results in better social and school adjustment as measured by the Self-Description Questionnaire (refer to Chapter 3, p.169).

An integral part of resilience development in a latent child is **self-esteem** development that is based on an affirmative sense of self and positive recognition from other people, according to Urbis (2011). A child has to feel he/she belongs and is supported. The child becomes more independent and needs more opportunities to be independent in places that are outside the immediate arena of the family in the middle childhood years. A child has the need to feel competent and this is reached through activities where he/she can learn and achieve. The development of resilience in the middle childhood years furthermore requires situations where the child can make his/her own choices and where they feel people are listening to him/her.

Meaning and purpose to life is the ability to see a greater purpose in life, to have a spiritual connection, to have hope and to experience a sense of gratitude. The child sensing there is meaning and purpose to his/her life, may be able to see him/herself in relationship with others and not expect the community to owe him/her something (Williams et al., 2001).

Spirituality provides strength and a strong sense of connectedness where the child believes in something bigger than just his/her immediate situation. A child experiencing meaning in life is more willing to help others and to give back to the community. He/she cares about his/her community and values other people. Helping other people can give a sense of purpose. There is a shift from the self to the larger community (Williams et al., 2001). Boyden and Mann (2005) additionally refer to the important individual attributes in children where a sense of purpose and a belief in a bright future have a significant impact on resilience. These protective factors help a child to form strategies which he/she can use to manage stress successfully and to defend themselves against painful experiences. A goal to live for and a need and ability to help others are indicative of temperament and coping styles.

Children who can stay hopeful and positive about their futures are more flexible and adaptive, they use enhanced problemsolving skills and feel that they have control over their lives. This has the effect that they feel less vulnerable than those who just accept their adverse circumstances. The powerful source of hope provided by dreams can inspire and direct behaviour of children. It provides a sense of meaning and significance to life, according to Muindi (2003).

Helping and supporting others in the community is an important resilience indicator. Muindi (2003) draws attention to the situation where children's resilience is strengthened by receiving assistance, but it is moreover strengthened by giving assistance. Williams et al. (2001) refer to the strong sense of connectedness a child has when he/she experiences a sense of meaning in life. This child is more willing to support and help other people because he/she values and cares about other people. Helping provides a sense of purpose and belonging.

Self-determination is an attribute that refers to a purpose in life and a positive future orientation. A child with self-determination will feel he/she can succeed in life despite all the barriers he/she may experience in his/her present situation. Self-determination includes the concept of self-worth and overcoming feelings of hopelessness (Earvolino-Ramirez, 2007). Children displaying determination have a persistency to reach goals, show inner strength and are proud of their achievements. Determination results in the development of self-confidence and self-sufficiency (Williams et al., 2001).

4.7.2. Skills and knowledge domain (indicators)

Effective coping skills, communication skills, flexibility, humour and effective problem-solving skills are cognitive attributes assisting a child to deal with difficult life situations. **Coping** is described by Lazarus and Folkman (1984) as "*constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person*" (p.141). Resilient children have greater efficacy in coping with stress and coping, together with interpersonal problemsolving skills, play an important role in a child's adjustment, according to Murphy and Marelich (2008). Coping is an interactive process between a child and his/her environment. Coping is a reaction to the question 'What do I do?' and is learned through modelling significant others such as mothers, grandmothers and other children. Coping is a child's cognitive and behavioural effort to manage a difficult situation such as a mother's illness either consciously or unconsciously. A coping style can be effective or ineffective (Helseth & Ulfsæt, 2003).

The stages in transactional coping involve an internal of external event where the child experiences stress. The child appraises the situation according to his/her developmental stage by giving it meaning that is based on personal experiences, values and beliefs. These experiences, beliefs and values guide the child with his/her decision making process. The decision made is then evaluated and accordingly expressed in behaviour or thoughts. Physiological coping through the expression of somatic symptoms are common in young children and more specifically common in traumatised children. A young child has limited coping repertoires and, according to resilience research, in need of access to internal and external resources to cope effectively (Ebersöhn & Eloff, 2002; Helseth & Ulfsæt, 2003). Quota, El-Sarray and Punamäki (2001) additionally refer to the importance of a flexible information processing style for effective coping. The systematic use of a wide variety of coping strategies in different situations indicates a better coping style than one solely relying on a few coping strategies. Lazarus (1993) proposes that coping shapes emotion. It shapes emotion by influencing the person-environment relationship and how the child appraises this relationship.

Coping is explained in the literature according to different dimensions or subtypes. The overly broad problem- versus emotional-focused coping dimension refers to cognitive actions such as seeking information and taking action to remove the stressor whereas emotional coping refers to seeking support from others, expressing one's emotions and an active avoidance of the stressful situation. A different coping dimension is the primary and secondary coping styles, indicating the child's choice to either enhance his/her personal control and reaction over the stressful situation (primary) or to adapt to his/her environment (secondary). According to Harbeck-Weber, Fisher and Dittner (2003), some researchers suggest that secondary coping skills are more effective in coping with uncontrollable stressors, for instance illness, than primary coping skills, indicated to be more effective with controllable stressors. The engagement and disengagement coping styles furthermore make a distinction between a coping style orientated towards the source of the stress and a child's own emotions (engagement) and a coping style oriented away from the stressor and the child's own emotions and thoughts. As children grow older they tend to utilise a more emotion-focused coping style and they are more likely to use a broader range of coping skills in order to cope with the stressor at hand. They are in addition more able to focus on the positive factors associated with the different stressors (Harbeck-Weber, Fisher, & Dittner, 2003).

Clarke (2006) challenges the significance of research focussing on the importance of active coping. She argues that there is a small correlation between active coping skills and psychosocial functioning. She furthermore questions the effectiveness of an intervention programme focussing only on the enhancement of active coping skills. Folkman and Moskowitz (2004) counter Clarke's (2006) opinion by referring to research indicating the importance of future-oriented proactive coping. The proactive coping process has five interrelated components. It stresses the importance of building resources, recognises potential stressors, assists in the initial appraisals of stressors, provides preliminary coping efforts and utilises feedback of the success of a child's effort in coping with a stressor. Proactive coping is a particularly appropriate coping skill to include in psychoeducational interventions.

Religious coping has received less attention than other types of coping, according to Folkman and Moskowitz (2004). They refer to recent studies providing evidence of the effect or religious involvement on mental and physical health.

It is indicated; however, that religious involvement is not the same as religious coping *per se* (Folkman & Moskowitz, 2004). Religious involvement is described by Jones et al. (2011) as the social aspect of religion where children attend for example church activities. Jones et al. (2011) identifies "*worship as a community activity where participants may engage in community rituals as part of the religious ceremony*" (p.211). Religious coping on the other hand refers to personal meaning attached to spirituality (Holder, Coleman & Wallace, 2010).

Coping is a complex, dynamic process involving the child, his/her environment and the relationship existing between them. It influences a child's psychological, behavioural and physical dimensions in the short- and long term (Folkman & Moskowitz, 2004).

Communication skills include both verbal and non-verbal communication. Verbal communication refers to the ability to use and understand words effectively whereas non-verbal communication refers to the child's ability to understand the body language of self and others (Simon, 2003). Communication skills are important for a child to form and maintain relationships with significant others in their lives. A child has to be able to articulate clearly and be able to listen to what is being said to him/her. Child and parent interaction depends to a large degree on adequate communication skills (Carr, 2006).

Flexibility is an emotional attribute as well as a behavioural attribute. This term relates to the ability of a person to adapt to situations, be able to cooperate and cope with changes. A child with an easy temperament may be able to adapt more easily to changing life circumstances (Earvolino-Ramirez, 2007). Self-control can be effective or less effective for functioning in a social group. Eisenberg, Spinrad and Morris (2002) proposes that flexible regulation and control are important for resilience and over-control is linked to children with internalising problems.

Research (Earvolino-Ramirez, 2007; Janas, 2002) is pointing to the fact that **a sense of humour** across all age groups, where a person can laugh for him/herself or a situation, is a resilience quality. A sense of humour can lessen the impact of adversity and enhance coping mechanisms.

Effective problem-solving skills help a resilient child to take personal responsibility and deal with difficult situations (Williams et al., 2001). Problem-solving skills play a role in adjustment and an active approach towards problem-solving indicates a high inclination to resilience (Murphy & Marelich, 2008). Problems-solving is referred to by BarOn, (2004) as "*the ability to identify and define problems as well as to generate and implement potentially effective solutions*" (p.17). The multiphase problem-solving process involves the identification of a problem, the confidence to solve it, clear formulation of the problem, the generation of many solutions and deciding upon the best solution before implementing it. The desire to confront the problem rather than to avoid it is essential for effective problem-solving according to BarOn (2004).

The socio-emotional well-being and skills and knowledge domains contribute to the child's ability to cope with adversity. Children who experience difficulty in coping with their situation can be taught resilience or adaptive behaviour through demonstration and practice, focussing on these particular domains in intervention programmes. Support-group interventions are the ideal platform for teaching these skills where other group members are available to model adaptive behaviour in the group and the group can comment on its appropriateness or inappropriateness.

In this study the social-emotional well-being of the child participants were measured, focussing on the children's ability to identify and express emotions, their ability to identify and correctly react to others' emotions, self-efficacy, a realistic self-esteem, a sense of humour, flexibility in different situations, self-determinism and a positive future perspective. The skills and knowledge of the child participants measured in this study, are the children's effective coping skills, communication skills and effective problem-solving skills.

4.8. Principles underlying the development of interventions aimed at resilience enhancement

Developmental psychopathologists aim to identify processes that cause adaptive and maladaptive outcomes in high-risk groups, according to Gilgun and Abrams (2005). Their main objective is to enhance resilience opportunities and adaptive behaviour in interventions and to lessen possible risks.

Researchers have spent little time though in trying to understand the different responses of children to their difficult life circumstances where some of the responses are viewed by outsiders as maladaptive. Researchers have to study the contexts of the research participants as a whole in order to fully understand resilience. A gap exists in how children interpret their own behaviour in certain contexts and how an outsider (researcher) interprets this behaviour. This difference in viewpoints contributes to the effectiveness or ineffectiveness of an intervention. A child might for example not attend school to take care of his/her ill mother. This caregiving behaviour may be seen as maladaptive in another situation where there are enough resources and help for the family. The choices of a child are limited to time, setting and exposure to culture. Social contexts filter decisions and behaviours of children in adverse life circumstances (Gilgun & Abrams, 2005; Klimes-Dougan & Kendziora, 2004). The importance of investigating the processes in intervention planning that have an impact on the resilient adaptation of children from diverse cultural, ethnic and racial backgrounds are highlighted by García et al. (1996).

Children are in many instances exposed to many adversities and therefore they must develop many protective systems. They also utilise different protective systems and experience different vulnerabilities at different times in their development. Luther et al. (2000) indicate that the research done in the field of resilience indicates that developmental progression exists as new vulnerabilities and/or strengths emerge with changing life situations. The use of global approaches to resilience is therefore questionable and a more fine-tuned population-specific approach is arguably a better option. Interventions must be carefully designed and evaluated. The intervention must aim to enhance as many protective factors available as possible and to target multiple risks. The gender and development phase of the child has to be taken in consideration in all child resilience studies (Masten & Coatsworth, 1998).

Johnston et al. (1992) refer to research indicating that resilient children in the early years display independence, appropriate behaviour, the ability to process information and to maintain constructive social relationships. Later on they develop their own adaptive personality structure and they do not hesitate to ask for support when they are in need of it. There is a difference in the way a girl and boy react to adversity. Girls who mature earlier tend to respond to adversity with greater autonomy and capability. Condly (2006) furthermore refers to the interesting phenomenon where research is indicating that boys are more vulnerable to biological insults and problematic caregiver behaviour than girls.

Important aspects for a well-designed intervention are thus, a design that focuses on prevention where the individual's characteristics, risks, protective factors, resources and processes are well defined and evaluated. Researchers such as Garmezy, Rutter, Werner, Smith, Masten, Coatsworth, Beeghly, Cicchetti, Luthar and Richter[2] have identified parental mental illness, maltreatment, urban poverty and community violence, chronic illness and catastrophic life effects as adverse events that may have an impact on a child's resilience. Three sets of factors were identified as important for the development of resilience. These factors include the children's own attributes, family aspects and aspects of the wider social environment (Luthar & Cicchetti, 2000). The focus in resilience research has shifted away from identifying protective factors to understanding how these factors can play a role in achieving positive outcomes.

Luthar et al. (2000) propose guiding principles for the development of an intervention focussing on resilience. They indicate that the intervention has to be firmly anchored in theory and research where the transactional influences between the children and their environments are taken into consideration. The emphasis has to be placed on both the reduction of negative outcomes and on the promotion of positive adaptation.

It is advantageous to make use of the resources in the community and not only to focus on the reduction of negative influences. The intervention has to target, as far as possible, the whole ecosystem of the participant and his/her development. Luthar et al. (2000) concur with Masten and Coatsworth (1998) that the developmental domains of a child, such as psychological, behavioural and physical capabilities, must be taken into consideration when an intervention is developed. Through collaborative partnerships with community members, parents, teachers, clinicians and children who receive the intervention, it would be possible to ensure that the identified intervention goals are perceived as personally meaningful and thus more effective in the long run. The main aim of the intervention must be that the intervention aims become self-sustainable. A resilience-focused intervention has an implicit emphasis on primary prevention. Where problems have already surfaced, the resilience paradigm focuses on the deficits and the areas of strength. The intervention must therefore aim to use the strengths of the vulnerable population to overcome adversity (Luthar et al., 2000).

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[2] Refer to 'References' on p. 349-383 for the complete publication details of the researchers mentioned.

Masten and Obradović (2006) list a group of factors which they describe as systems that are necessary for a person's adaptation in his/her environment and therefore important in intervention planning. When these adaptive systems are available and working, the individual has a better chance to be resilient in his/her environment. Factors referred to are cognitive learning systems such as problem-solving skills; attachment systems such as close relationships with caregivers and other people; motivation systems such as self-efficacy processes; stress response systems; self-regulation systems; family systems which include parenting, school systems, peer systems, cultural systems and societal systems including religion and traditions. These factors integrate the biological and behavioural approaches of resilience and aim to guide researchers in their intervention planning.

Janas (2002) promulgates that resilience has a definite influence on children's successful adaptation and coping behaviour. She therefore urges that resilience intervention must commence early in a child's life. She urges that cognisance be taken of the following factors when planning a resilience intervention programme for children:

- Positive unconditional love because of its importance for future decision-making and actions.
- Close supportive relationships with a significant adult (group facilitator) where trust develops. This trust is also important for the development of future relationships.
- Communication of realistic standards where there is a belief that the child is capable of achieving and at the same time providing the necessary support so that the child can achieve the set goals.
- Clear boundaries are important as a child feels secure in set boundaries. An older child can assist to set some of the benchmarks to feel that his/her contributions are appreciated.
- A low-criticism style of interaction where the focus is placed on desired behaviour rather than critical remarks.
- Frequent praise in order to increase the likelihood that a child will repeat the positive behaviour.
- The method of reaching certain goals must be discussed with a child so that problem-solving skills are explored.
- A child's efforts to reach goals must be appropriately acknowledged and celebrated individually or in a group.

- Children must be provided with opportunities in the group sessions to delay gratification where their flexibility is enhanced and impulsiveness is tapered.

- Survival and life skills are important competency skills for children to learn.

- Age-appropriate interests must be the guiding post for structured activities. The activities will give the child ample opportunities to practice new behaviours and skills.

- Gender-related issues are important to take into consideration when developing an intervention programme as different genders react differently to structure and content.

- The provision of helping opportunities will teach the child to be helpful and achieve a sense of accomplishment while practicing new skills.

- Placing the emphasis on being part of something bigger and a broad perspective of the world and the child's place therein is important for resilience.

- The practice of communication skills is crucial for a child to build relationships and emotional intelligence.

- A child can be taught resilience with the help of stories from DVDs and books. Problem-solving skills, moral development and communication skills are only some of the myriad of skills that can be taught through stories.

- Meaningful participation in groups teaches a child to relate to others in different context and roles.

- Children need support in structuring meaning. A meaningful belief system can be generated through helping children to connect their thoughts, words and behaviour.

- Humour is an important coping strategy and humour needs to be modelled by an adult in a challenging situation.

- A vital prerequisite for resilience is that a child needs an adult who is resilient in order to observe how to react in difficult situations.

The researcher of the Child Support Group Evaluation Study supports the principles, as proposed by Janas (2002), for enhancing resilience of young children in a resilience intervention programme.

4.9. Summary

Studies searching for protective factors in the presence of adversity have an illustrious history and date back to studies referring to the coping of children with schizophrenic mothers (Masten, Best, & Garmezy, 1990). Risks and resilience are multifaceted and expressed in different behaviours. Resilience refers to the interaction between a child's genetic predisposition and the support he/she receives. Childhood resilience is observed in the competence displayed by the child, but the child's viewpoint on his/her resilience also has to be taken into account. Resilience cannot be ascribed to a child if he/she has not experienced significant stress nor is it a pre-existing condition. Resilience is not an 'all or nothing' characteristic but rather a situation where a child can deal with some adversities and have difficulties dealing with others. Resilience is not a fixed attribute of a child, nor universal across domains and is changeable over time as the child develops.

Resilience definitions often refer to "*exposure to adverse or traumatic circumstances*" and "*successful adaptation following exposure*" (Garmezy, 1985; Masten & Obradović, 2006; Werner, 1993). For the purpose of this Child Support Group Evaluation Study, resilience is made operational in adaptive behaviour or stated otherwise adaptive behaviour converges in resilience. Resilience is described as a continuous process that encompasses the protective factors which buffer children exposed to adverse circumstances. Risk factors can be described as stressors in a child's life that may have result in emotional, social or behavioural problems (for example, genetics, illness, violence). Children affected by maternal HIV/Aids are specifically vulnerable and at risk to develop psychosocial problems. These vulnerable children may react to the risk factors by displaying internalising or externalising behaviour problems.

Protective factors are ameliorating factors, assisting a child to adapt successfully to a stressful situation or chronic adversity. Family factors associated with resilience include a warm and supportive relationship between a mother and her child, paternal involvement, a safe family environment where the child is not exposed to abuse or violence, a positive future expectation of the child, limited separation during infancy and positive and stable discipline practices. External resources associated with resilience are, for example, adequate financial and material resources, a functioning and supportive school system and the availability of medical and psychological services.

It has been established that resilience skills are teachable and the social-emotional domains and skills and knowledge domains are important in assisting a child to deal with difficult life situations. Their main objective is to enhance resilience opportunities and adaptive behaviour in interventions. It is indicated that researchers have to study the contexts of the research participants and the intervention has to be firmly anchored in theory and research where the transactional influences between the children and their environments are taken into consideration. For this study the intervention aim was to use the strengths of the vulnerable population to overcome adversity.

5. Intervention groups for children

"*Being together with peers, within the safe setting of the [therapy] group, creates a 'laboratory' for experimentation with new ways of thinking, feeling and behaving which can then give the child the confidence to approach other people outside the group in a new way. Because the [therapy] group takes place in the company of peers, there is often a rapid carry over in terms of improvements into their school lives*" (Lanyado & Horne, 2009, p.258).

5.1. Introduction

Children who experience psychosocial problems might gain from individual counselling sessions, but professionals indicate that group work is more '*reflective of real life*' (Akos, 2000, p. 214). Psychologists, for example Carl Rogers, refer to an individual as a social-being and therefore group therapy may be more reality orientated than other types of counselling (Thompson & Henderson, 2006). A latent-phase child's development is influenced notably by the groups surrounding them. The group context provides children with modelling opportunities to imitate positive behaviour and observe the problem-solving behaviour of their peers (Akos, 2000). To interact with their peers children have to learn a plethora of social skills. They have to be able to identify emotions of others and understand their own emotions, have the ability to initiate and to maintain satisfactory relationships with other people and cope with social stressors, to name just a few interpersonal and intrapersonal skills necessary to maintain group cohesion (Finestone, 2005). Children in this developmental phase are aware of the link between thinking and emotions. Empathy occurs in both the affective (ability to identify and react appropriately to emotions) and cognitive (language and representational symbols) realms (Akos, 2000).

Groups provide the building blocks for developing empathy and social skills. A child displaying empathy tends to have better peer relationships, better coping mechanisms, better stress tolerance, less problematic behaviour, and more understanding parents and teachers who are willing to help them (Akos, 2000). Schaefer, Jacobsen and Ghahramanlou (2000) further refer to the importance for children in the middle-childhood years to establish and maintain social relationships. Peer relationships have a particularly important impact on later life. Peer relationships give a child the opportunity to achieve a level of social competence and this achievement may prevent later emotional, social and adjustment problems.

Masten and Coatsworth (1998) connect prosocial behaviour with the ability of a child to impact his/her own future through the choices he/she make and the friends he/she chooses. Support groups present a situation for children to interact with peers experiencing similar problems. An intervention support group has three core activities, according to Thompson and Henderson (2006). The support group has to accomplish its goals as set in the beginning, it must be able to sustain itself and it must change and develop to improve its effectiveness.

5.2. Advantages of group work

Support groups for parents, group sessions for children and group activities are the most powerful interventions in a non-medical context, according to Kmita, Baranska, and Niemiec (2002). In addition, support groups for parents seem to have a positive impact on a child's psychosocial development. Children can safely express their fears and anxieties in a secure environment with a caring facilitator and supporting group members. The advantages of group work are multiple. Group work is more than just a cost-effective alternative to reach a larger population of children. Geldard and Geldard (2001), Malouff and Schutte (1998) and Sharry (2004) list the advantages of group work as a vehicle to promote change, a parallel to the wider social environment, it provides a sense of belonging and the possibility that common needs can be addressed. The developmental phase of middle-childhood lends itself fully to group work where a child moves away from being egocentric to caring about other's feelings and their needs. Group work provides children with the opportunity to establish support networks. Children who implement social skills are more altruistic, self-confident, have more friends and are more cooperative than children lacking social skills.

Drost and Bailey (2001) refer to the therapeutic change processes of groups as curative intervention factors. Children encounter other children in a group experiencing the same type of problems and realise that their problems are not unique. The group process provides a learning opportunity for children which can be generalised to the outside world. The group lends itself to helping others and in the process the child receives through giving to others. They learn how to relate to other children, but they also learn how others relate to them. The child becomes part of a cohesive group with its own identity. The group provides catharsis opportunities in a safe environment. A group also opens up the possibility for a child to experience different relationships and models of behaviour and thereby provides alternative perspectives of situations. This group characteristic is particularly important for children who experience difficulty with self-reflection (Lanyado & Horne, 2009).

Lanyado and Horne (2009) offer group work as an alternative to one-to-one therapy where some children may experience it as too intrusive. Within a group, a child has the opportunity to see the results of their own behaviour on others but also experience the impact of others' behaviours on them. The company of other children with diverse personalities displaying different weaknesses and strengths in the group give the child the opportunity to rediscover aspects of him- or herself. Self-worth is hereby enhanced. These reciprocal relationships also provide the opportunity for developing emotional intelligence.

Children living with chronic illnesses often experience disruptions in their social development and friendships, according to Harbeck-Weber et al. (2003). Children living in families affected by HIV may experience similar disruptions. An HIV-infected mother is likely to keep her child isolated from other children because of the stigma associated with HIV/Aids and the mother's fear that the child may talk about the family 'secret' (Deacon & Stephney, 2007). The child may have the knowledge that his/her mother is ill when seeing his/her mother developing HIV/Aids-related symptoms and if the mother additionally did not disclose her illness, it may lead to anxiety. These anxieties negatively impact on a child's social interaction. A child may withdraw from social interaction opportunities and consequently have fewer opportunities to practice his/her social skills. The child operates within and is influenced by the group he/she is part of.

In this study children affected by maternal HIV/Aids received support in a peer group setting. The children in the groups were in the latent developmental stage and they experienced similar socio-economic difficulties. Although most of the children were unaware of their mother's HIV-status, the children were exposed to similar anxieties and problems as typically caused by maternal illness. The children had the opportunity to practice and learn new skills, for example problem-solving and social interaction skills to cope with these difficulties. The group provided a safe space for the children to talk about their dreams and fears.

5.3. Limitations of group work

Group intervention may be contra-indicated for children with a lack of impulse control as they may display excessive energy and could disrupt the group process. Aggressive children displaying overt destructive behaviour may impact on the group negatively. Incompatible developmental ages, children with psychotic disorders and children with receptive-expressive language disorders are also unlikely candidates to benefit from a group unless the group is specifically designed for their needs. Although groups may have advantages when compared to individual therapy sessions, it also has disadvantages (Geldard & Geldard, 2001). Children may be unable to talk about personal issues in a large group. Children experiencing high levels of psychological disturbances or stressors may gain, in this instance, more from individual sessions (Geldard & Geldard, 2001).

A limitation to family-centred group intervention models is the difficulty in recruiting more than one family member to participate in the group sessions – for example a HIV-positive mother and her school-aged child. Both of the participants simultaneously have to attend the group sessions and the mothers have to be willing to have their sessions in the afternoon as their children are attending school in the mornings. Transport problems may complicate the situation. A further complication is instances where an HIV-infected mother failed to disclose her status to her child. This situation has to be dealt with carefully to ensure the mother's status is not revealed to the child during the group sessions without her permission (Leeper, Montague, Friedman, & Flannigan, 2010).

Human resources, infrastructural capacity, innovative and culturally sensitive methods to assess participants and the availability of specialised services, such as individual counselling, are factors that may have an impact on the success of group work (Geldard & Geldard, 2001).

An intervention programme requires sufficient financial, material, human and other temporal resources. Generalisations to the wider environment are furthermore complex. Changes that occurred in the group could be limited to the group setting. The ultimate goal of an intervention group is for the child to transfer the skills that he/she has learned in the group to the real world he/she lives in. This may not be necessarily the case. The child must have the necessary motivation to use his/her new learned skills. Homework may enhance the practice opportunity for a group member, but it is limited to the willingness of the child to do the homework and the parent's support (Geldard & Geldard, 2001; Leeper et al., 2010).

In this study the careworkers received intensive training before the intervention commenced, in order to facilitate difficult behaviour, for instance hyperactivity. The careworkers could furthermore ask for guidance from a child psychologist at any stage of the group session. Individual counselling sessions from outside agencies were available to the children identified with specific psychological problems. The children in the support groups were in the latent developmental phase and therefore age difference was not indicated as a possible complication for the group process.

In this study the mothers were asked during the recruitment phase whether they were willing to bring their children along to the group sessions. Although the participants reacted positively to this request, transportation problems and after school activities posed a challenge to the study. Some mothers and children attended some of the sessions by themselves as joint participation was not always possible in these instances. The mothers' health problems furthermore had an effect on their participation and attendance. The careworkers were aware of the fact that most of the mothers had not disclosed their HIV-status to their children and were therefore vigilant not to disclose information regarding the mothers' illness to their children. The content of the children's group sessions were structured to steer clear of any reference to maternal HIV/Aids.

The Promoting Resilience in Young Children Study was a NIMH-funded study and therefore the infrastructure and human resources were available to optimally support the objective of resilience enhancement in the group sessions. Donated resources from the community furthermore assisted in providing healthy meals to the participants.

The content, methods and processes of the group sessions were innovative and structured to be culturally and developmentally appropriate, for example the 'masekitlana' and 'morabaraba' games used in the sessions. The ability to apply what was learnt in the group sessions to the real world was practiced in the group sessions and in the joint sessions with the mothers. Homework was also given to the group participants in order to practice at home what they had learnt in the group sessions.

5.4. Different types of intervention groups for children

Therapy groups, counselling groups, psycho-educational groups, personal growth groups, developmental skills groups and support groups are different group types identified by Geldard and Geldard (2001) and Lanyado and Horne (2009). Therapy groups target children diagnosed with a mental health problem and its purpose is to alleviate specific symptoms, for example depression or anxiety. A counselling group focuses primarily on general life challenges associated with different developmental stages. This type of group is preventative in nature. A psycho-educational group aims at changing behaviour and emotional responses and it is mostly preventative. It focuses on the acquisition of knowledge and information.

Personal growth groups aim to enhance children's intrapersonal and interpersonal functioning. Developmental skills groups are developed specifically for children with developmental delays. The aim of this group type is to enhance the social competence of the children in the group. The children may also be supported to master certain life skills (Geldard & Geldard, 2001; Lanyado & Horne, 2009).

A support group does exactly what the name implies – it is a group where the members provide support to each other. Lanyado and Horne (2009) describe the function of a support group as "*from acceptance grows the sense of belonging 'come what may'; with trust it becomes safe and possible to be one's self....out of this grows a sense of group cohesion*" (p.257). Although support is the group's main function, it also has extra utilities, for instance facilitating emotional, cognitive and behavioural changes in children. Support groups are generally established for children experiencing the same type of life challenge. The facilitators of a support session have to emphasise the importance of interdependence and the facilitator's role thus becomes less significant with time.

The main aims of a support group are for children to receive mutual support in a safe environment, to share coping strategies, to share information and to develop confidence in dealing with the stressor at hand. Support groups and counselling groups are to a certain extent similar in that they enrol children who experience specific challenges and the children may exhibit behavioural and emotional symptoms because of the life challenge. The difference is that in a support group the emphasis is on supporting each other, whereas with a counselling group the emphasis is on personal development. Support groups are more likely to be heterogeneous, according to Geldard and Geldard (2001).

Hughes-d'Aeth (2002) propagates the appropriateness and effectiveness of a peer education strategy. A person at risk can be reached by his/her peers as a peer engenders trust and is seen as 'one of us'. Peers provide information, life skills to cope with high-risk situations and practical ways to support behavioural changes. They enable participants to retain a measure of dignity while facing uncertainties and fears.

Family-centred group intervention is another type of group proposed by Leeper et al. (2010) as a care delivery option to children in developing world settings. The researchers support this view by indicating that most HIV infections occur in the context of a family, the family accepts most of the responsibility for the care and support of persons living with HIV, the stigmatisation associated with HIV/Aids are experienced by both the infected person and the rest of the family and HIV/Aids has a profound adverse effect on the family's structure, functioning and well-being, even long after the HIV-infected family member passed away. Additional care such as comprehensive childcare services, supplementary services such as play therapy and terminal care services are further essential in family-centred group interventions.

The type of group intervention in this study was a support group for children in the latent-phase who were affected by maternal HIV/Aids. The children experienced similar life challenges and socio-economic circumstances. The main aim of the support groups was to enhance the children's resilience with the support of peers. The children in this study had the opportunity to discuss their problems, to socialise, to share information and to learn additional coping skills form their peers who experienced similar life challenges, during the separate group sessions. Furthermore, the mothers were involved in the joint support groups and this family-centred approach intended to ameliorate the effect of the HIV on the family.

5.5. Practical considerations in planning a support group

Moral, emotional, cognitive, sexual, social and cultural perspectives are dimensions of development that require specific attention in the establishment of groups. A support group has to include members with compatible developmental ages in order for researchers to use the information to make assumptions regarding the target group (Akos, 2000).

Akos (2000) emphasises that the diversity of a group is important. Race, ethnicity, different schools, age and gender are some of the characteristics that play a significant role in assessment and socialisation in the groups. Akos (2000) refers, for example, to results indicating that boys and girls display different levels of empathy. Additionally he indicated that 'growth-centred' groups can be open, but that 'problem-centred' groups need to adhere to closed membership and have to have a fixed duration. Even numbered group membership for partner activities is recommended.

Geldard and Geldard (2001) and Dwivede (2005) point to the issues that need consideration before a group is formed. The group composition and group size are decisions that can impact the effectiveness of a group. The researcher generally must take cognisance of the age, gender, culture, purpose of the group and the level of activity. Balance in certain groups is important and heterogeneity is preferred, specifically in support groups. Homogeneity may be desirable in certain instances for common-problem groups such as children with divorced parents. Mixed-gender groups are preferred by most counsellors as research indicates that this type of group is more productive than same-gender groups. In the latency phase it could be expected that children divide themselves up into same-sex sub-groups (Geldard & Geldard, 2001; Thompson & Henderson, 2006).

A large group may be more economical, but it may lead to a lack of cohesion. Although there are no hard and fast rules regarding the size of a group, the size depends on the goal, age of the children, maturity, attention span and activities of the planned sessions. According to Geldard and Geldard (2001), groups usually consist of three to eight members. Thompson and Henderson (2006) recommend that groups for children aged five to six years have to be kept small (in the range of three to four participants) and the groups have to take place frequently for short periods of time. Groups with more mature children can include more children in the group and the group duration can be extended.

According to Thompson and Henderson (2006), groups function most effectively with eight children. Akos (2000) indicates that a large group of children (10–12 members) is more suitable for empathy development and a smaller group (4–6 members) is more appropriate for remedial prosocial behaviour. It is recommended that more children are admitted to the group if there is a possibility that the children may not attend regularly and natural attrition may occur. Group size is also dependent on the amount of facilitators available per group.

Planning for an intervention group requires suitable facilitators who will be available for the full duration of the intervention. The facilitators must be able to speak the language of the participants and have experience in dealing with children and their behaviour. There also needs to be substitute facilitators available in case a facilitator takes sick leave. The number of participants available in order for the group to be viable is of utmost importance (Dwivede, 2005; Geldard & Geldard, 2001).

The intake procedure, confidentiality, the site where the intervention group is meeting for their sessions (needs to be safe and conducive to the group activities), the average length and overall duration of the sessions (have to be decided upon before the group commences) and the financial costs involved in running the group, are of importance. The timing of the support group makes a difference in how well the group is received and attended as for instance during school holidays the children may not be available to attend the group (Dwivede, 2005; Geldard & Geldard, 2001).

Kerig et al. (2012) furthermore point to ethnic and cross-cultural diversity issues in interventions with children. One treatment is not a fit-all treatment. They firstly suggest that the effectiveness and acceptability of an intervention can be increased if it is adapted to the diverse needs and experiences of the specific population it is intended for. Cultural sensitivity and responsiveness is therefore a necessity. Cultural adaptability is increased if the group facilitator is a member of the same cultural group and able to speak the language of the group. Specific cultural differences that may have an impact on the success of an intervention programme are the cultural differences in pathology were there are differences between cultures in their definitions of social problems, socio-cultural practices and normalcy. Parents' beliefs, for instance about socialisation and proper child behaviour, may differ between cultures and need to be taken into consideration.

In Thailand, research is indicating that children are more referred to psychologists for internalising problems because the Thai culture encourages inhibition and peacefulness whereby American children are more referred for externalising problems in a culture where independence and competiveness are encouraged (Kerig et.al., 2012). The cultural differences in treatment have to take into account accessibility and effectiveness for the intended population. Cultural differences in knowledge direct the development of culturally-specific interventions where it has to address the unique needs and culture of the specific child. The general driving power is however pointing towards the development of 'culturally responsive treatment' where interventions are modified to fit the child and his/her family's cultural perspectives, according to Kerig et al. (2012).

In this study the groups were composed of boys and girls within the age range of 6–10 years from different schools in the community. Every new intake wave consisted of 15 children who were randomised to the intervention group. This number was decided on to factor in the possibility of children not attending regularly and natural attrition. The average attendance rate was eight participants per group and corresponds with Thompson and Henderson's (2006) suggestion that a group functions most effectively with an average of eight members. Every group session was led by both a facilitator and a co-facilitator (careworkers) to ensure continuity when a careworker had to take leave. The facilitators were able to understand and speak the different languages of the participants. They received intensive training in order to accurately facilitate the group sessions and to be able to deal with difficult behaviour of group participants.

The intervention sites, the average length of the sessions and the overall duration of the group sessions were carefully planned to ensure maximum benefit to the group participants. Both the intervention sites were chosen for their safety and easy access as some of the children attended the group sessions without their mothers. The venues were big enough to accommodate a group of 15 children. The sessions, with an average length of one-and-a-half hours each, took place on a weekly basis for a total of 24 weeks. The sessions were scheduled for three o'clock in the afternoon to allow the participants enough time after school to reach the intervention sessions on time. The school holidays did seem to have a slight effect on the group attendance of the children and during the longer school holidays of December the support sessions were postponed for a month to ensure optimal group attendance.

The session activities were chosen, adapted and alternated to be age and culturally appropriate. Cultural adaptability was increased with the careworkers being able to speak the languages of the children in the groups, as suggested by Kerig et al. (2012). Furthermore, the careworkers were familiar with the cultural practices and beliefs of the communities in which the intervention took place.

5.6. Principles in designing a support group intervention

Geldard and Geldard (2001) and Thompson and Henderson (2006) suggest that the assumptions of the target group are listed beforehand. The topics and themes have to be identified from the assumptions, taking into account the developmental level and aim of the intervention group. The topics and themes are sequenced to fit the anticipated, logical stages of the group. The initial welcoming session and the final termination session need special consideration in the planning phase. Each individual session has to start with a specific topic/theme before the goals of the session are decided upon.

The methods are chosen according to the goal of the session. The goals should describe what the researchers intend to achieve with the session. The purpose of the session has to be fully explained to the group participants and their (and the facilitator's) roles and expectations explained to them in order to make the group session a less threatening experience. This process also provides structure to facilitate interaction. A wide variety of methods are indicated to keep the session interesting for the children. The methods chosen guide the researcher to choose specific media and activities. The activities must not be too long in order to keep the children's attention and the activities need to flow smoothly from one activity to the next. Sessions have to be structured with age-appropriate activities (Geldard & Geldard, 2001; Thompson & Henderson, 2006). Activities, such as bibliotherapy, DVDs, board games, puppets and role-playing, have the ability to stimulate discussion and problem-solving, according to Thompson and Henderson (2006). A researcher should consciously avoid intervention strategies and methods that are not familiar to a child's culture, systems of expression or understanding. Pillay (2007) proposes storytelling, projective techniques and other culturally friendly activities to address and approach the psychological challenges of children affected by maternal HIV/Aids.

Sharry (2004) refers to the importance of flexibility in structuring children's groups. Activities and games are important for non-verbal expression whereas discussions focus on verbal expression. Cognitive exercises may be draining for the children and therefore have to be balanced with expressive exercises such as painting and puppet play. Children's groups require many different activities and frequent activity changes depending on the children's developmental level. Although flexibility is crucial in children-support groups, it is also important to include routine and structure in a group to ensure the group runs smoothly.

The development of a group intervention session has to take into consideration the stages of group development for both the participant and the facilitator. The first stage is the preparation stage. During this stage the assessment and intake procedures take place and the facilitator and children build rapport. This relationship may impact the decision of a child to take part in the group. It is where members attempt to learn the group structure and group rules and assess where they fit in (Geldard & Geldard, 2001; Thompson & Henderson, 2006).

The second stage is the forming stage where the children start to explore and orientate themselves in the programme. This stage may be accompanied by some anxiety and tension as it is a new experience and group for both the children and the facilitators. This stage may also invite sharing and create a climate of safety. Dependency is important during this stage for the group to get well established. The storming stage is where the children and facilitators feel comfortable enough with each other to challenge certain ideas and where change is possible. The norming stage is where the conflicts in the group are resolved and the participants become productive. They start working mutually towards specific goals and solving problems. The mourning or adjourning stage is when the group sessions reach an end and this session is specifically difficult for the facilitators and participants. The closure session is when the intervention sessions end. The facilitators, participants and their parents have the opportunity to assess the intervention programme at this stage (Geldard & Geldard, 2001; Thompson & Henderson, 2006).

In this study the developmental level of the participants and the aim of resilience enhancement were taken into consideration in the planning phase of the support session manual. The group activities and homework assignments were synchronised with the group sessions for the mothers. The initial welcoming sessions for the separate and joint sessions (sessions 1 and 15) included a discussion of the goals and purpose of the sessions.

The final termination sessions (sessions 14 and 24) were carefully structured to ensure that the children were not left feeling abandoned by the support group. A wide variety of age-appropriate activities were included in the support session manual. The cognitive exercises were alternated with more expressive and physical activities to hold the children's attention. Activities included storytelling, for example the 'Little Hare' story, DVDs, for example 'Finding Nemo', boardgames, for example 'Don't talk to strangers', puppets, role-play, ball games and discussions. Although the activities were chosen to aid flexibility in the group sessions, the routine and structure of the group were seen as important aspects. Every session started and ended with the same type of activities to ensure routine and structure. The activities included the 'climbing down the tree' exercise, 'the feeling thermometer' exercise and homework activities.

The stages of group development were kept in mind during the development of the support group manual in both the separate and joint sessions of the intervention. The initial activities were included in the manual for the participants to get to know each other, to establish group rules and to learn to trust each other (preparation stage). The second stage (forming stage) activities included more sharing activities, for example the 'identifying strengths' activity and 'masekitlana' activity, whereas the third stage (storming stage) included activities which were more challenging, for instance the 'identifying emotions' puppet activity. The fourth stage (norming stage) contained activities where the participants could work together and help each other, for instance the 'making soup' activity. The mourning stage activities were included to prepare the children for the end of the sessions and comprised of a party and certificate ceremony. The participants were furthermore encouraged to share their contact details with each other.

Parental involvement in children-support groups are suggested by Sharry (2004). A parent has to legally give consent for his/her child to take part in a group intervention programme, but therapeutically the parent's involvement and support have advantages, especially if the group is designed to have an impact on the child's life on different levels. Sharry (2004) proposes parallel parent support groups in a bid to involve parents in the group process, but also to maximise the positive results of the group intervention. Parental involvement in the children's support groups has a further impact on the decision of the group setting. The building or area where the groups are held has to be in close proximity for both the parents and the children and easily accessible.

The building has to have enough space and rooms for both the parent and child groups to run simultaneously. Low noise levels in the rooms are important, specifically for children with poor attention. A room big enough for children to move around in and where tables and chairs can be arranged in a circle is recommended. Safe outside areas where the children can play are also suggested (Thompson & Henderson, 2006).

Group intervention development requires planning, setting of definite reachable goals and preparation before the programme is able to commence. The programme developer furthermore has to make sure that the facilitators are well trained to be able to facilitate the intervention programme and to reach the programme goals (Thompson & Henderson, 2006).

In this study the mothers not only consented to their children partaking in the group support sessions but also joined their children in the support sessions, from session number 15. The mothers attended parallel sessions (sessions 1–14) before joining their children in the groups. The careworkers received additional training, to be able to facilitate a group with both child and adult members.

5.7. Counselling and facilitation skills required to enhance adaptive behaviour in a support group setting

The type of group and the theoretical approach of the intervention guide the counselling skills necessary for facilitating the intervention group. A facilitator has to have certain basic counselling skills, for instance observation skills, active listening skills, the ability to give feedback, the ability to make use of questions and the ability to confront participants. Observation skills are of particular importance as the facilitator must be able to identify problems in the group and participants, but also be able to give feedback on the group process. The facilitator has to listen carefully, specifically when participants share personal information. Non-verbal responses are just as important as verbal cues. The facilitator has to reflect on the feelings of a participant in order for the child to feel heard and their emotions validated (Geldard & Geldard, 2001; Thompson & Henderson, 2006). In addition to counselling skills the facilitator has to develop facilitation skills. The facilitator has to feel comfortable to give clear directions and instructions. The facilitator has to remind the group of group rules, confidentiality rules and responsibilities of the group participants. Some children require that instructions be repeated a few times (Geldard & Geldard, 2001).

Facilitating discussions, teaching, giving advice, protective behaviour and modelling are some of the facilitation skills required from a group facilitator. The facilitator must be able to manage difficult behaviour and reinforce positive behaviour (Geldard & Geldard, 2001). The facilitator additionally must be able to block harmful group behaviours, direct communication, connect ideas generated in the group and give extra support to children who need it (Thompson & Henderson, 2006). The group intervention facilitator may be confronted with many challenges in a child group and good training therefore assists the facilitator in dealing with difficult situations.

In this study the group facilitators (careworkers) received intensive counselling and group facilitation skills training. The careworkers received additional training in the identification and facilitation of problematic behavioural, social and emotional behaviour. Weekly debriefing and discussion sessions with the social workers and research coordinator of the project furthermore ensured that the careworkers had the opportunity to ask questions and receive any additional information they required.

5.8. Support group intervention programmes to enhance adaptive behaviour

A support-group intervention programme has to be based on the specific needs of a community where the community and the individual are seen as full partners in the shared decision-making process. A successful intervention programme is sensitive to particular characteristics of a group such as age, sex, education level, developmental level and other factors. The intervention also has to be linguistically specific. Successful intervention has to be monitored in order to determine if the objectives of the programme were reached and if the programme has value for future intervention groups (Thompson & Henderson, 2006). Hughes-d'Aeth (2002) places emphasis on the importance of a baseline assessment for measuring and evaluating a group intervention. He also suggests an increased inclusion of qualitative aspects in monitoring an intervention.

Murphy and Marelich (2008) suggest that an intervention programme can provide a child with strong adult and peer attachments which are reported in resilience research to be an indicative protective factor. Interventions addressing coping and problem-solving skills are beneficial to non-resilient children as they are taught how to label their feelings, how to solve problems and other life skills.

Werner (1990) furthermore refers to the importance of early childhood interventions where the individual variations between children in their reactions to both negative and positive situations in their surroundings are significant. The different reactions of children imply the need for greater assistance for some children. A further suggestion for early child intervention is the need for assessing both the risk and protective factors in the lives of children and their families. A child requires consistent nurturance and a program has to provide this constant nurturance in order for a child to trust its availability. Research indicates the importance of at least one trusted person in a child's life who unconditionally accepts him/her (Murphy & Marelich, 2008; Werner, 1990).

Resilience enhancement does not rely on the complete removal of a stressor or adversity (this is furthermore not realistic in the real-life environment). A trusting person in a child's life can assist resilience promotion by presenting them with challenges to enhance their competence in a safe environment. An organised and predictable environment creates an opportunity for a child to practice resilience skills and to enhance their skills. The intervention programme environment has to combine warmth and caring with clearly-defined structures and boundaries in order for it to facilitate the enhancement of resilience skills (Werner, 1990).

The support group manual in this study was structured according to the model as explained in Figure 2.4. The researchers closely monitored the quality of the intervention content and processes by assessing the group support session notes and having weekly meetings with the group facilitators (careworkers). The group sessions were furthermore monitored by the social workers and the research coordinator to ensure that the process, as described and intended in the support session manual, was closely followed. The careworkers who were selected to facilitate the support sessions received specific training in order to establish a caring group environment with clearly-defined structures.

5.9. Support group intervention programmes for HIV-affected children

Masten and Coatsworth (1998) refer to resilience literature, indicating that prevention-interventions have to focus on risk-focused, resource-focused and process-focused strategies in their design. Stressors (risks) have to be identified before the intervention commences and care has to be taken to avert these stressors as far as possible.

If a stressor occurs during the intervention, efforts have to be made to reduce their impact, i.e. if a child attends a group session hungry, the child must receive something to eat. Resources can be added or improved to enhance the effects of the intervention, i.e. assets in the community could be identified to help the child cope with his/her stressors. Adaptation systems (process-focused strategies) that appear to be strongly tied to competence and adaptive behaviour are attachment, self-efficacy and self-regulation, according to Masten and Coatsworth (1998). Efforts thus have to be made to improve parent-child relationships. Programmes opening doors to new opportunities are referred to as process-orientated strategies.

Intervention strategies to develop competence in children have changed focus over the years. Strategies first focused on the definitions of competence and building singular or a core set of skills in children for example, programmes to teach problem-solving skills. The focus has shifted to more developmental, ecological and multi-causal models, according to Masten and Coatsworth (1998). These intervention strategies are more complex and focus on a broader set of skills over a longer time period. Interventions targeting cognitive, social, behavioural and parental interactions are showing long-term cumulative protective factors. This type of intervention is designed to enhance competence (for example, resilience) and reduce risks.

Young and Mustard (2008) suggest that children exposed to grief caused by HIV/Aids must be helped to adapt to new life circumstances and to cope with difficulties by given high priority to "…. *programs that provide quality environments (physical and social) for children as well as appropriate and effective care, nurturing, and stimulation… [to encourage] hope and new possibilities for the future*" (pp.73-74). King et al. (2009) studied the effectiveness of interventions with the main aim of improving the psychosocial well-being of children affected by HIV/Aids. They made use of electronic databases and reviewed 1 038 studies. Of these studies, only 11 studies indicated a clearly defined intervention. King et al. (2009) came to the conclusion that "*no studies of interventions for improving the psychosocial well-being of children affected by HIV and AIDS were identified*" *and* recommended "*the systematic review has identified the need for high quality intervention studies. In order to increase the quality and quantity of such studies there is a need for greater partnerships between program implementers and researchers*" (p.2).

The researchers mention that a reason for this lack of quality studies, is that psychosocial intervention for children affected by HIV/Aids is a relatively new concept. Researchers are still aiming to demonstrate a need for psychosocial interventions. Psychosocial intervention is a difficult and complex concept, especially in sub-Saharan Africa where the impact of HIV/Aids is immense (King et al., 2009). Luthar and Brown (2007) urge that the science and practice of prevention and treatment be brought closer together. They argue that an integrated intervention model involve the understanding of culture in the intervention effectiveness, the clarification of conditions under which a program may be successful or not, the explanation of the underlying methods that underlie the treatment effect, the testing of the intervention in a real-life context and making tested interventions accessible and useful to the wider community.

5.10. Summary

In this study it is assumed that intervention programmes will promote the expression of emotions, development of self-control, enhancement of problem-solving skills and other much needed techniques to become more resilient. Children who are part of an intervention group may show skills acquisition, but also a decrease in clinical symptomatology, according to Murphy and Marelich (2008). An intervention may alternatively remove or alleviate the psychological distress (for example, depression or anxiety) associated with the adverse situation to such an extent that the child is more capable of using his/her resources to cope with the stressor at hand.

6. Theoretical framework

The theoretical framework used in this study is inspired by the bioecological systems theory. Toland and Carrigan (2011) indicate that the bio-ecological systems theory as proposed by Bronfenbrenner (1979) is a useful framework for understanding the complex structures and relationships of children across time and contexts. The bioecological model is based on the systems theory and therefore reciprocity and feedback are important concepts in the study of children's resilience (Schoon, 2006). Children are not mere passive recipients of their environments but active participants who contribute and interact with their environment (National Scientific Council on the Developing Child, 2004).

The relationships of children with their environment and the people in their environment are of particular importance in this study. According to Luthar and Brown (2007), there is an urgent need to design and test interventions for children in *'real world settings'* (p.945). Resilience becomes a constructive concept when it is rooted in a theoretical model such as the bioecological systems model, according to Schoon (2006).

The conceptual model underlying the Promoting Resilience in Young Children Study is presented in Figure 2.4. According to this model the aims of the group intervention for children affected by maternal HIV/Aids (child outcomes) were to improve the group participants' adaptive functioning and school performance and to decrease depression, anxiety and behavioural problems. The Child Support Group Evaluation Study aimed to evaluate the efficacy of the group-based intervention as proposed by the Promoting Resilience in Young Children Study. In the Child Support Group Evaluation Study it is posed that the protective and risk factors are measurable by analysing the child, mother and careworker questionnaires and observations. The theory-driven evaluation model of Chen (refer to Chapter 3, p.145) and the bioecological system model (refer to Fig. 2.5) directed the qualitative and quantitative evaluation of the effectiveness of a group-based intervention programme for young children affected by maternal HIV/Aids in enhancing adaptive behaviour. The group-based intervention programme content, methods and processes were furthermore evaluated in this study by means of these models.

Figure 2.4 The conceptual model underlying the Promoting Resilience in Young Children Study
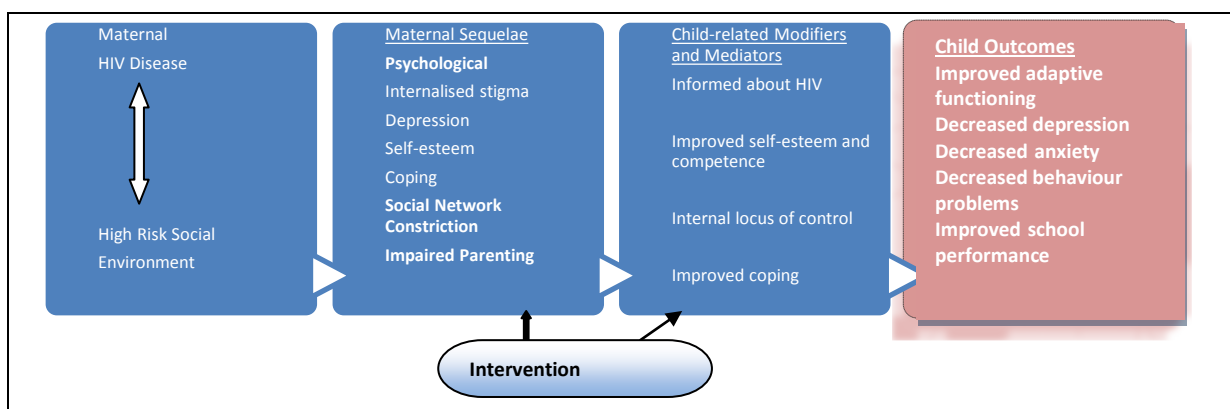
Permission granted by author to include Figure 2.4 in this thesis.

(Forsyth, B. 2005. Promoting resilience in Young Children of HIV-Infected Mothers in South Africa. Research Proposal submitted to the National Institutes of Health, April 2005).

Figure 2.5 Theoretical framework of the Child Support Group Evaluation Study

MACROSYSTEM	EXOSYSTEM	MESOSYSTEM

Culture
Stigma and discrimination

Socioeconomic status
Parent's employment

Relationships between two or more systems of the child

MICROSYSTEM
Protective and risk factors

CHILD VARIABLES

Latent-phase developmental characteristics and age

Peer relationships (group)

Adaptive and non-adaptive behaviour

Communication skills

Emotional intelligence

Social skills

MATERNAL ILLNESS (HIV/Aids) VARIABLES

Depression

Perceived and felt stigma

Disclosure

Parenting skills

FAMILY VARIABLES

Single parent families

Mother-child relationship

Socio-economic status of family

Close relatives

Neigbourhood

Response of the children and mothers to the intervention

Careworkers
Training
Application of intervention
Response to intervention

Child adjustment (child outcomes)
Internal and external behaviour problems
Coping (general and spiritual)
Socialisation-, daily living-, communication skills

THEORY-BASED PROGRAMME INTERVENTION – MEDIATOR
Content, Methods, Processes
24 Weeks intervention programme

ADAPTIVE BEHAVIOUR
(Resilience)

7. Conclusion

An encompassing literature study referring to the latent-phase developmental stage, the psychosocial effects of HIV/Aids, resilience (adaptive behaviour) in the context of HIV/Aids and an exploration of the characteristics and processes of children support groups were deemed essential to provide a theory-based background to evaluate an intervention programme for young children affected by HIV/Aids.

Literature indicate that a support-group intervention must be grounded in both theory and empirical evidence from a broad range of settings (for example, family, school, community) to effectively address the risks and needs of children affected by maternal HIV/Aids. The existing research into risks and resilience of children exposed to adversity provide several guidelines to addressing these requirements by stressing, for example, the significance of a caring mother-and-child relationship, paternal involvement, a positive future perspective and opportunities to practice adaptive behaviour in a supportive environment. Children exposed to maternal HIV/Aids are at a heightened risk for developing psychological and behavioural disorders. Some children exposed to a multiple of stressors and adversities such as parental illness, poverty and violence do not only survive, but thrive. These children are seen as resilient, according to Condly (2006). The main objective of an intervention is to enhance resilience opportunities and adaptive behaviour and to lessen possible risks, according to Gilgun and Abrams (2005). This chapter has offered some indication of pertinent aspects to consider in the evaluation of a support-group intervention for latent-phase children affected by maternal HIV/Aids.

CHAPTER 3

Research design and Methodology
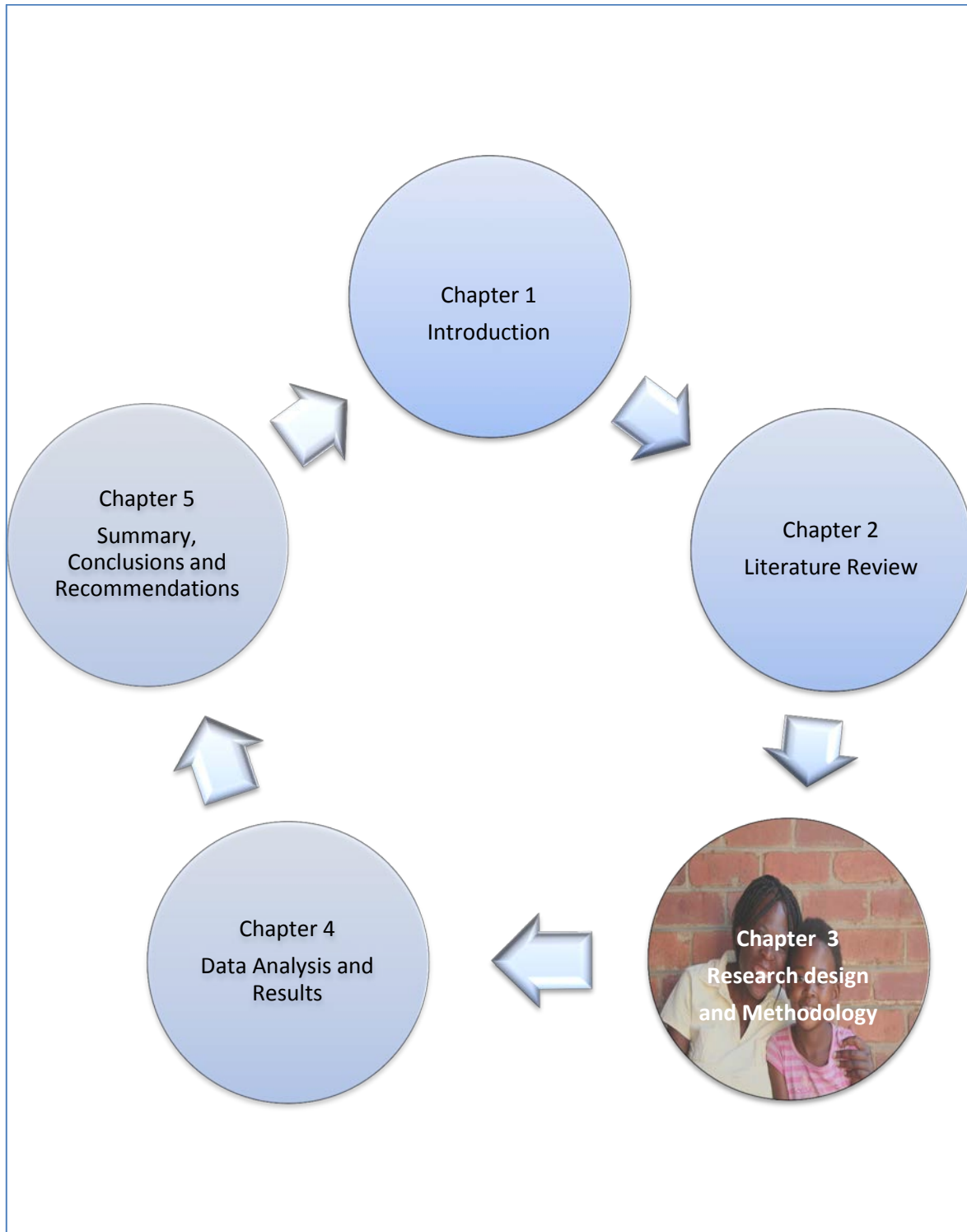
1. Introduction

Several risks factors for children affected by maternal HIV have been identified, including difficult mother/child relationships, single parent families, poverty, violence, stigmatisation, stress, behaviour disorders and emotional problems (Urbis, 2011). In addition, a range of protective variables has been proposed to reduce the negative impact of adverse life circumstances. These include interventions focussing on the enhancement of adaptive behaviour (Gilgun & Abrams, 2005). Thus there is a strong theoretical rationale for proposing an intervention designed to enhance resilience and to decrease the risks for vulnerable children affected by maternal HIV/Aids. Betancourt et al. (2012) places specific emphases on the significance of interventions that focus on potentially modifiable protective processes. To date, research referring to "building resilience in young children" is still in its formative years. Of the few evaluations that have focused specifically on vulnerable children, the majority have involved targeted interventions of orphans who have already experienced the death of a parent (Richter et al., 2010). The present study evaluates the impact of a theory-based support group intervention to enhance adaptive behaviour in young children. Table 3.1 provides an outline of the research methodology and process followed in the study. The conceptual lens and theory underlying the support group intervention was discussed in Chapter 2 and an overview of the full thesis study was presented in Chapter 1.

In an attempt to provide a rich description of the methodology followed in this thesis study, the researcher juxtaposed the methodology of the Promoting Resilience in Young Children Study[1] (Kgolo Mmogo main study[2]) with the methodology of the thesis study. The thesis study utilising secondary data from the main study is tightly interwoven with this study. The main or 'parent' study is referred to as the *'Promoting Resilience in Young Children'* – study and the thesis study is referred to as the *'Child Support Group Evaluation Study'* to make a clear distinction between the two studies as summarised in Table 3.2.

Discussion points included in this chapter are the research questions explored in the study and the research design and strategies utilised in an attempt to answer these questions. A mixed-method research design in the form of a theory-driven evaluation was conducted.

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[1] The Promoting resilience in young children study was funded by National Institutes of Mental Health.

[2] 'Promoting resilience in young children'-study had the epithet "Kgolo Mmogo" meaning "together we grow".

Table 3.1 An outline of the research design and methodology

PARADIGMATIC ASSUMPTIONS	
Methodological paradigm	Concurrent nested (QUALquan) mixed-method design
Meta-theoretical paradigm	Pragmatism and realism
RESEARCH DESIGN	
Nested multiple Case Study design (qualitative)	
Quasi-experimental design, the one-group pre-test-post-test design nested in a randomised control study design (quantitative)	
Theory-driven outcome programme evaluation	
DATA TYPES	
Data collection techniques:	Data documentation techniques:
Promoting Resilience in Young Children Study: Purposefully selected and randomised Child Support Group Evaluation Study: Purposeful sampling. Only participants who attended the support group sessions	Secondary data (refer to Appendix 2)
DATA ANALYSIS AND INTERPRETATION	
Storage and management	Questionnaire Design System (QDS). Data stored for 20 years in secure room.
Organising and sorting	Qualitative: WEFT Quantitative: SPSS 20
Coding and displaying	Qualitative: Themes and categories Quantitative: Paired-samples t-test for within-group comparisons was conducted.
VALIDATING THE ACCURACY OF FINDINGS	
Quantitative and qualitative validation of findings	
ETHICAL CONSIDERATIONS	
Respect for people; beneficence; justice; respect for the community	

Table 3.2 Juxtaposed Promoting Resilience in Young Children Study and thesis study

	Promoting Resilience in Young Children Study	Thesis study (Child Support Group Evaluation Study) nested in the Promoting Resilience in Young Children Study
Name of study	Promoting Resilience in Young Children Study	Child Support Group Evaluation Study
Research design	Quantitative design Experimental design Randomised Controlled Trial	Mixed-method design Quasi-experimental design (A paired sample t-test) Multiple case study design
Theory utilised	Resilience theory	Resilience theory Bioecological systems theory
Data collection strategies	Questionnaires Group session notes	Documents Focus groups Observations
Participant selection	Random assignment to intervention and no-treatment groups	Purposeful sampling (participants who received the intervention treatment)

This chapter explores the methodological choices made for the study. The quantitative approach in the study utilised a quasi-experimental research design to investigate the relationship between the independent and dependent variables having an impact on the efficaciousness of an intervention programme designed to improve children's adaptive behaviour. Inferential statistics were used to determine whether a significant difference existed between the pre-test and post-test results of the intervention group. Within the study the researcher aimed to uncover a causal relationship between the child support group programme (independent variable) and the perceived adaptive behaviour (dependent variable) of the children participants. There may be other variables, other than the intervention programme, that could cause similar improvements in adaptive behaviour of the children participants and a clear-cut cause-and-effect relationship will never be definite. In this regard, possible confounding variables are discussed in paragraph 7, p.153 under the heading – Data analysis and validation procedures. The self-report measurement data from the mother and child instruments at baseline and at the six-months interviews were reported on (refer to Appendix 2). A paired-sample t-test was conducted to compare the pre- and post-test behaviour of the children who attended the support group sessions.

The qualitative approach in this study used a nested multiple case study design and contributed to the largest part of the analysis in the study. A multiple case study design enables a researcher to examine several cases in order to understand discrepancies and similarities in a circumscribed population sample (Yin, 2003). In the case of this research study the children groups who received intervention treatment is seen as a bounded system and a collective case study. Support group session notes, focus group interviews and observations of the careworkers were utilised as rich data sources as well as the quality assurance questionnaires of the mothers and children participants. The intervention session manual, training, and programme contents and materials were furthermore used to examine the efficaciousness of the support group intervention. The goal of utilising different types of evidence was to triangulate the data in an attempt to answer the research questions effectively.

Participants selected for the Child Support Group Evaluation Study was purposefully selected from the Promoting Resilience in Young Children Study where the children participants were randomly selected to receive intervention treatment (refer to Chapter 1). Only the children who received intervention treatment and who attended the support sessions were purposefully selected for the Child Support Group Evaluation Study.

Furthermore, the validity and reliability of the data collection methods and data utilised for the study are discussed. The ethical principles that underlie the Child Support Group Evaluation Study and the role of the researcher in the evaluation study are explored in the final section of this chapter.

2. Research paradigms

The methodological paradigm utilised in the Child Support Group Evaluation Study is a concurrent nested (QUALquan) mixed-method strategy and the meta-theoretical paradigms underlying the study are pragmatism and realism. The research paradigms are furthermore described in detail.

2.1. Methodological paradigm

Dobrovolny and Fuentes (2008) propose that qualitative and quantitative methodologies share certain features. Both methodologies make use of a conceptual framework and a theory. In *evaluation* research both methodologies utilises clear evaluation questions and a structured plan to answer these questions according to established guidelines. Both methodologies encapsulate data- information and data-gathering processes in their systematic evaluations. Ethical guidelines underlie both types of evaluation methodologies and discuss results in terms of credibility, transferability and dependability in order to "*create the scientific rigor that makes the results of an evaluation project trustworthy*" (Dobrovolny & Fuentes, 2008, p.8).

In order to establish the extent to which both the qualitative and the quantitative methodology answers the research questions put forth in Child Support Group Evaluation Study it was important to understand the differences, strengths, limitations and implications of both the methodologies. The differences, advantages, limitations and implications of the quantitative and qualitative methodologies are summarised in Table 3.3.

Table 3.3 Differences, advantages, limitations and implications of the quantitative and qualitative methodologies

Quantitative Methods	Qualitative methods
Differences	
Aims to corroborate whether a hypothesis (assumption) is true for a specific context	A description of people/phenomena in their natural context
Objective reality (positivist perspective)	Individuals create their own reality (constructivist perspective)
Observer detached from the context	Observer part of the context
People participating in research are referred to as <u>subjects</u>	People participating in research are referred to as <u>participants</u>
Random selection on a large scale	Purposeful sampling of participants

Differences	
Utilise numbers to describe behaviour e.g. statistics	Utilise actions to describe behaviour e.g. words and artefacts
Examine observable variables	Examine the meaning that people create
Experimental setting	Natural setting
Utilise theories to determine data collection	Discover theories/concepts following data collection
Statistical methods (e.g., paired sample t-test and multivariate analysis) and deductive reasoning	Inductive analysis of data (e.g., coding and patterning)
Generalisation of findings	Provide rich description
Objective reports of findings	Discourse-intensive final reports with exemplary quotations
Advantages	
Time- and less resource intensive Results can be generalised to larger population Anonymity in data collection possible	Rich data 'Why' and 'How' questions possible Understanding of participants possible
Limitations	
Questions answered, but peripheral questions cannot be answered Thoughtful planning important Utilises a large sample	Generalisability limited Time dependent Resource intensive
Implications	
Can be seen as impersonal and not context specific Number of participants important Data security important	Possibility of discovering new issues Participants can provide realistic and viable solutions themselves Can change nature of relationships Data security of utmost importance

(Adapted from Dobrovolny & Fuentes, 2008; Needleman & Needleman, 1996; Tashakkori & Teddlie, 2009).

A mixed-method study design was decided upon, because the purpose of the study is to evaluate a child support group. The research questions guided the methods of the study. The types of data, the theoretical lens that underlies the current study and the subsequent methodological choices furthermore steered the researcher in this study to utilise a mixed-method approach.

2.1.1. Mixed-method design

In the mixed-method research paradigm there are six primary types of research designs described by Creswell (2003) and Hanson, Creswell, Plano Clark, Petska and Creswell (2005). The first group of research designs are described as 'sequential' and subdivided in explanatory, exploratory and transformative designs. The second group is known as the 'concurrent' designs and subdivided in triangulation, nested and transformative designs. The choice of research design depends on (1) the theoretical lens of the study, (2) the approach of data collection procedure, (3) the priority given to the quantitative and qualitative data which can be either equal or unequal, (4) the stage of which the data are analysed and integrated which can be separated, transformed or connected and finally (5) the procedural details.

For this study on a concurrent nested mixed-method design with the main emphasis on the qualitative data was chosen. Creswell et al. (2006) support and emphasise the role of qualitative research in mixed-method theory. (1) The theoretical lenses for this study are the pragmatic and critical realism lenses; (2) qualitative and quantitative data were collected concurrently; (3) the priority was given to the qualitative data; (4) the quantitative and qualitative data were analysed separately before comparing the two sets of data and finally (5) the procedure details for this study are visually represented in Figure 3.1.

This Child Support Group Evaluation Study utilised a mixed-method (Tashakkori & Teddlie, 2009) design which is defined as "*research where the researcher collects and analyses both qualitative and quantitative data, link the two data sets and draw conclusions using both qualitative and quantitative methods in one study*" (Tashakkori & Creswell, 2007, p.4).

The rationale for combining the quantitative and qualitative data in the Child Support Group Evaluation Study was to better understand the efficaciousness of a group-based resilience intervention programme for HIV-affected young children by triangulating both broad numeric tendencies from quantitative research and the detail of qualitative research (Creswell, 2003). The study used an interpretative integration framework to analyse the data (Dures, Rumsey, Morris, & Gleeson, 2011). The data were extracted from the population using qualitative and quantitative measures and were analysed separately before being theoretically integrated.

Figure 3.1 Mixed-method procedure details as followed in the Child Support Group Evaluation Study
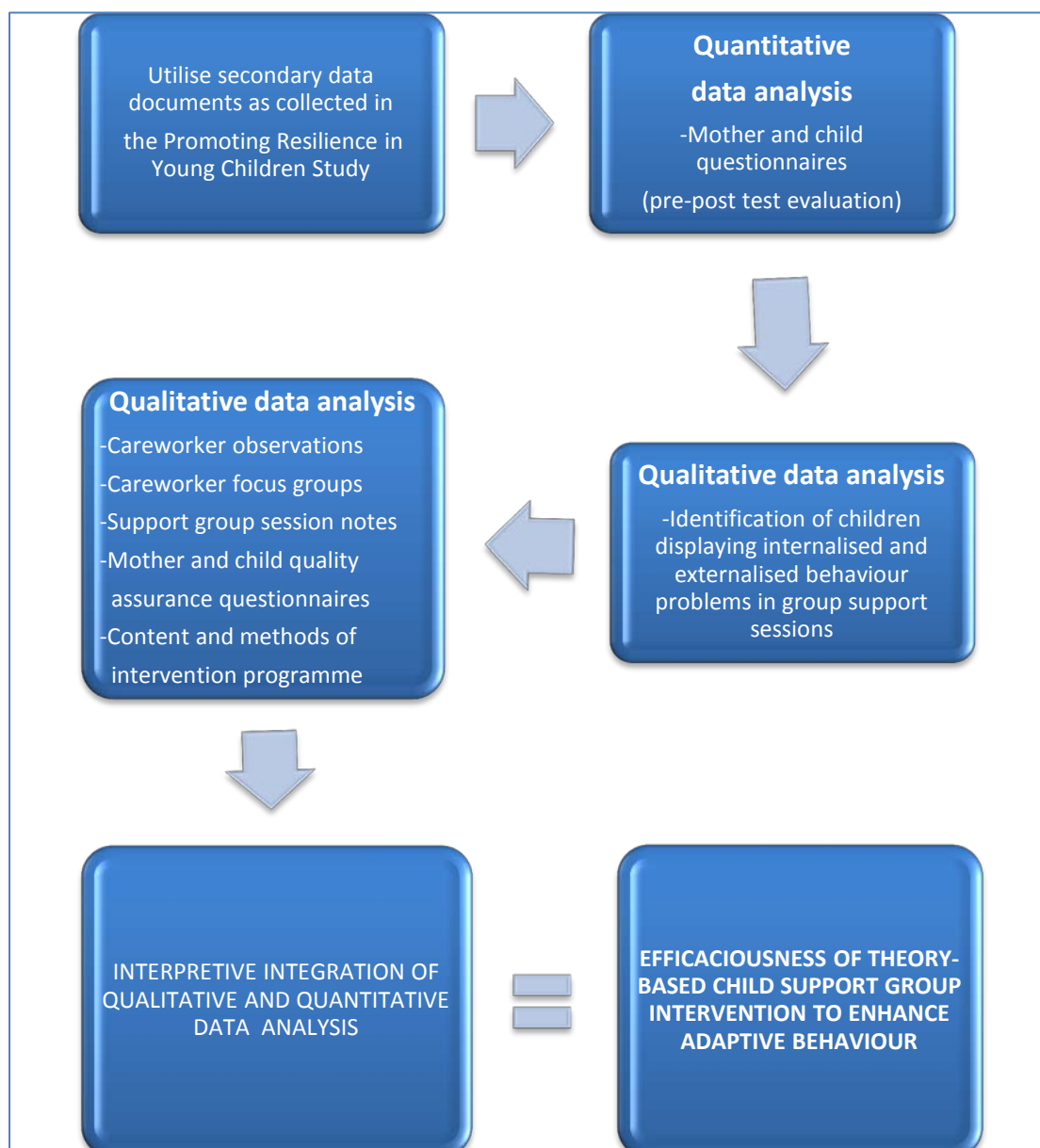
Creswell (2003) describes the concurrent triangulation approach as a model where qualitative and quantitative methods are used in an effort to support, verify and cross-validate the findings within one study. The visual model of the procedures for the concurrent nested mixed-method design of this study is presented in Figure 3.2.

Figure 3.2 Concurrent nested (QUALquan) mixed-method strategy
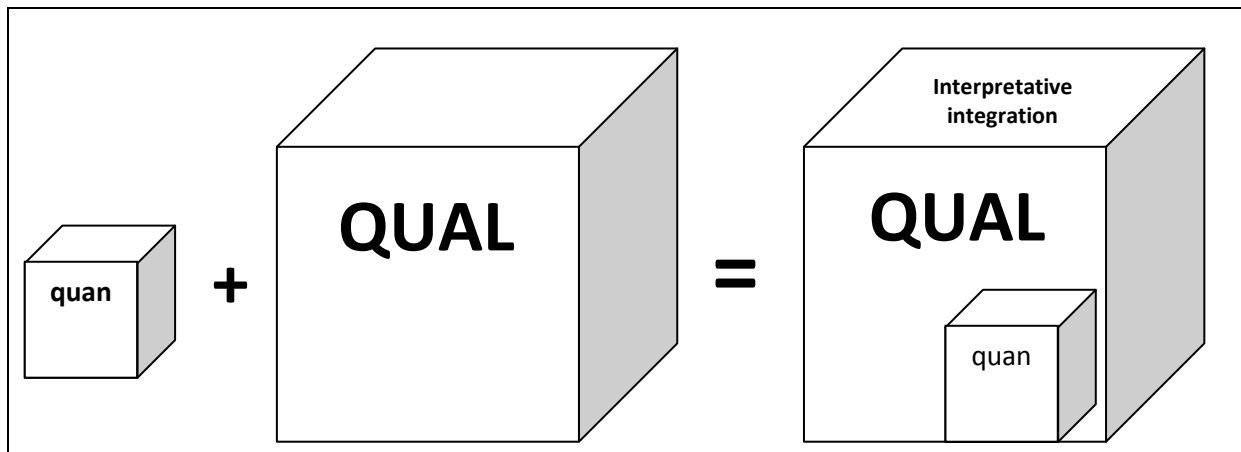
(Adapted from Creswell, 2003, p.214).

The approach aims to eradicate the weaknesses of one method by using the strengths of the concurrent method. Although the data collection occurred simultaneously, the results of both methods were separately analysed before being integrated during the interpretation phase. The results could either indicate a coming together of findings that may strengthen the knowledge claims made or could explain why there is divergence in the data. Advantages of this concurrent triangulation approach includes that it is a well-known method and may lead to validated and corroborated findings. A limitation that may be ascribed to this method is that it requires effort and expertise from the researcher to be able to study a phenomenon using two different methods. The method may also lead to complicated comparisons between the two different forms of data and it may be unclear how to resolve divergences that may arise during the analysis phase. The mixed-method approach is criticised as a costly method that may be time-consuming and is furthermore negatively judged for the high expectations that are set for a researcher to be competent in using and synthesising both quantitative and qualitative methodology (Tashakkori & Teddlie, 2010). The current research compensates for this weakness by using an existing data base.

The high expectations set by the researcher in the beginning of the project as mentioned by Tashakkori and Teddlie (2010) are tempered as she was closely involved with both the project's quantitative (data collection) and qualitative (intervention and training of careworkers) phases over a five-year period on a daily basis and thus capable of presenting a holistic picture of the child support group intervention.

2.1.2. The use of a mixed-method design in evaluation research

Evaluation research is conducted in settings where history, context, complex human behaviour and relationships are important interlinked aspects to consider during the planning- data collection- and data-analysis phases. The participants attach phenomenological and structural meanings to their settings and the relationships they form in these settings. Evaluation research aims to contribute to the overall social betterment of people. The evaluated phenomena of real people in real-life situations are thus complex, dynamic and contextually diverse (Greene, Benjamin, & Goodyear, 2001). This convolution requires a sophisticated research design that is able to manage a large quantity of quantitative and qualitative information in order to depict the complexities of the child support group intervention. Therefore a mixed-method approach was deemed necessary to address this. The child support group intervention was evaluated in an experimental setting and the children's behaviour and relationships were observed in this setting. The aim of the study was to enhance the adaptive behaviour of the children and the intervention programme thus endeavoured to contribute to the psycho-social betterment of children affected by maternal HIV/Aids. The statement by Cook (1985) who advocates for the use of a mixed-method approach for the evaluation of interventions, "*in a world where one way of conducting research was universally considered to be correct, scientific practice would be easy...It is the current absence of certainty about what constitutes correct practice that leads to advocacy of multiplism in perspectives and methods*" therefore further supports the design choice for this study, (p.22).

The evaluations of interventions are particularly difficult when only experimental scientific methods are applied to the setting under investigation. Experimental research departs from the viewpoint that the context is controlled for variables that may influence the outcome of the research study (Greene, Benjamin, & Goodyear, 2001).

That is feasible in evaluation research where it is good practice to adjust strategies as the circumstances change (Greene, Benjamin, & Goodyear, 2001). In this PhD-study a mixed-method approach was used in an attempt to provide a holistic view of the group-based intervention programme. Adjustments had to be made to the intervention programme to fit the participants' circumstances (for example, the starting time of the groups differed as it were dependant on school activities and holidays, social activities in the community and other unexpected events). Changes to fit the circumstances of the group and other uncontrollable variables were another reason a mixed-method approach was used.

Lewin, Glenton and Oxman (2009) explored the use of qualitative methods in 100 controlled randomised controlled trials published *in the Cochrane Effective Practice and Organisation of Care Review Group*. They concluded that the use of more than one method in an integrated manner can be valuable in the evaluation of the effectiveness of multifaceted health and social care interventions. A mixed-method design can thus be useful to generate further questions or hypothesis, explore the reasons for findings in the randomized controlled trials, explore the discrepancies in the effectiveness of the sample and examine the suitability of the underlying theory. In this study a mixed-method design was used to evaluate the effectiveness of the group-based intervention and thus it aligns with Lewin et al. (2009) that more than one method of research is important in order to establish the effectiveness of an intervention.

Lieber and Weisner (2010) propose that the social sciences may benefit from addressing difficult problems using an integration of different research methods: *"Mixed methods encourage and support holism, which more richly, authentically, and appropriately represents the true complexity of behaviors as they occur in natural social contexts"* (p.560). The utilisation of qualitative and quantitative data strands fortified and increased the researcher's understanding in this study of the resilience phenomenon under investigation. Taking into consideration the variances that may be present in the Kgolo Mmogo intervention programme's contexts, contents, processes and nature of outcomes, the experimental method might not be the best indicator of the overall quality of change for this programme. Walshe (2007) states that the value of experimental methods becomes ambiguous if there are high variances of domains present. The ability to empirically generalise subsequently becomes complicated and therefore the theoretical basis of the intervention has to be emphasised.

According to Walshe (2007) the result is then that *"the theoretical basis for the intervention (why and how it works) becomes more important than its empirical performance (whether it works) in any particular study"* (p.57). For this reason emphasis was therefore placed on the theory-driven evaluation approach in the thesis study to indicate 'why and how' the intervention support groups 'works'.

The natural heterogeneity of the domains present in the Child Support Group Evaluation Study is inherent to the intervention. It is a complex social intervention with high levels of variance in contexts, content, application and outcomes. Walshe (2007) indicates that these variances are often inherent and a desired attribute of interventions. Hence, the experimental design (quantitative) alone does not provide for an adequate measure for the Child Support Group Evaluation Study and a mixed-method approach was selected for a more comprehensive evaluation.

2.1.3. The advantages of making purposefully use of a mixed-method approach in evaluation research

The mixed-method approach became a firmly established approach in programme evaluation (McConney, Rudd, & Ayres, 2002; Tashakkori & Creswell, 2007). Evaluation pragmatists are interested in using whatever type of data or method that best answers evaluation questions and they are not limited by choosing methods according to epistemology. They believe in the combination of qualitative and qualitative data to strengthen their evaluations and therefore limits the biases of any one method (McConney, Rudd & Ayres, 2002; Weisz, Sandler, Drulak, & Anton, 2005).

The overall purpose of using a mixed-method approach in evaluation research is firstly to reduce vagueness and secondly to improve understanding of the social phenomena being evaluated. The *concurrent nested design* of the mixed-method approach has the objective of increasing the validity and credibility of deductions. This is done by using different methods to measure the same phenomenon (Greene, Benjamin, & Goodyear, 2001; Nastasi, Hitchcock, & Brown, 2010).

The Child Support Group Evaluation Study make use of the concurrent nested method by investigating the pre- and post-test quantitative measures of the mothers and children and comparing it with the qualitative measures of the group intervention session notes, the mothers and children quality assurance questionnaires, the careworker focus group data and the methods and processes of the intervention programme (refer to Appendix 1). A greater emphasis was placed on the qualitative data gathered and therefore this is a 'nested' mixed-method design. The mixed-method design according to Greene et al. (2001) offers a larger *comprehensive* picture of the phenomena under investigation. The different qualitative and quantitative methods used to evaluate the phenomena offer different lenses to capture the different dimensions of a programme and experiences of the participants. The thesis study engages with the children, mothers, caregivers and careworkers in the resilience intervention programme to cast a light on how the different role players experienced the intervention under investigation.

The mixed-method design may lead to a more *insightful understanding* as suggested by (Greene, Benjamin & Goodyear, 2001). It is posed that the design might indicate that findings do not always converge which may lead to further probing and the establishment of new relationships that may contribute to important theoretical or practical knowledge. This study utilised a mixed-method approach for the Child Support Group Evaluation Study to ensure that the underlying relationships and concepts in the intervention programme were explored and evaluated to generate a nuanced understanding of the resilience (adaptive behaviour) phenomena. The mixed-method approach lends itself to *diverse value perspectives and viewpoints* (Greene, Benjamin, & Goodyear, 2001). The Child Support Group Evaluation Study engaged with different role players and utilised different investigation methods that offered as a result different value perspectives and viewpoints for further dialogue and critical commentary.

2.2. Meta-theoretical paradigm

A paradigm refers according to Maxwell, (2009) to "*a set of very general philosophical assumptions about the nature of the world (ontology) and how we understand it (epistemology)*" (p.224).

Guba and Lincoln (1994) describe a paradigm as a representation of a worldview that "*defines for its holder, the nature of the 'world', the individual's place in it, and the range of possible relationships to that world and its parts*" (p.107). The paradigm or worldview that are utilised for this mixed-method Child Support Group Evaluation Study is **pragmatism** and **realism**. Greene et al. (2001) describe the difficulty to link a specific paradigm to a mixed-method evaluation by referring to the 'paradigm issue'. They mention that it is not necessary to link a method to a specific paradigm in theory but that practice necessitates it in most instances. The soundness and possibility of merging different philosophy traditions such as positivism and constructivism in a mixed- method study is the 'paradigm issue'. A conceptual framework that is grounded in an existing philosophical tradition and accepted by prominent scholars in mixed-method evaluation studies is the pragmatic view (Denzin & Lincoln, 2000; Greene, Benjamin, & Goodyear, 2001; Nastasi, Hitchcock, & Brown, 2010; Patton, 1997; Pawson & Tilley, 1997; Schalock, 2001).

Realism and pragmatism share many characteristics according to Maxwell and Mittapalli (2010). "*Philosophical realism, a currently prominent approach in the philosophy of science, is gaining increased attention as an alternative to both positivism/empiricism and constructivism as a stance for research and evaluation in the social sciences*" (p.146). Maxwell and Mittapalli (2010) argue that critical realism's philosophical stance is well-suited for both qualitative and quantitative research. The 'real world' with which we interact, creates a substantial argument for the use of critical realism as a philosophical stance. The child support group intervention programme is a real intervention with real children experiencing real- life problems where HIV affects their lives.

Greene et al. (2001) describe the pragmatic view simply as where an evaluator works as a pragmatist. A pragmatist takes cognisance that a specific context has natural restraints and opportunities. In this study cognisance was taken that the Child Support Group Evaluation Study had a host of natural restraints that might have had an impact on the intervention programme. Transportation and other socio-economical restraints had an impact on the children's attendance and behaviour in the group sessions. The study also had natural and unexpected opportunities, for example the teachers in the community reported that some participants' performed better in school. This meant that the teachers were willing to report on the children's behaviour they observed in class.

The children also brought friends with them to the group to share their experience. These factors are more significant for a pragmatist when choosing a mixed-method design than the philosophical compatibility of different inquiry traditions where it is more descriptive and not prescriptive for practical research.

Pragmatists believe, according to Creswell (2003) that knowledge claims arise from conduct, circumstances and consequences rather than from precursor conditions. He claims that the focus must be placed on the problem in social sciences research and then multiple approaches may be used to gain understanding of the problem. Pragmatism uses multiple systems of philosophy and reality. As a result of the multiple systems of philosophy used in pragmatism the evaluator has the opportunity to use both quantitative and qualitative assumptions to conduct research. The most appropriate methods for a specific study can be utilised by pragmatists and they are not bound to one specific method. They have the freedom to use both quantitative and qualitative data to provide the best conceptualisation of the problem under investigation. According to Creswell (2003) pragmatism is not dedicated to a specific system of philosophy or reality which has as consequence that the mixed-method researcher can draw from both quantitative and qualitative assumptions with a freedom of choice.

Pragmatism therefore provides an opportunity to collect and analyse data in more than one way. The 'truth', according to the pragmatist viewpoint, is what works at that specific time and what provides the best understanding of a problem. The 'what' and 'how' are prominent in the pragmatist researcher's effort to provide a rationale for mixing qualitative and quantitative data sets. The researcher in this study concurs with Creswell (2003) that the focus must be placed on what worked well for the Child Support Group Evaluation Study at that specific time of implementation and that this viewpoint provide a better understanding of the intervention programme. A mixed-method approach was used in order to give a fuller and richer evaluation of the group-based intervention programme for the children participants in the study.

Biesta as cited in Tashakkori and Teddlie (2010) explains that *"pragmatism should not be understood as a philosophical position among others, but rather as a set of philosophical tools that can be used to address problems – not in the least problems created by other philosophical approaches and positions. One of the central ideas in pragmatism is that engagement in philosophical activity should be done in order to address problems, not to build systems"* (p.97). He hereby argues that pragmatism offers a more precise understanding of the strengths and weaknesses of the mixed-method approach. Pragmatism presents a particular view on knowledge, one where knowledge can be obtained through the blending of action and reflection. In this study, the researcher not only obtained data from the group, but also reflected on the data after each support session and discussed it with the group facilitators. In the debriefing and discussion sessions the group facilitators had the opportunity to share difficulties, positive experiences and to ask for guidance. Pragmatically, this process ensured that the research was executed correctly and problems could be eradicated before it became a fixed pattern. Data concerning the group process and participants could also be collected by following this process.

According to Christ (2010) and Johnson and Gray (2010) pragmatism can be summarised as rejecting dichotomous either/or thinking, emphasising Dewey's premise that epistemology originates from person-environment interactions, that knowledge is created based on empirical truths, that multiple theories/perspectives can be true, that multiple ways are available to create knowledge and thus the idea of one universal truth is challenged. It also shows the incompleteness of theories but is helpful in predicting and explaining change. It demonstrates the ontological stance that values are of great importance in research and that the ultimate 'truth' will only be obtainable at the end of history. In this study the researcher agrees with this statement in that she used the theories available to her in full awareness that these theories might not be able to fully explain the strengths and weaknesses of the child support group programme. Multiple, complex variables might also have an impact on assigning cause and effect to the results obtained by evaluating the intervention programme. By taking a pragmatic stance the researcher in this study thus acknowledged that the research were able to provide insights of what had worked in the specific child support group intervention programme and not what was or what would working in future programmes.

The problem-centred, real-world practice orientated and pluralistic pragmatic research paradigm guided the researcher in this study's choice of data collection and data analysis methods. A mixed-method approach was selected with data collection tools from both the positivist and interpretivist paradigms to evaluate the child support groups for children affected by maternal HIV/Aids.

3. Research design

"A conceptual framework explains, either graphically or in a narrative form, the main things to be studied – the key factors, constructs or variables – and the presumed relationships among them" (Miles & Huberman, 1994, p.18).

Where the researcher is situated in the 'world of experience' the research design has according to Denzin and Lincoln (2005) important underlying premises. The researcher has to indicate how the research design decided upon connects to the paradigm. The empirical data have to be informed by and interact with the paradigm utilised. The data have to allow the researcher to answer the problems of praxis and change. The participants and their environment have to be clearly defined in addition to the strategies of inquiry utilised. The methods and tools for collecting and analysing empirical data have to be stated and described upfront. The researcher in this study aimed with the construction of the research design for the Child Support Group Evaluation Study to answer and adhere to the underlying premises as set forth by Denzin and Lincoln (2005) and is visually presented and summarised in Figure 4.1.

The empirical data sources and the theory-driven qualities of the intervention programme guided the researcher to utilise a mixed-method approach. A theory-driven programme outcome evaluation was furthermore utilised to evaluate the efficaciousness of the child support group intervention. The concurrent nested QUALquan mixed-method design was decided upon as it provided a rich description of the child support group intervention. The pragmatist and realism paradigms support the use of a mixed-method approach as this approach provide insight into what and why the intervention might have worked well or not.

The children and mother participants and their environment are clearly defined in the following sections as well as the methods and tools used for collecting and analysing the empirical data of the theory-driven intervention to give a clear picture of how the research design was constructed and decided upon.

3.1. Nested multiple case study design

The qualitative research problem (refer to par. 4., p.148) is explored by means of comparative data analysis and an in-depth interpretation of multiple case studies. A nested multiple case study design is a holistic investigation that studies a contemporary phenomenon in its setting. The phenomenon may refer to either an individual or to a specific programme, activity or event (Harling, 2002). In the Child Support Group Evaluation Study it refers to an intervention programme. The setting is the context wherein the phenomenon occurs. Two settings were utilised for the intervention programme. The Mamelodi and Atteridgeville settings are fully described in paragraph 10, p.172. The holistic enquiry involves rich, in-depth data description from multiple sources of observation. The multiple sources indicated in the Child Support Group Evaluation Study are summarised in Appendix 2.

A nested multiple case study design for the Child Support Group Evaluation Study was chosen. The data of the full data set of 163 cases (participants) who attended the group support sessions and received the intended treatment was used.

The Child Support Group Evaluation Study includes multiple cases to provide a "*general understanding using a number of instrumental case studies that occurred in multiple sites*" (Harling, 2002, p.2). Multiple cases and sites have the added benefit that it is robust and provide more compelling results than a single case study (Yin, 2009). A case study allows a researcher to gain a holistic view of a specific (in this case child support groups) phenomenon (Noor, 2008). A multiple case study is also referred to by Stake (1995) as a collective case study and is similar in nature. A case study enables a researcher to answer the "how" and "why" type of questions while taking into consideration the multi-directional relationship between the context and the case study participants (Baxter & Jack, 2008; Rowly, 2002). This type of design supports bio-ecological system theory research.

Yin (2009) proposes furthermore that different types of data evidence have to be used and triangulated when the research questions are answered to minimise critique and to maximise generalisability. The embedded units of analysis are described by Yin (2009) as data that originates from different layers of a case study. The nested multiple case study design followed in the Child Support Group Evaluation Study made it possible to analyse data on different levels of the intervention as for instance on the careworker level, mother participant level, child level, project coordinator level and community level.

Harling (2002) describes the role of theory in a case study design as important in order for a researcher to add to existing theory and not just to reinvent the wheel. Theory is according to him a starting point for direction and structure of the initial set of questions a researcher pose. In this study the bioecological systems theory was chosen to structure and to direct the evaluation research. The theory-driven Promoting Resilience in Young Children Study furthermore guided the programme evaluation process as described in paragraph 3.3.6., p.145. Baxter and Jack (2008) and Stake (1995) propose that propositions are helpful in a case study. Propositions originate from literature studies, professional practice, theories and generalisations of empirical data. The propositions enhance the feasibility of completing a research project and place limits on the scope of the study. For this study the following propositions (Table 3.4) to guide the qualitative phase of the study were proposed:

Table 3.4   Multiple case study propositions

Propositions	Sources[3]
Children in the latent-phase are in a developmental phase where support groups are helpful to enhance their potential for maximum positive growth	**Literature and professional experience** Huston, A.C. & Ripke, M.N. (2006). Middle Childhood. Contexts of development. In A.C. Huske & M.N. Ripke (Eds.), *Developmental contexts in middle childhood. Bridges to adolescence and adulthood.* (p.1). Cambridge: Cambridge University Press.
Children in the middle-childhood years may experience maternal illness as difficult and this may be even more so for children living in single parent families. The risk factor of maternal illness heightens the probability that children may experience poor outcomes.	**Literature** Annunziato, R.A., Rakotomihamina, V. & Rubacka, J. (2007). Examining the effects of maternal chronic illness on child well-being in single parent families. *Journal of Developmental & Behavioural Pediatrics, 28*, 386-391.

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[3] These are only examples of literature and do not reflect a full literature review.

Propositions	Sources
	Korneluk, Y.G. & Lee, C.M. (1998). Children's adjustment to parental physical illness. *Clinical Child and Family Psychology Review, 1*(3), 179-193.
Children affected by <u>maternal HIV/Aids are particularly vulnerable</u> to develop emotional and psychological problems	**Literature and professional experience** Forehand, R., Jones, D.J., Kotchick, B.A., Armistead, L., Morse, E., Morse, P.S., & Stock, M. (2002). Noninfected children of HIV-infected mothers: a 4-year longitudinal study of child psychosocial adjustment and parenting. *Behavior Therapy, 33*, 579-600. Murphy, D.A., Marelich, W.D., Armistead, L., Herbeck, D.M., & Payne, D.L. (2010). Anxiety/stress among mothers living with HIV: effects on parenting skills and child outcomes, *AIDS Care, 22*(12),1449-1458.
<u>Strengthening the protective factors of children and their families</u> may buffer them and increase the likelihood of a positive outcome.	**Literature** Condly, S.J. (2006). Resilience in children. A review of literature with implications for education. *Urban Education, 41*(3), 211-236. Urbis. (2011). *The psychological and emotional wellbeing needs of children and young people: models of effective practice in educational settings*. Final report. Prepared for the Department of Education and Communities. Australia: Urbis Pty.
A latent-phase child's development is influenced notably by the groups surrounding them. <u>The group context provides children with modelling opportunities</u> to imitate positive behaviour and observe problem-solving behaviour of their peers.	**Literature and professional experience** Akos, P. (2000). Building emphatic skills in elementary school children through group work. *The Journal of Specialists in Group Work, 25*(2), 214-223. Lanyado, M. & Horne, A. (2009). *The handbook of child and adolescent psychotherapy. Psychoanalytic approaches*. London: Routledge.
Child development is influenced by the quality of the communication between a parent and a child. Joint group sessions have to incorporate activities to <u>improve parent-child communication.</u>	**Literature and professional experience** Sharry, J. (2004). *Counselling children, adolescents and families. A strengths-based approach*. London: Sage.

Yin (2009) proposes that the evidence as collected in the intervention study has to be presented objectively and apart from the researcher's interpretation in order for the readers to reach their own conclusions before reading the researcher's interpretation and to improve the quality of the case study design.

This study did make use of multiple cases in two different sites and triangulated different types of data evidence (refer to Appendix 2) in order to answer the research questions (refer to par. 4, p.148). The findings of the research were first presented in Chapter 4 and then interpreted at a later stage in order to allow the reader the opportunity to make his/her own judgment.

Baxter and Jack (2008) furthermore recommend that to ensure the validity and credibility of a case study design the research question(s) must be clearly stated, propositions must be provided, the case study design must address the research questions, purposeful sampling strategies must be appropriately applied, the data must be collected systematically and analysed correctly. The research questions (refer to par. 4, p.148) are clearly stated and provided specific propositions to guide the research. A purposeful sampling strategy was utilised in the qualitative phase of the research design. The data were collected systematically from the child support groups, focus groups, observations and quality assurance questionnaires and analysed correctly (refer to Chapter 4).

3.2. Quasi-experimental design nested in a randomised control study

The Child Support Group Evaluation Study included data extracted from the Promoting Resilience in Young Children Study pertaining to the baseline interviews, intervention and six-month interviews of the participants who received treatment. The main aim of a quasi-experimental design is to test if a causal relationship exists between two or more variables (Bickman & Rog, 2009; Cohen, Manion, & Morrison, 2000). The quasi-experimental comparison base was established through the inclusion of pre- and posttreatment observations of the treatment group and is referred to as a one-group pretest-posttest design as described by Fouche and De Vos, (2001). A baseline interview preceded the introduction of the independent variable (treatment) and a posttest followed at the six-month scheduled interviews. Multiple observations over time were important as the treatment group served as its own comparison in the Child Support Group Evaluation Study.

3.3 Programme evaluation

3.3.1. Introduction

There are many definitions for 'programme evaluation' or 'evaluation research'. The approach followed in this study is best described by a definition given by Michael Quinn Patton: "*I use the term evaluation quite broadly to include any effort to increase human effectiveness through systematic data-based inquiry. When one examines and judges accomplishments and effectiveness, one is engaged in evaluation. When this examination of effectiveness is conducted systematically and empirically through careful data collection and thoughtful analysis, one is engaged in evaluation research...Evaluation is applied research, or a type of 'action science'. This distinguishes evaluation research from basic academic research...The purpose of applied research and evaluation is to inform action, enhance decision-making, and apply knowledge to solve human and societal problems...Applied evaluation research is judged by its usefulness in making human actions and interventions more effective and by its practical utility to decision makers, policymakers and others who have a stake in efforts to improve the world*" (Patton, 2009, pp.11-12).

Evaluation research is a unique form of social inquiry because it focuses on the provision of practical knowledge to aid decision making processes. Emphasis is placed on the discovery of cause and effect relationships that exist between the activities of a programme and the outcomes of the programme. The idea behind evaluation research is not just to ascertain whether a programme is working, but to explain why it is working or not working (Clarke, 1999; Rossi & Freeman, 1993). The Child Support Group Evaluation Study aimed to provide reasons and examine the intervention programme's impact on adaptive behaviour enhancement of children affected by maternal HIV/Aids.

3.3.2. The role of the programme evaluator

A programme evaluator should work closely with the programme decision makers to establish rapport but should also keep a safe distance to ensure impartiality and a neutral stance (Patton, 1997).

The focus of an intervention evaluation is on how useful the evaluation will be and how it will be used by the intended users. The evaluator has to facilitate judgement and decision-making and therefore cannot act as an independent referee. The notion that no evaluation can be value-free, directs attention to the highly personal and situational nature of evaluations. Principles to guide the evaluator are that the data have to be evaluated in a systematic and competent manner, the evaluator has to ensure integrity in the evaluation process, show respect for all the people involved in the evaluation and she must take responsibility for the general welfare of the public (Patton, 1997). In this study the researcher worked in a close relationship with the Yale University and University of Pretoria's principal investigators of the broader study. She was part of the multi-disciplinary team that helped to develop the intervention programme and coordinator of the overall programme. The Kgolo Mmogo Study data collection was completed in 2009 and the researcher thus has had some time to distance herself from the programme. She did not act as an independent referee as she was in contact with the principal investigators of the project who also evaluated her thesis study.

3.3.3. Selecting an appropriate evaluation design

Research done by Walshe (2007) postulates that clinicians are often confronted with the question whether there is evidence that a programme '*works'*. To answer this question they are frequently expected to perform a randomised control study in order to provide credible evidence that the programme indeed produced worthwhile improvements. Walshe (2007) argues that this evidence of improvements seldom show major changes and by most only moderate effect changes. This evidence then poses the question of how to investigate the quality of programmes. According to Walshe (2007) the general use of a randomised control study and quantitative only methods to answer the study questions need to be challenged and the point of departure should be to match the research methods to the questions and issues under investigation. Important factors in choosing the most appropriate research methods are the domains of context, content, process and nature of the results of the programme under investigation. Needleman and Needleman (1996) support this view and indicate that quantitative measures cannot satisfactorily provide answers to intervention research questions. The qualitative understanding of social meanings and relationships in the intervention environment is important to provide alternative explanations and interpretations of observed phenomena.

The study aligns with the Walshe (2007) and Neeldleman and Needleman's (1996) view in that in the Child Support Group Evaluation Study the more appropriate evaluation design is a theory-driven outcome evaluation approach wherein qualitative and quantitative data are collected and analysed. This design is able to provide a more in-depth evaluation of the context, content, process and nature of the intervention programme as discussed in paragraph 11, p.174.

According to Rossi and Freeman (1993) and Greene (1994) every program is unique and therefore every evaluation must be designed to fit the specific programme under investigation. The planning process includes assessing the goals and objectives of the program planners, assessing if the actual conditions under which the program will function may help or hamper the realisation of the specified goals and objectives, investigating the human and financial resources and developing specific criteria to judge if the program is successful. The objectives that are assessed have to be measurable and plausible. The Child Support Group Evaluation Study was unique in that it had the specific goal of enhancing adaptive behaviour in young children affected by maternal HIV utilising a group-based intervention. Different psychological instruments were used to make this goal measurable and the data were collected in the intervention groups. The programme was delivered by care-workers in the community and the interviews were done by trained research assistants. The programme aimed to reduce implementation costs in the low resource context the study was implemented in. The evaluation of the Child Support Group Evaluation Study is therefore designed to fit this specific program with its specific challenges. The model Paulsen and Dailey (2002) put forward is a model that incorporates all the important aspects as proposed by Patton (1997), Rossi and Freeman (1993) and Schalock (2001). An encompassing evaluation model that guided the researcher in selecting an appropriate evaluation design is presented by Paulsen and Dailey (2002) in Figure 3.3.

The most pertinent goal for an evaluation according to Paulsen and Dailey (2002) is to determine whether or not an intervention has improved the problem or situation it was intended to modify. Program evaluation and basic research display many similarities in the logical, orderly way of investigation. Both start out with a problem, investigate a question and review the relevant literature in order to solve the problem under investigation.

The following logical step is the development of a research design, gathering of data and then the analysis of the data. The difference between the classic research design and evaluation design lies in the use of the data (Paulsen & Dailey, 2002). Program evaluation can be seen according to Royse et al. (2010) as a tool to make decisions about a social program and to improve the quality of service rendered to the participants of the program. In the Child Support Group Evaluation Study the researcher utilised the data gathered from the Promoting Resilience in Young Children Study to evaluate the efficaciousness of the group-based intervention programme for young children affected by maternal HIV/Aids.

3.3.4. The difference between effectiveness and efficacy evaluation

Chen (2005) differentiates between an effectiveness evaluation and efficacy evaluation. Both evaluation types focus on how well a programme performs but efficacy evaluation involves assessing the effect of an intervention in ideal conditions whereas an effectiveness evaluation occurs in a real world situation. Efficacy evaluation is closely regulated to ensure that the 'precise measured dosage' is delivered in a standardised manner to all the participants in the intervention. Efficacy evaluation has to ensure the setting in which the intervention takes place are controlled for in order to reduce environmental influences or interferences. The intervention conditions, participant selection and facilitator behaviour have to be controlled for to minimise the external factors which may influence the outcomes of the intervention. Recruitment of a homogenous group is helpful, but a randomised controlled trial is preferred to ensure an unbiased assessment of the intervention effects.

The Child Support Group Evaluation Study was an efficacy evaluation as the intervention settings were controlled to ensure minimal environmental interferences. The participants were randomly selected in the Promoting Resilience in Young Children Study and these participants were evaluated in the Child Support Group Evaluation Study. The careworkers received similar training and they were monitored on a daily basis to ensure unbiased treatment.

Figure 3.3 Evaluation design

The holistic view	Evaluating a group-based support intervention for children affected by maternal HIV/Aids.
What evaluation **questions** need to be answered?	-To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?(Quantitative) -What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display? (Qualitative) -What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child? (Qualitative). Refer to paragraph 4 p. 148.
What type of evaluation **design**?	Theory-driven outcome evaluation (Chen, 2005). Refer to paragraph 3.3.5., p.145).
What evaluation **tools** should be used?	-Quantitative: psychological and socio-demographic questionnaires -Qualitative : Quality assurance questionnaires, group session notes, field notes, intervention manual, focus groups.
How to collect data?	The data was collected at baseline, during the intervention and at 6 months after completion of the intervention (refer to par. 6, p.151). There were 12 intervention groups with an average of 8 children in each group evaluated.
What to do with data once collected?	The quantitative data were analysed quantitatively with the use of the SPSS Version 20 statistical programme and the qualitative data were analysed. Refer to paragraph 7, p.153.
Report of evaluation findings.	The evaluation findings were reported in Chapter 5 in the thesis study for perusal of all stakeholders. An executive summary accompanied the final thesis.

(Adapted from Paulsen & Dailey, 2002).

According to Chen (2005) and Clarke (2006) the outcome evaluation of an efficacy and effectiveness intervention programme generally involves a *'black box or input-output evaluation'*. The *'black box'* indicates the space between actual inputs and expected output of a programme. These types of evaluation generally only measure an intervention's merits and not 'how' the processes can be improved. In order to comment on the merits of an intervention and to provide answers on how an intervention can be improved a theory-driven outcome evaluation is indicated.

Chen (2005) describes a theory-driven outcome as an evaluation that "*takes into account both underlying causal mechanisms and the implementation process when assessing the effect of a progam. It can provide stakeholders with understanding of whether a program is reaching its goals and document insightfully the how and whys of a program success or failure*" (p.232). Pawson and Tilley (1997) place emphasis on this type of evaluation to understand "*what works better for whom in what circumstances, and why*" (p.161).

3.3.5. An overview of theory-driven outcome evaluation

The theory-driven outcome evaluation approach is recommended when the qualities of a programme and the process changes are evaluated in order to improve an intervention. This evaluation approach focuses on causal effects and implementation effects in assessing a program. The 'how's' and 'why's' of a programme's success or failure are provided by this type of evaluation. The underlying assumptions of how a programme is supposed to operate on a day-to-day basis in the field and the programme components that have an effect on the success of a programme are furthermore highlighted by this approach. The accountability of a programme and the areas in need of improvement are addressed by theory-driven outcome evaluation. The focus on the underlying needs of a programme subsequently has the potential to contribute to scientific knowledge. The theory-driven outcome evaluation process examining causal effects has as an effect the ability to assess if the '*right thing in the right way*' is measured and therefore contribute to construct validity assessment. Internal validity is enhanced as the specification of the underlying programme theory (Chen, 2005; Pawson & Tilley, 1997; Weiss, 1997).

3.3.6. The implementation of Chen's guidelines for conducting a theory-driven outcome evaluation in the Child Support Group Evaluation Study

Chen (2005) directs attention to three guidelines in utilising a theory-driven outcome evaluation. He firstly refers to the establishment of a common understanding between the evaluator and the intervention developers of what theory-driven outcome evaluation is and what its purpose is. It guides questions to why the need of such an intervention, the steps that will be followed in the evaluation and the roles of each party in the evaluation.

In this study the researcher discussed her intention to utilise a theory-driven outcome evaluation with the intervention developers and the roles in the evaluation process of the researcher and the intervention developers were clarified. The steps of the evaluation as decided upon by the researcher and the intervention developers is summarised in Figure 3.3. Secondly, the clarification of the intervention developers' theory is an important step where the conceptual framework of the programme rationale is decided upon. The conceptual framework refers to the identification of the problem that has to be alleviated, the identification of the target population, the intervention utilised to affect the determinants, the determinants which will be focused on and the goals/outcomes intended to be achieved by implementing the programme. The programme rationale forms the underpinning for planning, it provides a communication medium and it forms a basis for outcome evaluation. The conceptual framework guides an evaluator in focussing on a change model (programme rationale), an action model (programme plan) or both.

The Child Support Group Evaluation Study focused on both a change and an action model in order to combine the outcome evaluation with the process evaluation. The conceptual framework of the Child Support Group Evaluation Study programme is based on the ecological systemic resilience theory underlying the manualised Promoting Resilience in Young Children Study and is summarised in Figure 3.4. The conceptual framework of the programme plan is summarised in Figure 3.5. Lastly, the construction of a research design and data collection method is indicated as an important guideline for conducting theory-driven outcome evaluation. According to Chen (2005) and Walshe (2007) the theory-driven outcome evaluation demands contextual information and therefore mixed-method data collection is indicated to generate a holistic view of a programme. The concurrent QUALquan nested mixed-method approach utilised in the Child Support Group Evaluation Study is described in paragraph 2.1.1., p.125.

Figure 3.4 Conceptual framework of the programme rationale: Child Support Group Evaluation study
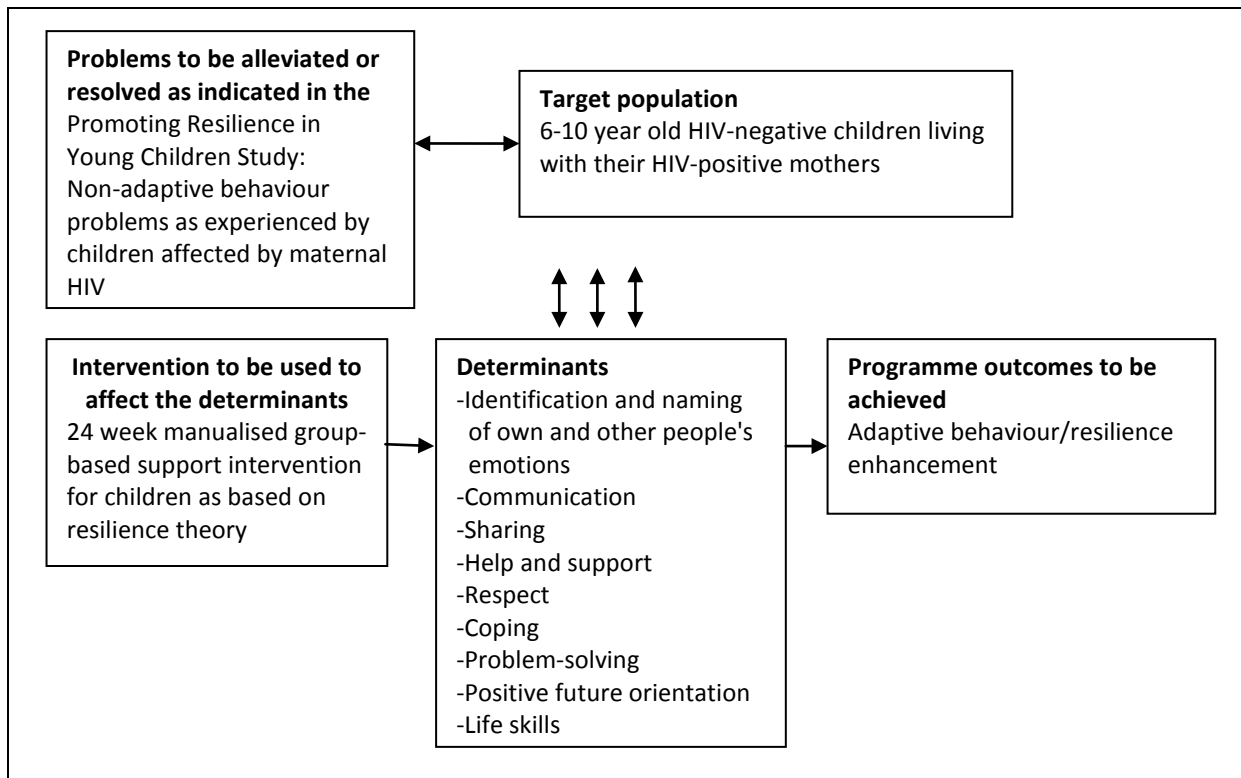
(Adapted from Chen, 2005, p.74).

The core of the theory-driven outcome evaluation is according to Chen (2005) "*the assessment of relationships among the intervention, the determinants, and the outcomes*" (p.240). The theory-driven outcome evaluation model utilised in the Child Support Group Evaluation Study is the integrative process/outcome evaluation approach. This approach involves the systematic assessment of the important assumptions underlying the programme implementation and the causal processes of the programme. This holistic assessment provides information on what works and does not work in the programme, ranging from implementation processes to causal processes to outcome effects. Chen (2005) proposes that the design of an integrative process/outcome evaluation has to consider the theory of the programme, multi-method data collection and analysis and the programme has to be characterised in its entirety and then by its parts.

Figure 3.5 Conceptual framework of the Child Support Group Evaluation Study programme plan
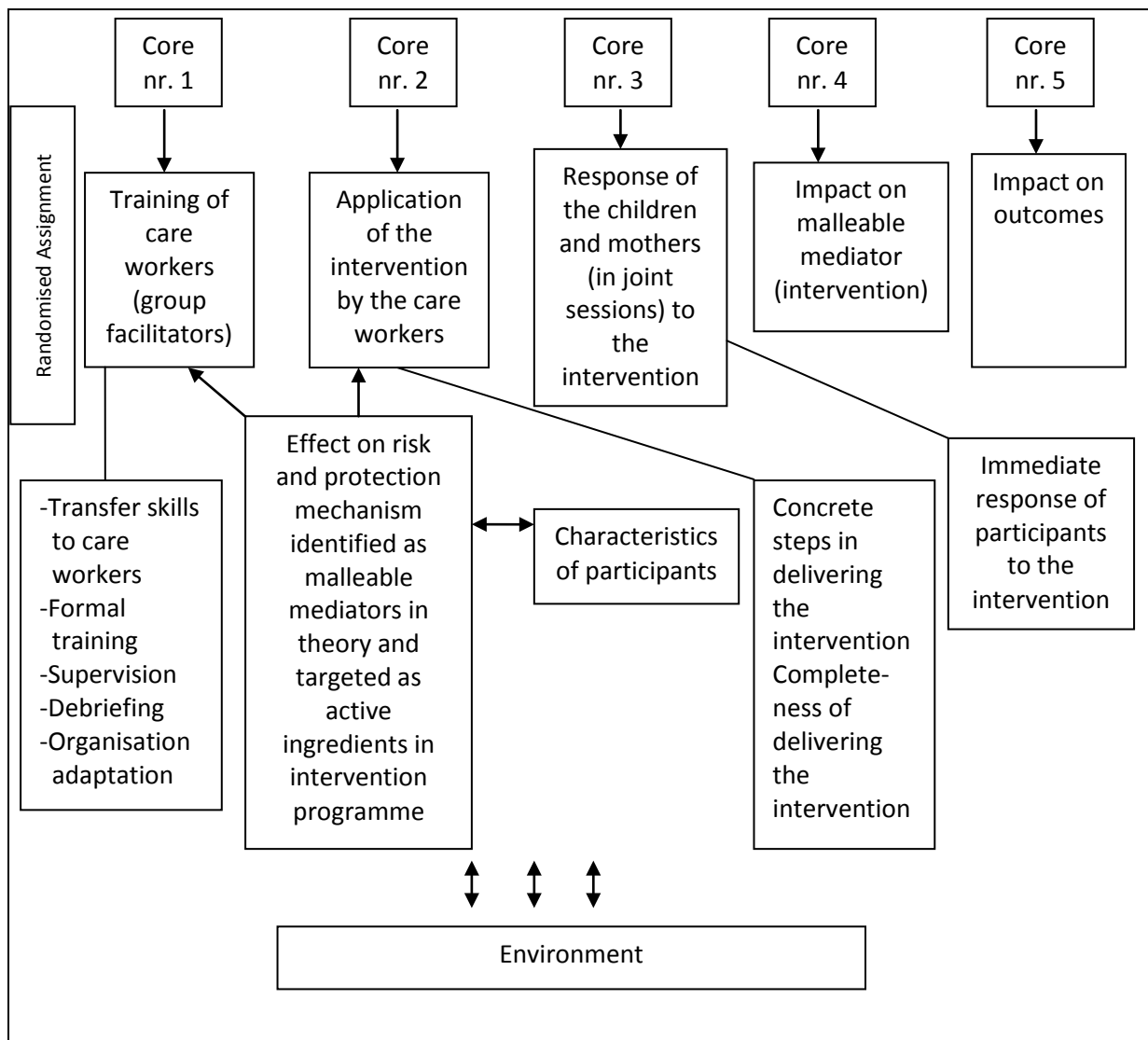
(Adapted from Snyder, 2006, p.54).

4. Research questions posed in the Child Support Group Evaluation Study

For this study the guiding research question is:

How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?

In order to answer the main research question the following quantitative sub-question is explored and guided the first of two quantitative approaches in the study:

A. **To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?**

The following qualitative sub-questions are examined to elucidate the critical aspects of this research:

B. **What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?**

C. **What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child?**

5. Participant selection and sampling procedure

The Child Support Group Evaluation Study is a direct result of the Promoting Resilience in Young Children Study and therefore reference is made firstly to the process of participant selection in the Promoting Resilience in Young Children Study and secondly to the process employed to select participants for the study. The Promoting Resilience in Young Children Study researchers purposefully selected the participants for the study and from this selection the researcher randomised the participants who received the intervention treatment.

The process of random sampling involves drawing a sample from a specific population in order for each member of the population to have an even chance to be selected. Random sampling methods have the ability to draw a sample from a population "*so that all possible samples of fixed size n have the same probability of being selected*" (Strydom & De Vos, 2001, p.193). The process of participant selection for the Promoting Resilience in Young Children Study involved HIV/Aids volunteer counsellors at clinics in Atteridgeville and Mamelodi.

The HIV/Aids volunteer counsellors identified HIV-positive women with children between the ages of 6 – 10 years. After the objectives of the study were explained to the HIV-positive women, they were asked if they and their children would be interested to partake in the Promoting Resilience in Young Children Study. A group of 440 HIV-positive mothers and their children were selected to take part in the resilience study.

The eligibility criteria for the children with HIV-positive mothers were:
- ✓ The child has a mother who is HIV-positive.
- ✓ The child is not infected by HIV him/herself.
- ✓ The child is between the ages of 6 – 10 years old.
- ✓ The child is cared for by his/her mother for at least 5 days a week.
- ✓ The child stays in Mamelodi or Atteridgeville area.

The HIV-positive women whose children complied with the above mentioned eligibility criteria received a pamphlet with information of the project and they were asked if their telephone numbers could be distributed to the Kgolo Mmogo research team. The mothers were assured of their confidentiality. The interested mothers were phoned by the research assistants (RA's) of the Kgolo Mmogo project and they and their children were invited to the Mamelodi or Atteridgeville site. The research assistants explained the project in detail to the mothers in their home languages and re-assessed the mother and child eligibility. The interested mothers were then asked to complete a consent form (refer to Appendix 3). The consent forms were translated into Sepedi, isiZulu, Setswana and Sesotho. The forms were read to the mothers and they also received a copy of the form. The mothers could voice their concerns and had the opportunity to ask questions regarding the project. The child was asked to sign an assent form after the mother indicated that she is willing to participate in the project with her child.

The child assent form (refer to Appendix 4) was composed to be child and culturally friendly and it was subsequently translated into the children's home languages. The research assistants explained the assent form and the project to the children. The children were given the opportunity to indicate if they wanted to take part in the project. Each mother and child pair received a unique KM identity number.

The randomisation process was explained to the mothers. A biomedical statistician applied a systematic sampling procedure where each mother and child pair had an equal chance to be selected for the sample. A computer probability programme was used to allocate the mother and child pairs to the treatment or no treatment groups. The project coordinator filled non-transparent envelopes with either 'interview only' or 'interview and group' cards by using the randomised tables as presented by the statistician. Only the project coordinator completed this task and the research assistants were not aware of the content of the envelopes. The KM researchers pre-decided that for each wave 30 participants (mother/child pairs) were selected where 15 pairs received the treatment and 15 pairs did not. Each envelope was marked from 1-30 and given to the mothers numerically. Each mother/child pair thus had an equal opportunity to receive the treatment or not.

A group of 440 HIV-positive mothers and their children were selected to take part in the Promoting Resilience in Young Children Study. 220 mother/child pairs received the treatment and 220 mother/child pairs did not receive the treatment.

The Promoting Resilience in Young Children Study sample was thus purposefully selected (refer to Figure 1.1) from the clinic and hospital population in Atteridgeville and Mamelodi. From the complete sample who received the group-based intervention the researcher **purposefully sampled** the data of children who were identified to receive the treatment for the current Child Support Group Evaluation Study. Purposeful sampling is a non-probability sampling method and evidence was obtained from participants whose experiences are of particular relevance to the study's research questions (Henry, 2009). The data of 163 children who received the intervention treatment and who attended the intervention groups were identified for the thesis study. A single-group pre-post-test design nested in a randomised controlled study was consequently adhered to.

6. Data-collection

The Child Support Group Evaluation Study included both quantitative and qualitative data collection. The **quantitative data** collected at two points, at baseline and 6-months, were analysed as well as the qualitative data gathered regarding the treatment or group support intervention programme.

A single-group pre-post-test design offered a comparison of the same group of children at baseline and 6 months intervals. The before and after design was a quasi-experimental design (refer to par. 3.2., p.139) and was indicated as the participants were purposefully selected from a randomised control trial population. The intervention duration of 24 weeks was sufficiently long for the intervention to make an impact on a child's life and to provide useful pre-and post-treatment data.

The **qualitative data** of the 12 groups receiving the Kgolo Mmogo group-based intervention as treatment (group session reports), the careworker observations, the mother and child quality assurance questionnaires and the careworker focus group data were used to qualitatively compare the pre- and post-treatment data. Both quantitative and qualitative data (refer to Appendix 2) of the 12 groups were collected in the study to address the possibility that other uncontrollable factors, which are not measured in a single-group pre-post-test design, may have an effect on the children's behaviour (Mark & Reichardt, 2009). These possible factors were taken into consideration when conclusions were drawn about the results and they were evaluated against the bioecological systems theory as discussed in Chapter 2. The large group comparison was another ameliorating factor to counteract for the variables that could not have been controlled for because the intervention was carried out in a real world context. Curtis, Gesler, Smith and Washburn (2000) indicate that qualitative sampling strategies have to adhere to certain criteria when applied to an evaluation study and the strategies utilised in the thesis study complied with this criteria. The sampling strategies have to be relevant to the conceptual framework (multiple case study design) and proposed research questions. The data collected in the Child Support Group Evaluation Study were suitable to answer the qualitative research questions. The sample has to be able to generate rich data about the phenomenon under investigation and in this thesis study it was about children's adaptive behaviour in support groups. The sample was able to contribute to the generalisability of the findings and produce explanations for the observed behaviour of the children. The sample strategy was feasible as secondary data were utilised and ethical strategies were applied throughout the Promoting Resilience in Young Children Study and the subsequent Child Support Group Evaluation study. The quantitative data and qualitative data that were collected for the Child Support Group Evaluation Study are summarised in Appendix 2. The researcher evaluated 12 groups with an average of 8 children in each group who received the treatment intervention.

7. Data analysis and validation procedures

Onwuegbuzie & Teddlie (2003) indicate that *"The point at which the **data** begins and ends depends on the type of data collected, which in turn depends on the sample size, which in turn depends on the research design, which in turn depends on the purpose"* (p.531). Data transformation is a process whereby the researcher may qualify the quantitative data in an effort to create factors or themes that can be compared with the factors and themes of the qualitative database (Creswell, 2003). The series of steps that have been taken to check the validity of the quantitative data findings were described in this study by describing the validity and reliability of the scores from past uses of the instruments utilised in this study and the internal validity of the single-group pre-post-test design. The qualitative data were scrutinised for accuracy by using triangulation procedures and detailed descriptions.

The data analysis section for this study are organised into three distinct phases (1) quantitative data collection findings and analysis followed by (2) qualitative data collection findings and analysis of individual participant's behaviour. The last section (3) presents the qualitative data collection findings and analysis of the group session data. Three distinct phases are thus explored in the study. The analyses utilised in the programme evaluation indicate how the qualitative findings helped to elaborate on the quantitative findings.

7.1. Quantitative phase (phases 1)

The quantitative data from the questionnaires were analysed using univariate and multivariate analyses (Kline, 2005). The results included descriptive statistics for all the variables and were summarised in the text and reported in tabular format. In the case of categorical data, frequencies and percentages were used. Means and standard deviations were used to describe continuous data (Makin, 2010). The research question "To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?" predetermined the choice of statistical test and analysis used in this evaluation study. The purpose of this phase of analysis was to evaluate if the Child Support Group intervention programme had an impact on children affected by maternal HIV/Aids.

The data were analysed to see if there were any changes in the dependent variable, the relationships between variables were looked at and the researcher attempted to determine whether it was the independent variable (treatment) that affected the dependent (adaptive behaviour) variable.

The proposed inferential statistical method identified for testing the research question and related hypotheses was the paired-samples t-test. The statistical test was conducted to compare the pre-test and post-test data in the first phase of the quantitative data analysis. A paired-samples t-test (or correlated groups t-test) is used when two observations and a within-groups design are available. The distribution of means when the sample standard deviation is used is called the t distribution (Dawson & Trapp, 2004).

All statistical analyses of the quantitative results were conducted using the Statistical Package for Social Sciences software (SPSS), version 20. In the quantitative phase of the Child Support Group Evaluation Study the following design effects may have had an impact on the validity of the impact of the assessments. The *stochastic effects* are the chance-produced fluctuations where it is difficult to decide whether a difference is large enough not to be attributed to chance alone (Rossi & Freeman, 1993). The researcher was aware of the possible stochastic effects that might have an impact on the data findings and she therefore utilised concurrent qualitative data to ensure that these errors are taken in consideration.

The researcher utilised instruments that are internationally reported on and where the validity and reliability scores are known in order to ensure measurement reliability and validity. She reported on each of the instruments validity and reliability scores as indicated in the scientific literature. The *Hawthorne effect* is also known as the placebo effect where the act of research in itself is an intervention. Every aspect of the Promoting Resilience in Young Children Study intervention delivery system was scrutinised and studied carefully for unexpected effects on the mothers and children participants. *Missing information* is another design effect that may bias the validity of the impact assessment. The missing data are clearly indicated in the data findings and dealt with appropriately to lessen the impact on the data analysis. *Sample design effects* might be reduced by choosing an intervention sample that is not biased and a reliable sample for the population it represents.

The study participants were chosen from a reliable sample of children who were affected by maternal HIV/Aids from the randomised controlled Promoting Resilience in Young Children Study. A further design strategy for isolating the effects of the extraneous factors is to use reflexive controls where targets who received the intervention are compared to themselves by measuring before and after the intervention. In following this guideline each child and mother assessment measure in the Child Support Group Evaluation Study was compared before and after the intervention treatment (Dawson & Trapp, 2004; Rossi & Freeman, 1993).

The reliability and validity of the instruments are of significant importance in quantitative research and in this study the researcher aimed to decrease the errors of possible measurement errors. The researcher took cognisance of the design effects such as possible missing data, the Hawthorne effect and sample design effects that could have had an impact on the validity of programme evaluation and took precautions such as utilising a pre- and post-test, various instruments measuring adaptive behaviour and triangulated data in the analysis of the data to limit the effects.

7.2. Qualitative phase (phases 2 and 3)

The text obtained through the interviews, documents and focus groups were coded and analysed for themes. In analysing the qualitative data, the researcher followed the steps as outlined by Creswell (2003) and Tesch (1990): The data were firstly organised and prepped for data analysis. The focus group data were transcribed, the field notes were digitally captured and the data types were arranged according to the source of information. The data were numbered using the wave and KM number of the participants to ensure that the text could be traced back to the original context. Secondly, the data were scrutinised and thoroughly read to obtain a general sense of the overall meaning. In this step the researcher familiarised herself with the data as presented to her. The third step included a detailed analysis where the coding took place by utilising labels. The fourth step entailed the generation of themes and categories and finally the data findings were interpreted, compared to the literature findings in Chapter 2 and assigned meaning. The themes of the emergent concepts were re-coded to establish improved defined categories. The collection of data continued until saturation was reached and the research questions could be answered.

Enumeration where qualitative data were quantified was applied to a sub-section of the qualitative data (findings regarding adaptive behaviour as set out in the objectives of the manualised intervention) [refer to Chapter 4]. The researcher made use of inductive analysis and deductive analysis in the study. She utilised deductive analysis to ensure that the data were consistent with prior assumptions and hypothesis (Thomas, 2006) as set out in the Promoting Resilience in Young Children Study and she used inductive reasoning to code and make interpretations from raw data (Thomas, 2006) as presented in the Child Support Group Evaluation Study.

In the qualitative data analysis it was important to establish credibility. In this qualitative design, the researcher sought credibility through utilising general strategies to enhance trustworthiness (refer to Table 3.5.). She hereby aimed to demonstrate that the methods she used in the study were reproducible and consistent. To validate the findings of this study the researcher used the following specific strategies as summarised in Table 3.6.

Table 3.5 General strategies to enhance trustworthiness in the qualitative phase of data-collection and data analysis

Strategy	Description
Triangulation. -triangulation of methods. -triangulation of people.	The usage of different information sources to collect data and to make inferences.
Respondent validation.	The participant is invited to examine the results and conclusions drawn for accuracy.
Use of thick, rich descriptions to report findings.	The reader is invited to take part in the study through an element of shared experience.
Description of researchers' bias.	Self-reflection creates an open and honest narrative.
Presentation of negative/contradictory information.	All perspectives cannot support and describe each other and therefore the report of contradictory information is necessary to enhance the trustworthiness of a study.
Peer group review and debriefing.	The researcher makes use of an external person to review the research process to enhance the accuracy of the data presented.
Use of an external reviewer	An external reviewer reviews and assesses the complete evaluation study.
Alternative records of data. (e.g., recordings, photos)	Accurate and relatively exhaustive records are ensured by utilising different data methods.
Language of participant: verbatim responses.	Verbatim responses in the language of the participant are captured.

Strategy	Description
Avoidance of selective usage of data.	All data are reported in a study to avoid false verification of findings.
Conclusions have to be supported by adequate evidence.	Over-generalisation and false conclusions are avoided by providing adequate evidence.
Avoidance of subjective interpretation.	The researcher ensures objectivity in subjectivity when the results are standardised and moderated.
Prolonged time spend in research field.	Quality time spend by the researcher in the research field to enable the researcher to provide an in-depth description of a phenomenon.

(Adapted from Creswell, 2003, Denzin & Lincoln, 2000; Denzin & Lincoln, 2005; McMillan & Schumacher, 1997).

Table 3.6 Specific strategies utilised in the Child Support Group Evaluation Study to enhance trustworthiness in the qualitative phase of data-collection and data analysis

Strategy utilised	Description
Triangulation. -triangulation of methods. -triangulation of people.	Data were collected from the careworkers, mothers and children. Different questionnaires for the mothers and children were utilised (refer to Appendix 2). A mixed-method study was employed as well as different data collection methods (refer to fig. 3.6.). A critical literature study further aimed to triangulate the data presented in the Child Support Group Evaluation Study.
Respondent validation.	The careworkers were given the opportunity to comment on the results and themes as presented in the study. The child and mother evaluation questionnaires gave an indication of their experience of the support sessions.
Use of thick, rich descriptions to report findings.	The participants' translated verbatim responses were used and the intervention environment of the participants was described in-depth.
Description of researchers' bias.	The researcher's self-reflection is an open and honest attempt at limiting bias and is presented in the research study.
Presentation of negative/contradictory information.	The researcher continuously attempted to report on the data as comprehensively as possible and through this endeavour aimed to report on negative or contradictory information.
Peer group review and debriefing.	The researcher continuously consulted members of the multi-disciplinary team who developed and implemented the child support group intervention.
Use of an external assessor.	Competent and experienced external reviewers who have knowledge of the child support group intervention assessed the thesis study.

Strategy	Description
Alternative records of data. (e.g. recordings, photos)	Cassette recordings and photos were utilised in the study.
Language of participant: verbatim responses.	The participants' responses were recorded verbatim and where necessary translated to English.
Avoidance of selective usage of data.	Data were not used to falsely verify findings. The external assessor/coder was of assistance in this regard.
Conclusions have to be supported by adequate evidence.	Conclusions were exclusively drawn from the data collected in the Child Support Group Evaluation Study.
Avoidance of subjective interpretation.	The questionnaires were standardised and the researcher made use of an external assessor/coder to avoid subjective interpretation. In addition, the researcher was not part of the intervention process for the past four years in order to lessen subjectivity.
Prolonged time spend in research field.	The researcher was the project coordinator for the Promoting Resilience in Young Children Study for five years and was part of the development of the intervention manual.

(Compiled by the researcher of the Child Support Group Evaluation Study).

De Vos (2001) furthermore describes the **triangulation process in programme evaluation** as a process where multiple methods are used to collect data. The use of multiple methods has the objective to increase the reliability of observations and as a result the evaluation in the context of the Child Support Group Evaluation Study.

The qualitative and quantitative data for the evaluation of the intervention programme were collected through multiple sampling strategies. The researcher utilised:

- Socio-demographic questionnaires (baseline and six-month follow-up information).
- Questionnaires of mothers describing their children's behaviour and development (baseline and six-month follow-up assessments).
- Children questionnaires where they were assessed for multiple factors relating to resilience or adaptive behaviour (baseline and six-month follow-up assessments).
- Session notes completed by multiple careworkers for each group session.
- Focus groups with group facilitators (careworkers and social workers).
- Group evaluation feedback forms (children and mothers).
- Observation (careworkers).
- Field notes (project coordinator).

The different data sampling strategies assisted the researcher in triangulating the data for improved evaluation reliability. Reliability was established by describing the approach and procedures used to analyse the data and it was justified in terms of appropriateness in the context of the study. Clear documentation and numbering systems were utilised in the process of presenting findings. A clear audit trail as suggested by Holloway and Wheeler (2009) was established in this process. In the literature study the researcher furthermore referred to external evidence from relevant studies to explore the nature of the correlative or casual relationships of the phenomenon under the research lens as prescribed by Bradly, Curry and Devers (2007). The researcher aimed to fairly and accurately present the data collected and thereby established validity. The impact of the design and approach on the results of the study were described. Inter-rater reliability was established through involving an external psychologist and epidemiologist to verify the consistency of findings. All cases were presented and specific deviant cases were indicated in data interpretations. The original data as recorded from different data sources and people were utilised to further enhance the validity of the study.

7.2.1. Crisis of representation

The researcher of the Child Support Group Evaluation Study takes cognisance of the crisis of representation of qualitative data findings. Stimpson (1988) describe representation as *"like every great word, 'representation/s' is a stew. A scramble menu, it serves up several meanings at once. For a representation can be an image – visual, verbal, or aural… A representation can also be a narrative, a sequence of images and ideas…or, a representation can be the product of ideology, that vast scheme for showing forth the world and justifying its dealings"* (p.223). The crisis of representation refers to the inability of a researcher to authentically convey the experiences of research participants in social science (Denzin & Lincoln, 2003). The final text is controlled by the researcher *"no matter how much it has been modified or influenced by the subject"* (Denzin & Lincoln, 2003, p. 617). It is not possible for a text not to bear traces of its author and to authentically represent a subject to accurately capture lived experiences (Sandelowski, 2006; Sparkes, 1995). The crisis of representation has a direct effect on generalisation practices where a general proposition on the basis of empirical findings are inferred and applied beyond the data it was based on (Dey, 1993). Qualitative data analysis is more "suggestive" than "conclusive" according to Dey (1993).

The identification of the context in which the inferences are made though "*can provide a key to elucidating the conditions under which a generalization can be expected to hold*" according to Dey (1993), p.271. The researcher of this study identified and comprehensively described the context of the group intervention and the participants in order to address the crisis of representation to the extent in which this was possible.

8. The Promoting Resilience in Young Children Study assessment battery (quantitative data-collection methods)

The quantitative instruments selected from the Promoting Resilience in Young Children Study assessment battery for the Child Support Group Evaluation Study are the Child Behavioural Checklist, Vineland Adaptive Behavior Scales- II, Child Depression Inventory, KidCope, Revised Child Management Anxiety Scale, Child Spiritual Coping Scale, BarOn EQ-i: Youth Version™ and Self-Description Questionnaire (refer to Appendix 2). The instruments were selected on the basis of their usefulness in measuring the variables relevant to the goals of the intervention group.

8.1. Administration of the Promoting Resilience in Young Children assessment battery

The questionnaires were translated into the mother and child's home language. The questionnaires were scrutinised and piloted to ensure cultural sensitivity. The research assistants had previous assessment experience and were furthermore trained by psychologists to administer the different questionnaires. They received specific training to assess children between the ages of 6-10 years. The research assistants read the questionnaires aloud to the mothers and children.

The mothers and the children could point to a bar diagram[4] to indicate their answers on the scales of the different questionnaires. The research team concurrently developed a concrete visual aid for the mothers and children to choose between the different scale options. Empty pill bottles were filled with seeds to indicate the values of the scales. The bottles were then placed in order according to their scale value. The participants could point to the bottle they felt portrayed their answer best (refer to Figure 3.6).

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[4] Refer to Appendix 5 for examples of the bar diagrams used in the Promoting Resilience in Young Children Study as visual aids.

Figure 3.6 An example of the concrete visual aids utilised in the Promoting Resilience in Young Children Study indicating scale values
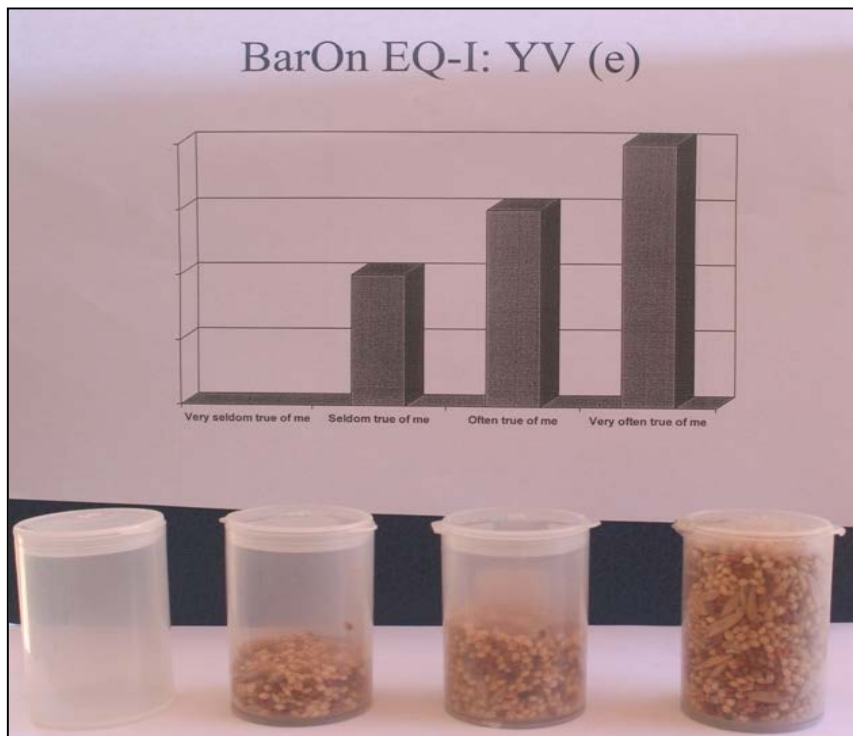
8.2. Translation process

The instruments that were identified to measure resilience in the Kgolo Mmogo sample were originally standardised for an English speaking population. The Promoting Resilience in Young Children Study received permission from the relevant test distributors to translate the English instruments to the languages spoken by the population in the study. The instruments were translated to Sepedi, Setswana, Isizulu and Sesotho. The Promoting Resilience in Young Children Study translated the instruments by adhering to strict rules of translation conduct. The English instruments were scrutinised by the research team and the research assistants who understand and live in the community the instruments were intended to be used in. After the instruments were confirmed to be culturally sensitive and in certain instances rephrased, the instruments were discussed with the careworkers in order to confirm the cultural sensitivity and the applicability of the questionnaire. The research team contracted a well-known translation firm to translate the questionnaires in the different languages. Another translator from the translation firm completed the back-translations of the questionnaires to English.

The back-translation procedure is the most commonly used method to evaluate the appropriateness of a translation according to Van Widenfelt, Treffers, De Beurs, Siebelink and Koudijs (2005). The back translation versions were verified by the project coordinator. The translated versions were discussed with all the role-players and after modifications the questionnaires were accepted as culturally sensitive and relevant for the intended population. The translated versions were used in a pilot study with 30 mothers and children to confirm the usefulness and cultural sensitivity of the instruments.

Snider and Dawes (2006) refer to the instances where items from standardised behaviour, anxiety and depression scales are adapted for developing countries such as South Africa. They caution that even with translational adaptation to fit the terminology, cultural and linguistic differences of the population the instruments are indented for, it is still difficult to distinguish if the participants really understand questions related to emotions and behaviour. The four local languages the instruments were translated to had for instance a smaller emotional vocabulary than the English language and this posed a further challenge for the translators. The question is asked if these instruments truly reflect the local understandings of well-being and distress. Swartz (2002) pointed out that the possibility of "*the impossibility of finding a perfect translation*" (p.41) had to be taken in consideration. Creswell (2009) therefore suggested that an external auditor is necessary to assure the overall validity of the research. The auditor has to be knowledgeable of the research setting and the language used. The research assistants and careworkers provided such valuable support.

8.3. Cross-cultural adaptability of quantitative measures

A concern the researchers faced in the Child Support Group Evaluation Study is that there were limited instruments standardised for the South African community available to measure resilience in children. Moletsane (2004) alludes in her study to the growing sensitivity surrounding cultural issues in assessment practice and research. She refers to the possible methodological difficulties that may be encountered when psychometric assessment is done cross-culturally. The absence of meaningful normative data for specific cultural groups is one such a difficulty. According to her, most tests used in South Africa are direct standardised adaptations of tests developed in the other countries. The cultural context of children requires specific attention in South Africa.

Hall and Maramba (2001) furthermore direct attention to the complexity a test developer face. There are many languages[5] the instruments have to be translated to and each language group has a different ethnic and cultural background that has to be taken into consideration to adhere to cultural fairness. Moletsane (2004) refers to a study with Zulu speaking children to emphasise this point. In this study it was shown that Zulu speaking children accepted instructions without questioning it, they learned through observation, the adult as authority figure was seen as important, the inquisitive child was seen as disrespectful, 'why' questions were not tolerated and passive learning was encouraged. This type of relationship between an adult (research assistant in the case of this study) may result in negative outcomes for the psychological assessment as the child may for instance not understand a question but because the child is not expected to ask questions will only answer to placate the adult asking the questions. They may also answer what they expect the adult wants to hear.

Leong, Qin and Huang (2008) caution that "*Measures of social and psychological constructs are usually culturally relative and their equivalence in meaning and application should not be assumed*" (p.66). They further proposed that selected instruments have to be evaluated to ensure that they are applicable for the intended cultural group. The researchers of the Promoting Resilience in Young Children Study aimed to adhere to the cross-cultural adaptability challenges by making use of a reputable translation company utilising translation and back-translation processes. The questionnaires were thoroughly scrutinised by the research assistants and peers in the community before the translation commenced and after the translation and back translation occurred. The research assistants and peers who stayed in the community knew the community values and were able to speak and understand the languages of the participants. The instruments were piloted on a sample of the intended study population. They were selected using the exact same exclusion criteria as the study participants. The research assistants were chosen as interviewers because of their prior experience as interviewers in the community and their knowledge of the cultures and languages. The research assistants could thus converse with the study participants in their home languages and could reduce misunderstandings due to language issues.

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[5] In the case of the Promoting Resilience in Young Children Study the instruments were translated from English to Sepedi, Setswana, Isizulu and Sesotho.

8.4. Child Support Group Evaluation Study – quantitative data collection methods

The quantitative measurements as collected in the Promoting Resilience in Young Children Study and selectively chosen to be utilised in the Child Support Group Evaluation Study could be divided in two categories. The first category included data as reported by the mother participants and the second category included data as reported by the children participants. Both data sets are hereafter described in detail.

8.4.1. Kgolo Mmogo Sociodemographic Questionnaire

The Kgolo Mmogo sociodemographic questionnaire was subdivided into two focus areas. The first focus area included the mother's description of the family's life circumstances and information related to her HIV-infection. The second focus area included information regarding the child's physical and developmental history and data referring to maternal HIV-disclosure.

8.4.2. Child Behavior Check List (CBCL)

The CBCL is a widely used and well-established 90-item (items selected according to international recommendations) checklist for school-aged children (school-age version 6-18 years). The measure has an international acceptable test-retest reliability (above *r >.80)*. It has internal consistency (broad domains alpha >.70) and is valid in detecting clinical significant behavioural and emotional problems in children. The checklist is designed to be user-friendly and to be utilised in assessing children in diverse settings. The mother reports behavioural and/or emotional problems of the child on this checklist. A three point scale is utilised with "0 = not true" and "2 = Very true". The items are summed to yield 8 syndrome scores and two broadband category scores (Achenbach, 1991) as indicated in Table 3.7. The Internalising T-score and the Externalising T-score were the only scores used in the paired-samples t-test analysis for this investigation.

Table 3.7 Child Behavior Check List (CBCL) categories

Broad band category scores	
Internalising problems	Externalising problems
Syndrome scores	
Withdrawn	Somatic complaints
Anxious/depressed	Social problems
Thought problems	Attention problems
Sleep problems	Aggressive behaviour

8.4.3. The Vineland Adaptive Behavior Scales – II Edition, Survey Form

The Vineland-II is a widely used, internationally normed measure to measure children's adaptive behaviour. The domains of the Vineland-II are indicated in Table 3.8.

Table 3.8 The Vineland Adaptive Behavior - II Scales: Domains and sub-domains

Domain	Sub-domain
Socialisation	• Interpersonal behaviour • Play and leisure activities • Coping skills
Daily living skills	• Self-care • Domestic skills • Community skills
Communication	• Receptive skills • Expressive skills • Writing skills
Motors skills	• Gross motor skills • Fine motor skills

The Vineland-II is a semi-structured interview conducted with the child's mother by a trained research assistant. The mother had to describe how her child performed on each activity specified and she had to give examples. The interviewer allocated a mark between 0-2 or don't know where 0= developmental task not reached and 2=developmental task reached. The Vineland-II has acceptable internal consistency (Chronbach's alpha >.80) and test-retest reliability (correlations >.80) (Sparrow, Balla, & Cicchetti, 1984; Sparrow, Balla & Cicchetti, 2005). The Vineland Survey Intervention Form was adapted for use in South Africa with the permission from the authors in 2006.

8.4.4. Child Depression Inventory (CDI)

According to Forehand et al. (2002) the CDI is best conceptualised as a measure of 'general distress' or 'negative affectivity'. Kovacs's (1980) CDI is a 27-item modification of the Beck Depression Inventory and designed for children. It is a self-report questionnaire where the child had to choose a sentence that describes him/her best for the past two weeks. The item choices have a numerical value assigned from 0-2. Each item contains a list of three statements. Each of the three statements signifies severity levels of a depression symptom. High scores on the CDI indicate high levels of depression. The CDI shows with acceptable two-week test-retest reliability (.60) and internal consistency (coefficient alpha .83) in a North American Study (Ialongo et al., 2004).

8.4.5. Kidcope

The Kidcope checklist is a 15-item brief self-report questionnaire to assess cognitive and behavioural coping strategies. The children had to choose a stressful situation or problem they recently encountered and then in reference to this situation or problem indicate whether they did employ certain actions and if the answer was yes they had to indicated to what extent it was helpful on a scale with 1 (not at all) to 3 (a lot). The Kidcope questionnaire yields two scales as indicated above: Frequency and Efficacy. The checklist provides valuable information and is relatively objective according to Pretzlik and Sylva (1999) as it was developed for paediatric patients and based on a theoretical framework. The checklist consists of four parts: the stressor as experienced by the child in his/her environment, the distress the child experience in relation to this stressor, the child's way of coping with this stressor and the helpfulness of this coping mechanism (Pretzlik & Sylva, 1999; Spirito et al., 1991). The results indicated on the validity studies according to Spirito, Stark and Williams (1988) are moderate to high. The coefficients range from .33 to .77 when the Kidcope was correlated with the commonly used coping scale, the Coping Strategies Inventory.

8.4.6. Revised Children Manifest Anxiety Scale (RCMAS)

The RCMAS measure was used to evaluate the anxiety levels of the children participants. The RCMAS is a 66-item self-report questionnaire with Yes and No responses.

The test-retest reliability of the RCMAS instrument is .68 and the internal consistency is acceptable according to international studies (Reynolds & Richmond, 1978, 1985).

8.4.7. Child Spiritual Coping Scale (CSCS)

Items from Boeving's (2003) Child Spiritual Coping Scale (CSCS) were used to assess the degree to which various types of religious coping methods were involved in dealing with stressors the participants faced. Participants responded to the 22-items of the CSCS on a 5-point Likert scale ranging from 0 (never) to 4 (always). The children had to name a stressor and indicate how much they use a certain coping mechanism and then in the second part of the question they indicate how much they felt it helped them to use this specific mechanism. The scale is divided into two subscales, Religious Coping and Existential Coping which is scored according to frequency and efficacy. The scale's internal consistencies have been internationally reported at alpha levels of .93 (religious subscale) and .86 (spiritual subscale).

8.4.8. BarOn EQ-i: Youth Version™

The BarOn EQ-i: YV™ self-reporting questionnaire was developed for children and adolescents between the ages 7 – 18 years for assessing emotional and social functioning. The short version comprises of 30 items and makes use of a four-point Likert-type response set (ranging from "Not true of Me" to "True of Me"). On the BarOn EQ-i: YV™ scales the higher scores are indicative of high emotional intelligence. The self-report measure gives an indication of a person's self-concept of how s/he copes with stressors (Mayer, Caruso, & Salovey, 2000). The questionnaire utilises the following sub-scales to measure emotional intelligence: Intrapersonal scale, Interpersonal scale, Adaptability scale (check) and Stress management scales. The BarOn-model utilised in the BarOn EQ-i: YV™ includes four dimensions with relevant sub-components (refer to table 3.9.). The positive Impression scale identifies individuals who wish to portray a better image. The Inconsistency index establishes if there are non-consequential answering styles on the questionnaire (BarOn & Parker, 2000). The BarOn EQ-i: YV™ is intended to measure different cognitive capabilities, competencies and skills influencing how a child copes with stressors from the environment (BarOn & Parker, 2000).

Table 3.9 The BarOn-model of emotional intelligence utilised in the BarOn EQ-i:YV™

Intrapersonal dimension. (self-consciousness and expression)	• **Self-regard**. Acceptance, understanding and consciousness of the self. • **Emotional self-consciousness.** Consciousness and understanding of own emotions. • **Assertiveness.** The non-destructive ability to give expression to own emotions. • **Independence.** The ability to depend on own abilities and not to be emotional dependent on other people. • **Self-actualisation.** The ability to set goals and the motivation to reach it.
Interpersonal dimension. (social awareness and interpersonal relationships)	• **Empathy.** The ability to be aware of other's emotions and to understand their emotions. • **Social responsibility.** The ability to identify and to feel part of a social group. • **Interpersonal relationships.** The ability to initiate and to maintain satisfactory relationships with other people.
Adaptability dimension. (coping with change)	• **Reality testing.** The ability to validate own emotions and external reality. • **Flexibility.** The ability to cope with daily changes. • **Problem-solving.** The ability to generate effective solutions for personal and social problems.
Stress management dimension. (emotional coping and regulation)	• **Stress toleration.** The ability to manage emotions effectively. • **Impulse control.** The ability to manage emotions constructively.

(Adapted from BarOn, 2003, p.15 ; Finestone, 2005, p.59).

The BarOn EQ-i:YV™ is based on the BarOn model of emotional and social intelligence and it forms the theoretical basis for the questionnaires. The BarOn model assume that emotional intelligence is the ability of a person to understand him/herself, to understand others, to adapt to different life circumstances and the ability to control emotions (BarOn & Parker, 2000; Finestone, 2005).

The BarOn EQ-i:YV™ was not standardised on a South African population and the study received permission from the South African test distributor, Jopie van Rooyen and Partners and from the international distributor Multi-Health Systems inc. to translate the questionnaires adhering to the prescriptions as explained in paragraph 8.2., p.161.

The internal consistency was measured using Chronbach alpha-coefficients in a North American sample and fluctuated between 0.76 and 0.90. The average inter-item correlations in the study sample supported the internal consistency of the BarOn EQ-i:YV™. The sample's test-retest reliability coefficient scores fluctuated between 0.77 and 0.89 and indicate test-retest reliability for the BarOn EQ-i:YV™ scales.

8.4.9. Self-Description Questionnaire (SDQ)

The SDQ is a multi-dimensional self-concept instrument developed by Herbert Marsh (Marsh, Craven, & Debus, 1998). It consists of 40 items and has a yes, no or 'child understands but does not state yes or no' scale. The 'no' answer has a 'no always' or 'no sometimes' response and the 'yes' answer has a 'yes sometimes' or 'yes always' response. The measure has been validated in North American population sample and show reliability (generally greater than .80) (Leach, Henson, Odom, & Cagle, 2006).

9. Child Support Group Evaluation Study – qualitative data collection methods

The qualitative data collection methods included the child and mother evaluation feedback forms, session reports for the child only groups and the mother and child joint groups, focus group interviews with the careworkers and the social workers, observations of the care-workers and observations of the project coordinator.

9.1. Child and mother group evaluation feedback forms

The children completed an evaluation feedback form (child perception of group[6]) during their 6-month follow-up interview. The research assistants read the questions to the children and the children had an opportunity to ask for further help in answering it.

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[6] Refer to Appendix 6 for Child Perception of Group – evaluation form.

The first part of the self-report evaluation feedback form (child perception of group) comprises of 11 items and makes use of a four-point Likert-type response set (ranging from "not true" to "very true"). The response set is illustrated with smiley typefaces to help the children interpret the scale response set. The second part of the evaluation form comprises of open-ended questions regarding the children's experience of the support group sessions and their experience of their mothers being part of the mother-child joint sessions in the support group. The questions regarding the mothers' participation in the group focused specifically on communication and interaction.

The mothers completed an evaluation form[7] regarding their experience of the support sessions. The evaluation feedback form focuses on their experience of their separate group sessions and two open-ended questions focus explicitly on their joint mother-child support sessions referring to parenting and their experience of their child's behaviour after s/he completed the support sessions. The Child Support Group Evaluation Study utilises the two questions focussing on the mothers' description of how they experience their parenting and their children's behaviour. The evaluation form was translated (refer to par. 8.2., p. 161) and the research assistants asked the questions to the mothers during their 6 months follow-up interviews.

9.2. Group session reports[8]

Documentary resources are important to provide evidence and to cross-validate information gathered from focus group interviews and observations (Noor, 2008). The corroboration of multiple qualitative measures enhances the validity and reliability of the Child Support Group Evaluation Study. The group session reports consisted of forms that the careworkers completed after each of the 24 sessions. The two group facilitators filled out the session reports independently from each other to guard against bias. The social workers and project coordinator discussed the group session reports during weekly meetings. On the group session report the careworkers indicated the number of group members who attended and their KM ID numbers were used to ensure confidentiality. Reasons for absence and amount of participation were indicated on the form.

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[7] Refer to Appendix 7 for mother evaluation form.
[8] Refer to Appendix 8 for an example of the group session report form.

The content discussed and/or practiced during the specific session was listed and the careworkers specified whether each of the objectives were reached in the group and to what extent. The session reports further entailed open-ended process notes where the careworkers gave their opinion on the session goals reached; interaction and communication; facilitator observation; other/unexpected topic; problems and concerns; notes and other issues or observations. The session reports were divided into the child only support session reports and the mother-child joint group session reports. The format for the session report is similar for both types of group sessions.

9.3. Focus group interviews

Focus groups are cost effective as they allow collection of data from a group of people in a short time frame. The project coordinator was able to communicate directly with the careworkers and clarification and probing of responses were possible. Rich contextual data to understand the depth and dimensions of interventions with children and their families as recommended by Brotherson (1994) were presented in the focus groups as the questions were open-ended. The careworkers were able as a group to build on each other's responses and the group was flexible in their topic discussions as suggested by Stewart, Shamdasani and Rook (2009).

After the end of each wave the careworkers and social workers were invited to take part in focus group interviews. A focus group interview also took place after completion of all 12 wave group sessions. The research coordinator asked the careworkers to report on what worked well in the group; what didn't work in the group; whether or not they felt the support sessions were effective in reaching the main objective of helping children to develop resilience; what could change in the group/group sessions; how they experienced the sessions and any other observations or comments. The social workers were involved in the group sessions and discussions of the session reports and therefore were invited to join the focus group interviews. The sessions were tape recorded with the permission of the careworkers for further analysis.

9.4. Observation by careworkers

The careworkers' observations were guided by a pre-designed questionnaire focussing on adaptive and non-adaptive behaviour. They also used a template for the group session observations and a laminated cue card indicating the main objectives of the support sessions to direct their observations. They discussed their observations after each group session in a meeting with the project coordinator and the social workers. During these sessions the care-workers observations were examined in detail and explored further if it was deemed necessary. Referrals were additionally made to appropriate organisations if a need therefore was identified.

9.5. Observations by project coordinator

The researcher analysed the qualitative data alongside the randomised control trial data of the Promoting Resilience in Young Children Study. The project coordinator was involved in the planning phase, the training phase, the data collection phase, the intervention phase and dissemination phase of the study. She made use of detailed guidelines to structure the data collection and analysis as proposed by Bickman and Rog (2009) as the different aspects of the study were complex. She kept a record of her observations during the different phases of the research project.

10. The intervention setting

The design of the Promoting Resilience in Young Children randomised controlled study required two sites for the planned interventions in Atteridgeville and Mamelodi. The two townships are situated in Gauteng, South Africa. Two sites were chosen in order to control for community variable effects on the intervention. The settlements are situated approximately 40 kilometres from each other. Mamelodi is situated about 20km East of Pretoria and comprises of 10732 hectares of land. The population approximates one million residents (www.saweb.co.za/township/tshwane/mamelodi.html). Atteridgeville is a smaller community but a highly populated area with approximately 200,000 residents (www.saweb.co.za/township/tshwane/atteridgeville.html). The township is situated south west of Pretoria and comprises of about 5.16 km^2. Both townships have mixed housing types for different economic groups.

The types of housing includes informal settlements (generally poor free standing shacks made of poor quality building material such as plastic and corrugated iron) , free standing detached and semi-detached housing and backyard shacks.

The Mamelodi site (refer to Fig. 3.7 A) was situated in Mamelodi West on a main taxi route. The building used for the intervention was separate from the other buildings utilised by a church group on the premise. Three rooms were allocated to the mothers and the two children groups (older and younger child groups). The two children group rooms were painted in bright colours and they were decorated in a child-friendly manner. The older child group room was big enough for 15 chairs and tables. A large kitchen was part of the building and an outside play area was available to the children. The facilitators had to supervise the children at all stages as the gate to the main road was near the group rooms. The interviews for both the mothers and children took place at a nearby clinic in temporary offices.

Figure 3.7   Mamelodi intervention site (photo A) and Atteridgeville intervention site (photo B)[9]

The Atteridgeville intervention site (refer to Fig. 3.7 B) was on the premises of a hospital in Atteridgeville and functioned independently from the hospital. The site was near Immunology and other clinics in the area where the mothers went for their HIV/Aids check-ups. It consisted of an abandoned four-floor building that was cleaned-up for a previous project (Serithi project).

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[9] Participants' eyes are blotted out on the photo to ensure anonymity. Permission to use the photo was obtained from the participants' mothers.

The building was painted in bright colours and a more child-friendly atmosphere was created for the Promoting Resilience in Young Children Study project. Educational toys and books were collected from outside organisations for both the Atteridgeville and Mamelodi intervention sites. Three dedicated group intervention rooms were allocated to the mothers, children (aged 6-10 years) group and the smaller children group. All three rooms were large enough to be fitted with chairs and tables for a group of 15 participants and leaving enough space for activities requiring a larger area. A big outside area was available for the children where they could play. The interviews took place in separate child-friendly offices in the same building. A large kitchen area was part of the building.

11. The Promoting Resilience in Young Children Study intervention programme

The Promoting Resilience in Young Children[10] intervention programme was developed in collaboration with a team of child development experts from the University of Pretoria and Yale University. This theory based intervention was developed after a meticulous study of the most recent advances in the study of resilience. The cultural environment of the South African child and the children's developmental level were also taken into consideration (Forsyth, 2005). The content was discussed with advisors in the community to ensure that the content is culturally sensitive and relevant to the community.

11.1. Pilot phase of the Promoting Resilience in Young Children Study intervention programme

The Promoting Resilience in Young Children Study programme was piloted for two consecutive waves[11] at the Atteridgeville setting with a group of children and their HIV-infected mothers who were randomly selected from the community and who were fitting the pre-selected criteria. The group facilitators for the pilot study were four Master students in the field of counselling psychology. They were observed, shadowed and supported by the careworkers who were selected to later facilitate the full study intervention programme.

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[10] The Promoting Resilience in Young Children Study was also referred to as the Kgolo Mmogo intervention study by the care workers and the participants.
[11] In reference to this thesis study a wave refers to a group of children who were randomised to the intervention study group and who received 24 intervention sessions.

The project coordinator and the students' supervisor who are both psychologists attended all the sessions in order to evaluate the group process and content. After each session a group discussion was scheduled and the facilitators and observers examined the process and content of the previous session. The facilitators further completed an exhaustive group evaluation form for every session in order to measure the session outcomes.

Recommendations that emerged after the completion of the children intervention programme pilot were the following:

a) Facilitator (careworker)

- Two co-facilitators per session were recommended.
- The facilitator had to be knowledgeable in the field of child development and resilience.
- The facilitator had to be fluent in the local vernacular.
- If HIV-positive, the facilitator had to have dealt emotionally with her own HIV/Aids diagnosis.
- The facilitator had to be able to discuss issues related to HIV and in specific be able to give guidance during the 'Creating a family legacy' session.
- The facilitator had to have knowledge of group processes and group facilitation.
- The facilitator had to have basic knowledge of child behaviour and to identify behaviour that was not expected of a well-adapted child.
- The facilitator had to know how to support a child experiencing difficulties (accommodation within the group and referral procedures).
- The facilitator had to be trained in the content of the sessions and execution of the activities.
- The facilitator had to be trained in observation skills and completion of the group evaluation form.

b) The group process

- The full intervention length had to be shortened to 24 sessions (24 weeks).
- The session length had to be shortened (60-75 minutes).
- Full lunches had to be served as a small snack was not enough for a child who was in school the whole day - a small snack directly from school was necessary.

- Transport money had to be increased as the taxi fees in the community increased.
- Mothers had to be phoned before every session to remind them to bring their children to the sessions.

c) The manual content[12]

- Certain content in the manual needed revision. The emotions board game had to be revised where there were references to fairies and magicians. In the community where the intervention took place fairies and magicians were seen as very unfavourable. They were equated with witchcraft.

- The references to HIV/Aids in the emotions board game had to be dealt with carefully in order not to disclose a mother's status without her permission. It was suggested that not all the references were removed from the board game as it was a prevalent problem, but that the children had be guided in understanding that the questions have relevance to the whole of the society and not just on their own environment.

- Some of the stories selected for the manual had to be changed as the children were not able to relate to the stories. The stories were changed with animal stories.

- Some of the content had to be made more practical for the children to understand the underlying message e.g., the future train/taxi. The children have to act out the imaginary exercise in order to understand.

- Some of the content in the sessions were too difficult for the children to understand and the content had to be changed to fit the child's level of understanding.

- In the pilot phase the memory box activity was explained to the mothers as a way to leave a tangible memory for their children. The mothers experienced the activity as emotionally draining and the facilitators reported that the mothers voiced their distress. In the main intervention study the memory box activity was explained as a family legacy and that every parent no matter their HIV status had to leave something behind for their children. In this instance it was a memory box where they could include songs, letters and other important information.

- Some of the joint sessions had to be split in two groups, but only for a part of the session and not the whole session to keep with the group cohesion.

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[12]Refer to Appendix 9 for the materials needed for the intervention programme.

- The sessions in the manual for the children had to be shifted in order to be more aligned with the mothers' group sessions. This allowed for the mothers and children to do homework together.

d) The group setting

- The children's group had to have a large room for activities.
- The children's group had to have access to an outside playground for some of the activities in the manual.
- The sessions had to be conducted in an area central in the community because the children had to travel to the venue after school.

The two pilot sessions were conducted concurrently and they were completed in a six- month time frame. The manual was developed over a period of one year and it was finalised after the completion of the pilot studies. The manual went through a process of several changes and four drafts. All the role players in the development of the manual had an opportunity to give their opinions and suggestions before the final version was drafted.

11.2. Design and content of the Kgolo Mmogo group-based intervention programme

The Kgolo Mmogo Intervention programme for children was conducted at the same time the mothers attended their intervention sessions. The Kgolo Mmogo Intervention programme for mothers was drafted on the programme developed for mothers in the Serithi project[13]. The individual mothers' sessions were adapted to the outcomes envisaged for the Kgolo Mmogo project that are:

- Empowering women living with HIV to have knowledge in order to make better choices for them and their children.
- Empowering women with knowledge and skills to enable them to assist their children to become more resilient.
- Empowering women to improve their relationships with their children and partners.
- Advocating the right of people living with HIV.
- Reducing stigma.
- Providing support and a referral system for women.

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[13] The Serithi project refers to a previous NIH-funded study at the Atteridgeville site concerning prevention of mother to child HIV transfer (PMTC).

The mother and children sessions were matched to a large extent to ensure there is transferral between them[14]. The first 14 sessions were sessions where the children and their mothers were attending the group together but in separate sessions. The following 10 sessions were joint sessions where the mothers and children had the opportunity to share their life worlds with each other. Additionally there was a group for children under the age of five years during the same time of the above groups in order for the mothers to bring their younger children to the intervention. The mothers indicated that it was difficult for them leaving the younger siblings at home because there were no caregivers at home.

The current thesis study focuses exclusively on the evaluation of the 24 sessions the children attended. The content of the programme for the children's sessions are therefore fully described in the following section.

11.2.1. Design and content of the Kgolo Mmogo intervention programme manual for children

The Kgolo Mmogo resilience intervention programme was developed for young children affected by maternal HIV-infection. The intervention was designed on a precise rationale: it was motivated by evidence that (a) Sub-Saharan Africa has the highest HIV-infection in the world and (b) children of HIV-infected mothers are at high risk to experience various problems such as anxiety, depression, social withdrawal, learning problems, attention deficits (Korneluk & Lee, 1998; Lichtenstein, Sturdevant, & Mujumdar, 2010; UNAIDS, 2009). An intervention that supported mothers and children affected by HIV was therefore deemed as appropriate.

This intervention was grounded in a systematic review of accrued evidence on compelling vulnerability and protective processes that tend to modify the effects of maternal HIV-infection. The intervention was developed to improve children's maladaptive patterns as well as to build their strengths. Attention to developmental issues was reflected in the focus on children between the ages of 6-10 years who were developmentally at a latent-phase.

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[14] Refer to Appendix 10 for a content summary of the mother and children intervention sessions.

On the evidence presented on significant vulnerability and protective processes, an intervention was developed by a team of psychologists specialising in the field of child psychology and resilience. The following treatment goals were set as targets: enhancement of adaptive behaviour and reduction of non-adaptive behaviour. The intervention entailed 24 weekly sessions and was led by careworkers from the community. Careful attention was given to documentation and to ensure treatment fidelity the sessions was carefully monitored by a psychologist and a social worker. Before and after treatment assessments were completed by the child and the mother. The multi-method, multiple informant assessment batteries assessed several hypothesised vulnerability and protective factors, as well as possible child behavioural outcomes.

The Kgolo Mmogo Intervention children sessions were developed in order to enhance the resilience of children and subsequent adaptive behaviour. The mothers' HIV statuses could not be disclosed to the children by the intervention team and therefore the content sessions were focussing on resilience and not on HIV *per se*. The content for the intervention programme was selected purposefully and all the sessions had to implement the following themes:

1) Coping.
   a. Coping with stress.
   b. Coping with life challenges.
   c. Engaging with stress in an adaptive manner.
2) Optimism.
   a. To reinforce children's positive behaviour.
   b. Encourage optimistic and hopeful statements and behaviours.
   c. Encourage positive future perspectives.
3) Emotional Intelligence.
   a. Naming and identifying emotions.
   b. Appropriate expression of own emotions.
   c. Appropriate responses to other's emotions.

4) Social Skills.

   a. Reinforce appropriate social skills demonstrated in the sessions.

      i. Sharing.

      ii. Communication.

      iii. Support of peers/group members.

5) Identifying meaning and purpose.

The facilitators received a laminated cue card that they had to keep with them during the session in order for them to remember the resilience characteristics to facilitate and encourage during the group sessions.[15] The average session length was indicated as an hour and a half and this excluded the time spent having lunch.

The 'climbing up and down the tree' and 'feeling thermometer' exercises were done in each of the fourteen individual sessions. The 'climbing up and down the tree' exercise was chosen as a tradition to mark the beginning and ending of every session and to link all the experiences of the group to a shared symbol. Each group chose their own routine and sequence. The 'feeling thermometer' exercise was chosen in order to identify, share and verbalise feelings of the group members. The group members indicated before every session started on a 'thermometer' with smiley faces how they felt at that particular moment.

Homework was included in the child sessions where the mothers had to help their children to complete the tasks. The aim was to enhance the mother and child communication and to extrapolate new skills taught in the support group to the family.

The mothers and children received a fully cooked, balanced meal after each group session. The careworkers, mothers and children ate together and they helped to clean the kitchen after lunch. The careworkers and the social workers prepared the food for the groups[16]. The mothers and children additionally received transport money after each group session. The amount of transport money differed depending on how far the mothers and children had to travel to the group sites.

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[15] Refer to Appendix 11 for 'Important resilient characteristics to facilitate and encourage' observation cue card for group facilitators.
[16] See Appendix 12 for an example of the lunch menu.

The manual utilised in the Promoting Resilience in Young Children Study and evaluated in the Child Support Group Evaluation Study is summarised in Table 3.10.

Table 3.10   A summary of the manual used in the Promoting Resilience in Young Children Study

Child Separate sessions 1-14		
Session number	**Goals of session**	**Programme**
Session 1 Introduction, orientation and relationships of trust	1) General understanding of function of support groups and aim of study 2) Discussing and deciding upon group rules (emphasis on confidentiality) 3) Understanding the role of facilitator in the group 4) General understanding of content of group sessions	• Welcome • Climbing down the tree exercise • Name of the game – ice-breaker • Introduction • Setting up of group rules • Introducing the feeling thermometer and setting it up • *Break* • Activity 1 – Blind walk with directions or alternatively Blind snake game • Ending: What was today about? • Climbing down the tree exercise No homework indicated for session 1.
Session 2 Developing relationships within the group "Let's get to know each other"	1) Building trust in the group 2) Sharing general information with the group 3) Experiencing group dynamics 4) Showing respect for peers	• Welcome • The feeling thermometer • Climbing down the tree exercise • Tennis ball – game ice-breaker • Activity 1 – The falling game • Discussion • *Break* • Activity 2 – Making a feel-good quilt • Discussion • Ending: What was today about? • Climbing down the tree exercise No homework indicated for session 2.
Session 3 Describe self and self in family: "Who am I?"	1) Exploring and describing own self 2) Describing the family environment 3) Identifying the roles in a family 4) Identifying own role in a family 5) Discussing how the child's viewpoint of how other family members experience him/her 6) Identifying the importance of oneself in the family	• Welcome • The feeling thermometer • Climbing down the tree exercise • People sorting – game ice-breaker • Activity 1 – Body mapping • Discussion • *Break* • Activity 2 – My family exercise • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: The children must show their mothers their drawings.
Session 4 Describe self and family within community "My community"	1) Identifying the roles in a family 2) Discussing the importance of a family 3) Exploring the values and central aspects of a community	• Welcome • The feeling thermometer • Climbing down the tree exercise • The penguin game - ice-breaker • Activity 1 – The little hare story

	4) Identifying assets 5) Identifying values	• Activity 2 – Asset map exercise • *Break* • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: Make a list of assets in their environment and ask their mothers for help.
Session 5 Identify strengths within self "What do I look like? I have, I am, I can!"	1) Identifying strengths 2) Identifying weaknesses 3) Discussing the concept of being strong 4) Practicing and discussing coping skills 5) Practicing asking for help	• Welcome • The feeling thermometer • Climbing down the tree exercise • Wool web - ice-breaker • Activity 1 – The story of Little Peter Bear • Discussion • *Break* • Discuss own strengths • Activity 2 – Draw own strengths • Activity 3 – Masekitlana[17] • Ending: What was today about? • Climbing down the tree exercise Homework: Ask mother to help him/her to identify personal strengths.
Session 6 Identify coping that is linked to strengths identified "What can I do/ what am I good at?"	1) Coping in difficult situations using with own strengths and abilities 2) Resolving problems 3) Being taught values 4) Coping with stressful situations	• Welcome • The feeling thermometer • Climbing down the tree exercise • Breathing exercise - ice-breaker • Activity 1 – Same and different • Discussion • *Break* • Activity 2 – Strengths exercise • Discussion • Activity 3 – Puppet play (scenarios) • Ending: What was today about? • Climbing down the tree exercise Homework: Show mothers their body maps and discuss their strengths as pasted on the body maps with them.
Session 7 Problem-solving: "How can I do it?"	1) Identifying of problems (at school and at home) 2) Discussing and practicing the effect of consequences of decisions 3) Identifying where to begin when looking at problems (things you have control over and things you can't control) 4) Recognising that some problems do not have a good solution 5) Exploring the value of sharing problems with others	• Welcome • The feeling thermometer • Climbing down the tree exercise • Decisions and consequences – ice-breaker • Activity 1 – Using picture cards - 'The man in the hole' • Discussion • *Break* • Discuss own strengths • Activity 2 – Using picture cards – 'The fire' • Discussion • Activity 3 – Role play • Discussion • Ending: What was today about?

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[17] Masekitlana is a traditional game played with stones. The game is also known as the "talking stones game". The child bangs stones together while he/she tells a story of his/her life. While 'talking with the stones' they act out roles in the family and real life experiences (Kekae-Moletsane, 2008).

		• Climbing down the tree exercise Homework: Children must tell their mothers 'The man in the hole' story.
Session 8 Protecting self and identifying boundaries "Protecting myself"	1) Discussing personal safety 2) Identifying unsafe situations 3) Discussing and practicing actions to take if in an unsafe situation 4) Discussing how to protect one self 5) Exploring and discussing children's rights	• Welcome • The feeling thermometer • Climbing down the tree exercise • The safe place - ice-breaker • Activity 1 – The children's charter • Discussion • *Break* • Discuss own strengths • Activity 2 – Don't talk to strangers - board game • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: List all the important telephone numbers and ask mothers for help (contact details of parents, ambulance, police etc.).
Session 9 Social skills "Socialising with peers"	1) Communication skills 2) Being taught accepted behaviour in a group for e.g. sharing 3) Building of friendships 4) Exploring the different roles in a group 5) Showing respect for self and others 6) Exploring values 7) Being taught what is acceptable behaviour in a group and how to gain approval in a group	• Welcome • The feeling thermometer • Climbing down the tree exercise • Ring and string - ice-breaker • Activity 1 – Metaphorical story 'The Lion, Hyena and Tortoise' • Discussion • *Break* • Activity 2 – Social links • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: Must make new friend using the skills practiced in the session. Opportunity to share the experience with the rest of the group at following session.
Session 10 Identifying emotions (focus on self) "How do I feel?"	1) Identifying own emotions 2) Being taught how to express emotions 3) Being taught all emotions are acceptable but not all behaviour 4) Practicing and identifying verbal and non-verbal communication cues and skills	• Welcome • The feeling thermometer • Climbing down the tree exercise • Emotion dice - ice-breaker • Activity 1 – If you are happy and you know it - song • Discussion • *Break* • Discuss own strengths • Activity 2 – Emotions - board game • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: Mothers give homework (homework discussed with mothers in mother support group).
Session 11 Identifying emotions	1) Identifying other people's emotions by making use of cues such as words, body language and	• Welcome • The feeling thermometer • Climbing down the tree exercise

(focus on others and communication) "How do others feel?"	facial expressions 2) Identifying persons with whom emotions can be shared 3) Different ways of responding to emotions of other people 4) Become skilled in ways to cope and regulate own emotions	• Broken telephone - ice-breaker • Activity 1 – What am I doing? • Discussion • *Break* • Activity 2 – Puppets • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: Identify life skills that children want to demonstrate at next week's session e.g. how to wash dishes, how to make food, how to make tea etc.
Session 12 Survival skills "Look and learn"	1) Identifying primary tasks in the home environment 2) Showing responsibility 3) Learn the importance of tasks 4) Demonstration of tasks 5) Discussion of learning of safety rules 6) Discussing survival strategies 7) Discussing the importance of helping others	• Welcome • The feeling thermometer • Climbing down the tree exercise • On a ship - ice-breaker • Discussion • *Break* • Activity 1 – Showing a specific skill • Discussion • Activity 2 – 'What if?' – game • Activity 3 – Masekitlana (refer to session 5) • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: Children demonstrate tasks for mothers learned in session 12 and feedback in session 13.
Session 13 Survival skills (Part 2) "Let's practice our skills"	1) Exploring what is survival skills 2) Practicing a survival skill (cooking) 3) Planning for the future 4) Taking care of others 5) Experiencing sense of efficacy and accomplishment 6) Practicing social skills	• Welcome • The feeling thermometer • Climbing down the tree exercise • Feedback on previous sessions • Activity 1 – How to make my own soup? • *Break* • Activity 2 – How to grow a potato seed man? • Discussion • Ending: What was today about? • Climbing down the tree exercise • Dishing up the soup and having lunch Homework: Water and take care of 'potato head' man/woman. Bring with to session 14.
Session 14: Identifying meaning, purpose and future orientation "Let's live life"	1) Learn the importance of caring for others 2) Learn how to ask for guidance and help 3) Setting goals for the future 4) Learning how to deal with difficult situations 5) Sharing dreams for the future	• Welcome • The feeling thermometer • Climbing down the tree exercise • What was the most important lesson I learnt in the group? - ice-breaker • Activity 1 – The future train/taxi • *Break* • Activity 2 – End game • Discussion • Ending: What was today about? • Climbing down the tree exercise

| | | • Have a party |
| | | Homework: No homework indicated for session 14. |

Joint sessions (Session 15-24)

Session number	Goals of session	Programme
Session 15 Mother and child getting to know each other (Part 1) "Knowing me, knowing you"	1) Interaction between mother and child 2) Interaction between mothers/child pairs 3) Awareness of self and others 4) Communication skills 5) Building self-awareness 6) Fostering cooperation *The aim of the activities is that the mother and her child spend time together and get to know each other better. The activities are designed for the mothers and children to strengthen their relationship. They are in addition given an opportunity to start practicing their skills that they have learnt from the previous sessions e.g. decision making, problem-solving, asking for help and interpersonal skills.*	• Welcome • Activity 1 (The feeling thermometer and Climbing down the tree exercise (children show mothers how) • Activity 2 (Preparing picnic food – sandwiches and cupcakes) • Picnic (mothers and children) • Activity 3 Games (egg race with mother and child legs tied together and balloon popping race) • Discussion (mothers and children split into separate groups for discussion) • Ending: What was today about? • Climbing down the tree exercise Homework: Mother/child pair has to think of a game they can play together and have to teach the rest of the group the game in session 16.
Session 16 Mother and child getting to know each other (Part 2) "Knowing me, knowing you"	1) Interaction between mother and child following direct instructions 2) Building of trust between mother and child 3) Awareness of self and others 4) Communication skills 5) Nurturing according to the Marschak Interaction Method 6) Engagement according to the Marschak Interaction Method 7) Setting of challenges according to the Marschak Interaction Method 8) Structure according to the Marschak Interaction Method *Aim: The activities allow a parent and child to practice important patterns of interaction in a fun way. The joint activities may help the mother to see what works in her relationship with her child and how to accommodate differences.* • Activity 1: *Aim: The idea is to relieve the child of the burden of maintaining control of interactions. The mother sets limits, defines body boundaries and keeps the child safe.* • Activity 2: *Aim: The idea is to establish and maintain a connection with the child to focus on the child*	• 20 minute separate session. Mothers are asked feedback of the previous session and prepared for the session to follow. The Marschak Interaction Method (M.I.M) is explained. Every activity is also discussed in detail with the mothers so that they can facilitate the M.I.M thera-play process. Children group (separate): • Welcome • Climbing down the tree exercise • Feeling thermometer • Ask feedback of the previous picnic session and ask the children how they experienced their first joint session with their mothers • Clay modelling. The children have to make a sculpture of an enjoyable activity • Discussion (questions related to mother/child interaction and possible activities they can do together) • The children are informed that the mothers will explain the M.I.M activities to them in the joint session. Joint session: 60 minutes • Activity 1: Structure (Pop the bubble and wrapping) • Activity 2: Engagement (Hand clapping game and special handshake) • Activity 3: Nurture (Cotton ball touch and paint hand print

	in an intense way, and to surprise the child into enjoying new experiences. • Activity 3: *Aim: The idea is to reinforce the message that the child is worthy of care and that adults will provide care without the child having to ask.* • Activity 4: *Aim: The idea is to help the child feel more competent and confident by encouraging the child to take a slight risk to accomplish an activity with the help of his/her mother.*	• Activity 4: Challenge (Balloon between two bodies, newspaper basketball and feeding each other Smarties) Child group (separate): 15 minutes • Ending: What was today about? • Climbing down the tree exercise Homework: Mother and child pairs practice one of the activities at home.
Session 17 Mother and child getting to know each other (Part 3) "Knowing me, knowing you"	1) Interaction between mother and child 2) Expressing verbal and non-verbal communication skills 3) Expressing emotions 4) Being creative together 5) Planning together	Mothers have a separate session for 15 minutes where they discuss their experiences of last week's joint session. This week's session activities and aims for the activity are discussed in detail with the mothers Child separate session: 15 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Activities for session are discussed with the children. Joint session: 60 minutes • Activity 1 – Body mapping • Activity 2 – Puppet socks (mothers and children switch roles) • Joint feedback and questions. • Ending: What was today about? • Climbing down the tree exercise Homework: No homework indicted for session 17.
Session 18 Creating a legacy (Part 1) "Let's make a family memory"	1) Interaction between mother and child 2) Making a memory box 3) Being creative and sharing of emotions *Aim: At the end of session 18 the mothers should have a basic understanding of the psycho-social needs of their children. In brief they should know who can benefit from making memory boxes, why memory boxes are important to make and how to make a memory box. The children experience the making of a memory box as a very enjoyable activity and they understand the importance of a memory box. The concept of death or illness is never mentioned and it is explained to them as an activity with their mothers to make memories for the future.*	Mothers have a separate session for 60 minutes where they discuss their experiences of last week's joint session. This week's session activities and aims for the activity are discussed in detail with the mothers. The purpose of a memory box, the objects to include in a memory box and the emotions surrounding this activity are discussed with the mothers. Child separate session: 60 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Activities for session are discussed with the children. • Activity 1 – Memory box decoration • Activity 2 – Digital photos taken of mother and child pairs • Discussion

		Joint session: 30 minutes
		• Activity 1 – Make handprints together with paint
		• Discuss the hand prints (same and different)
		• Include in memory box
		• Ending: What was today about?
		• Climbing down the tree exercise
		Homework: Mother/child pairs have to search for objects to include in memory box.
Session 19 Creating a legacy (Part 2) "Let's make a family memory"	1) Interaction between mother and child 2) Learning basic skills in memory-box methodology 3) Discussing the importance of creating a memory box 4) Making memories through taking digital photographs of mother and child pairs 5) Experiencing belongingness by making a family tree 6) Mother and child sharing their feelings by writing a poem/song together 7) Sharing between mother and child by discussing each other's likes and dislikes	Mothers have a separate session for 10 minutes where they discuss their experiences of last week's joint session. This week's session activities and aims for the activity are discussed in detail with the mothers. Child separate session: 10 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Activities for session are discussed with the children . Joint session: 75 minutes • Activity 1 – Digital photos taken in session 18 handed out to mother and child pair • In-depth discussion of photo and include in memory box • Activity 2 – Make a family tree • Discussion and include in memory box • Activity 3 – Mother and child writes poem/song together • Activity 4 – Likes and dislikes activity • Discussion and include drawings in memory box Child separate session: 10 minutes • Ball game • Ending: What was today about? • Climbing down the tree exercise Homework: Mother/child pairs have to search for objects to include in memory box.
Session 20 Interaction between mother and child (Part 1) "Let's have fun"	1) Communication between mother and child 2) Engagement by doing an activity of making clay 3) Engagement and sharing of emotions by doing an activity of making a 'feeling' bracelet 4) Sharing and working together towards a common goal	Mothers have a separate session for 10 minutes where they discuss their experiences of last week's joint session. This week's session activities and aims for the activity are discussed in detail with the mothers. Child separate session: 10 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Activities for session are discussed with the children.

		Joint session: 75 minutes • Activity 1 – Making own clay from raw ingredients • Activity 2 – Making objects from clay and mother/child guessing game • Discussion • Activity 3 – Making a bracelet with beads. Decide on colours of beads and meaning of colours for mother/child pairs. • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: No homework indicated for session 20.
Session 21 Interaction between mother and child (Part 2) 'Let's have fun'	1) Identification of emotions 2) Interaction between mother and child following instructions 3) Improvement of communication between mother and child 4) Engagement and sharing of emotions through 'morabaraba' game 5) Engagement through drawing each other's emotions on paper 6) Sharing of emotions through acting out each other's emotions *Aim: Mother and child spend time together in a fun way. The main aim of this session is for the mothers and children to share their emotions. They have to identify each other's emotions, express their emotions and interpret each other's emotions. The mothers are given the opportunity to practice their parenting skills that they have learnt in previous sessions e.g. decision making, problem-solving, asking for help, disciplining and interpersonal skills. The children practice the skills they have learnt in previous sessions e.g. problem-solving, asking for help, identifying emotions in self and others and communication skills.*	Mothers have a separate session for 10 minutes where they discuss their experiences of last week's joint session. This week's session activities and aims for the activity are discussed in detail with the mothers. Child separate session: 10 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Activities for session are discussed with the children Joint session: 60 minutes • Activity 1 – Drawing emotions on paper • Discussion • Activity 2 – Emotion masks • Discussion • Activity 3 – Morabaraba[18] indigenous game • Discussion • Ending: What was today about? • Climbing down the tree exercise Homework: Mothers and children encouraged to play the morabaraba game at home.
Session 22 Mother and child session revised (separate session) "Where are we at now?"	1) Revisiting of how to identify emotions 2) Revisiting of how to assess emotions 3) Revisiting of how to express emotions 4) Revisiting of safety rules 5) Revisiting of coping skills 6) Revisiting of problem-solving skills	Separate session for mothers and children. Child separate session: 120 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Child focused discussion (discussion of group experience and skills learned) • Activities for session are discussed with the children.

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[18] Morabaraba is a traditional game. It is a strategic game played with stones on a paper grid (Futhwa, 2011).

		• Activity 1 – Watching DVD (Finding Nemo) or reading 'Finding Nemo'-story if DVD not available • Focused discussion relating to DVD • Ending: What was today about? • Climbing down the tree exercise Homework: Children discuss DVD with mothers and the lessons they learnt in Finding Nemo-story.
Session 23 Planning for the future "Let's dream together"	1) Communication between mother and child 2) Sharing of future plans 3) Setting objectives for reaching the identified future plans 4) Sharing of ideas through making a collage 5) Sharing through drawing a 'future path'	Joint session: 70 minutes • Welcome • The feeling thermometer • Climbing down the tree exercise • Discussion of future goals • Activity 1 – Making a collage (future goals depicted with magazine photos and own drawings) • Discussion • Activity 2 – Future path drawing/painting • Discussion Child separate session: 10 minute • Ending: What was today about? • Climbing down the tree exercise • Free play Homework: Discuss future paths and collages at home.
Session 24 Family celebration "Let's celebrate life"	1) Practicing communication skills learned 2) Having a sense of accomplishment by receiving a certificate[19] 3) Practicing social skills learned 4) Sharing of future plans 5) Saying goodbye and sharing of contact details for future support *Aim: A joyful occasion to end off the 24 week group intervention. The mothers and children have time to share their group experiences and future plans. They are reminded of all the support systems that they have identified. The mothers and children have the opportunity to share contact details. The mothers and children are reminded of their six month follow-up interviews and they are invited to phone or visit the careworkers at the site.*	Joint session • Welcome • Handing out of certificates to mothers and children • Party • Saying goodbye and sharing of contact details (optional).

12. Facilitator training and the implementation process

The Kgolo Mmogo careworkers received basic training in the field of counselling, group facilitation, psychology, social work and HIV/Aids.

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[19] Refer to Appendix 13 for example of child certificate for group session completion.

The careworkers had a Grade 12 certificate, but they had no experience in counselling or facilitation of a group. Some of them had limited experience of group processes in attending the Serithi study. On-going national and international training took place and the focus of the training was placed on:

- Basic communication skills.

- Group facilitation skills.

- Counselling skills.

- Identification of problematic behavioural problems and emotional problems.

- Identification of social problems (when and where to refer).

- HIV and Aids information.

The careworkers discussed the sessions they facilitated after each session with the social workers and once a week the project coordinator attended a meeting where all the sessions of the week were discussed in a group discussion. The problems, referrals, course of action and other observations were examined during the meetings. The careworkers received weekly debriefing sessions. Every group session was practiced in the careworker group and every care worker had a chance to facilitate the group. The other careworkers, social workers and project coordinator could comment on the facilitation process and make positive suggestions for improvement. Quality assurance was an outcome of these practice sessions and it also empowered the careworkers to have confidence in facilitating the groups.

13. Staff of the Promoting Resilience in Young Children Study

13.1. Social workers

A junior and senior Social Worker was part of resilience study and they supported the care-workers with their preparation as facilitator for the children groups. The social workers were on site and they could be approached for help at any stage during the support sessions. They also helped the careworkers in their completion of the group session notes. The social workers assessed the difficult cases as identified and presented by the careworkers and made appropriate referrals to different social welfare organisations for counselling and/or other support if they deemed it necessary. The social workers were able to refer medical issues to an on-site doctor who gave advice or made the necessary referrals. The participants in the study had the opportunity to directly converse with the social workers and ask for assistance.

The social workers accompanied the careworkers on home visits where a mother was too ill to bring her child to the support session. They assessed the mother and child circumstances and made referrals if it was necessary. The senior social worker arranged for food parcels where there were food shortages at some of the group members' households. She also arranged for food donations for the group sessions.

13.2. Careworkers

The careworkers who facilitated the groups were selected from the communities where the study was implemented. The prerequisites for the appointment were that the careworkers are fluent in the different languages spoken in the community and that they had a good written and spoken English ability. The careworkers were volunteers in the community and they received a small stipend for their service. The careworkers, who facilitated the children groups, although not a prerequisite of the study were all women and mothers, completed grade 12 and displayed good interpersonal skills. Some of the careworkers were HIV-positive participants from the Serithi project and thus had previous experience of being part of a research study. Counselling on- site and off-site with social workers was available to the careworkers at all times if they were in need of additional support. They received weekly debriefing sessions with a senior social worker and a psychologist to cope with the emotional demands of their work.

13.3. Research Assistants (RA's)

There were eight research assistants appointed at any specific time during the resilience study. The research assistants who were appointed in the Serithi project that ended when the resilience study commenced were appointed and two more research assistants who complied with the prerequisites. The prerequisites for the research assistants were that they must be able to speak and write in English, must be able to speak and write in the local community languages (Sepedi, Setswana, Isizulu and Setsotho), be computer literate, are graduates in the medical and/or social fields and have experience in the HIV-field.

The research assistants received training from national and international psychologists (training in administering the Vineland instrument) in how to administer the specific instruments, how to enter the data on the QDS computer programme and skills to interview adults and children. They had meetings and debriefing sessions with the project coordinator and social workers on a weekly basis.

13.4. Multi-disciplinary research consulting team

The research team consisted of doctors, psychologists and social workers who assisted as expert consultants in the development and implementation of the Promoting Resilience in Young Children Study. Although the consultants were off site and not part of the day-to-day activities of the intervention group, they were intricately part in guiding and giving direction to the intervention study.

13.5. Project Coordinator

The project coordinator was an educational psychologist with expertise in the HIV/Aids field. She helped in the planning phase of the manual and was part of the day-to-day activities of the intervention sessions. She furthermore assisted in the training of the careworkers and research assistants. The practical implementation of the research design in the communities was her main responsibility. The project coordinator liaised continuously with the community leaders and volunteers at the hospitals and clinics. She was the link between the practical day-to-day intervention activities and the Promoting Resilience in Young Children research team.

14. Cost of the group sessions

The careworkers who facilitated the groups received a small stipend as volunteer workers. The buildings' rent was negotiated with the responsible organisations. A low rent was negotiated for both buildings. The buildings were painted, furnished and decorated inexpensively. The community donated toys and furniture. Two churches and a supermarket helped with the donation of food and food parcels to vulnerable families. The project funded the transport costs of the mothers and children.

The mothers and children received just enough money to cover their transport costs and the transport money differed according to the distances they had to travel to the support sessions (between R25 and R40 per pair). The materials needed for the group sessions were inexpensive and were mostly re-usable.

15. Ethical issues in evaluating the Child Support Group Evaluation Study

An evaluation of a programme may have more benefits and better process direction if there are ethical standards set up before the evaluation process commences. These ethical standards include setting up a code of conduct for the evaluator, setting limited areas and methods of investigation. It also guides the evaluator in how the information obtained from the evaluation can be used. Transparency is an important ethical aspect to ensure that the evaluation process is integrative and participatory. Confidentiality is another crucial factor in the liaison (Ramashia & Rankin, 1995; Royse et. al., 2010).

Three central principles that are universally followed as the basis for research ethics doing research with human subjects are The Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). **Respect for people** refers to an obligation to 'ensure the autonomy of research participants' and where the participants cannot take responsibility for their own decisions the vulnerability of these individuals must be protected from abuse. **Beneficence** refers to the minimising of risks associated with the research (both psychological and social risks) and maximising the effects of the research outcomes for the research participant. The methods on how this is to be achieved have to be shared with the participants. **Justice** is the fair allotment of risks and benefits as a result of the research endeavour. All participants should be able to share in the benefits of the research. **Respect for the community** refers to the researcher's responsibility to respect the values and interests of the community.

Royse et al. (2010) adapted the three ethical principles of beneficence, respect and justice identified for the research on humans by the National Commission for the protection of Humans Subjects in biomedical and Behavioral Research (the Belmont report drafted in 1979).

The principles were adapted to the practical ethical guidelines of research participants (1) they must be volunteers; (2) potential participants should be given sufficient information about the study to determine any possible risks or discomforts as well as benefits; (3) no harm shall result as a consequence of participation in the evaluation and (4) protection of sensitive information.

(1) The research participants of the Child Support Group Evaluation Study were volunteers. The eligible adult participants in the Kgolo Mmogo resilience project decided out of free will to participate in the project without coercion and as legal caregivers gave permission for their children to participate in the research project. The adult participants signed a consent form in their language of choice for both themselves and their children. The consent form was written in the first person "I" to make the informed consent easier to read. This consent form was in addition orally explained by the research assistant to the adult and child participant in his/her mother tongue language. The Promoting Resilience in Young Children Study's objectives and content were explained to the adult participants and formulated in child-friendly language. The children participants signed an assent form (refer to Appendix 4). The adult and children participants were assured that their identity would be protected and that they had the right to withdraw from the study at any time without any consequences.

(2) The potential participants were given sufficient information about the study to determine any possible risks or discomforts as well as benefits. The Child Support Group Evaluation Study participants were given sufficient information about the project and an explanation of the purpose of the research. The 6-month duration of the groups were explained to them as well as the three follow-up interventions that were to follow the group intervention sessions. The potential risks of group members that may disclose the HIV status of another member were discussed. The possibility of a child finding out about his/her mother's HIV status was also discussed. The participants were given the opportunity to ask questions about the study. The potential resilience outcomes were mentioned during the consent interview.

(3) The ethical guideline of 'no harm shall result as a consequence of participation in the evaluation' was closely monitored. The participants had the opportunity to indicate if it was acceptable for the research assistants and careworkers to phone them at home and/or their cellular phones.

If they did approve they had to indicate how the Kgolo Mmogo member must introduce herself to the person who answered the phone. The adult participants were ensured that their HIV status will not be revealed to their children or anyone else. The children group sessions at no stage made any explicit reference to HIV/Aids. The adult participants were reassured that the Kgolo Mmogo project will focus on building resilience in children and not on their HIV/Aids status. Adult and children participants had the opportunity to be referred to a health worker e.g., doctor, social worker, psychologist at any stage in the project at their request. The adult and child participant were however informed that they will be immediately reported to a health careworker if there were any harm indicated to her/himself or others.

(4) The privacy of research participants is protected by separating any individual identifying information from the answered questionnaires and ascribing a project identification number. According to this ethical guideline all the research data would be stored in locked cabinets in a room that was locked at all times. The key to this room would only be available to the project coordinator and data analyst. The data would be stored for 20 years for any future enquiries and the personal identification information of the participants were destroyed.

This study adhered to the Ethical Code Guidelines of the Faculty of Education at the University of Pretoria. The permission to do research with a vulnerable population in clinics and hospitals in the Mamelodi and Atteridgeville districts was obtained from the Gauteng Department of Health. The Promoting Resilience in Young Children Study, which the Child Support Group Evaluation Study forms part of, applied and received ethical clearance in 2005 from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria and the Yale University institutional review boards (IRB's). The researcher of this study additionally applied for permission from the Ethical Committee at the Faculty of Education, University of Pretoria (Protocol 11/11/01) to commence with her research focused on the data subset of the Promoting Resilience in Young Children Study (refer to Appendix 14).

The Promoting Resilience in Young Children Study which encapsulates the Child Support Group Evaluation Study adhered to the National Institutes of Health (NIH) ethical guidelines. The researcher completed the NIH ethical clearance certificate. The Child Support Group Evaluation Study consequently adhered to the same ethical guidelines.

The Child Support Group Evaluation Study utilised secondary data and additionally placed emphasis on the "*confirm that all stakeholders understand the limits to the activity and next steps*" - ethical criteria guideline as proposed by Schenk and Williamson (2005, p.ix) to gather information from children and adolescents. The researcher used appropriate procedures in maintaining the safety and security of the participants. She only made use of their KM identity numbers and didn't use specific date references for the purpose of keeping the children's identity confidential. She also shared her findings with community members and other research team members in an accessible and appropriate format.

16. Role of the researcher

According to Dahlberg and McCaig (2010) the practitioner-researcher is "*anybody who combines his/her position within practice with conducting research concerning that practice*", (p.2). The practitioner–researcher has to have knowledge about the subject and the context of the participants. She also has to envisage the implications of the social change that may occur as a result of the research done in the context. The research coordinator of the Child Support Group Evaluation Study was involved in the development and implementation of the intervention treatment for the children. She had five years of personal experience with the participants and the context they live in. Her involvement in the day-to-day planning of the support sessions and on-site experience helped her to be aware of any social changes that had an impact on the support sessions as for instance the teacher strikes. As the practitioner-researcher for Child Support Group Evaluation Study she collected, analysed and scrutinised the data as presented in the children intervention groups objectively. The research process that she followed was externally audited by co-researchers of the Promoting Resilience in Young Children Study to ensure objectivity.

17. Summary

This study uses a research design that would guide the answers to the research questions as posed in the Child Support Group Evaluation Study and which could evaluate the empirical data available. The nested multiple case study- and the quasi-experimental designs were chosen to answer the qualitative and quantitative questions and is aligned with the pragmatic and critical realism paradigms.

The utilisation of both a quantitative and qualitative design in the proposed data collection and data analysis strategies provided the opportunity for a holistic evaluation of the Child Support Group Evaluation Study. A theory-driven outcome evaluation programme design was furthermore proposed to guide the evaluation of the efficacy of the intervention programme for children affected by maternal HIV/Aids. The manual utilised in the Promoting Resilience in Young Children Study and subsequently evaluated as part of the Child Support Group Evaluation Study was summarised and the ethical guidelines the researcher followed were discussed in detail. The conceptual framework for the Child Support Group Evaluation Study is recapitulated in Figure 3.8. The data analysis and results are subsequently presented in Chapter 4.

Figure 3.8 Conceptual framework of the Child Support Group Evaluation Study

Main study completed – Promoting Resilience in Young Children Study (Randomised control study)

Thesis study - **Child Support Group Evaluation Study**
Participants purposefully selected from the Promoting Resilience in Young Children Study

The purpose of this evaluative study is to evaluate a 24-week resilience intervention programme for young children affected by HIV-Chapter1

Literature study – Chapter 2
-Middle-childhood developmental phase (latent phase)
-Child's experience of parental illness
-Maternal HIV/Aids impact on child
-Resilience and enhancement of adaptive behaviour
-Group based support interventions

Main research question
How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?

Embedded Mixed Methods Design
Quan → Quasi-experimental design
QUAL→ Multiple case study design
- Chapter 3

quan sub-question
To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?

QUAL sub-questions
-What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?
-What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child?

Meta-theoretical Paradigm: Pragmatism and critical realism

Theory driven outcome evaluation

Historical documentation

quan data collected
Mother and child questionnaires paragraph 8.4., p.164.

quan data analysed
SPSS 20 paired-samples t-test, descriptive statistics

Validity and reliability

QUAL data collected
Group process notes, focus groups, QA questionnaires,

QUAL data analysed
Coding, themes, categories

Trustworthi-ness and rigor

QUAL+quan = theory driven outcome evaluation – Chapter 4

Bioecological systems theory
A developmental and ecological systems lens is applied to evaluate the intervention

Main research question answered – Chapter 5
How efficacious is a group-base intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?

CHAPTER 4

Data Analysis and Results

Figure 4. 1 Framework of the data analysis and results in Chapter 4

Quantitative measures of efficacy

Child questionnaires

Mother questionnaires

A. To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?

Qualitative measures of efficacy

Evaluation feedback questionnaires (children)

Evaluation feedback questionnaires (mothers)

Session reports (children and joint session groups) and observation notes

Focus groups (careworkers)

B. What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?

C. What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child?

How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?

Theory-based group intervention evaluation

1. Introduction

Pawson and Tilley (1993) state *"… it is not actual programmes which 'work' but the reasoning and opportunities of the people experiencing the programmes which make them work"* (p.2). A single treatment does not change the behaviour or thoughts of a person, but is the culmination of complex interactions between people, according to Clarke (2006). *"Outcomes follow from mechanisms acting in context"* and *"programs 'work' if subjects choose to make them work and are placed in the right conditions to enable to do so"* (Pawson & Tilley, 1997, pp.77, 413).

In Chapter 3 the methodology used to evaluate the theory-based resilience group intervention for children was discussed. The group-based intervention was evaluated, using a mixed-method approach. The pragmatic and critical realism paradigms guided the research process where a concurrent nested approach to data collection and data analysis was followed. Quantitative data were used to support the more dominant qualitative data in this study. The sample of children was purposefully extracted from the larger Promoting Resilience in Young Children Study, using the data of the children who attended the intervention groups. The quantitative phase of the study employed a quasi-experimental design, where the data were extracted from relevant child and mother questionnaires. The qualitative phase of the study made use of group session reports, mother and child group evaluation questionnaires, focus groups and observation data. The conceptual framework of the Child Support Group Evaluation Study programme plan (refer to Fig.3.8) was followed in the presentation of the data.

The literature review in Chapter 2 provided background and set the stage for the evaluation of a group-based resilience intervention programme for children with HIV-infected mothers. The literature review drew attention to the middle-childhood developmental phase and the latent child's experience of maternal illness. The impact of parental illness, specifically maternal illness, on a child was investigated. Maternal HIV/Aids was described as a complex phenomenon and particular challenges associated with this illness were highlighted. The influence of maternal HIV/Aids on a child was deliberated and comprehensively interpreted. The bioecological-systems model of Bronfenbrenner and Lerner's developmental model was discussed and used as theoretical lens in the Child Support Group Evaluation Study.

Some children flourished despite experiencing adversity and the resilience factors associated with the child's ability or inability to cope with their mother's HIV diagnosis were discussed. The protective domains and risk factors associated with maternal HIV-infection were examined to provide a holistic framework for the evaluation study. The dynamics of a group-based intervention were explored, focusing on the development, dynamics and training of facilitators, as well as the principles underlying group-based interventions.

The findings and data analysis are described in this chapter (refer to Figure 4.1). The Socio-Demographic Questionnaire information as indicated by the mother participants is used to describe the characteristics of the sample population in the Child Support Group Evaluation Study. The findings (at baseline and 6-month follow-up interviews) of the child-focused questionnaires, as answered by the children and mothers, are quantitatively compared and interpreted. Qualitative methods are employed to identify children who displayed adaptive and non-adaptive behaviour as observed by the careworkers. In the following qualitative phase the resilience or adaptive behaviour indicators are analysed, the content, process and content of the group sessions findings are presented and subsequently interpreted. A summary reviews the findings and interpretations and aims to answer the stated research questions as posed in Chapter 1.

2. Population characteristics

The Child Support Group Evaluation Study quantitative sample consisted of 139 children (76 boys, 63 girls) from the Mamelodi and Atteridgeville areas. Although 220 mother-and-child pairs were initially randomly selected to the intervention (treatment) groups, only 161 mother-and-child pairs attended the group sessions. Due to the unequal number of mothers and children returning to the 6-month follow-up interviews and incomplete child questionnaires (in instances where children did not understand the questions), it was necessary to balance the number of responses in each interview group for quantitative and qualitative evaluation (refer to Figure 4.2).

Figure 4.2 Number of participants evaluated in the Child Support Group Evaluation Study
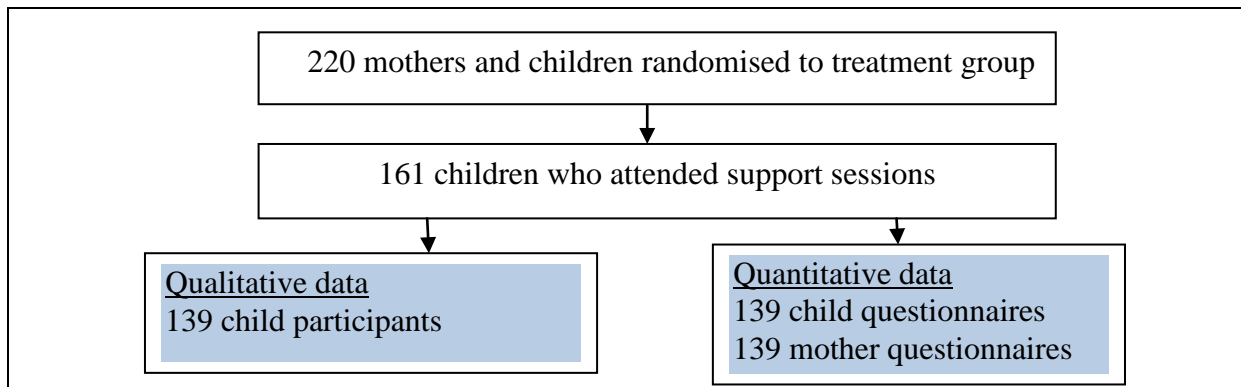
The quantitative and qualitative data of children who were identified during the course of the intervention as displaying HIV-positive symptoms, were excluded from the current study. The final sample consisted of 139 children. At the time of the data collection the mean age of the children was 8.2 years (98.5 months) (SD=17.9). The mean age of the mothers was 33.3 years (SD=6.1) (Table 4.2) and 69.1% mothers had at minimum a Grade 10 educational level (Table 4.3). A percentage of 78.4% mothers were unemployed at the start of the intervention sessions (Table 4.4). A total of 18.7 % mothers were married and 46% of mothers were not married but had a partner (Table 4.5). Only 17 (12.2%) mother participants indicated that they (or others) had disclosed to their children that they were infected with the HIV-virus (Table 4.6).

Table 4.1 Gender of child participants

	Frequency	Percent
Male	76	55%
Female	63	45%
Total	139	100%

Table 4.2 Age of child and mother participants

	N	Minimum	Maximum	Mean	Std. deviation
Age of child participants (months)	139	63	133	98.5	17.9
Age of mother participants (years)	139	23	52	33.3	6.1

Figure 4.3 Educational levels of mother participants
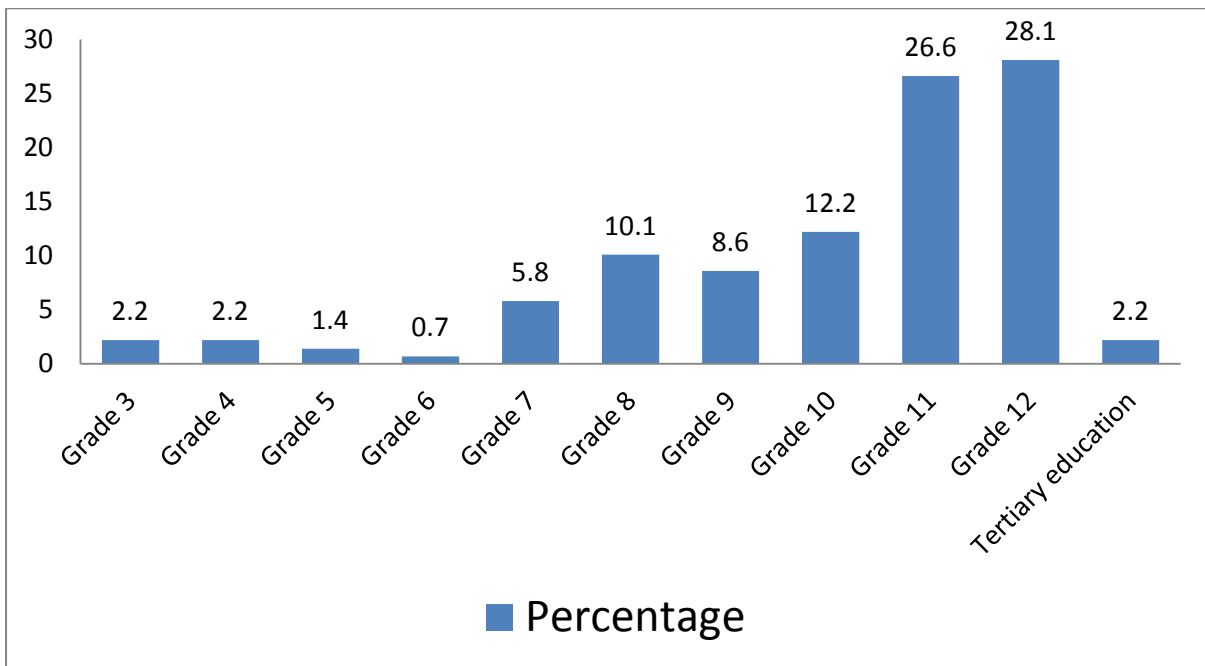
Figure 4.4 Employment status of mother participants
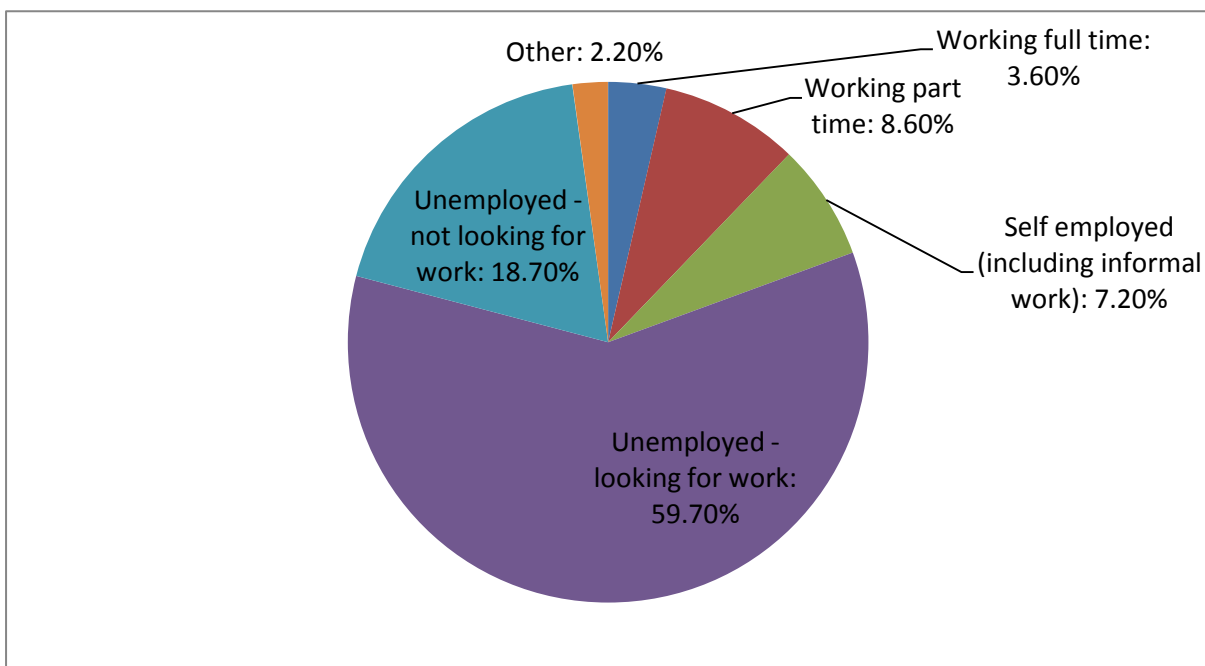
Figure 4.5 Marital status of mother participants

Widowed: 5.80%

Married (including common-law): 18.70%

Single (no partner): 29.50%

Not married (has partner): 46%
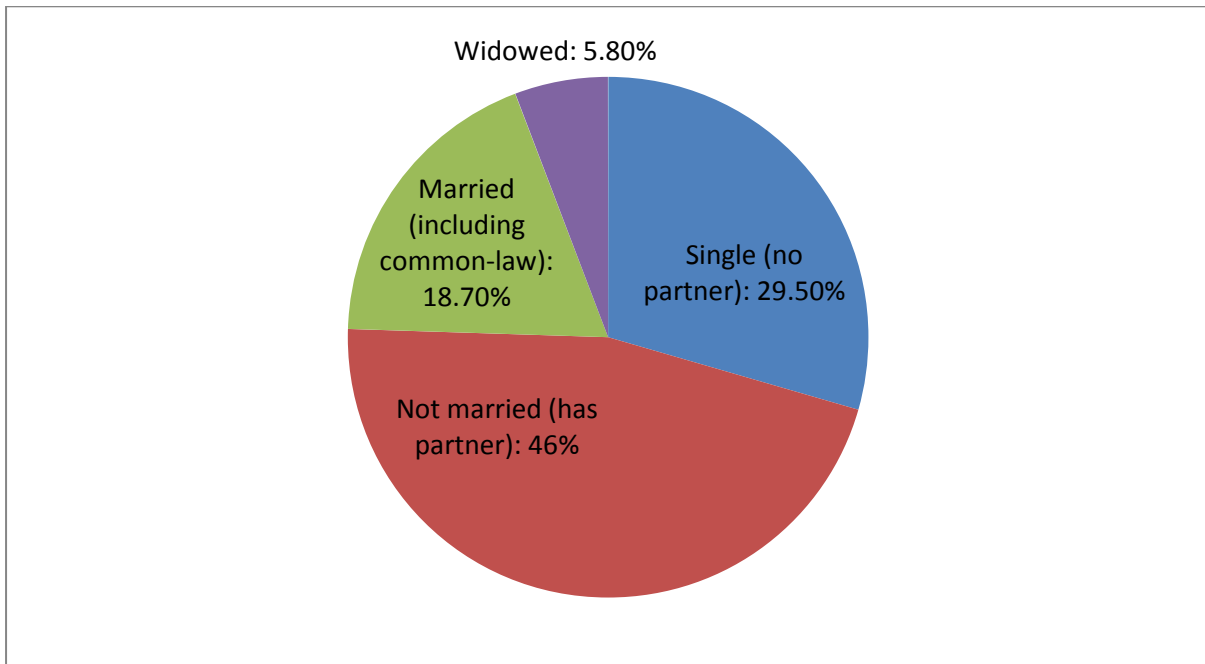
Figure 4.6 Mothers who disclosed their HIV status to their children[1]

Unknown: 0.70%

HIV disclosure to child: 12.20%

No HIV disclosure: 87.10%

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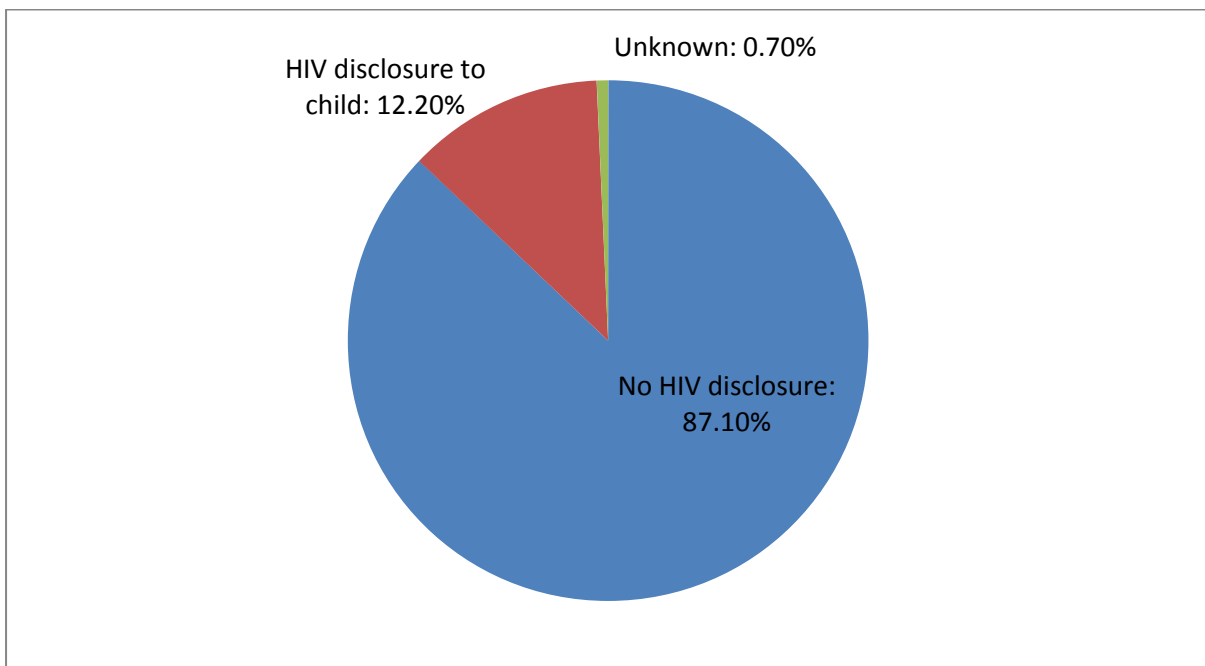
[1] The child is aware of the mother's status because the mother or another person has told him/her.

3. Quantitative analysis of the child-focused questionnaires

The guiding research question for this evaluation study is 'How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?' In order to answer the main research question the following quantitative sub-question is explored: **'To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?'**

This quantitative phase of the study examined the efficaciousness of a support group intervention programme to enhance the adaptive behaviour of 139 children who are affected by maternal HIV/AIDS. A causal comparative design was used in this study to address the research question presented in figure 4.1. To answer the question, comparison of the means using a two-tailed, paired t-test at the alpha 0.05 level was applied. The data were computed using the Statistical Package for the Social Sciences (SPSS)® computer software programme, Version 20.

3.1. Child-focused measures – Findings

The child self-report questionnaires completed at baseline and after completing a six-month support group included (refer to Chapter 3, p.166):

- Revised Child Manifest Anxiety Scale (RCMAS)
- Child Depression Inventory (CDI)
- BarOn EQ-i: YV™
- Kidcope
- Child Spiritual Coping Scale (CSCS)
- Self-Descriptive Questionnaire (SDQ)

The findings of child self-report questionnaires at baseline and six-months are presented below.

Table 4.3 Descriptive statistics of child psychological instruments

Psychological questionnaires	Baseline interview	Six-month interview
Revised Child Manifest Anxiety Scale (RCMAS)		
Mean	8.21	9.04
N	110	110
Std Deviation	5.04	4.85
Std Error Mean	0.5	0.48
Child Depression Inventory (CDI)		
Mean	7.03	7.63
N	95	95
Std Deviation	4.08	4.65
Std Error Mean	0.42	0.48
BarOn EQ-i: YV™		
Mean	59.82	59.80
N	98	98
Std Deviation	9.32	9.52
Std Error Mean	0.94	0.96
Kidcope – Approach Frequency		
Mean	1.43	1.90
N	90	90
Std Deviation	0.97	0.97
Std Error Mean	0.10	0.10
Kidcope – Avoidance Frequency		
Mean	2.24	2.60
N	92	92
Std Deviation	1.18	0.98
Std Error Mean	0.12	0.10
Kidcope – Approach Efficacy		
Mean	1.93	2.56
N	89	89
Std Deviation	1.64	1.78
Std Error Mean	0.17	0.19
Kidcope – Avoidance Efficacy		
Mean	3.16	3.61
N	90	90
Std Deviation	1.95	1.85
Std Error Mean	0.21	0.19
Child Spiritual Coping Scale (CSCS) – Frequency		
Mean	54.16	59.01
N	98	98
Std Deviation	13.80	13.50
Std Error Mean	1.39	1.36

Psychological questionnaires	Baseline interview	Six-months interview
Child Spiritual Coping Scale (CSCS) – Efficacy		
Mean	68.80	70.88
N	61	61
Std Deviation	9.22	11.23
Std Error Mean	1.18	1.44
Self Descriptive Questionnaire (SDQ)		
Mean	182.04	179.62
N	100	100
Std Deviation	15.38	15.74
Std Error Mean	1.54	0.04

Note: The total N does not add up to N=139 for various reasons: participants missing the 6-month interviews, mothers completing questionnaires but children not, incomplete questionnaires because some children were too young or participants could not answer some of the questions.

Table 4.4   Paired Sample t-Test of Total Means between the baseline interview and six-month interview (child psychological instruments)

Paired Sample Test	Baseline and Six-month interview questionnaires Total
Revised Child Manifest Anxiety Scale (RCMAS)	
Mean	-.84
Standard Deviation	6.02
t	-1.40
df	100
Sig. (2-tailed)	.166
Child Depression Inventory (CDI)	
Mean	-.60
Standard Deviation	5.50
t	-1.07
df	94
Sig. (2-tailed)	.289
BarOn EQ-i: YV™	
Mean	.020
Standard Deviation	12.34
t	0.02
df	97
Sig. (2-tailed)	.987
Kidcope – Approach Frequency	
Mean	-.47
Standard Deviation	1.42
t	-3.11
df	89
Sig. (2-tailed)	.003
Kidcope – Avoidance Frequency	
Mean	-.36
Standard Deviation	1.50
t	-2.30
df	91
Sig. (2-tailed)	.024

Paired Sample Test	Baseline and Six-month interview questionnaires Total
Kidcope – Approach Efficacy	
Mean	-.63
Standard Deviation	2.50
t	-2.37
df	88
Sig. (2-tailed)	.020
Kidcope – Avoidance Efficacy	
Mean	-.456
Standard Deviation	2.60
t	-1.66
df	89
Sig. (2-tailed)	0.100
Child Spiritual Coping Scale (CSCS) – Frequency	
Mean	-4.85
Standard Deviation	16.55
t	-2.90
df	97
Sig. (2-tailed)	0.005
Child Spiritual Coping Scale (CSCS) – Efficacy	
Mean	-2.07
Standard Deviation	13.64
t	-1.89
df	60
Sig. (2-tailed)	.240
Self Descriptive Questionnaire (SDQ)	
Mean	2.42
Standard Deviation	17.30
t	1.40
df	99
Sig. (2-tailed)	0.17

Table 4.3 outlines the means and standard deviations of the pre-treatment and post-treatment total scores on the self-report child instrument measures. Table 4.4 outlines the paired sample t-Test of total means between the baseline interview and six-month interview of the child psychological instruments. There were not significant differences for the majority of instruments, except for the Kidcope and the Child Spiritual Coping Scale (CSCS).

The results indicated that the children reported on the **Revised Child Manifest Anxiety Scale (RCMAS)** that there was no significant change in their anxiety levels before (M = 8.21, SD 5.04) and after (M = 9.05, SD = 4.85) the intervention sessions, $t(100) = 1.40$, $p = 0.166$.

Using a paired t-test, children's self-reported depression levels on the **Child Depression Inventory (CDI)** prior to the support group intervention (M = 7.03, SD = 4.08) were compared to their self-reported depression levels after attending the support group intervention (7.63, SD = 4.65). The difference in depression levels were not statistically significant as indicated by the paired t-test, $t(94) = 1.07$, $p = .289$.

The t-value difference for the Paired Sample t-Test of the total means derived from the **BarOn EQ-i: YV™** from the baseline interview and the six-month interview is 0.02 and $p = 0.987$, indicating a non-significant difference in the two values. The mean for the baseline BarOn EQ-i: YV™ measurement was 59.82 and for the six-month measurement it was 59.80, indicating a non-significant shift in the mean, $t(97) = 0.02$.

When examining the approach and avoidance frequency scale scores of the **Kidcope** before and after treatment, there was a 0.47 point increase on the approach frequency scale (SD unchanged) and a 0.36 point increase on the avoidance frequency scale with a decrease in the standard deviation. An analysis of the comparison of the mean using a two-tailed, paired t-test at the alpha 0.05 level showed that there was a significant difference on the Kidcope approach frequency scale ($p = 0.003$) and avoidance frequency scale ($p = 0.024$). The approach frequency scale t-score was $t(89) = 3.11$, $p = 0.003$ and avoidance frequency scale t-score was $t(91) = 2.30$, $p = 0.024$. The Kidcope approach efficacy scale indicated a significant difference between the scale scores at baseline (1.93) and after six months (2.56) with $p = 0.02$. The difference in the approach efficacy coping levels were statistically significant as indicated by the paired t-test, $t(88) = 2.37$, $p = 0.02$. The Kidcope avoidance efficacy scale indicated a non-significant difference between the scale scores at baseline (3.16) and after six months (3.61) with $p = 0.1$. The difference in the avoidance efficacy coping levels were not statistically significant as indicated by the paired t-test, $t(89) = 1.66$, $p = 0.1$.

To measure the dependant variable, spiritual coping, a paired sample t-test was conducted on the means computed from the baseline and six-month **Child Spiritual Coping Scale (CSCS)** questionnaires. The CSCS comprises of a frequency and an efficacy scale (refer to Chapter 3, p.167).

Using a paired t-test, the frequency in the use of spiritual coping strategies according to the CSCS prior to the support group intervention (M = 54.16, SD = 13.80) were compared to the reported frequency of spiritual coping strategies after attending the support group intervention (M = 59.01, SD = 13.50). The difference in the frequency spiritual coping levels were statistically significant as indicated by the paired t-test, $t(97) = 2.90$, $p = .0005$. The efficacy of employing spiritual coping strategies, reported by the children before the intervention (M = 68.80, SD = 9.22) and after the intervention (M = 70.88, SD = 11.23) were not statistically significant as indicated by the paired *t*-test, $t(60) = 1.89$, $p = 0.24$.

There was not a significant difference ($p = 0.17$) between the self-concept scale as reported on the **Self Descriptive Questionnaire (SDQ)** of children before the intervention (M = 182, SD = 15.38) and after the intervention (M = 179.62, SD = 15.74) as indicated by the paired *t*-test, $t(99) = 1.4$, $p = 0.17$).

3.2. Child behaviour and adaptive functioning as assessed by the mothers – Findings

The mothers of the child participants completed two questionnaires regarding their children's behaviour and adaptive functioning before the support group commenced and after the completion of the support group. They completed the Child Behavior Checklist and the Vineland Adaptive Behavior Scales Second Edition (Vineland II) Survey Form (refer to Chapter 3, p.165). The findings of questionnaires at baseline and six months are presented below.

Table 4.5 Descriptive statistics of child behaviour as assessed by the mother participants on the child-focused questionnaires

Psychological questionnaires	Baseline interview	Six-month interview
Child Behavior Checklist (CBCL) – internalised behaviour		
Mean	12.63	9.52
N	110	110
Std Deviation	9.58	7.20
Std Error Mean	0.91	0.69

Psychological questionnaires	Baseline interview	Six-month interview
Child Behavior Checklist (CBCL) – externalised behaviour		
Mean	14.95	11.19
N	110	110
Std Deviation	12.55	9.49
Std Error Mean	1.20	0.90
Vineland-II – Communication		
Mean	95.42	101.98
N	105	105
Std Deviation	18.91	16.45
Std Error Mean	1.85	1.61
Vineland-II – Daily Living		
Mean	89.80	100.18
N	97	97
Std Deviation	18.04	17.53
Std Error Mean	1.83	1.78
Vineland-II – Socialisation		
Mean	109.77	119.71
N	99	99
Std Deviation	17.07	18.68
Std Error Mean	1.72	1.88

Note: The total N does not add up to N=139 because of missing six-month interviews.

Table 4.6 Paired Sample t-Test of Total Means between the baseline interview and six-month interview (child behaviour as assessed by the mother participants on the child-focused questionnaires)

Paired Samples Test	Baseline and Six-month interview questionnaires Total
Child Behavior Checklist (CBCL) – internalised behaviour	
Mean	3.10
Standard Deviation	10.48
t	3.11
df	109
Sig. (2-tailed)	.002
Child Behavior Checklist (CBCL) – externalised behaviour	
Mean	3.76
Standard Deviation	12.01
t	3.28
df	109
Sig. (2-tailed)	.0001
Vineland-II – Communication	
Mean	-6.56
Standard Deviation	23.37
t	-2.88
df	104
Sig. (2-tailed)	.005

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Paired Samples Test	Baseline and Six-month interview questionnaires Total
Vineland-II – Daily Living	
Mean	-10.38
Standard Deviation	23.61
t	-4.33
df	96
Sig. (2-tailed)	<0.001
Vineland-II – Socialisation	
Mean	-9.94
Standard Deviation	26.04
t	-3.80
df	98
Sig. (2-tailed)	<0.001

Table 4.5 outlines the means and standard deviations of the pre-treatment and post-treatment internalised and externalised behaviour problems as reported by the mother participants on the **Child Behavior Checklist (CBCL)** and the children's adaptive behaviour on the Vineland Adaptive Behavior Scales Second Edition (Vineland II) Survey Form. Table 4.6 outlines the paired sample t-test of total means between the baseline interview and six-month interview of the child-focused questionnaires as reported by the mother participants.

When looking at the average scale sores of the reported internalised behaviour problems on the Child Behavior Checklist (CBCL) before and after treatment, there was a 3.11 point decrease in internalised behaviour problems and a decrease in the standard deviation. An analysis of the comparison of the mean using a two-tailed, paired t-test at the alpha = 0.05 level showed that there was a significant difference in the internalised behaviour problems reported by the mothers, $t(109) = 3.11$, $p = 0.002$. There was furthermore a 3.76 point decrease in reported externalised behaviour problems and a decrease in the standard deviation. An analysis showed that there was a significant difference in the externalised problems reported by the mothers, $t(109) = 3.28$, $p = 0.0001$.

Using a paired measures t-test, mothers' rating of their children's communication, daily living and socialisation skills on the **Vineland-II scale** before the children attended a support group intervention and after they attended a support group intervention, indicated that there was a significant difference on all three of the Vineland subscales. When analysing the before and after treatment scores of the communication subscale, there was a 6.56 increase and a decrease in the standard deviation. The results of the two-tailed paired t-test showed a significant difference, $t(104) = 2.88$, $p = .005$.

The daily living subscale showed a 10.38 point increase and a decrease in the standard deviation. The results of the two-tailed paired t-test showed a significant difference, $t(96) = 4.33$, $p<0.0001$. The before and after treatments scores of the Socialisation subscale indicated a 9.94 point increase and an increase in the standard deviation. The two-tailed paired t-test showed a significant difference, $t(98) = 3.80$, $p<0.000$.

In an attempt to answer the quantitative research question 'To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?' the Child Support Group Evaluation Study quantitative data of the child focused questionnaires were presented in this section. The findings of the quantitative data are interpreted in paragraph 7, p.310.

4. Qualitative analysis (individual group members)

4.1. Group session notes and careworker observations – Findings

A total of 75 children were part of this observed group[2]. These children's behaviour and participation were particularly noticeable as they have displayed either observable adaptive behaviour (e.g. participated in the group, helped other group members) or non-adaptive behaviour (e.g. aggression, bullying and negative behaviour). These children's data were juxtaposed with the careworkers' written observations of each child at the end of the group sessions. Their observations indicated a clear distinction between children who displayed adaptive and non-adaptive behaviour. The children displaying non-adaptive behaviour could further be sub-divided into externalised behaviour and internalised behaviour categories. The major themes that emerged under the three main categories: adaptive behaviour (protective factors), non-adaptive behaviour: externalised behaviour (risk factors) and internalised behaviour (risk factors) are subsequently listed according to significance (most observed factors) in Table 4.7.

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[2] Refer to Appendix 15 for complete data findings of this group.

Table 4.7 Summary of findings for selected group member's behaviour as observed by the careworkers

Adaptive behaviour protective factors	Non-adaptive behaviour risk factors	
	Externalised behaviour (risk factors)	Internalised behaviour (risk factors)
Good mother and child relationship	Problematic mother and child relationship	Problematic mother and child relationship
Sharing of emotions	Illness of mother	Illness of mother
Good communication skills	Exposure to violence	Isolation/withdraw
Positive religious coping skills	Poverty	Anxiety/fear
Positive future orientation	Not feeling respected	Unsafe/insecurity
Could extrapolate skills learned in sessions to other situations	Hyperactivity	Inattention
Adaptive behaviour protective factors	**Non-adaptive behaviour risk factors**	
	Externalised behaviour (risk factors)	**Internalised behaviour (risk factors)**
Participated in the group	Abuse (physical, sexual and emotional)	Sexual abuse
Sense of responsibility	Inattention	Poverty
Life skills	Externalised behaviour coupled with internalised behaviour	Age (being the youngest in group)
Could discern between right and wrong	Age (being the youngest in group)	Keeping family secrets
Independency (attend group alone)		Not expressing emotions
Displayed and sought respect		Negative father relationship
Observed intelligent behaviour		
Positive disposition		
Helping others		
Problem-solving skills		
Tenacity		
Good relationship with another family member (grandmother, sibling, father)		

The aforementioned is illustrated by the following adaptive and non-adaptive behaviour examples:

Example: Adaptive behaviour

> [3]**KM 453**, *KM 500 and KM 414 they came alone because their parents are working and they promised to come to every session without their parents because they enjoy being part of the group and the things we do here helped them even at school e.g. how to communicate with peers and talk about your feeling (6:13)*[4]
>
> *It was good. They interacted with each other following instructions. They were able to share with us what makes them happy KM 453 said it is because her mom is healthy (6:21)*
>
> *KM 453 said if she gets lost she will call her mother because she knows her contact numbers. She was the one who told others that everything which is happening in Nemo we did in previous sessions i.e. she said we don't talk to strangers and survival skills where we practiced household chores (6:22)*
>
> *KM 453 said she want to be a social worker she is aware that her mother save money for her for further studies. She said the reason is she wants to help family in need and children who don't have parents. She want to open centre for orphans and say thank you for God for protecting her on future path and keeping her mom healthy (6:23)*
>
> *KM 453 – She was participating and helping other children with activities when they have difficulties but she is shy and does not like talking a lot. She enjoyed coming to the group even if the mother was no longer coming* (Careworker observation)

Interpretation

KM 453 displayed protective resilience factors by participating in the group sessions alone. Her mother was working and could not attend the sessions. Although she was shy, she was able to share her emotions in the group and she enjoyed the support she received from her peers in the group. KM 453 was able to learn from the group sessions and extrapolate skills learnt in previous sessions. She showed independence by attending the group sessions alone when her mother became ill. She was positive in her expectations of her future and indicated that she wanted to help others. KM 453 related her own happiness to her mother's health and showed positive religious coping. She had a good relationship with her mother.

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[3] The example extracts in the study are direct quotations taken from the careworkers and may contain language mistakes because English was a second language for most of them.

[4] (a:b) whereby 'a' denotes wave number and 'b' denotes session number e.g. (6:13) is referring to wave 6 session 13.

Example: Adaptive behaviour

> *KM 525 is a very intelligent guy, he has a very good reasoning capacity and he is very open and not shy (9:1)*
>
> *KM 525 was the leader in discussing the feeling good quilt (9:2).*
>
> *KM 525 says teacher you were honest when saying there will be more than us two attending this week (9:2)*
>
> *KM 525, 590 and 637 said they don't trust their uncles because they drink alcohol and sometimes asked them to go and buy cigarettes and alcohol and that is illegal (9:8)*
>
> *KM 525 said he is unhappy because his teacher punished him because he didn't do homework but he blamed himself (9:9)*
>
> *KM 525 says he is happy on feeling thermometer because he did his homework this week (9:10)*
>
> *KM 525 said he wishes that illegal businesses must be stopped because some people don't have future because of that. He gave example of drug sellers (9:10)*
>
> *KM 525 helped a lot in the session and helped to make tea for everyone (9:12)*
>
> *KM 525 missed to play with his mother and sometimes she is not able to as she is physically disabled, but this made the boy unhappy, but we careworkers assisted him (9:16)*
>
> *KM 525 said he say thank you so much because he was not aware of this strengths but now he is sure about it (9:24)*
>
> *KM 525 and 550 brought their photos while still babies and Baptist certificates. KM 525 brought photos (9:24)*
>
> *KM 525 put his name on a sad face, he said he is sad the group is ending and he wishes the group can go on (9:24)*
>
> *KM 525 always participate in the group sometimes help smaller ones to say something. If you ask him question he gave you more than you wanted. He was always neat. During joint session he did very well with his mother. Their bond was very strong. You could see that even at home their bond and relationship was good* (Careworker observation)

Interpretation

KM 525's behaviour was described by the facilitators as intelligent. He displayed good reasoning in the group and leadership skills. He showed adaptive behaviour skills by indicating that he wanted to do well in school; he took responsibility for his own behaviour and he easily shared his emotions with the group members.

He displayed good morality and he could distinguish between right and wrong behaviour. He did however display apprehension when referring to his uncle. He experienced his uncle as a negative influence in his life. He experienced his mother's disability as difficult, but he was able to cope with the situation. He played well with the careworkers in situations where his mother could not physically take part in some of the activities. KM 525 and his mother displayed a positive relationship and they communicated well with each other (protective factor). KM 525 enjoyed the group sessions and indicted he wanted to continue with the group sessions.

Example: Non-adaptive behaviour (external behaviour problems)

KM 112 in his family exercise he coloured his mother's face black and said it is because she is ugly (6:3)

KM 112 said he didn't want to do feel thermometer (6:4)

KM 112 – He needs to much attention and he disturbs the group, he does things that will make other children lose focus and he wants to do things is own way, if he does not want to do the activity he will withdraw himself from the group. He does not listen to his mother. He is sometimes aggressive and start fights with others (Careworker observation)

KM 112 asked to go to the toilet and did not come back to the group. When we went to look for him he was sitting outside and said he was afraid of KM 441. That is far from the truth as KM441 is bullied by KM 112, he is lying (6:5)

KM 441 and KM 112 during the previous sessions they were not getting along but this session they helped each other with picture cutting, when someone needed a picture the other will give them the picture. Definite improvement in KM 112 behaviour (6:6)

After the body mapping KM 112 (better) and his mother were enjoying play with puppets and the child was doing what his mother do when they are at home and they were laughing about it (6:17)

Interpretation

KM 112 displayed an array of external behaviour problems ranging from hyperactivity and lying, to overt aggressive behaviour towards other children. He didn't want to take part in the separate sessions but he showed improvement in the later separate sessions.

Possible explanations for improvement in later sessions might have been developmental maturity reached with time, the following of exemplar behaviour of other children or the impact of the joint sessions where the child was exposed to time alone with his mother. The mother-child relationship also seemed problematic. The joint sessions were indicative of definite improvement in the child's behaviour and relationship with his mother. The mother and child were able to communicate with each other through the group platform.

Example: Non-adaptive behaviour (internalised behaviour problems)

> *KM 199 understands happy face only when singing 'if you are and you know it'. Could not in other sessions (2:10)*
>
> *KM 199 did not want her mother to help her decorate the cup cake with caramel, she waited for the group to finish decorating then she decorated hers without her mother (1:15)*
>
> *KM 199 told her mother she does not like wrapping activity and she wanted to stop playing (2:16)*
>
> *KM 199 – At first she was crying. When time goes on and others accommodate her she stopped crying and participated well. Group members helped her a lot. During joint sessions she had good communication with mom. They were close towards session 18 and later session* (Careworker observation)

Interpretation

The mother-child relationship seems to be a risk factor for KM 199. She could not express her emotions in the separate sessions. A factor could be her age as she was six years old at the time of the intervention. The group supported her during the separate sessions and this support gave impetus for her to participate in the group. During the first joint session she negated her mother's help and indicated that she wanted to complete the activity by herself. She directly communicated to her mother that she didn't want to complete the tasks with her. As the joint sessions progressed she developed a better relationship with her mother. A possible explanation posed is the value of the one-on-one time during these sessions where the mother-child pair had time to get to know each other, to communicate and to share with each other.

4.2. Interpretation: Individual behaviour observations

The careworkers' observations indicated that some children displayed more prominent behaviour than others. These children either displayed adaptive behaviour (influenced the group in a positive manner) on the one extreme or non-adaptive behaviour (influenced the group in a negative manner) on the other extreme. Werner (1990) indicated the importance of focusing in an intervention with children on both the risk and the protective factors in the lives of children and their families. The data extracted from the Child Support Group Evaluation Study support this suggestion and demonstrate the focus of the child group sessions on both the protective and risk factors.

Masten and Obradović (2006) distinguished a group of factors which they described as systems that are necessary for a person's adaptation in his/her environment. When these adaptive systems are available and function well the individual has a better chance of being resilient in his/her environment. Children who experience poverty, violence and abusive behaviour in their environment may be prone to non-adaptive behaviour. Some children do show resilience despite exposure to maternal HIV/Aids (Ebersöhn & Maree, 2006).

The children who displayed **non-adaptive behaviour** showed inattention, anxiety, an inability to express their emotions adequately and did not feel respected. They indicated that they had family secrets which they had to keep and could not talk about. The burden of the **illness** knowledge is immense for children as they have to keep a secret in fear of discrimination against the family, according to Deacon and Stephney (2007).

Although both the groups of children who displayed adaptive and non-adaptive behaviour were exposed to the same type of life circumstances, the children who displayed non-adaptive behaviour verbalised a heightened awareness of their insecurity in their unsafe environment where violence and abuse were prevalent. The poverty in the community exacerbated their already negative experience of their environment.

Helseth and Ulfsaet (2003) describe situations where a child's coping strategies are adequate to maintain well-being but they caution that a child can reach a point where the burden becomes too heavy and they then experience extreme levels of stress.

The burden of keeping their **mother's illness secret** and not being able to share their feelings with other people could have had the effect that their overall well-being was compromised. Inattentiveness and anxious behaviour might have been a result of their experiences of their uncertain circumstances. The children additionally experience a confusing array of emotions ranging from anger towards the sick mother to feeling guilty about being angry. These conflicting emotions make it even more difficult for children to express their emotions, according to Johnston et al. (1992). Families who live in poverty and experience parental HIV-infection are facing double jeopardy, according to Johnston et al. (1992). Lewis, Woods, Hough and Bensley (1989) refer to the immense impact of the socio-economic status of the family and support from significant others on adaptive family functioning. Community violence is an added factor that places these children in extremely vulnerable situations where they have to negotiate developmental opportunities in their unsafe environment (for example, making friends).

Children who displayed adaptive behaviour in spite of being exposed to poverty, maternal illness and violence in their immediate surroundings had the advantage of a good mother-and-child relationship. Their good communication skills further helped them to maintain a positive relationship with the significant others in their lives (Carr, 2006). Trust, information exchange and good communication are necessary for an effective relationship, according to Bronfenbrenner (1990). Werner (2005) elaborates on the positive aspects of a close relationship with a caregiver and indicates that it gives a child the opportunity to learn positive problem-solving skills and coping skills by modelling their (caregiver) behaviour and these results in adaptive behaviour.

The younger children showed more external and internal behaviour problems in the groups. Their coping skills and problem-solving skills may still need time to mature, whereas an older child's cognitive repertoire may be more developed to cope with traumatic events such as maternal illness, according to Korneluk and Lee (1998) and Johnson et al. (1992). The child's age, maternal illness and a problematic mother-child relationship may all have a negative impact on a child's behaviour. Steele et al. (1995) mentioned that parental emotional distress and the parent-child relationship may be affected by parental illness. The younger children also displayed hyperactive behaviour more often than the rest of the group members, according to the careworkers' observations.

The hyperactivity could have been a result of the younger children's inability to cope with the demands of the group. This observation is aligned with Geldard and Geldard's (2001) opinion that for group members to benefit from the group, the developmental ages of the children have to be compatible.

A good relationship with a significant other (in this instance mother or other family member), sharing of emotions, good communication skills, positive coping skills (in this instance religious coping skills), positive future orientation, problem-solving skills, life skills, intelligent behaviour, a positive disposition and helping others are all protective factors as displayed by the identified resilient children and discussed in the resilience literature in Chapter 2 (Condly, 2006; Murphy & Marelich, 2008; Theron & Theron, 2010; Werner, 1990) highlight the central role of warmth and support in a mother-child relationship indicating that this type of behaviour has a salutary effect on internalised and externalised behaviour problems. This could be seen in the children observed in the study and described as resilient. The resilient children furthermore displayed good communication skills, which are important for a child to form and maintain relationships with significant others in their lives (Carr, 2006).

The good mother-and-child relationship and communication skills as displayed by this grouping of children emphasised the importance of the role of the family in ameliorating the effects of maternal illness, as mentioned by Korneluk and Lee (1998). Williams et al. (2001) concur that children with a strong sense of belongingness cope better with his/her situation and that spirituality provides a further buffer. Most of the children identified as resilient, also displayed religious coping skills.

The ability to extrapolate skills learned in sessions to other situations, the ability to discern between right and wrong, participation in the support group, sense of responsibility, independency, displaying and seeking respect, helping others and tenacity were furthermore observed in the children who displayed adaptive behaviour. The children were given the opportunity for meaningful participation with one another. Janas (2002) strongly support this group function as the participation teaches children to relate to others outside the group context. Effective problem-solving skills might have helped the resilient children to take personal responsibility in dealing with situations, according to Williams et al. (2001).

The resilient children showed a desire to help their peers and Jackson and Abosi (2006) indicated that the children in the group the other members of the household had to be HIV-negative had a tendency and desire to help their peers to ensure the well-being of the group. Additionally a resilient child is more willing to accept help and support from their peers and adults as indicated by Condly (2006) and displayed in the group sessions. The group thus provided the opportunity for children to be helpful and to achieve a sense of accomplishment while practicing new skills as suggested by Janas (2002).

Independency was displayed by children who attended the group session by themselves and this correlates with Jackson and Abosi's (2006) statement that school-aged children in Africa generally exhibit independency early in life. Ubis (2011) proposes that a latent-phase child needs more opportunities to be independent in situations that are outside the immediate family and the groups sessions provided the children with this developmental opportunity. A resilient child according to Werner (2005) is able to display independent behaviour.

Intelligent children with non-temperamental personalities tend to understand situations better and use coping skills to actively cope with the adverse situation, according to Condly (2006). The children in the study who displayed a positive disposition and whose behaviour was described as intelligent accordingly exhibited adaptive behaviour. The careworkers often reported on their positive behaviour. This may be because a child with a non-temperamental personality seems to attract more positive responses from their caregivers (Werner & Smith, 1992).

The parent has a *"buffering role providing emotional scaffolding for their children"* according to Korneluk and Lee (1998, p.188). A father's involvement has a direct mediating effect on a child's resiliency (Condly, 2006). In the children who displayed non-adaptive behaviour the father figures were absent in their lives. The mother-and-child relationship was the factor that had the most impact on both adaptive and non-adaptive behaviour of the group members. Almost 30% of the participants (Figure 4.5) were in a single-parent family. Single-parent families are challenged by additional risk factors, such as poverty, child neglect and growing up in unsafe neighbourhoods (Mattingly & Walsh, 2010).

Werner (1990) and Luthar et al. (2000) refer to the importance of at least one trusted person in a child's life who unconditionally accepts him/her. The complete removal of a stressor or adversity is not realistic and such a trusting person could help that a child adequately actualises his/her potential in a safe environment. The sharing of emotions helped children to cope with their life circumstances and display adaptive behaviour, whereas children who could not share their emotions had difficulty in sharing their anxieties regarding their mothers' illness. This could have resulted in both internalised and externalised behaviour problems. The mother-and-child relationship is even more important, taking into account the findings of Forehand et al. (2002) indicating that children with HIV-infected mothers exhibit more depressive symptoms and less warm and supportive relationships with their mothers than children whose mothers are not infected. Dutra et al. (2000) refer to the resources provided by a good, dependable mother-and-child relationship to enable a child to adapt well, in spite of maternal HIV/Aids. The children in the group who had such a caring relationship with their mothers and displayed adaptive behaviour were thus able to better cope with their mothers' illness.

5. Qualitative analysis of the groups

5.1. Adaptive behaviour indicators, group content and group process – Findings

The guiding research question for this evaluation study is 'How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?' In order to answer the main research question the following qualitative sub-questions are explored **'What qualitative observed and reported behaviours and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?'** and **'What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child?'** The findings of the children's evaluation of the group sessions as measured by the child evaluation questionnaire (section A and B) are described first, followed by the resilience/adaptive behaviour indicators as taken from the group session reports. The children's group attendance findings are furthermore qualitatively discussed. The findings of the content and the process of the child support groups are subsequently reported and the careworker report findings as indicated in the careworker focus groups are described.

Finally the mothers' evaluations of the child support groups as measured on the mother evaluation questionnaire and the description of group settings are recorded. This presentation of the findings aims to adhere to the conceptual framework of the Child Support Group Evaluation Study as discussed in the methodology chapter on p.200 in order to answer the qualitative sub-questions.

5.1.1. Children's evaluation of the group sessions (child evaluation questionnaires) – Findings

The child and mother group evaluation feedback questionnaire content is discussed in detail in Chapter 3, p.169.

Child evaluation feedback findings – Section A

Figure 4.7 Child group evaluation feedback (Question 1)
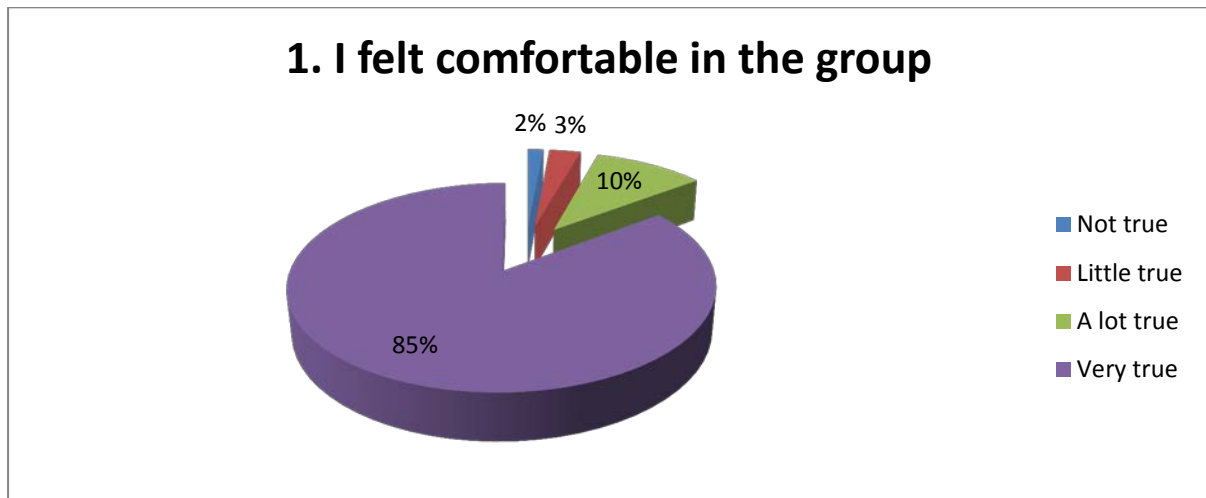
Figure 4.8 Child group evaluation feedback (Question 2)

2. I made friends in the group

0% 1%
21%
78%

- Not true
- A Little true
- A lot true
- Very true
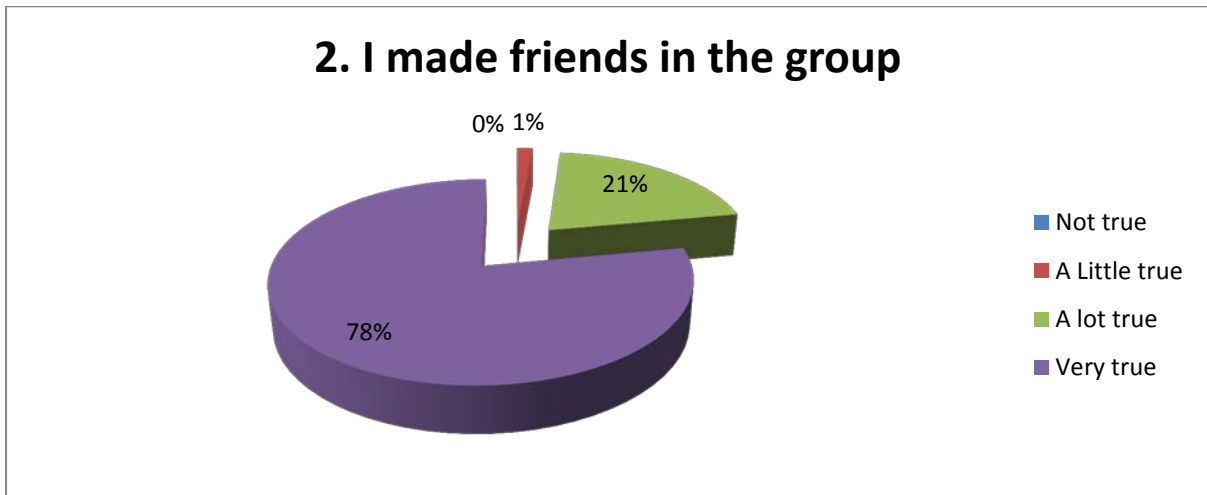
Figure 4.9 Child group evaluation feedback (Question 3)

3. I learned new things in the group

0% 2%
13%
85%

- Not true
- A little true
- A lot true
- Very true
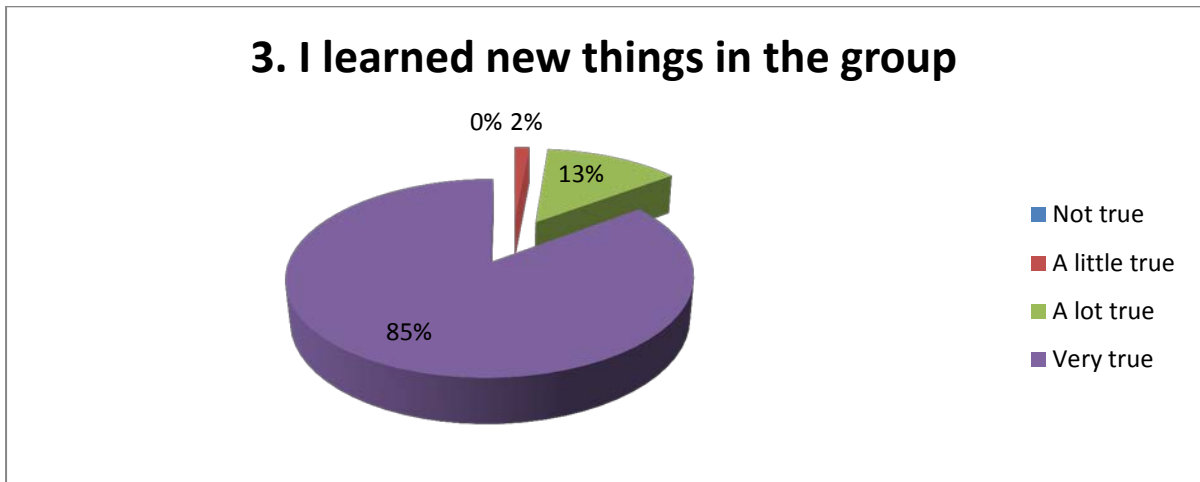
Figure 4.10 Child group evaluation feedback (Question 4)

4. I understood what I was supposed to do during the group session

0% 10%
10%
80%

- Not true
- A little true
- A lot true
- Very true

Figure 4.11 Child group evaluation feedback (Question 5)

5. Children in the group quarrelled and fought too much

- Not true — 60%
- A little true — 22%
- A lot true — 8%
- Very true — 10%
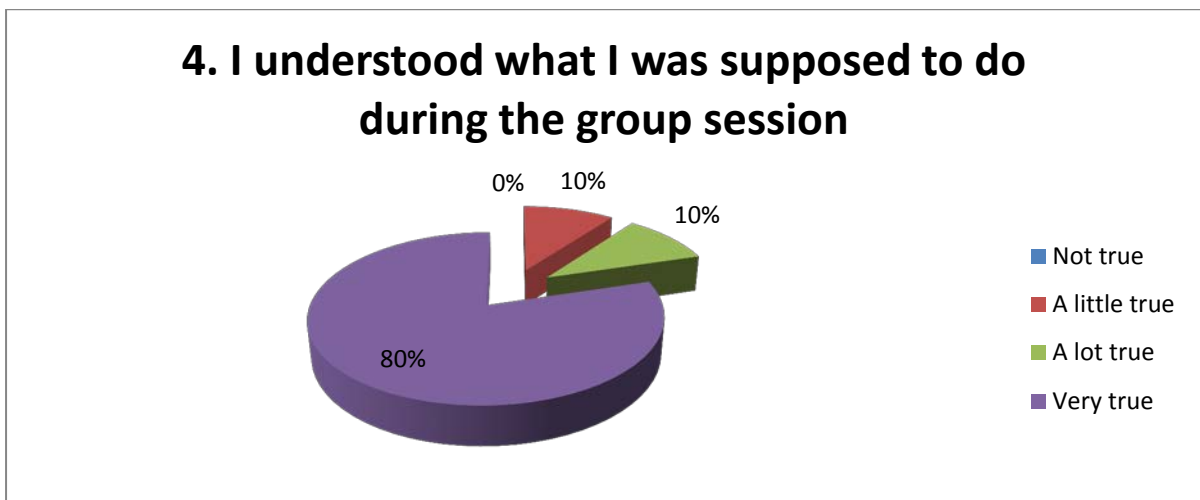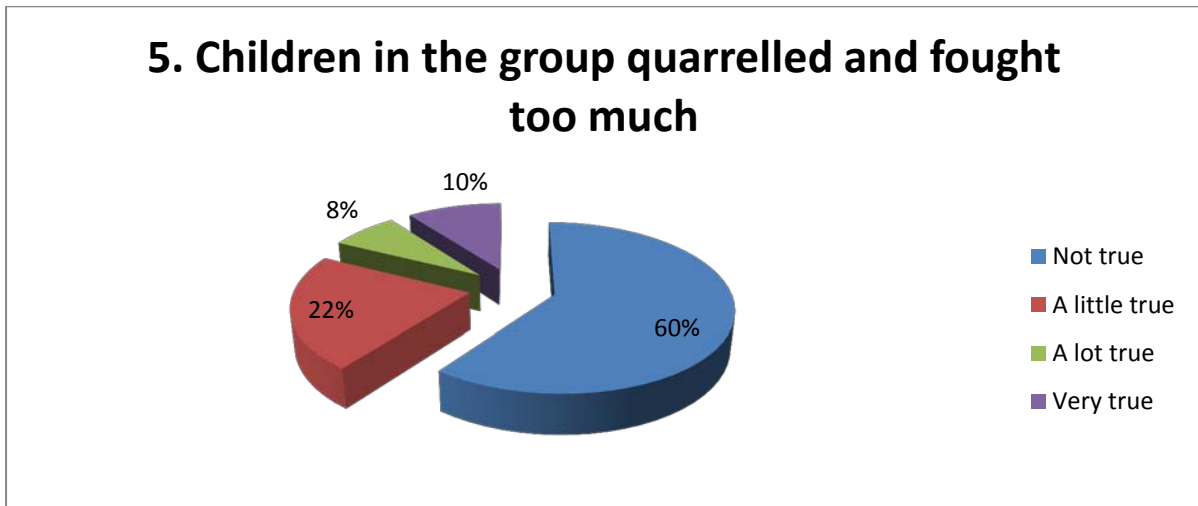
Figure 4.12 Child group evaluation feedback (Question 6)

6. My friends from group care about me

- Not true — 0%
- A little true — 5%
- A lot true — 15%
- Very true — 80%
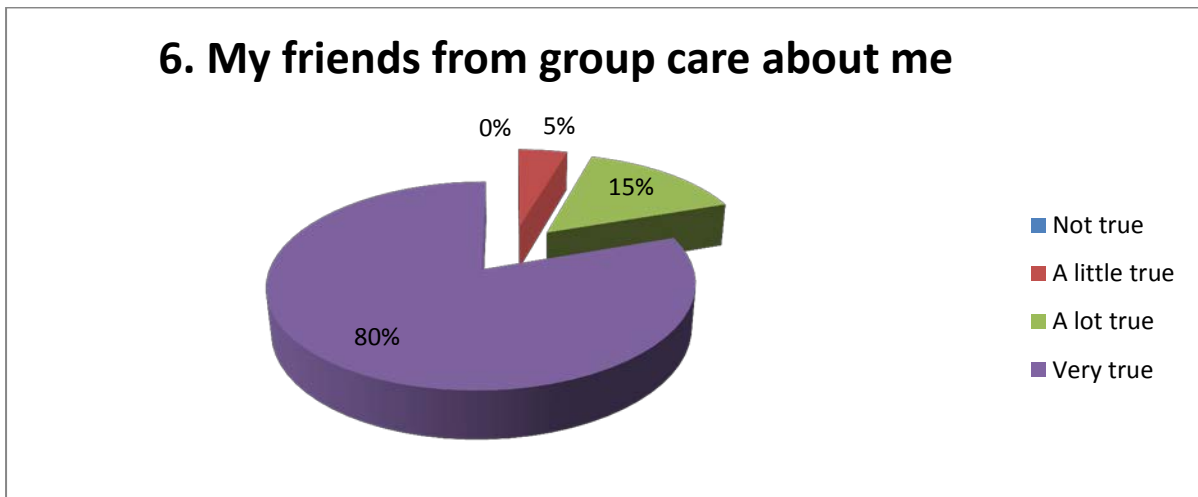
Figure 4.13 Child group evaluation feedback (Question 7)

7. It was hard to understand what was happening in the group

- Not true — 66%
- A little true — 18%
- A lot true — 14%
- Very true — 2%
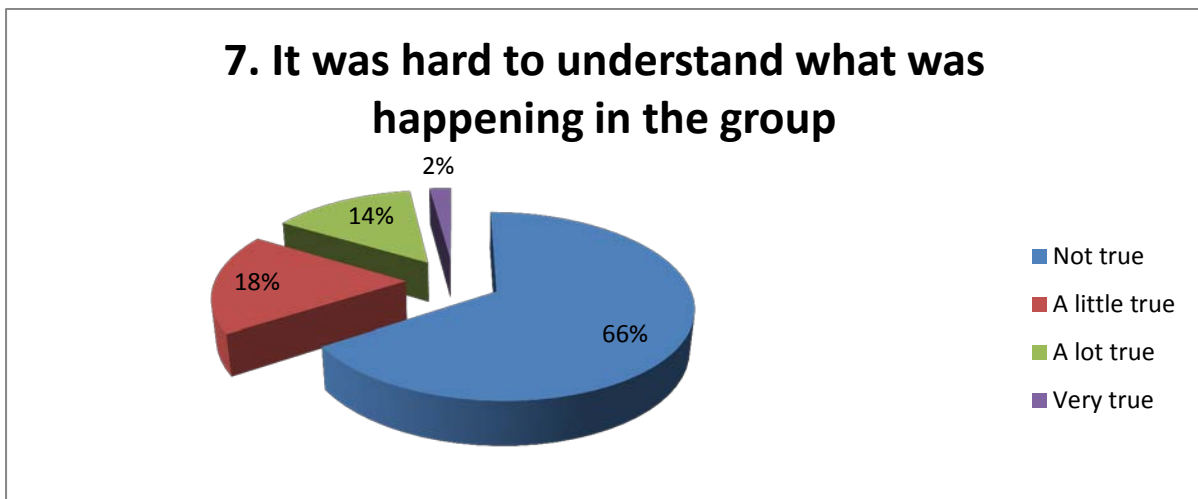
Figure 4.14 Child group evaluation feedback (Question 8)

8. The things I learned in the group helped me

- Not true
- A little true
- A lot true
- Very true

0%
9%
13%
78%
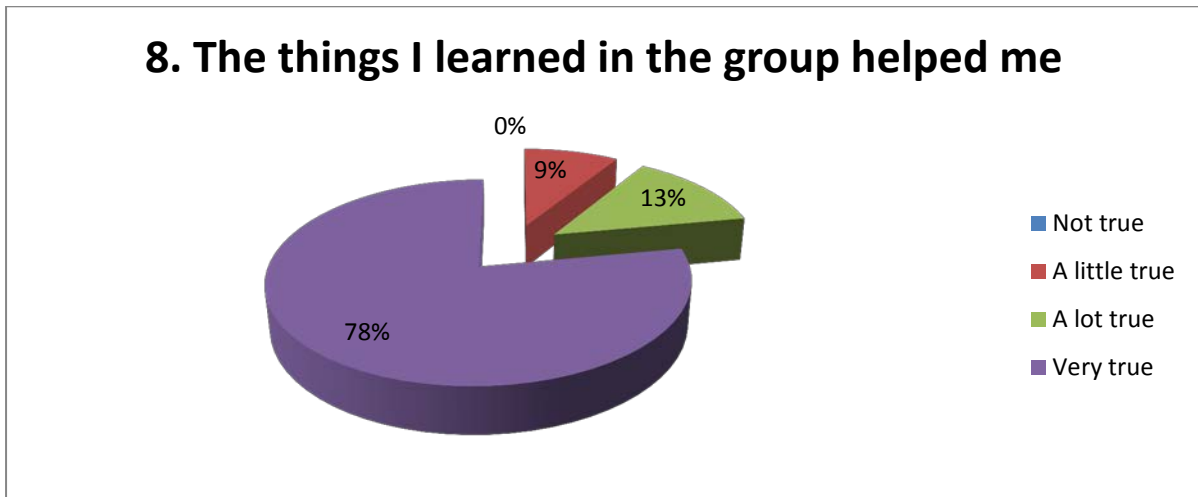
Figure 4.15 Child group evaluation feedback (Question 9)

9. My friends and I helped each other in the group

- Not true
- A little true
- A lot true
- Very true

3% 2%
13%
82%
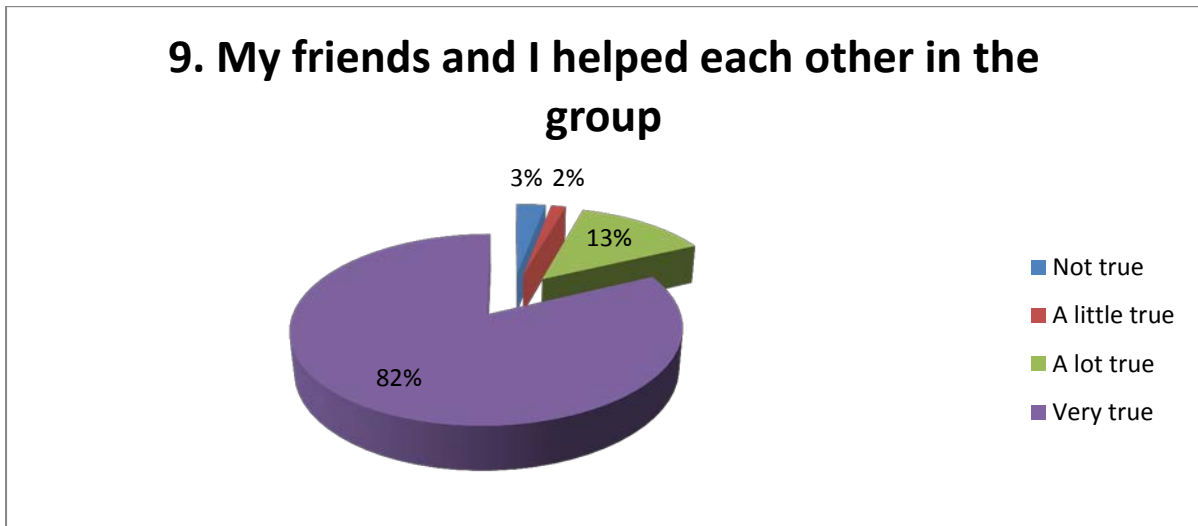
Figure 4.16 Child group evaluation feedback (Question 10)

10. I could easily do what I was asked to do during the group session

- Not true
- Little true
- A lot true
- Very true

6% 5%
21%
68%
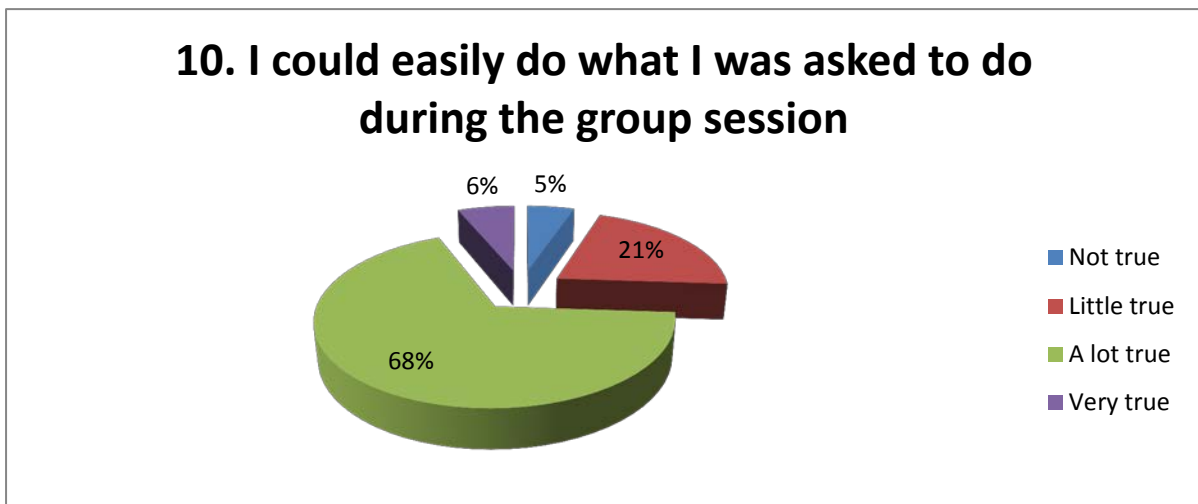
Figure 4.17 Child group evaluation feedback (Question 11)
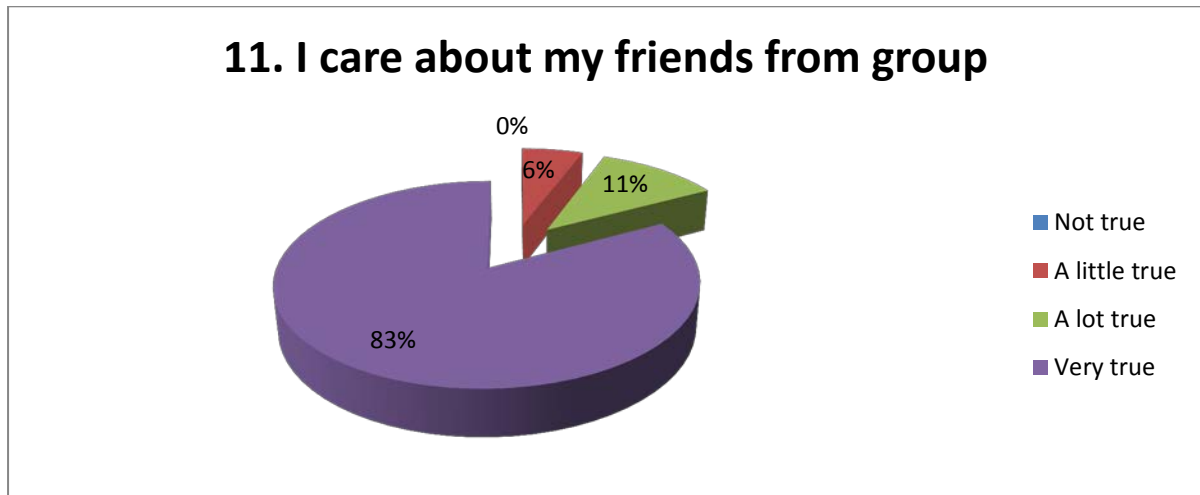
The majority of children (95%) indicated that they felt comfortable in the group (Figure 4.7). The children understood what was expected of them in the group (90%) and understood the group process (84%) (Figures 4.10 and 4.13). The children (74%) indicated that they could easily do what was expected of them in the group (Figure 4.16). The children specified that they learnt new skills in the group (98%) and that these skills were helpful (91%) (Figures 4.9 and 4.14).

The group provided the opportunity to make new friends according to the children (99%) (Figure 4.8). They experienced their friends as caring about them (95%), they cared about their friends (94%) and they supported each other (95%) (Figures 4.12, 4.17 & 4.15.). They did not feel that there were disagreements among group members (82%) (Figure 4.11).

Child group evaluation feedback findings – Section B

The themes that were identified by analysing the open-ended question 'what did you like best about the group' are, in order of importance, the opportunity to play with friends, games that challenged them, the refreshments they received at the group, the opportunity to learn new things, the chance to make new friends, the help they received from each other, the lessons they learnt in respecting parents and peers, the group climate of respect and no tolerance for fighting and they indicated that they enjoyed being asked questions. The type of activities that the children themselves indicated as enjoyable in the group were writing, reading, painting and drawing activities.

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The children especially enjoyed the activities where they could play with their mothers. Being actively kept busy and games with puppets, activities of feeling thermometer, making food for mothers, body mapping, 'Don't talk to strangers board game', 'Finding Nemo' DVD, dancing- and singing activities where mentioned and discussed in detail. The children also indicated that the toys they received where important to them.

Examples:

> *Having new friends who does not attend my school and doing things and game with my mom (KM 537)*
>
> *To continue with groups for ever and ever even Saturday (KM 350)*
>
> *When we talk about our emotions and when we play with puppets and play (KM 567)*
>
> *They taught us about life, our career plans. I loved to play (KM 718)*
>
> *The group mates, they were friendly, supportive, co-operative and kind. I know myself better than before. I used to enjoy the meals (KM 588)*
>
> *I made new friends. Career help and the importance of education we talked about. I liked teaching to do things such as washing clothes, washing dishes and making tea (KM 208)*
>
> *I want my teachers to see my friends; I also want him to see how peaceful the place is (KM 149)*
>
> *To enjoy and be taught about good behaviour (KM 545)*
>
> *Because KM staff love people (KM 550)*
>
> *Learn many things about respecting other people and listening to teachers (KM 621)*
>
> *To come when they are not happy at home or at school (KM 476)*
>
> *Being asked questions because they helped me to perform better in my class tests. I developed a better way of understanding and answering questions (KM 477)*
>
> *The people at KM support group took care of us; they did not punish us (KM 438)*
>
> *Because KM treat people equally (KM 441)*
>
> *The questions especially about feeling, something that we never have anyone talk to us about (KM 453)*
>
> *Doing things together with my mom e.g. decorating cakes (KM 202)*
>
> *Learn about good things and bad things and pray to God every day because he loves children (KM 421)*

5.1.2. Resilience/adaptive behaviour indicators (group session reports) – Findings

In reference to Chapter 1 (par.2.1., p.5) a primary aim of the Promoting Resilience in Young Children Study is to "*assess the effectiveness of a theory-based support intervention for HIV-infected mothers and their children designed to improve maternal functioning and help mothers promote resilience in children.....school-aged children (ages six to ten)*" (Forsyth, 2005, p.2). The present study focuses exclusively on the efficacy of the group-based intervention for children. The Promoting Resilience in Young Children Study conceptual model as indicated in Figure 2.4. lists the child group-based intervention outcomes as improved adaptive functioning, decreased depression, decreased anxiety, decreased behaviour problems and improved school performance. As a result the proposed outcomes of the manualised group-based intervention under investigation in the Child Support Group Evaluation Study set forth to achieve the following resilience skills[5]: naming and identifying emotions; appropriate expression of own emotions; appropriate response to others' emotions; communication with group members; sharing with group members; supporting group members and asking for help; respect for group members; coping with stress; appropriate problem-solving; a positive future perspective and life skills.

The findings of the resilience or adaptive behaviour indicators per wave (refer to Figure 4.18) as reported[6] by the careworkers, indicate that there was consistency in the indicated adaptive behaviour indicators across the waves. There was furthermore inter-rater reliability between the findings of the researcher and the external coder's enumeration of the adaptive behaviour indicators as presented in the group session reports (refer to Figure 4.19).

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[5] The resilience skills as measured in the Child Support Group Evaluation Study were drawn from the over-arching objectives as set for each group session in the group session manual (refer to Appendices 10 and 11).

[6] The researcher of this study takes cognisance of the fact that the data used in this study is resilience behaviour as reported by the careworkers (group facilitators) in the study. The reported data do not necessarily indicate that the children showed resilient behaviour *per se*. The data reported were the children's verbalisation of resilient behaviour and the careworkers' observation of resilient behaviour.

Figure 4.18 Average resilience indicators per wave[7]
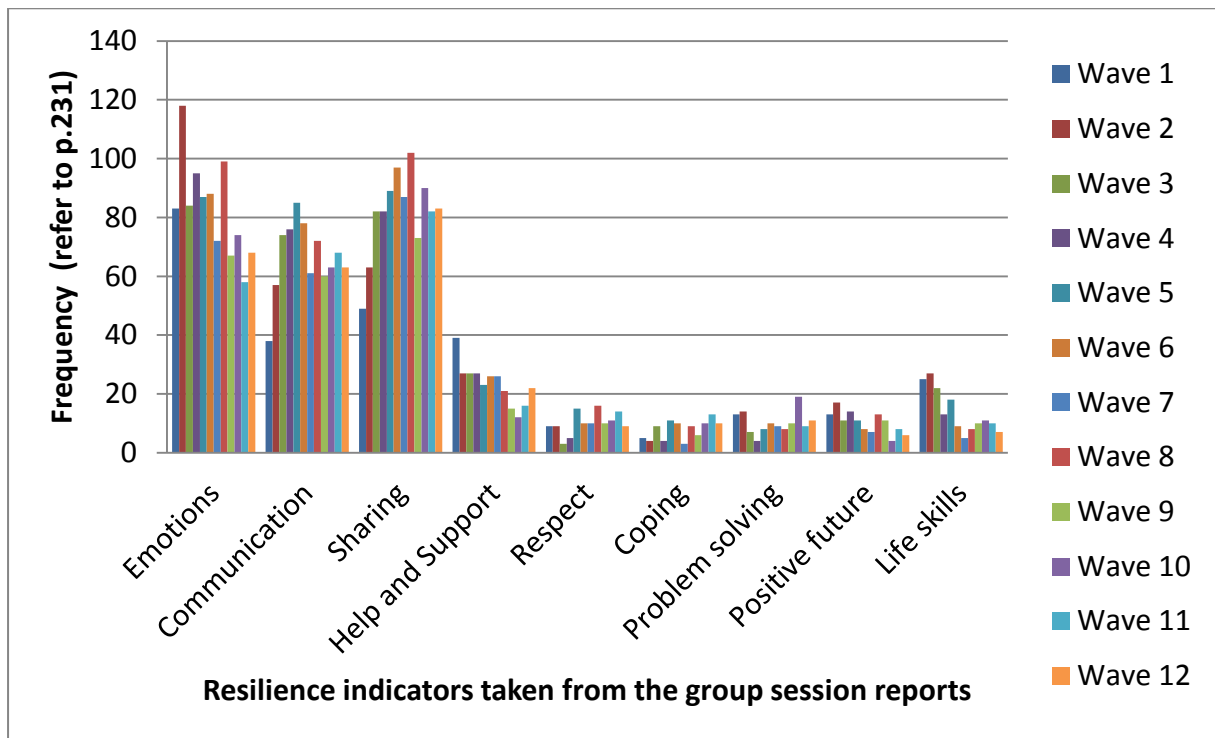
Figure 4.19 Inter-rater reliability of the average total occurrence of resilience indicators as observed by the researcher and the external coder

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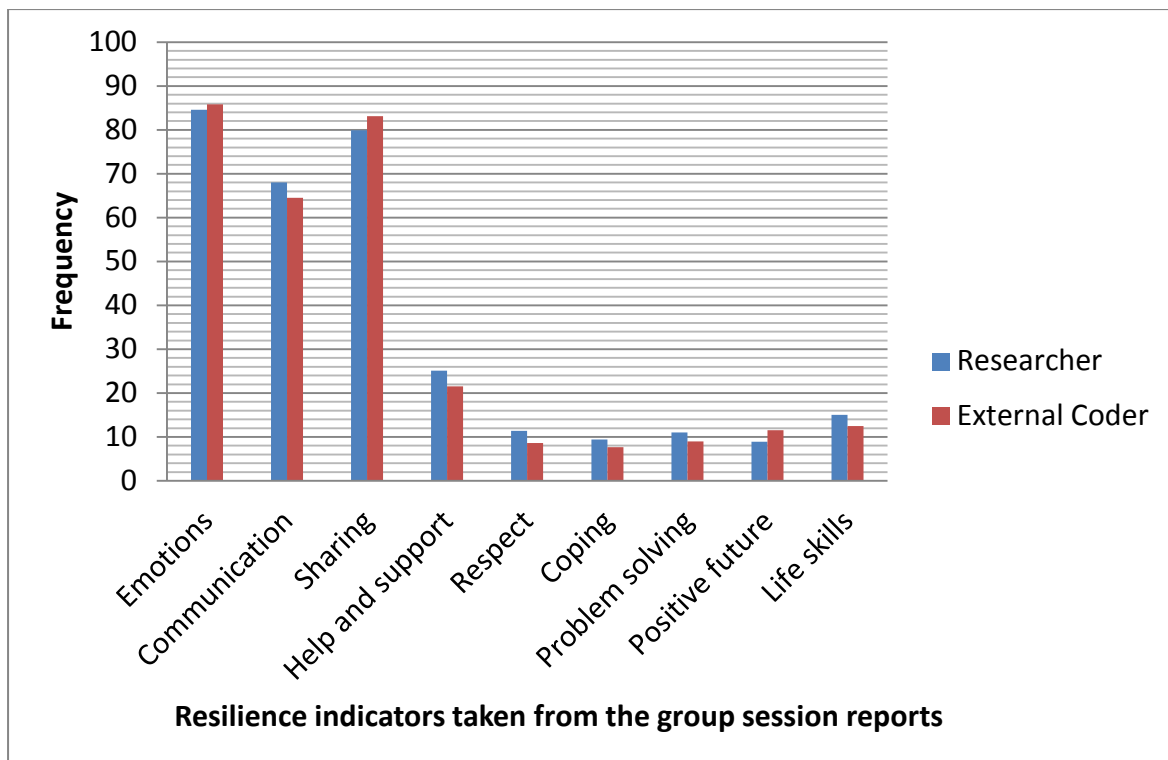
[7] The resilient behaviour observed by the careworkers.

Figure 4.20 Average total occurrences of resilience indicators
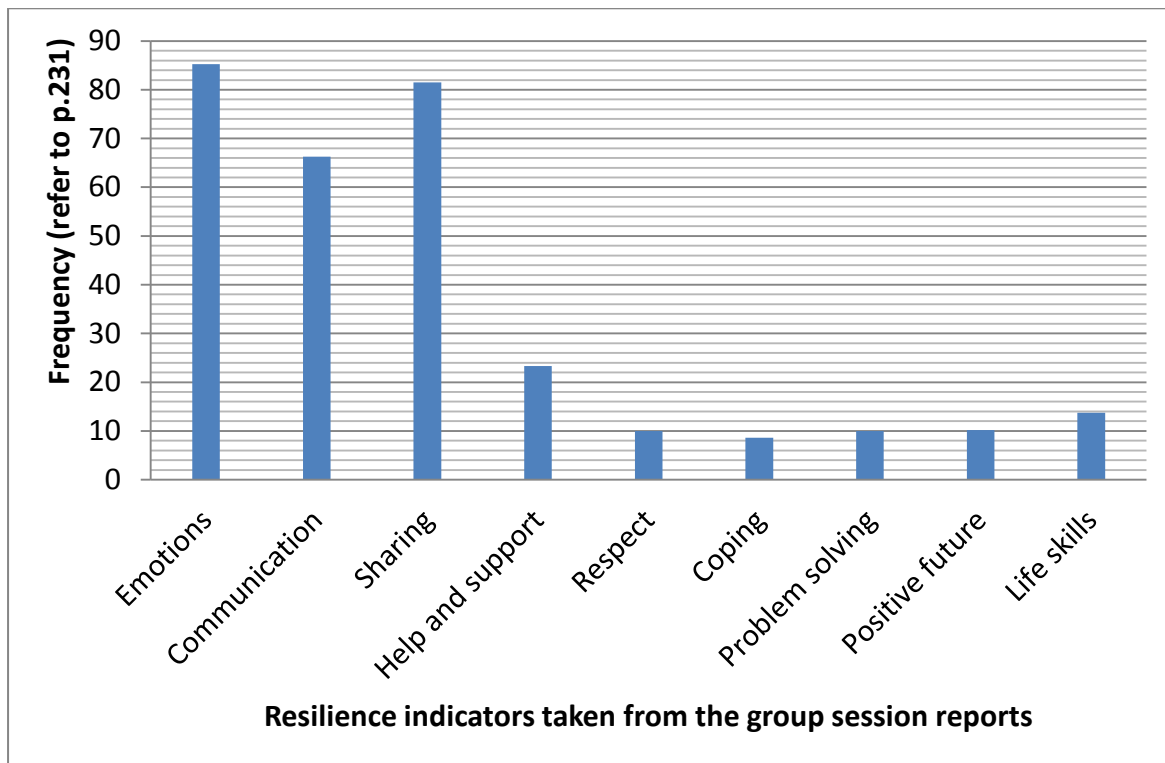
The sum total of the average occurrence of resilience indicators[8] in the group sessions demonstrates that the identification and verbalisation of own and others' emotions, sharing and communication transpired most often during the group sessions (Figure 4.20). A possible explanation for the higher frequency of the identification and verbalisation of own and others' emotions, sharing and communication indicators could be that they are more overarching in concept than the other measured indicators. Help and support, life skills, problem-solving, positive future, respect and coping were also addressed in the child support groups and the findings of each indicator in the group sessions and notable themes or trends (mother's illness, violence and poverty) are subsequently discussed.

5.1.2.1. Emotions

The theme that occurred most frequently during the group sessions was identification and verbalisation of own and others' emotions.

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[8] The researcher of this study acknowledges that the specific behaviour the careworkers have chosen to report on could have had a limiting influence on the frequency measurement of the data. Therefore additional qualitative data were used in the analysis process to support the frequency measurements.

The children were willing to share their pleasant and unpleasant emotions. The group provided a safe environment for the children to explore and display a repertoire of emotions ranging from joy to aggression. The children showed emotional support for each other. They experienced that sharing and displaying emotions have a healing effect.

The aforementioned is illustrated by the following examples:

KM 434 said he is sad and angry when his mother is sick, but he will pray for her and ask her to go the doctor (7:10)

KM 502 said he can see his mother on her face if she is not happy, after that all agreed with him. He then try and make her happy. He doesn't feel happy if his mother is not feeling happy (7:10)

KM 586 said he is scared when his mom is not feeling well (8:4)

When we were discussing some of the questions about the previous session KM 116 said what makes her laugh is when her mother is well because her mother was sick for long (1:16)

KM 319 told the group about her brother who is a thief and the grandmother is angry about it. She hates him (4:2)

KM 179 asked 173 what will happen when his friend died and he answered he is going to cry and the group said yes he should cry. (2:10)

5.1.2.2. Communication

During the group sessions the children were able to communicate their ideas and emotions. Communication helped rectify misunderstandings and this improved, among other things, the relationship between mother and child. The safe environment of the group enabled children to disagree with their mothers. The group sessions empowered withdrawn children to become leaders. Communication as a theme occurred frequently.

Examples to support this theme are as follows:

Communication was very high, during the poem and writing a song activity. Children and their mothers were excited and they were able to compose and recite a poem together (2:19)

Was high, they were explaining to each other the rules of morabaraba game. They asked each other how you felt when you win/lose the game. They explained to each other it is only a game and should not be angry with each other (3:21)

> *When talking with puppet socks mothers were amazed because we explained to them what and how your child said is how you are talking to him/ her at home. They said they know each other better now and they enjoyed doing activities with their children (4:17)*
>
> *KM 199 told her mother she does not like wrapping activity and she wanted to stop playing (2:16)*
>
> *KM 699 comes to group with careworker, mother passed away during group sessions. She told careworkers that her mother passed away (11:16)*
>
> *When doing puppet plays KM 213 was very happy to play. She also gives some of the children things to role play. She was quiet but now she is like a director (2:6)*

5.1.2.3. Sharing

Sharing occurred between group members, between mother and child and between children and group facilitators, as evidenced by the notes of the careworkers and the observations. The children shared emotions (refer to a p.233), information and normative values regarding their personal world and their external world (family and school). They also shared constructive and negative information in the safe environment of the group.

Examples to draw attention to the sharing activities that took place during the group sessions are:

> *During the making of a feel good quilt, everybody drew his home and the way their homes looks like and they said its where they feel safe and happy because they stay with their mothers and they know their mothers love them (7:2)*
>
> *During the puppet play, they were sharing information on how to play and what to say during the play. When playing making a friend scenario they were talking positive things and encouraging each other (4:1)*
>
> *KM 491 said he want to be careworker's body guard when he grows up (7:14)*
>
> *KM 197 said his mother never said he is special, although he fixed cassette deck and DVD for his mom (12:4)*
>
> *KM 358 asked his mother to come and look what he did during the session (5:2)*
>
> *All the children said they enjoyed the falling exercise, except for KM 197 he said he didn't enjoy and we accepted it (12:3)*

> *When playing masekitlana KM 302 was talking about her brother "because his mother gives him money to buy bread and he didn't bring change". It shows that he robbed his mother (4:5)*
>
> *KM 570 and 536 said sometimes they take their mother/father's change after buying something for them. KM 576 said it is wrong because you can be thief for rest of life (8:9)*

5.1.2.4. Help and support

The group participants developed tight bonds with each other and this cohesion assisted the group participants in taking notice of other children's discomfort. They supported these children by allowing them to take part in the activities at their own pace and comfort level. In most of the group sessions the children displayed a willingness to work together and to support one another. When a child asked for help or indicated that they were in need of help, the group supported them. In situations where there was disagreement between members, the strong group cohesion most probably enabled children to compromise and support each other. The support structure of the group included the provision of community donated food parcels to children and their families.

In order to illustrate the above, the following examples are given:

> *KM 504 did not want to mime or act. She was shy but the group did not force her to do he activity and said to her she can do it in her own time if she feels ready (7:11)*
>
> *During the body mapping activity they were helping each other with the drawings. They listened when we tell them what to do. They communicated well with each other (4:3)*
>
> *When making soup they were working together. They were giving each other chance to put ingredients inside pot. They were very careful and helped each other. They first discussed how they will lay table before they did it (8:13)*
>
> *Although there were only a small group the communication was good. They sang in pairs. They were helping each other if they know the song. They listened and supported each other (4:11)*
>
> *KM 441 and KM 112 during the previous sessions they were not getting along but this session they helped each other with picture cutting, when someone needed a picture the other will give them the picture. Definite improvement in KM 112 behaviour (6:6)*

> *KM 399 brought cake because it was her birthday. We celebrated together. Children now know what makes their mothers to be angry e.g. when they don't listen to them. They are developing a strong bond (5:21)*
>
> *KM 470 – He could not participate in the group properly because of the social needs at home. Most of the time there was not food at home and the only place he could get food was in the support groups*

5.1.2.5. Respect

Respect, pertaining to different areas of life, was displayed during the group sessions. The normative area referring to religion and group rules and the area referring to respect and disrespect towards parents and other adults were especially important. The children indicated that they desired to be respected as human beings by adults and other children. Data from the study showed that the group interaction taught children what respect is and how to show it.

The above mentioned are referred to in the following examples:

> *KM 331 said he likes to go to church and he dislikes disrespect (5:2)*
>
> *KM 441 was not respecting group rules he was making noise and he said he is not interested but the group asked him to go outside and he can come back when he is ready, he did so and came back to group (6:11)*
>
> *KM 590 said we must respect our parents when they asked us to help them (9:5)*
>
> *KM 329 said he didn't respect his father as Nemo is not listening to his father, he does respect his mother and listen when she talks to him (7:22)*
>
> *There is team work and respect in the group when someone do mistake they helped him to correct it and they don't laugh at each other (7:2)*
>
> *It is a big group and it will take time to some of the group members to trust us and some group members said that they don't want to be shouted at by their parents. They should talk to them on a polite manner because they also get angry. They need to be respected in order for them to respect (3:9)*

5.1.2.6. Coping

Religion[9] was the most important positive coping mechanism displayed and reported by the children, as observed by the careworkers. The qualitative data from the study showed that they received comfort and also offered comfort to others through their religion. Their religious practices included attending church and Sunday school, prayer, reading the Bible by themselves and with their families. The children requested that the Bible be read to them during the group sessions.

The children experienced their mothers and grandmothers as a further source of support while coping with challenging life circumstances. The group facilitated the teaching of coping strategies, identification of strengths and other assets in their life.

Coping examples are listed as follows:

KM 714 had a Bible cutting amongst his cuttings. He explained to us that the Bible is a good book to read for it can comfort him and others who are in pain or trouble and it also guides him to be a person with good manners and respect for peers and older people (12:19)

KM 419 said if there is someone in the family, very sick, he will pray for him/her and accompany him/her to hospital (7:10)

KM 234 had drawn a cross during the making feel good quilts and after the session she prayed for the long time asking God to give her strength in everything she does (3:2)

The children all said they attend Sunday school and they sang praise songs (2:4)

KM 545 said she likes her family because they pray together and go to outing together. They love each other (8:6)

The children said we should read Bibles for them during the session (3:2)

When doing the story of the little hare they were listening very carefully and after that we asked the questions of what happen if they are not feeling well. KM 217 said "I sit on my grandmother's lap" and the others said they sit on their mothers' laps (3:4)

About their strengths e.g. rugby and athletics they said their teachers encourage them to do well at school (5:6)

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[9] The religion referred to in this study is the Christian religion.

5.1.2.7. Problem-solving

The children were able to provide different types of solutions to the problems posed in the groups. The groups were supportive and encouraged members to explore the best-fit solutions for their problems, according to the observations of the careworkers. They were able to extrapolate problem-solving skills learnt in previous group sessions to new situations. Life skills were also used to solve problems. It seemed that life skills, as taught in the groups, significantly empowered children who were fearful to embrace the challenges of life. The members used the group rules as a problem-solving strategy to resolve interpersonal conflict situations. The discussion and practice of problem-solving strategies contributed to the children's comprehension of the cause-and-effect logic underlying their decision-making behaviour. Most of the children identified their mother as the person they could turn to if they experienced a problem. In communicating their problems with their mothers the children experienced emotional security and subsequently the mothers were made aware of the challenges their children experienced.

Problem-solving examples from the qualitative data in the study are shown below:

> *Children gave different solutions to man's problem and said how they solve problems. Group members help each other with problem solve (1:6)*
>
> *KM 589 said he will just sit in the hole and cry, but the group encouraged him to think of a plan and then he came up with a good plan to get out of the hole (8:7)*
>
> *We were watching Nemo. It was all about emotions, safety, coping skills and problem-solving. They were aware that everything which was happening in Nemo we did in previous sessions and they spoke about it (8:22)*
>
> *They were able to make story applicable on own life. They said if something happens to them they will make a plan to survive. KM 545 said "if I get lost I will make a plan to survive and use skills I learnt". KM 545 said "if I get lost I will call my mom because I now know her contact details". KM 576 said "we must be safe" (8:22)*
>
> *On previous session (5:6) they were shy to play with puppets but this time they were comfortable and express themselves. They understand how to solve problems because in their role play the father gives the mother money to replace neighbours window (5:7)*

> *They were not disturbed by the fight that they had at the beginning of the group but they said we should follow our group rules and help each other and play together as a group. If we have a disagreement we should talk but not fight to get a solution (6:2)*
>
> *Children indicated that they enjoyed the decision and consequences exercise because they learnt that if you do something you must expect the results (7:14)*
>
> *It was good; they gave each other a chance to tell us what they have learnt. All children said they liked story 'man in the hole' because it teaches them to be careful and aware of dangerous situations. They also said if they have a problem they will inform their parents. It also taught them responsibilities (4:24)*
>
> *Children said they enjoyed doing activities with their mothers. Mothers said they say thank you because now their children can confront them when they have a problem (5:24)*

5.1.2.8. Positive future

The child participants in this study realised in their short- and long term future planning that they have to study to reach their goals. It was significant that the future careers the children visualised originated from their experience of personal life circumstances. They selected care giving careers aimed at: helping their own families financially, materially and with food provisions; helping sick people and helping people in need. The group members expressed their desire to have families of their own and be responsible parents. Discussing their children's future plans, gave the mothers hope. Some of the mothers have already opened up savings plans for their children's future careers and helped them do career planning. Irrespective of the children's personal circumstances and environment, collectively they had a positive future perspective and encouraged each other to talk about the future.

Examples of a positive future orientation are shown below:

> *They discussed their future plans with their mothers. KM 552 said he want to be soccer star and have thousands. He also said he will go to UNISA and do business skills, commercial science to do business well. All of them said they want to further their studies and have their own houses and families (8:23)*
>
> *KM 522 and 545 they knew in order to be a successful person you must not have children first and have finished your studies (8:23)*

KM 576 said she want to be a teacher and have lovely family. She also said she want to do small agricultural because she want to have sheep so that her family will not suffer and they will not have to buy meat from butcher. They made collages and future path together. At the end they said they enjoyed the activities and mothers thanked saying they were not aware of sitting with child to talk of wishes and dreams were so rewarding (8:23)

During the strengths exercise the children decorated their body maps and they decorated with things they wanted to achieve when they grow up e.g. having cars, computers and big house. They all have positive attitude towards their future. They all want to help their parents when they grow up (5:6)

KM 205 cut picture of doctor checking the baby in hospital and explained to his mother that he want to be a doctor to make her healthy (2:19)

We had doctors, policemen and social workers for tomorrow. KM 537 said she want to be a social worker to help orphans and vulnerable children (9:23)

KM 350 said he want to be a fire-fighter to help people who life in informal settlements when their shacks are burning (5:23)

KM 453 said she want to be a social worker she is aware that her mother save money for her for further studies. She said the reason is she wants to help family in need and children who don't have parents. She want to open centre for orphans and say thank you for God for protecting her on future path and keeping her mom healthy (6:23)

Their work (collage and future path) were very neat and attractive. On their pictures there were short term materials e.g. cell phones and long term material e.g. dream houses. KM 441 said he wants to be professional soccer star and he already started. He also said he want to be a responsible man and father for his family when he grows up (6:23)

They made collages and future paths together. At the end mothers were very happy and said thanks for us because it was the first time together with their children and planning for the future. Some of the mothers said they have policies for their children and discussed it with other mothers (4:22)

It was very high, children were able to tell their parents what they want to be in the future, some said they want to be doctors, police etc. and mothers were able to explain to them which subjects to take at school and what to do after matric (3:23)

They were working as a team when making feel good quilt. Their pictures were very beautiful. They drew stars and said it is for a brighter future. House with a beautiful garden and flowers. They showed creativity. They combined their pictures and called it a Family house because they love each other as one family. They came with this family house idea after a discussion among themselves (8:2)

KM 526 during the future train activity said he was enjoying the activity and he was living the dream because after the activity he encouraged other to talk about their future dreams and also asked advice from the parents on which subject he needs to take in school (9:14)

5.1.2.9. Life skills

The life skills the children displayed included mostly housekeeping skills. As a result of the mothers' health issues, this responsibility was placed on the child participants in this study. Gaining these skills contributed to their self-confidence in the group. It seemed that the group process helped children develop adequate life skills. Data show that the children could extrapolate life skills learned in previous sessions to other situations in their lives.

Examples of life skills to illustrate the abovementioned statements:

The group members were excited to do the activities and they wanted to demonstrate his/her skills in front of the group. They were giving each other a chance. It was fun. When doing demonstration of specific skill, they showed team building and sharing because they give each other chance to do that e.g. washing the dishes. They all do that in a good way and they know the safety rules (5:13)

KM 134 said that she learnt that if her mommy is sick, she will be able to make food for her. She loves her mommy because she takes care of them (2:12)

KM 379 said he is preparing himself to be able to make food for his little brother when their mother gets sick, because sometimes she is not feeling well (5:13)

They were happy to make soup and they prepared themselves mentally because we explained to them last week we are going to do. Some asked their mothers how to make soup and they came to the group with that information (5:13)

> *KM 453 said if she gets lost she will call her mother because she knows her contact numbers. She was the one who told others that everything which is happening in Nemo we did in previous sessions e.g. she said we did don't talk to strangers and survival skills where we practiced household chores (6:22)*

5.1.2.10. Notable themes/trends from the data

While section 5.1.2. of the thesis study focused on resilience/adaptive behaviour indicators, it was noted that some themes emerged from the data relating to the adaptive behaviour of the child participants.

- **Mother's illness**

The children displayed internalised (withdrawal and anxiety) and externalised (bullying and aggressiveness) behaviour problems related to their mother's illness, as evidenced by the group session data. The children were able to express their fear of losing their mothers through illness. They knew their mothers were ill, but it seemed from the careworkers' observation of the group sessions that the children were not aware of the implications. In most instances they took up the responsibility to care for their mothers. There seems to be a correlation between the mothers' physical wellness and the children's psychological wellbeing and behaviour, according to the data as obtained from the group session notes of the careworkers.

Examples:

> *KM 616 – The child seems unhappy and she was always quiet and sometimes when we ask her questions you could see that her mind was far away. And she had that fear and most of the time she was not participating well in the group, she was always quiet but the relationship with her mother was very good. Her mother was ill (care giver observation)*
>
> *KM 193 says he fears most of all that if his mother gets sick or if she can pass away that is his biggest fear. He said he can't live without her (12:10)*
>
> *KM 179 he was bullying other children and he said he feels pain when somebody passed away and he is worried when is mother is sick, he thinks she is going to die. (2:10)*

> *Last week KM 193 said he won't help his friends because they also don't help him. After saying he want to be a doctor I asked him why and he said he want to help sick people. He is taking out his anger on other children while mother is sick (12:23)*
>
> *KM 586 said he is scared when his mom is not feeling well (8:4)*
>
> *KM 552 says her mom cry over "a secret", she is ill (8:15)*
>
> *KM 561 said she want to be a nurse. And she also said she remind her mother to take her medication every day, she needs her medication every day otherwise she will become ill (8:10)*
>
> *KM 561 was old self after last week. Mother was ill, but better now (8:17)*

- **Violence**

The children's expressions and projections of episodes of violence during their participation in the group activities[10] could indicate exposure to violence and/or expression of deep-rooted problems. One hypothesis is that the children display aggressive behaviour, as a coping mechanism to deal with their underlying fears and anxieties. The group provided a safe environment within which to express this behaviour. The opportunity to vent these negative emotions may have provided crucial emotional release.

Many children feared and reported abuse (emotional, physical and sexual abuse) in their close family proximity (specifically uncles). They displayed fear when they reported situations where family members threatened them with violence if they did not take part in illegal behaviour such as buying liquor and cigarettes for family members, although legally under aged. From the data it seemed that they were able to discern between right and wrong behaviour. Their distrust in the police to whom they were supposed to report this abusive behaviour contributed to their general feeling of insecurity. Their day-to-day exposure to violence in the community where they resided enhanced their feelings of insecurity.

---

[10] Reports of personal violence or abuse were addressed through standard reporting procedures.

Examples:

> *During masekitlana most of the group members told their stories using violence in the family and there are much of guns and shooting and stabbing in the community (5:5)*
>
> *KM 143 is having a burnt wound in the face, when we asked him about it he started to cry and didn't want to talk about it. (1:11)*
>
> *KM 627 and KM 679 said that their uncles beat them when drunk. KM 670 just cried and she didn't want to talk when we spoke about the uncle thing. KM 616 says she is scared of her uncle because he raped her (10:8)*
>
> *KM 376, 350 and 373 said they feel unsafe with their uncles because they are drinking. They don't trust them. They trust their friends more than their uncle (5:8)*
>
> *KM 525, 590 and 637 said they don't trust their uncles because they drink alcohol and sometimes asked them to go and buy cigarettes and alcohol and that is illegal (9:8)*
>
> *KM 219 said he does not feel safe with police because sometime they beat people and arrest them without their parent's consent (3:8)*
>
> *They said if they are at home, inside house, locking doors, they feel safe. They feel safe with mothers and teachers (3:8)*

- **Poverty**

Food scarcity was a prominent result of the poverty the children experienced. In attending the group sessions the children's physical needs were taken care of, if only for a short period of time. They received nutritious lunches and food parcels.

Examples:

> *KM 539 said he will kill himself on island and the food is finished. The will kill himself before hunger kills him (8:12)*
>
> *During the decoration of the memory box most of the children decorated their box on things they wish to have, some they don't have enough food and they pasted their boxes with food (7:18)*

5.1.3. Group attendance – Findings

There were 20 children and mothers initially randomly selected for each wave or group. The findings of the group attendance indicated that an average of 8.5 children from the initially randomised wave of 20 children attended the group sessions. Five waves ended with less children in the groups than it initially started with, one group ended with the same amount of children in the group and six groups ended with more children than were initially in session 1 (refer to Figure 4.21). The largest group had an average of 12 children and the smallest group had an average of six children attending the sessions. The reasons for not attending specific group sessions were, according to the careworkers' group session records, the following:

- Mothers were working
- Mothers were ill
- Mothers passed away
- Mothers were pregnant or recently gave birth
- Heavy rain
- Difficulty with transport
- Specific dates where the mothers received grants
- Specific dates where the mothers had a clinic check-up
- Children had extra-mural activities
- Mothers and children went to visit family in other areas (specifically during school holidays)
- Riots and unrest in the communities that prevented mothers and children from attending certain of the group sessions.

There were children who attended some group sessions by themselves if their mothers could not attend the session. One child continued to attend the group sessions with a caregiver after her mother passed away.

Figure 4.21 Group attendance
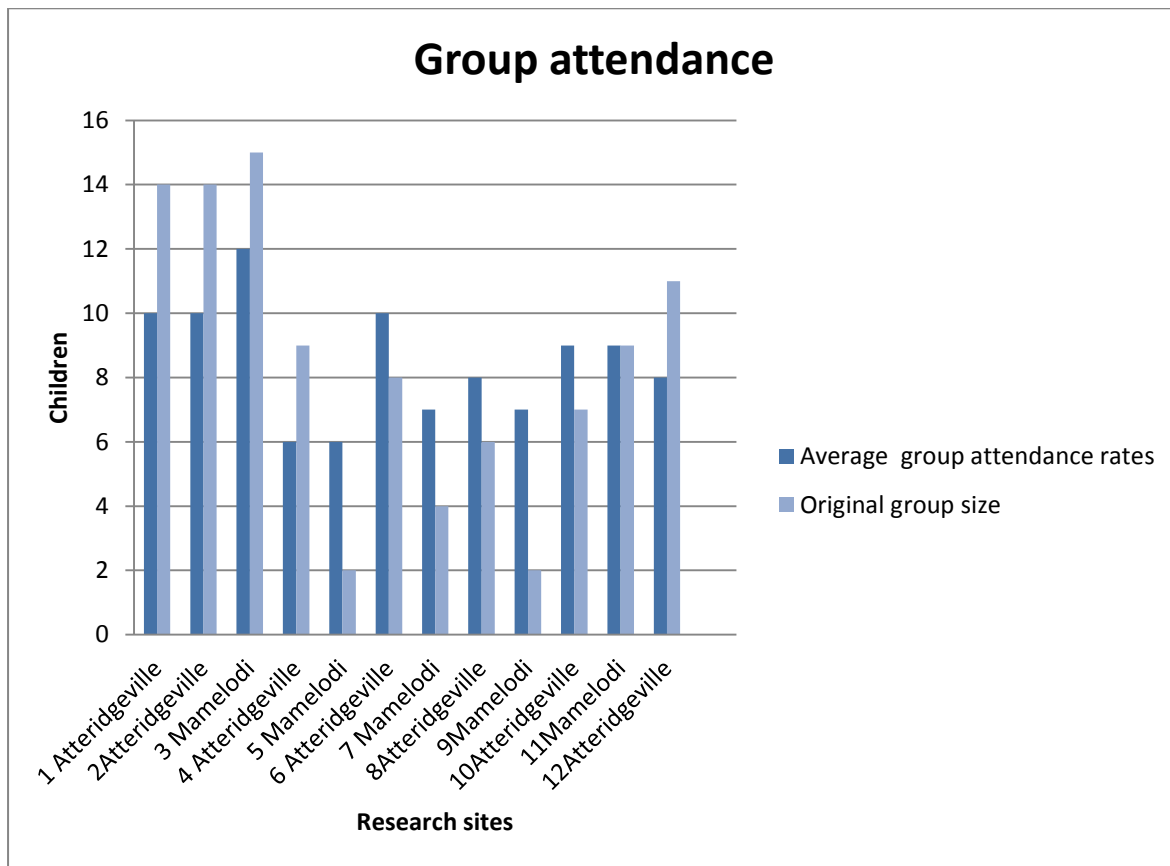
5.1.4. Group content and process (group session reports) – Findings

The findings about the group content and process according to the group session reports completed by the careworkers and discussed with the social workers and project coordinator are indicated in the following section. The goals of each session are indicated before the findings are presented. The findings of the 'feeling thermometer' and 'homework' activities are discussed separately as these two activities were repeated in each session.

Feeling thermometer

The **feeling thermometer** activity encouraged children to identify and share their emotions. Before each session commenced, the children had to place their decorated name tag on the feeling thermometer. Faces with different emotions were drawn on the 'feeling' thermometer.

The data show that the children could identify their own emotions and they expressed both positive and negative emotions. The sharing of emotions in the group most probably encouraged children to express their emotions.

Examples:

> *When feeling thermometer KM 711 said she is happy because she managed to come and find new friends (11:2)*
>
> *KM 399 said he is happy to play with his mother and he will ask his mother to do it again at home. During the feeling thermometer all of the group members said they are happy to be with their mothers (5:15)*
>
> *KM 707 was not himself yesterday even when filling the thermometer, he put his name on the unhappy face, when we asked him what makes him unhappy he was biting his finger nails and said "I don't know". And he participated only on the ship exercise and goes outside to be with his brother. We didn't force him to come back. KM 707 looks unhappy and he came with his brother because his mother is sick (12:12)*
>
> *KM 561 said with feeling thermometer she is not happy, because one child at school beats her. The group encouraged her to go to the teacher and talk about it (8:1)*

Homework

The homework exercises as given during the first eight separate group sessions were seldom completed by the children. It was expected of the mothers to support their children in the completion of these tasks. There was a significant improvement in the completion of the homework activities after session 9. After session 9 there was a focused shifted from the mother's own coping to children in the mother's separate sessions. The homework activity provided the children and mothers with the opportunity to communicate and share and thus provide the child with further skills to cope with the demands of homework.

Examples:

> *"Who am I" Mothers must be more involved in child's homework activities (1:4)*
>
> *Mothers should talk to their children about the session and discuss the activity and they should practice them so that the children could try and concentrate, knowing that the mother will ask some discussions about the session (1:3)*

> *KM 419 said he tell/share with his mother. He also brings homework we gave them last week. The mother's message was "he is meaningful and supportive to me". He read it to group and said he loves his mother (7:9)*

Session 1

Goals of session 1:

- General understanding of function of support groups and aim of study.
- Discussing and deciding group rules (emphasis on confidentiality).
- Understanding the role of facilitator in the group.
- General understanding of content of group sessions.

Outcomes of session 1:

Session 1 was experienced as a difficult session, as observed by the careworkers. The mothers did not explain or gave the incorrect explanation of the group sessions to their children (for example, the mothers told their children they are going to a school or social worker) and the uncertainty led to some children not being motivated to take part in the activities. Some children though were comfortable enough to share their feelings in the first session. The session activities were designed for a group larger than four members and a smaller group experienced difficulties in completing the activities. As with all interventions, the first session was the building block for further collaboration in the group session to come, as the group rules established in session 1 were extrapolated to several difficult group situations and real-life scenarios.

Examples:

> *They said their mothers told them they are going to school (7:1)*
>
> *It is a difficult group. The older ones they don't want to do some of the activities like climbing down the tree exercise. They don't understand why they are there, because parents did not explain to them (2:1)*

> *KM 561 said with feeling thermometer she is not happy, because one child at school beats her. The group encouraged her to go to the teacher and talk about it (8:1)*
>
> *It was a difficult session because the group was small and the activity asked for more members. The facilitators had to join (4:1)*
>
> *We managed to do all the activities. They all participated. At the end they said they enjoyed all the activities and they don't want to miss others (6:1)*
>
> *KM 699 came for the first time and she tried to break room/group rules but member KM 694 realised that and she said lets tell our group rules so that she must know and she agreed on the rules (11:4)*
>
> *KM 193 says he applies group rules outside at home and at school and he also taught others to behave good (12:14)*

Session 2

Goals of session 2:

- Building trust in the group.
- Sharing general information with the group.
- Experiencing group dynamics.
- Showing respect for peers.

Outcomes of session 2:

The children enjoyed the drawing activity, involving the drawing of a 'feel-good quilt' and showed group cohesion. The data show that they shared and communicated with each other easily during this activity. The children experienced difficulty in playing the falling game activity in a small group, but enjoyed the activity. The falling game activity is designed for more than four members in a group because the children have to be able to catch the group member who falls backwards. The group session often elicited sharing of religious coping skills and also negative experiences of violence. In one group only boys were part of the group and this was described as a positive experience. The group gave the children the opportunity to make new friends and they showed and experienced respect in the group.

Examples:

> *They enjoyed drawing and they use making jokes about each other's drawings in a good way (2:2)*
>
> *They were working as a team when making feel good quilt. Their pictures were very beautiful. They drew stars and said it is for a brighter future. House with a beautiful garden and flowers. They showed creativity. They combined their pictures and called it a Family house because they love each other as one family. They came with this family house idea after a discussion among themselves (8:2)*
>
> *It was a difficult session because the group was small to do the falling activity and the facilitator had to play with. They were able to remember the group rules. They sometimes asked where the others were. They enjoyed each other's company (4:2)*
>
> *All the children said they enjoyed the falling exercise, except for KM 197 he said he didn't enjoy and we accepted it (12:3)*
>
> *The children said we should read Bibles for them during the session (3:2)*
>
> *Some of them said they don't like guns because it shoots and kills people (1:2)*
>
> *They said they enjoyed to be boys only. They said they want to use a whistle to climb down the tree (5:2)*
>
> *When feeling thermometer KM 711 said she is happy because she managed to come and find new friends (11:2)*
>
> *There is team work and respect in the group when someone do mistake they helped him to correct it and they don't laugh at each other (7:2)*

Session 3

Goals of session 3:

- Exploring and describing own self.
- Describing the family environment.
- Identifying the roles in a family.
- Identifying own role in a family.
- Discussing the child's viewpoint of how other family members experience him/her.
- Identifying the importance of oneself in the family.

Outcomes of session 3:

Although the children were able to complete the exercises, many children indicated that they were unsure of who to include in their family drawing exercise and in some instances they refused to include certain family members. Many children expressed negative (fathers) and positive emotions (mothers and grandmothers) towards their family members. The data show that they were able to share and communicate their emotions and experiences with the group. Younger children in the study often experienced difficulty in completing the family drawing and body map exercises. Some children didn't want to take part in the body map exercise.

Examples:

> *They were able to describe themselves, their families within the community (4:3)*
>
> *Children were not sure who to include in family drawing (8:3)*
>
> *When doing my family exercise some of the children didn't want to include some of their family members (1:3)*
>
> *When 219 was doing family exercise he drew only him and his mother. He said "I didn't draw my father and brother because I don't love them" (3:3)*
>
> *All the children said they love their mothers because mothers are buying food, clothes for them and do everything for them, without mothers they are nobody (12:3)*
>
> *They praised their grannies for taking care of them (12:3)*
>
> *KM 707 drew only his grandmother who passed away and said "I love her even if she is dead because she took care of me" (12:3)*
>
> *During the body mapping activity they were helping each other with the drawings. They listened when we tell them what to do. They communicated well with each other (4:3)*
>
> *The younger children can't describe drawing. They are passive; always we should push them to do things (2:3)*
>
> *KM 219 said he don't want other person to draw him. He said he wants to draw himself and we give him permission. He was disturbing other children (3:3)*

Session 4

Goals of session 4:

- Identifying the roles in a family.
- Discussing the importance of a family.

- Exploring the values and central aspects of a community.
- Identifying assets and values.

Outcomes of session 4:

Most of the children were able to communicate and share their emotions in session 4. After reading the 'Little Hare' story they shared positive and negative emotions regarding their mothers. They felt supported in the group and displayed a need for respect in their families. The asset map exercise was experienced as difficult by some of the group members, but they were able to identify the assets in their community. This activity required abstract thinking skills.

Examples:

> *KM 586 said he is scared when his mom is not feeling well (8:4)*
>
> *After reading the story of the little hare KM 602 said her mother told her that she is special especially when she asked her to buy something at the shop and she choose the correct things. Some said their mothers don't tell them they are special and don't hug them (10:4)*
>
> *Some children were honest saying that their mothers don't tell them they are special or hug them. They feel special in the group (8:4)*
>
> *It was difficult for some of them to identify community assets and their family (2:4)*
>
> *It is a big group and it will take time to some of the group members to trust us and some group members said that they don't want to be shouted at by their parents. They should talk to them on a polite manner because they also get angry. They need to be respected in order for them to respect (3:4)*
>
> *The children all said they attend Sunday school and they sang praise songs (2:4)*

Session 5

Goals of session 5:
- Identifying strengths.
- Identifying weaknesses.
- Discussing the concept of being strong.
- Practicing and discussing coping skills.
- Practicing asking for help.

Outcomes of session 5:

From the data it seemed that session 5 and specifically the 'Little Peter Bear' story helped the children to identify their strengths as they were able to identify with the story. The children initially did not know their own strengths (resilience) but by listening to this story realised the following are strengths: honesty with their mothers; participation in their school work and in the group; study skills and emotional strength. They were able to assist each other to identify their strengths and to support each other. Masekitlana (talking stones game) is a familiar game in the participants' culture and therefore the children engaged freely in the game. Masekitlana elicited deep-grounded emotional projections from the children. It provided the opportunity for the children to cope with stressors in their situation and vent their feelings, fears and anxieties as they were not allowed or encouraged to talk freely at home about their emotions. Some children hesitated to talk about their family life and expressed their inner experiences surrounding their families by playing wordlessly.

Examples:

Examples (Little Peter Bear story)

I was impressed with KM 467 when we asked them if they are ever dishonest she said that "yes I sometime don't give my mom change when I am from the shops". What is good is that after hearing what happened to Peter Bear because of cheating she promise to never be dishonest again (6:5)

KM 290 said she like reading, do school work. All liked Peter Bear story (4:5)

They said that they are not like little Peter Bear. They don't cheat others at school. KM 419 said he never failed his exams/ tests if he knows that he is going to write he practice. They said their mothers and brothers helped them with their homework (7:5)

They were able to discuss their strengths and able to compare themselves with Little Peter Bear's story. One child did not use her real name until yesterday after reading Little Peter Bear's story that she told us her name and why she did not use her own (1:5)

They were able to identify their strengths and they understand that it is good to cry it does not mean you are not strong but it is a way of dealing with issues (3:5)

KM 399 cried when we ask him to spell and write. The group comforted him (5:5)

Examples (Masekitlana):

They are open about themselves and they need to be encouraged to talk about what's bothering them. We should play masekitlana more often so that they can be able to talk and be able to cope about what's happening in their families (1:5)

Masekitlana (talking stones game) brought to my attention the fact that all our children play mostly about fathers that drink and not maintaining their families. KM 648 told a story of a father who goes to work and goes to the beer drinking after being payed he drinks the money and comes home late and shouts for the mother to open the door, after demanding food and when the mother gives him pap he demands meat and beat her. All the stories talked about aggression and scolding (10:5)

They all participated. During masekitlana all of them agreed and enjoyed to play. KM 537 on her story said we must choose good friends because if we don't choose good friends we will come to difficult situations because you will do what s/he does. KM 590 said we must respect our parents when they asked us to help them. KM 588 said we must not do naughty things (9:5)

When playing masekitlana KM 221 told us that her brother and uncle are always fighting and it is something she does not like (3:5)

KM 412 said she doesn't want to talk about her family. We gave her chance to play on her own and saw how she threw the stones hard on the floor (7:5)

It was difficult for some of the group members to play masekitlana. They did not want us to listen to them playing, because they were doing what is happening in their families and they played by themselves throwing the stones (3:5)

Session 6

Goals of session 6:

- Coping in difficult situations using strengths and abilities.

- Resolving problems.

- Being taught values.

- Coping with stressful situations.

Outcomes of session 6:

Puppets were used as a communication tool in both session 6 and session 11. In session 6 the puppet play presented the children with problematic scenarios where the children then had to apply the problem-solving skills they had learnt. By doing this activity the children displayed communication, problem-solving and coping life skills. The children's participation in the puppet play scenarios displayed an extrapolation of the skills they had acquired in previous sessions. The children played with culturally friendly puppets and they communicated and shared freely. The group displayed emotional intelligence by identifying and accommodating children who were not comfortable playing with the puppets in session 6. The anonymity of the puppets and the puppet play-box provided the opportunity for children, who previously exhibited socially inept behaviour in the group, to gain self-confidence and express their ideas and feelings.

The 'strength' activity provided the children with an opportunity to communicate with their mothers. A positive future orientation and a sense of responsibility were elicited through this activity. Helping each other in the group was important in this session and they were able to identify their family and religion as strengths in their lives.

Examples (puppet activity):

> *There was communication between each other during role play puppets. They planned before they acted. KM 525 and 588 their story was about a child who got lost and found help from other grandfather on street (9:6)*
>
> *KM 329 and 419 their story with puppet play was playing in the park and other start to fight with him and he reminds the child about the Kgolo Mmogo room rules. He also told him what we must behave the same, if we are at home and at school (7:6)*
>
> *When doing puppet plays KM 213 was very happy to play. She also gives some of the children things to role play. She was quiet but now she is like a director (2:6)*
>
> *Puppet play most of the children enjoyed using puppets and they were able to give solutions. Some of them said moms make them angry when shouting at them (1:6)*

Examples (strengths activity):

During the strengths exercise the children decorated their body maps and they decorated with things they wanted to achieve when they grow up e.g. having cars, computers and big house. They all have positive attitude towards their future. They all want to help their parents when they grow up (5:6)

We managed to do all activities. They now know their strengths better than last week because they discussed their strengths with their mothers. They all came back with new strengths they identified (6:6)

They have internal rules. Part of their strengths is helping others in group (7:6)

KM 516 cut Bible picture and said that he love to go to church. He also said he saw KM 492 at the same church (6:6)

KM 545 said she likes her family because they pray together and go to outing together. They love each other (8:6)

Session 7

Goals of session 7:

- Identifying of problems (at school and at home).
- Discussing and practicing the effect of consequences of decisions.
- Identifying where to begin when looking at problems (things you have control over and things you can't control).
- Recognising that some problems do not have a good solution.
- Exploring the value of sharing problems with others.

Outcomes of session 7:

The 'Decision and consequences' exercise gave children a playful opportunity to explore the consequences of their decisions. Most of the children were able to solve problems, share, and communicate and identify people who could support them in problematic situations. The 'Man in the hole' story in session 7 elicited problem-solving strategies, where the children had to internalise it and make it practical. The group members supported and helped each other to accurately resolve problems. They were able to identify people who would help them in case of an emergency. Personal responsibility was often shown in this activity.

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The 'Fire-picture cards' activity elicited examples of negative behaviour and the group acted as a norm-giving agency. From the 'Role play' activity there were indications that the group members internalised and extrapolated the decision and consequences exercise. They communicated and planned in the group in order to provide the best-fit solution to problematic situations. Leadership skills were highlighted by this activity.

Examples:

Examples (Decisions and consequences exercise):

When doing activity of decision and consequences after we explained to them, they were able to give examples, this shows that they understand. Everyone told us that if he/she have problem, he/she inform who (7:7)

Children indicated that they enjoyed the decision and consequences exercise because they learnt that if you do something you must expect the results (7:14)

Examples (Man in the hole-story):

KM 589 said he will just sit in the hole and cry, but the group encouraged him to think of a plan and then he came up with a good plan to get out of the hole (8:7)

Children gave different solutions to man's problem and said how they solve problems. Group members help each other with problem solve (1:7)

It was good; they gave each other a chance to tell us what they have learnt. All children said they liked story 'man in the hole' because it teaches them to be careful and aware of dangerous situations. They also said if they have a problem they will inform their parents. It also taught them responsibilities (4:24)

Example (Fire-picture cards):

KM 280 said he will keep quiet when there is a fire and won't tell his parents. The group said that is not good behaviour and KM 280 agreed that that was wrong (4:7)

Examples (Role play activity):

They were doing crime, housebreaking at the shops stole money and got arrested – role play (10:7)

There was communication between each other during role play activity. They planned before they acted. KM 525 and 588 their story was about a child who got lost and found help from other grandfather on street (9:6)

> *It is a big group there is also leaders who are able to control the group e.g. when someone is not respecting our group rules they will tell that person about the rule and they will ask him if he want to be part of activity or not but not to disturb group (6:7)*

Session 8

Goals of session 8:

- Discussing personal safety.
- Identifying unsafe situations.
- Discussing and practicing actions to take if in an unsafe situation.
- Discussing how to protect oneself.
- Exploring and discussing children's rights.

Outcomes of session 8:

The 'Don't talk to strangers' board game and 'The den' ice-breaker gave the group members the opportunity to disclose their fears regarding dangerous situations and experiences. In their culture, children were expected to listen to and obey adults. The data show that the children verbalised their discomfort in applying the principle of not talking to a stranger because of this cultural expectation. The children became aware of the dangers of talking to adults with whom they are unfamiliar. They displayed life skills, sharing and communication in this activity. The children internalised the danger of talking to strangers and the data show that they could extrapolate the session contents to other situations. 'The den' ice-breaker and the 'Don't talk to strangers' board game gave children the opportunity to verbalise inappropriate sexual behaviour of adults towards them. During and after the sessions the careworkers had to facilitate the disclosure situation and identify children who needed referral. The children revealed that they did not know the contact details of their parents and the group facilitated the opportunity for them to learn this important life skill. The group experienced 'The children charter' activity as difficult and the data show that they were unaware of the children's charter content.

Examples:

> *They said they don't know their rights only their responsibilities (8:8)*
>
> *The children did not understand about the children charter. The exercise was difficult to do (10:8)*
>
> *They were able to tell us whom they don't feel safe with and said they don't feel safe when they are with their uncles and brothers that they don't know, because sometimes they will abuse you e.g. rape or touch your in your private parts (4:8)*
>
> *During the 'don't talk to strangers' activity everyone was concentrating and were able to answer some of the questions. We had a problem with the question of 'What if a stranger ask you to do something for him' most of the group members said if you don't do what he is asking it show that you disrespect your adults (3:8)*
>
> *They said they learnt 'Don't talk to strangers' and Nemo didn't listen to his father not to swim. He talked to strangers (1:22)*
>
> *When playing 'The Den' some of children said they don't feel safe with their uncles, because they like touching them (1:8)*
>
> *They don't know their parents' contact numbers (1:8)*

Session 9

Goals of session 9:

- Communication skills.

- Being taught acceptable behaviour in a group for example, sharing.

- Building of friendships.

- Exploring the different roles in a group.

- Showing respect for self and others.

- Exploring values.

- Being taught what is acceptable behaviour in a group and how to gain approval in a group.

Outcomes of session 9:

The data show that the children displayed higher levels of participation and communication in this activity. They could relate to the animal story and the story gave children who didn't want to participate (or children who were shy) in previous activities the opportunity to partake in the sessions.

The metaphorical story elicited interpersonal and social skills from the group. They indicated the importance of trust, honesty, support and help in friendships. The group was able to correct negative behaviour (e.g. stigmatisation) and explain the nature of acceptable behaviour. The session offered the opportunity for positive mother-and-child interaction.

Examples:

KM 580 usually says minimum, but this session he is participating very good. He was also able to relate story to others (8:9)

Their participation was excellent. It was as if they knew what we are going to talk about. They were listening carefully and with attention when telling them story. They were able to relate to the story and answer questions. They all said they liked tortoise because he helped his friends. KM 567, 525, 590 said their friends are like hyena because they tease other people and thereafter said is them who did that but they said they are still playing with them trying to teach them the right way (9:9)

When asking questions about story of lion, hyena, vulture and tortoise and what they learnt, they say you must trust your friend, be honest, don't just take others things, ask permission. (2:9)

KM 545 said the story of hyena, lion, taught her to be like tortoise, helping each other because it's important (8:14)

KM 219 when we gave social links, he said he does not like people who are HIV positive because they will infect them. The group said no that is not so (3:9)

KM 570 and 536 said sometimes they take their mother/father's change after buying something for them. KM 576 said it is wrong because you can be thief for rest of life (8:9)

KM 419 said he tell/share with his mother. He also brings homework we gave them last week. The mother's message was "he is meaningful and supportive to me". He read it to group and said he loves his mother (7:9)

Session 10

Goals of session 10:

- Identifying own emotions.
- Being taught how to express emotions.
- Being taught that all emotions but not all behaviour are acceptable.
- Identifying and practicing verbal and non-verbal communication cues and skills.

Outcomes of session 10:

The 'Emotions' board game provided the opportunity for group members to communicate, identify and share their feelings regarding their mothers' illness. They expressed fear, anxiety and some children verbalised their anger regarding their mothers' illness. Data show that the positive religious skills they applied to cope with their feelings were verbalised in the group. Some children also felt they had a responsibility to take care of their sick mothers. The 'If you are happy and you know it' song was not regarded as appropriate for older children and they did not want to partake in this activity.

Examples:

KM 350 said he don't like to sing especially this song 'if you happy' because he is older and song for pre-schoolers (5:10)

KM 179 he was bullying other children and he said he feels pain when somebody passed away and he is worried when is mother is sick, he thinks she is going to die (2:10)

KM 248 during the board game he was asked when a special person is sick what is it that you are scared of and he said he is scared the person will die and he does not want his mother to die because he is still young and he needs her (3:10)

KM 434 said he is sad and angry when his mother is sick, but he will pray for her and ask her to go the doctor (7:10)

KM 209 said that if someone is sick she will pray for him/her and she will be happy if she will be healed (2:10)

KM 561 said she want to be a nurse. And she also said she remind her mother to take her medication every day, she needs her medication every day otherwise she will become ill (8:10)

Goals of session 11:

- Identifying other people's emotions by making use of cues such as words, body language and facial expressions.
- Identifying persons with whom emotions can be shared.
- Different ways of responding to emotions of other people.
- Becoming skilled in ways to cope and regulate own emotions.

Outcomes of session 11:

The 'broken telephone' ice-breaker facilitated listening skills, sharing and communication in the group. The 'puppet activity' in session 6 provided a learning opportunity for the children in communication and in session 11 they were more comfortable to partake. The children paired up during the puppet play activity in session 11 and in the given scenarios they focused on the identification of other's emotions. The children first planned and discussed the scenario they wanted to playact with the puppets with each other. The data show that the children encouraged, supported, shared and communicated their emotions with one another. The 'scenario' activity was an enjoyable exercise for the children and most of the children displayed communication skills and humour in executing the activity.

Examples:

> *When doing broken telephone KM 580 was very playful and passed the incorrect message. The group members asked him to be serious and after that he listened well and were able to pass the correct message (8:11)*
>
> *Children were laughing and telling a joke to each other. They all had fun and enjoyed the scenario activity (8:11)*
>
> *On previous session (5:6) they were shy to play with puppets but this time they were comfortable and express themselves. They understand how to solve problems because in their role play the father gives the mother money to replace neighbours window (5:11)*
>
> *KM 504 did not want to mime or act. She was shy but the group did not force her to do the activity and said to her she can do it in her own time if she feels ready (7:11)*
>
> *Most of the group members enjoyed the puppet activity because some of them could sing for us and tell a joke. KM 219 want to do all the scenarios and enjoyed the activity (3:11)*

> *During the puppet play, they were sharing information on how to play and what to say during the play. When playing making a friend scenario they were talking positive things and encouraging each other (4:11)*

Session 12

Goals of session 12:

- Identifying primary tasks in the home environment.
- Showing responsibility.
- Learning the importance of tasks.
- Demonstrating of tasks.
- Discussing learning of safety rules.
- Discussing survival strategies.
- Discussing the importance of helping others.

Outcomes of session 12:

The 'On the ship' exercise elicited support, communication and help from the group. The children shared advice and helped each other with the 'showing a specific skill' activity. They displayed a positive attitude in completing household chores and helping their mothers at home. The activities were enjoyed to such an extent that they wanted to share their experiences in the session with their mothers and encouraged their siblings to partake in the activities at home. The group members supported each other during the activities.

Examples:

> *KM 539 said he will kill himself on island and the food is finished. He will kill himself before hunger kills him. Group said it is not so good idea, and at end he agreed that he will drink water for a while and killing self was not good idea (8:12)*
>
> *The group members were excited to do the activities and they wanted to demonstrate his/her skills in front of the group. They were giving each other a chance. It was fun. When doing demonstration of specific skill, they showed team building and sharing because they give each other chance to do that e.g. washing the dishes. They all do that in a good way and they know the safety rules (5:12)*

> *They said they enjoyed all the activities. They said they are going to tell their mothers what we did in the session. They also said they are going to encourage their brothers and sisters about this activity. They enjoyed (7:12)*
>
> *We were very happy because they give us feedback (homework) about survival skills at home. KM 134 said she help her mommy by cleaning the house. KM 214 said she made tea for her mommy and she was participating well (2:12)*
>
> *Children helped each other in groups with chores and KM 521 made tea for the whole group (8:12)*

Session 13

Goals of session 13:

- Exploring nature of survival skills.
- Practicing a survival skill (cooking).
- Planning for the future.
- Taking care of others.
- Experiencing sense of efficacy and accomplishment.
- Practicing social skills.

Outcomes of session 13:

Data from the study show that the children displayed self-confidence in using the life skills they had learned in the group to help their mothers and displayed various coping and life skills. The children were empowered by the group and they showed the ability to cope with the demands of their situation within the group. The 'How to make my own soup' activity successfully facilitated help, support and communication between the group members. From the data it seemed that the life skills they had learned in this session were extrapolated to their own lives and they understood its importance. They were able to plan in the group, to help and support each other in the completion of the task. The homework in session 12 and the dishing up for the mothers in session 13 successfully promoted positive interaction between the mothers and children. The 'How to grow seed' exercise was an activity where the children showed responsibility.

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Examples:

> *Was very high interaction and the children helped each other with making of soup and telling each other what ingredients are needed. Every child served his/her mother with a smile (4:13)*
>
> *KM 379 said he is preparing himself to be able to make food for his little brother when their mother gets sick, because sometimes she is not feeling well (5:13)*
>
> *When making soup they were working together. They were giving each other chance to put ingredients inside pot. They were very careful and helped each other. They first discussed how they will lay table before they did it (8:13)*
>
> *KM 219 was very happy after serving food to his mother because the comment that was made was a positive one. He came back to the group and told the group his mother said "thanks my dear the food looks wonderful" (3:13)*
>
> *They were happy to make soup and they prepared themselves mentally because we explained to them last week we are going to do. Some asked their mothers how to make soup and they came to the group with that information (5:13)*
>
> *During potato man exercise everyone was interested in making his man look beautiful. They said they are happy now they have something of their own to take care of. They will make sure the man is nicely looked after (7:13)*

Session 14

Goals of session 14:

- Learning the importance of caring for others.
- Learning how to ask for guidance and help.
- Setting goals for the future.
- Learning how to deal with difficult situations.
- Sharing dreams for the future.

Outcomes of session 14:

Knowing your community assets, staying safe (not talking to strangers), identifying the people that care about you, having life skills (who to call in case of an emergency) and the importance of making good decisions were identified by the group members as the most important skills they had learned in the group sessions.

The children furthermore displayed a positive future orientation and an overall positive experience of the support groups. From the data it seemed that the groups gave the children self-confidence to help their mothers at home. The following session (Session 15) where they were to play with their mothers, was experienced as an unknown situation. Yet, they felt comfortable enough to express their apprehension about joining their mothers in the upcoming group. The children described the 'future train' activity as a helpful tool to plan for the future.

Examples:

They know and understand their community assets and they know who give them support, some said their mothers and grandmothers. They are now able to talk to their mothers about their feelings. They said the most important lesson they learnt is 'Don't talk to strangers' what makes them feel loved and special is their mothers because they take care of them and they buy clothes for them. When they are in trouble like e.g. someone is sick at home they will call the ambulance (3:14)

Children indicated that they enjoyed the decision and consequences exercise because they learnt that if you do something you must expect the results (7:14)

They know that their future is very important. They were able to tell us what they learnt in the group. The group said it is important to come to group, because it is fun and you learn important things (8:14)

KM 193 says he applies group rules outside at home and at school and he also taught others to behave good (12:14)

They said they feel sad to hear that this is the last session, but they are happy about what they learnt and they are going to help their mothers at home (1:14)

Children were not excited to know that the next session they are going to play with their mothers. They said they have never have done that (7:14)

KM 526 during the future train activity. He was enjoying the activity and he was living the dream because after the activity he encouraged other to talk about their future dreams and also asked advice for the parents on which subject he needs to take in school (9:14)

Session 15

Goals of session 15:

- Interaction between mother and child.

- Interaction between mothers/child pairs.

- Awareness of self and others.

- Communication skills.

- Building self-awareness.

- Fostering cooperation.

Outcomes of session 15:

The activities of preparing for a picnic, having a picnic and playing games facilitated interaction and communication between the mothers and children. The data show that most of the mothers in this study were unfamiliar with playing with their children in such a planned manner. The mothers were used to 'thinking' for the children and they were often authoritarian in their parenting style. They were unfamiliar and had to cope with the new challenge of taking their children's viewpoints into consideration and giving them the opportunity to take part in the decision-making process. Towards the end of the session the children and mothers overcame the initial unfamiliarity of playing with each other to such an extent that they wanted to repeat the experience at home.

Examples:

It was a very difficult session because it was for the first time together. They are not used playing together (2:15)
Some mothers were not happy when we told them that we are going to play the egg races and the popping balloon races with the children. They were like shocked and said that they never play with their children. As facilitators we have to follow up on mothers to see that they do play with kids (8:15)

> *It was minimal the communication. I think they are still building trust in each other. They tried to play together but you could see that they don't do this at home. Each pair gave each other chance to do activity (8:15)*
>
> *Some of the mothers did not share the information with their children and did everything themselves* (1:15)
>
> *When playing with the balloons and racing with eggs, it was difficult to some of the children because it was for the first time playing with their mothers ever. They had fun and want to do it again (1:15)*
>
> *KM 492 usually she is shy she does not say why she is happy. She will say just because she is, but today she said she was happy because she is going to play with her mother. She is looking forward to it, because they don't do it at home (6:15)*
>
> *Children were very happy to play together with their mothers because it was for the first time they play together with the mothers, they did not know that their mother could run. Each and every pair was prepared to play and they were having fun (7:15)*
>
> *They said that the enjoyed playing with their mother and that they have to do it at home* (8:15)
>
> *Mothers loved all the activities because they enjoy playing with their children for the first time. They are very much into continuing doing that and hope that their children feel the same (8:15)*

Session 16

Goals of session 16:

- Interaction between mother and child following direct instructions.
- Building of trust between mother and child.
- Awareness of self and others.
- Communication skills.
- Nurturing according to the Marschak Interaction Method.
- Engagement according to the Marschak Interaction Method.
- Setting of challenges according to the Marschak Interaction Method.
- Structure according to the Marschak Interaction Method.

Outcomes of session 16:

The focus of session 16 was on nurturing, engagement, the setting of challenges and structure according to the Marschak Interaction Method (MIM) and theraplay principles. This session helped to improve the communication and sharing (as observed in session 15) with each other in a fun, but structured way. Activities in session 16 seemed to successfully elicit enhanced communication, sharing of positive emotions and negative emotions, trust and bonding between the participants in this study. Both the mothers and children verbalised their positive experience of the activities and indicated the intension of repeating the activities at home.

Examples:

> *It was good. They communicated with each other. It was not like last week sessions. When doing their body map the children were listening to their mothers. Both parties were participating very well and communication was very high. Children were enjoying it (3:16)*
>
> *They all followed the instructions of the facilitator. Every child was comfortable with their mothers. They were laughing with each other a lot (4:16)*
>
> *When we were discussing some of the questions about the previous session KM 116 said what makes her laugh is when her mother is well because her mother was sick for long (1:16)*
>
> *KM 199 told her mother she does not like wrapping activity and she wanted to stop playing (2:16)*
>
> *When doing activity of hand clapping each child was teaching his/her mother how to play. Boys enjoyed this activity and we were surprised because most boys said hand clapping is for girls. They enjoyed it as much as the girls (7:16)*
>
> *Everyone was enjoying doing the activities and they were talking and sharing information about the activities. Children were very happy to see their mothers playing with them. They wanted to play more and they asked their mothers that they should do it at home (7:16)*
>
> *The activities were like by both mothers and children. Mothers told us that the communication here is better than at home but they are going to make work of that (12:16)*

Session 17

Goals of session 17:

- Interaction between mother and child.
- Expressing verbal and non-verbal communication skills.

- Expressing emotions.
- Being creative together.
- Planning together.

Outcomes of session 17:

The 'body map' activity was intended to and successfully elicited positive interaction and communication between the mothers and children. In most instances they were able to share their experience of the activity with each other. The data suggested that the 'sock puppet' activity in session 17 helped to improve the communication, identification of their own and other's emotions and also sharing between the mothers and their children. The activity involved role switching, using sock puppets. The children often expressed pleasure in doing this activity and for some mothers it was an eye opener to see themselves mirrored by their children. Although the children's sharing of their experience of their mother's communication (harsh and demanding) was embarrassing to the mothers, the mothers enjoyed the activity. They enjoyed this activity to such an extent that the children and mothers reported playing it at home with other siblings. The mothers indicated that they appreciated getting to know their children and thereby understanding them better.

Examples:

Examples (Body map activity):

They were now talking to each other; each mother drew her child when doing the body maps. The children were quiet and relaxed. The mothers were talking to their children when they were drawing them and the children were laughing (3:17)

When decorating the body maps KM 214 said "I love you my child". We explained to the mother that what their children said is what and how you talk to them (3:17)

Examples (Sock puppet activity):

Mothers and children are learning to understand each other and before doing any activity they talk and discuss how the activity should be done, if there is something that the child does not like she is able to tell her mother why and what is it that she does not like e.g. KM 256 did not want her mother to use a black colour during the puppet sock making. She said black is too dark and she chose orange (3:17)

The communication was high and well (3:17)

The mothers were acting as their children and the children were acting as their mothers and it was because the children did exactly what their mothers done. The way the mothers talk to their children was very harsh and embarrassing. KM 183 child use vulgar word to her mother when her mother asked her that she must clean the house and swipe the floor (12:17)

KM 168 child talk like the mother with puppet sock and said 'I will beat you to bits if you do not do the house chores' (12:17)

During the puppet play most of the children the role play exactly what their mothers do and to the mothers it was embarrassing. Most of the mothers are commanding and demanding according to their children. They said they didn't know and want to change how they speak to their children. The children also said they will listen more to their mothers (7:17)

All children said they played puppet socks with their mothers, brothers and sisters at home (7:18)

When talking with puppet socks mothers were amazed because we explained to them what and how your child said is how you are talking to him her at home. They said they know each other better now and they enjoyed doing activities with their children (4:17)

Session 18

Goals of session 18:

- Interaction between mother and child.

- Making a memory box.

- Being creative and sharing of emotions.

Outcomes of session 18:

The content of the session offered the opportunity for the mothers to discuss a difficult and emotionally charged topic (death) with their children. The facilitators were able to present the topic to them in such a way that they could share their feelings. The data suggest that the memory box activity contributed to the children's feeling of security. Communication, sharing and affection between the mother and child were seemingly enhanced with the aid of the activities in session 18. Most of the mothers and children in the study verbalised a positive experience of the session.

Examples:

> *KM 136 and the mother had good relationship and they always share information before doing things. To them a memory box means a lot because they talk about death and how to remember each other. Session 18 was a big success, children and their mothers were working together to decorate the boxes, they were sharing thoughts (1:18)*
>
> *KM 143 in his memory box he wrote a message to his mom telling her how much he loves her and she is a special mom (1:18)*
>
> *Children were very excited about decorating the memory boxes and every child wanted his/her memory box to look beautiful. In most of the decoration they decorated their boxes about something they like e.g. cars, clothes, food and beautiful houses. They were creative. Each child explained to her mother the pictures they chose. They all chose positive pictures. (3:18)*
>
> *KM 677 said that she was very happy to have been given the teaching about the memory box. She said that she never knew that a memory box can help one save good memories of her and her children. You could see it on her face that she was really given a good gift for life (11:18)*

Session 19

Goals of session 19:

- Interaction between mother and child.
- Learning basic skills in memory box methodology.
- Discussing the importance of creating a memory box.
- Making memories through taking digital photographs of mother-and-child pairs.
- Experiencing belonging by making a family tree.
- Mother and child sharing their feelings by writing a poem/song together.
- Sharing between mother and child by discussing each other's likes and dislikes.

Outcomes of session 19:

The qualitative data from the study suggest that the activities in session 19 enhanced the communication and sharing (emotional and cognitive) between the mothers and children. The discussion of the family tree seemed to give the children a stronger identity and a feeling of belonging. This conversation also provided a feeling of security for the children regarding their future. They found comfort in using their positive religious coping skills.

The data show that they displayed awareness of right and wrong behaviour and the importance of respect in a relationship. This activity was reported to be enjoyable for both mothers and children.

Examples:

> *KM 166 and the mother were able to discuss about their family tree and how are they related to others and who to take care of the child when the mother passed away (1:19)*
>
> *Children were interested to know their family members and how are they related. Some of the children did not know their family (5:19)*
>
> *They were able to explain to their mothers why did they choose those pictures and what does that decoration mean to them (1:19)*
>
> *KM 714 had a Bible cutting amongst his cuttings. He explained to us that the Bible is a good book to read for it can comfort him and others who are in pain or trouble and it also guides him to be a person with good manners and respect for peers and older people (12:19)*
>
> *Communication was very high, during the poem and writing and song activity. Children and their mothers were excited and they were able to compose and recite a poem together (2:19)*
>
> *When doing likes and dislikes exercise KM 285 said she don't like liqueur because its not good and he saw many people who are drinking alcohol and they are disrespecting (4:19)*

Session 20

Goals of session 20:

- Communication between mother and child.
- Engaging by doing an activity making clay.
- Engaging and sharing emotions by doing an activity of making a 'feeling' bracelet.
- Sharing and working together towards a common goal.

Outcomes of session 20:

The activities in session 20 had a fun element where the children and mothers could express themselves in a creative way. This activity involved a cognitive part where they had to be creative and play a guessing game. It included an affective component as well where they expressed their emotions in the products they made and in their joyful sharing of the experience.

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Data suggest that this session enhanced overall communication as the mothers and children were more comfortable with each other.

Examples[11]:

> *They were able to communicate and identify what they have created with clay and they had fun because the mothers were not able to tell what the children created and they all laughed. (2:20)*
>
> *Children are able to share their feelings with their mothers and it became easy for the mothers and children to do activities together. E.g. what makes you laugh and some of the children said when their mothers are not sick and when they don't shout at them. The mothers and children enjoyed the bead bracelet exercise together. They were making and playing with clay. The communication was good. In this group the pairs work very well together (3:20)*

Session 21

Goals of session of session 21:
- Identifying emotions.
- Interaction between mother and child following instructions.
- Improvement of communication between mother and child.
- Engaging and sharing emotions through 'morabaraba' game.
- Engaging by drawing each other's emotions on paper.
- Sharing of emotions by acting out each other's emotions.

Outcomes of session 21:

'Morabaraba' is a familiar game in the participants' culture and therefore the children and mothers engaged freely in the game. The game is played by two players using plastic playing discs on a pre-drawn grid on paper. The 'morabaraba' game is designed to and successfully elicited communication, sharing, team work and bonding between the mothers and children. The effect of the game (communication and sharing) was enjoyed to such an extent that they indicated that they wanted to repeat this game at home.

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[11] Data extracts in this session showed similar themes and therefore only a few examples are reported.

They also wanted to share this experience with the rest of their family. The 'emotional mask' and 'emotions drawing' activities gave an opportunity for identification and sharing of emotions between the mothers and the children.

Examples:

> *We asked them which activity they enjoyed and they all said morabaraba and drawing their mothers faces. When doing the emotion masks with paper plate it was very fun because they were talking to each other while wearing masks. When playing morabaraba mothers gave children chance to win (3:21)*
>
> *Morabaraba game was so interesting for mothers and their kids because they were having a lot of energy and concentration when playing it (2:21)*
>
> *Both parties were participating very well and communication was very high. Children were enjoying very much. They were all having smiling faces (3:17)*
>
> *Was high, they were explaining to each other the rules of morabaraba game. They asked each other how you felt when you win/lost the game. They explained to each other it is only a game and should not be angry with each other (3:21)*
>
> *They worked as a team to do the activities and they enjoyed playing games together, they are comfortable with each other. They were talking to each other and sharing information. Communication was at its highest compared to all the other sessions*
>
> *Mother and child were telling us about what they learnt form the group. All the children said they loved the morabaraba game. Communication was very high (3:24)*
>
> *Some mothers are saying they are doing the activities at home with the other siblings as well. (3:21)*

Session 22

Goals of session:

- Revisiting how to identify emotions.
- Revisiting how to assess emotions.
- Revisiting how to express emotions.
- Revisiting safety rules.
- Revisiting coping skills.
- Revisiting problem-solving skills.

Outcomes of session 22:

Session 22 was the first separate session for the mothers and children after the joint sessions started. The children watched the 'Finding Nemo' DVD. Data suggest that the children were able to extrapolate the skills they had learned in previous sessions to their own lives. They could identify skills and also made the skills practical in other situations in their own life and applicable to the movie they watched on DVD. The group could identify the danger of talking to strangers and give appropriate solutions to cope with the situation. They were able to identify their emotions and share their emotions in the group. The activity elicited emotional and behavioural reactions from the group members and it subsequently required special skills from the careworkers to identify and manage it. Some of the children, for example, cried when they saw the DVD as they were able to relate to the story where Nemo lost his parents.

Examples:

> *We were watching Nemo. It was all about emotions, safety, coping skills and problem-solving. They were aware that everything which was happening in Nemo we did in previous sessions and they spoke about it (8:22)*
>
> *They said they leant 'Don't talk to strangers' and Nemo didn't listen to his father not to swim. He talked to strangers (1:22)*
>
> *They were able to make story applicable on own life. They said if something happens to them they will make a plan to survive. KM 545 said if I get lost I will make a plan to survive and use skills I learnt. KM 545 said if I get lost I will call my mom because I now know her contact details. KM 576 said we must be safe (8:22)*
>
> *The children were concentrating and they were sad when Nemo was lost. Some of them put themselves in Nemo's shoes and they cried. KM 256 said she will be a good girl and listen to her mom. No one was disrupting or disturbing others. They were all quiet and concentrating (3:22)*
>
> *They were concerned about Nemo's safety and wanted to know what is going to happen when his father does not find him. It means he won't see his father and he will leave with strangers (1: 22)*

Session 23

Goals of session 23:

- Communication between mother and child.

- Sharing of future plans.

- Setting objectives for reaching the identified future plans.

- Sharing of ideas by making a collage.

- Sharing by drawing a 'future path'.

Outcomes of session 23:

The children in this study displayed a positive future orientation regarding their future careers. Their career choices pointed to the helping professions and they were able to suggest putting in place the correct strategies for reaching their goals. The mothers were helpful in this regard and they experienced this exercise as enriching. In their sharing and communication the children also expressed their expectations of having a future family and being a responsible parent.

Examples:

KM 205 cut doctor checking the baby in hospital and he explains to his mother that he wants to be a doctor when he grew up (2:23)

KM 147 said he want to be policeman to catch thugs in community (1:23) KM 350 said he want to be a fire-fighter to help people who life in informal settlements when their shacks are burning (5:23)

It was very high, children were able to tell their parents what they want to be in the future, some said they want to be doctors, police etc. and mothers were able to explain to them which subjects to take at school and what to do after matric (3:23)

At the end mothers said they thankful because they were not aware of how important to sit with your child and share about future. KM 373 said she is going to save money for her son so that he may go to University. (5:23)

KM 441 said he wants to be professional soccer star and he already started. He also said he want to be a responsible man and father for his family when he grows up (6:23)

> *KM453 said she want to be a social worker she is aware that her mother save money for her for further studies. She said the reason is she wants to help family in need and children who don't have parents. She want to open centre for orphans and say thank you for God for protecting her on future path and keeping her mom healthy* (6:23)
>
> *KM 576 said she want to be a teacher and have lovely family. She also said she want to do small agricultural because she want to have sheep so that her family will not suffer and they will not have to buy meat from butcher. They made collages and future path together. At the end they said they enjoyed the activities and mothers thanked saying they were not aware of sitting with child to talk of wishes and dreams were so rewarding (8:23)*

Session 24

Goals of session 24:

- Using communication skills and social skills (learned in group).
- Having a sense of accomplishment through receiving a certificate.
- Sharing of future plans.
- Saying goodbye and sharing of contact details for future support.

Outcomes of session 24:

The children and mothers verbalised their appreciation for what the group meant to them, but they also expressed sorrow that the group had come to an end. They wanted to keep in contact with one another and shared their contact details. The mothers and children were thankful for the bond that had developed between them. The data suggest that this bond was strengthened by learning to communicate, sharing emotions and playing with each other. The mothers conveyed their appreciation to the careworkers for the improvement in their children's behaviour. The group cohesion and friendships were positively experienced by the children.

Examples:

> *Communication was very high, children exchanged their mothers contact numbers and they wanted to continue their relationships and they will be visiting each other at home doing some of the activities (1:24)*

> *The children said they are happy because they can play with their mothers now and they do stuff together (11:24)*
>
> *KM 147 was birthdaying. His mommy brought cake and he was very happy to eat it with his friends. He was dancing (1:24)*
>
> *It was a very good session because it was difficult for the children to understand that it was the last session they wanted to come back and continue with the group. They said they made friends and it was nice being in the group. It's like their second home (2:24)*
>
> *KM 718 and 719 said they are happy because they now are able to talk to their children with love and understanding. Everyone wished that they could continue, but understand that it has to end somewhere. The children wrote messages for us and you could feel that they enjoyed coming to the group, and they are going to miss the group and the facilitators. They told us that what we taught them made them strong and confident at school (12:24)*
>
> *Mother of KM 297 said she is thankful because her child was shy but now she can socialise with peers even at school because a teacher told the mother that she is improving especially in communication (4:24)*
>
> *Children said they enjoyed doing activities with their mothers. Mothers said they thank because now their children can confront them when they have problem (5:24)*
>
> *Boys had secret discussion and has club now for after group ends (5:24)*
>
> *They still remember activities in precious session. KM 525 said he say thank you so much because he was not aware of this strengths but now he is sure about it (9:24)*

5.1.5. Group stages (group session reports) – Findings

The implementation of a group intervention session has to take into consideration the stages of group development. While various authors (Geldard & Geldard, 2001; Schaefer, Jacobsen, & Ghahramanlou, 2000; Thompson, 2011) conceptualise these stages differently, this study will subscribe to the following conceptualisation of group intervention stages. These stages are described as the preparation, forming, storming, norming- and adjourning stages (refer to par. 5.6., p.107).

Stage 1 – Preparation stage

The caregivers (group facilitators) discussed the aims of the group intervention in session 1. It was necessary because some of the children were either uninformed or misinformed by their mothers. Being the first session it was expected that the children would be reluctant to participate. They established their own group rules with the guidance of the group facilitator whereby they built cohesiveness and trust. As a result of the establishment of group rules and the structuring of the group most of the children felt comfortable enough to share with the group. During this stage they were able to make friends and mutual rapport between the facilitators and the group members developed. The facilitators created an atmosphere of understanding, genuineness and respect for the group members. Guidance, encouragement and support were furthermore provided by them.

In the first joint session (session 15) with the mothers the children showed reluctance and anxiousness to play with their mothers. The facilitators described this session as difficult. From the data it seemed that the interaction between the mothers (as adults) and the children in this study did not always include playing and sharing. Therefore the facilitators often had to support and guide them in this process. Towards the end of the process the initial unfamiliar situation for the mothers and children improved to the extent that they wanted to repeat the activities.

Examples:

It is a difficult group. The older ones they don't want to do some of the activities like climbing down the tree exercise. They don't understand why they are there, because parents did not explain to them (2:1)

KM 561 said with feeling thermometer she is not happy, because one child at school beats her. The group encouraged her to go to the teacher and talk about it (8:1)

They were able to put room rules but they said some will add when the group progresses (9:1)

They were working as a team when making feel good quilt (8:2)

It was a very difficult session because it was for the first time together. They are not used playing together (2:15)

> *When playing with the balloons and racing with eggs, it was difficult to some of the children because it was for the first time playing with their mothers ever. They had fun and want to do it again (1:15)*

Stage 2 – Forming stage

Uncertainty and anxiety were still notable in the forming stage of this intervention. As the sessions progressed the children communicated more freely in the group. The climate of safety they experienced seemed to subsequently make it easier for them to share. The facilitators were also responsible for helping children identify and define their problems and the accompanying feelings and thoughts. The data show that the support, encouragement and feedback from other group members helped the children to share and to feel at home.

The safe climate experienced by the mothers and children during this stage in the joint sessions had as a result spontaneous sharing of positive and negative emotions. The tasks on hand guided the mothers and children to depend on each other to complete the activities. From the data it is evident that the skills the facilitators used to intervene in this process enhanced the bonding between the mothers and children.

Examples:

> *When 219 was doing family exercise he drew only him and his mother. He said I didn't draw my father and brother because I don't love them (3:3)*
>
> *During the body mapping activity they were helping each other with the drawings. They listened when we tell them what to do. They communicated well with each other (4:3)*
>
> *Some children were honest saying that their mothers don't tell them day are special or hug them. They feel special in the group (8:4)*
>
> *They were now talking to each other; each mother drew her child when doing the body maps. The children were quiet and relaxed. The mothers were talking to their children when they were drawing them and the children were laughing (3:17)*
>
> *KM 136 and the mother had good relationship and they always share information before doing things. To them a memory box means a lot because they talk about death and how to remember each other. Session 18 was a big success, children and their mothers were working together to decorate the boxes, they were sharing thoughts (1:18)*

> *The interaction and communication skills between mothers and children are improving very steadily. There were more talk and action in this session and they are showing a closer bond (8:19)*

Stage 3 – Storming stage

During the storming stage tensions started to rise. Challenging behaviour and communication of group members were prominent in this stage. The joint sessions seemed to bring forth similar behaviour.

Examples:

> *KM 412 said she doesn't want to talk about her family. We gave her chance to play on her own and saw how she threw the stones hard on the floor (7:5)*
>
> *KM 679's mother said to son colour red to her means the blood of her son, because her son likes fighting (10:20)*
>
> *KM 453 was a teacher in the play and other children in group were jealous of this (6:7)*
>
> *KM 373 argued with his mother because she came late to the group. He cried (5:19)*

Stage 4 – Norming stage

During this phase most of the groups began to function effectively and move towards accomplishing tasks. The data suggest that the group members were more supportive and helpful to each other after knowing each other for a longer period of time. They helped each other to resolve conflict and problems.

Examples:

> *KM 589 said he will just sit in the hole and cry, but the group encouraged him to think of a plan and then he came up with a good plan to get out of the hole (8:7)*
>
> *Children gave different solutions to man's problem and said how they solve problems. Group members help each other with problem solve (1:7)*

> *KM 539 said he will kill himself on island and the food is finished. He will kill himself before hunger kills him. Group said it is not so good idea, and at end he agreed that he will drink water for a while and killing self was not good idea (8:12)*
>
> *Was very high interaction and the children helped each other with making of soup and telling each other what ingredients are needed. Every child served his/her mother with a smile (4:13)*
>
> *The mothers are now so open to discuss with their children and to talk to them you could see when they are in the group the way they communicate and talk, they are enjoying each other's company (12:21)*

Stage 5 – Mourning/Adjourning stage

The group members and the facilitators experienced the adjourning stage (session 14 and sessions 19–24) as difficult, because even though they enjoyed and learned a lot in the group they realised the group had reached its end. Although the end of the separate sessions brought forth the same emotional experiences for the mothers and the children, they were encouraged by the careworkers to look forward to the joint sessions. The group members were prepared for the joint sessions and the content of the sessions. The termination of the joint sessions were more intense as they realised it was final. The facilitators also had to deal with their own emotions regarding the separation as a strong bond had formed between them and the group members during the period of the intervention. The careworkers had to be able to facilitate the termination of the session and the accompanying emotions of the group members.

Examples:

> *They know and understand their community assets and they know who give them support, some said their mothers and grandmothers. They are now able to talk to their mothers about their feelings. They said the most important lesson they learnt is "Don't talk to strangers" what makes them feel loved and special is their mothers because they take care of them and they buy clothes for them. When they are in trouble like e.g. someone is sick at home they will call the ambulance (3:14)*

> *KM 718 and 719 said they are happy because they now are able to talk to their children with love and understanding. Everyone wished that they could continue, but understand that it has to end somewhere. The children wrote messages for us and you could feel that they enjoyed coming to the group, and they are going to miss the group and the facilitators. They told us that what we taught them made them strong and confident at school (12:24)*
>
> *The mothers are very pleased and said that Kgolo Mmogo helped their children to perform good at school and show better behaviour (12:19)*

The data suggest that the stages of the groups were, to a certain extent, influenced by the fact that the separate sessions were followed by the joint sessions. It is postulated that the stages seemed to re-emerge in the joint sessions because of this planned group organisation.

5.1.6. Careworker focus groups – Findings

The data obtained from the focus group discussions with the careworkers refer to their experiences as group facilitators, their observations of the effect of the group support sessions on the participants, their evaluation of the support group manual and intervention process and observations of difficulties experienced during the support group sessions. This section is a summary of the careworkers' experience of their training as group facilitators and subsequent self-report on the application of the support group session manual.

5.1.6.1. The careworkers' experiences as facilitators in the child support groups

The careworkers indicated specific skills and knowledge that helped them in their facilitator role. They indicated that listening skills and communication skills were of particular importance to a group facilitator of a child support group (*"With children one needs to listen to them and give them a chance to talk about their feelings and be able to help them, I think listening to them was the best option for the children"* – Facilitator A, Careworker focus group).

Mutual respect ("*We should show them love and be polite with them and not shout at them, I realised that when we shouted at them they would be withdrawn, not cooperate and they would disrespect us*"– Facilitator D, Careworker focus group), understanding ("*Working with this group made me realise that children also have feelings and emotions and we have to be careful how we talk to them and what we do to them, because if as parents we do something wrong they would do exactly as we did and it would not be nice because it would come back to us*"– Facilitator A, Careworker focus group) and engagement in the child's world on their level ("*By giving them a chance and showing them that you really appreciate what they are saying – by so doing we came to their level*" – Facilitator C, Careworker focus group) were mentioned by them as skills they felt helped them the most in their role as facilitators.

The careworkers furthermore mentioned that they felt their training helped them to be able to interpret and manage the children's behaviour, taking into account the child's developmental level *("I had to start to learn to talk to a group which can answer back and I realised that I needed to be careful how I talk to them because they can see if you are not speaking to them properly, unlike the toddlers who would do exactly as I told, I have also learned that children are very sensitive and it was an experience for me, I had to start practice to make them feel safe and protected and loved so that even if I rebuke them for something wrong they had done they should not feel uneasy or threatened. I have to work on the specific level of the child*" – Facilitator A, Careworker focus group).

5.1.6.2. Careworker observations of the effect of the group support sessions on the participants

The careworkers observed in the group sessions that the children modelled and verbalised the behaviour of adults in their family they were exposed to ("*I have learned that children are like a mirror, we would see through them regarding what is happening at home, they would tell us stories without you having to ask them questions, I think children are the most important people in our families because they take the secrets out of the house to the outside world so they define who we are really*" – Facilitator A, Careworker focus group).

They reported that most of the children displayed a positive future perspective ("*Most of the children do have high hopes in their lives and they know that in order to be successful in life they know that they need to study hard and work hard, and the mothers now know that they have to have investments in order for their children to further their studies*" – Facilitator D, Careworker focus group). The careworkers mentioned that the mother-and child-relationship improved during the support sessions *("Throughout the groups we found out from the children and the mothers that after mothers allowed children to express themselves we noticed that communication between them was much better*" – Facilitator B, Careworker focus group) and they were able to share their emotions and to plan for the future ("*Child couldn't speak to mother, but after group the child could speak to her about his emotions. It helped them with other children in the family as well. They learn to bond with their children. Not just about death and HIV but about life and the future*" – Facilitator B, Careworker focus group).

The careworkers reported that the mothers and teachers indicated that the support sessions enhanced the children's behaviour at home and at school "*Talking about their emotions they had difficulty talking at school and their mothers but after some sessions we got reports from parents that the school says they are talking, communicating and sharing with other children. They are doing better in their school work and listen to their teachers. The teachers want to know where the children go to therapy. The children will also bring to the group information from school and we talk about it. They take what we do here and share it with their friends at school and come back to share with us*" – Facilitator A, Careworker focus group).

5.1.6.3. The careworkers' evaluation of the support group manual and intervention process

Most of the careworkers indicated in their evaluation of the support group manual and intervention that they felt that the activities were appropriate but that the indigenous game 'masekitlana' was of particular value to the children. The children were able to share and verbalise their emotions during this game *("I think the activities that are designed are good, but what I'm suggesting is I would like to have more masekitlana games with the children so that we could follow up in the previous story so that we could know what is happening'* – Facilitator A, Careworker focus group).

All the careworkers furthermore mentioned that they thought the intervention definitely had a positive impact on the children's behaviour *("Children enjoyed coming to the group because at home there are problems like no food and domestic violence. When time gone by you saw positive changes in them. They talk more, smile more, are more caring and they talk about how they feel. The group accommodated each other"* – Facilitator B, Careworker focus group).

5.1.6.4. The careworkers' observations of difficulties experienced during the support group sessions

The careworkers reported specific situations where they experienced difficulties in the group sessions and needed support to cope with it. They mentioned that they experienced, in particular, difficulty with facilitating the groups where there were group members who were sexually molested *("It was difficult for me, but she didn't give me problems as such but she had problems and I wanted to reach out but she did not allow me so it was difficult for me to help her because when I tried to she withdrew every time"* – Facilitator A, Careworker focus group), who displayed hyperactivity (*"I remember a boy, he was a busybody, he was hyperactive, he did not finish what he was doing, if he was given a task in five minutes he has completed and he wants to do something else and as a result he was disturbing the group."* – Facilitator A, Careworker focus group), who displayed aggressiveness ("*There was one I forgot name, I think he was aggressive because sometimes he bullied other children especially when we did not see him, especially those who were not mentally sound"* – Facilitator A, Careworker focus group) who were to young for the group (*"KM 407 he is a young six years old and it is difficult for him to follow instructions. He only wants to play*" – Facilitator B, Careworker focus group) and children living in extreme poverty *("A very poor group with lots of socio economic problems. We couldn't change lots of domestic problems. The most poverty of all the groups. Still some want to come back to the group and learn more. Even through poverty and hunger you must try you best to help them"* – Facilitator B, Careworker focus group).

5.1.7. Mother evaluation of group sessions (mother evaluation questionnaires)
– Findings

The mother evaluation feedback form relating to the groups their children attended was completed by 82 mothers. The two questions extracted from the feedback form were discussed in Chapter 3 p.169. The majority of mothers who completed the evaluation feedback form indicated that they experienced their parenting to be easier after the group support sessions (95%). Only 5% of the mothers indicated that the support sessions made no difference to their parenting (refer to Figure 4.22).

The mothers indicated that the Kgolo Mmogo support sessions improved their communication with their children (KM 382 *"Now I know I have to communicate with my son and ask him some questions I would not have if I didn't came to KM, for example helping him with studies"*) to such an extent that they were able to discuss their illness with them (KM 202 *"I can now explain to my kids about my status"* and KM 464 *"My ability to communicate with my child on death has improved"*) as they were emotionally closer to their children after the sessions (KM 460 *"My child and I were not very close, but now we are"*). They mentioned that they enjoyed spending more time with their children (KM 419 *"I learned to give myself time to spend with my son. Sometimes we hang around like friends"*) where they played more often with them (KM 580 *"I never used to sit or play with my child, from KM I learnt to do those things"*). Their reported enhanced parenting skills (*KM 236 "The support I got from KM made me a real parent"*) supported them to have more patience with their children (KM 467 *"I was tough and impatient to my children, but now I am able to connect with them, give them the love they need and we are close"*), to be more supportive of their children (KM 549 *"I received support on how to spend time with my kids and support them"*) and to use more meaningful discipline practices (KM 438 *"I learned to be a better parent and to reprimand them. When I was angry I used to beat them, but since I come to KM I try to control myself"*).

The majority of the mothers (79%) who completed the mother evaluation form indicated that they experienced their children's behaviour as more positive after the Kgolo Mmogo child group intervention.

A small group of the mothers (21%) indicated that the group had no effect on their child and that their child was either 'always a good child' or 'hasn't changed'. None of the mothers indicated that the child group had a negative effect on their child's behaviour (refer to Figure 4.23).

Figure 4.22 Group effect on parenting according to the feedback of the mother participants
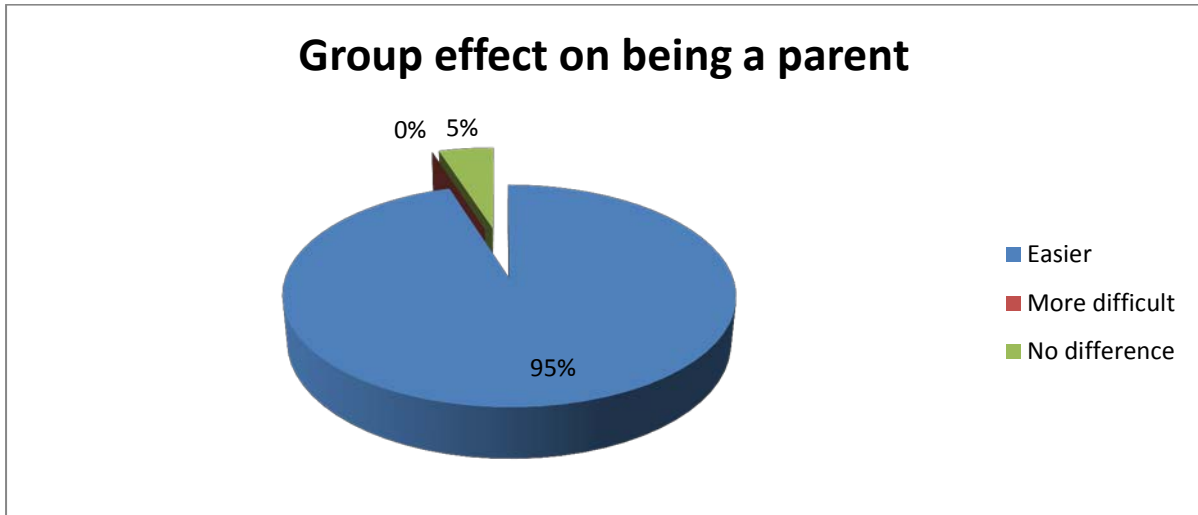
Figure 4.23 Effect of group on child behaviour according to the feedback of the mother participants
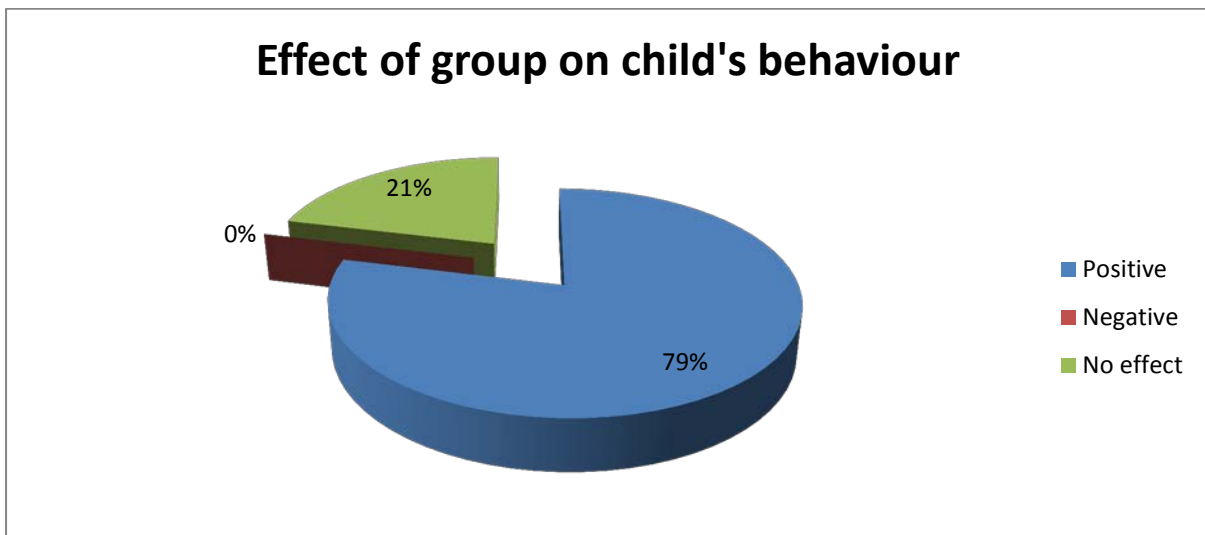
The aspects extracted from the mother evaluation questionnaires regarding the effect of the support sessions on the children's behaviour, according to their mothers, are listed as follows:

Mothers indicated that their children's communication skills have improved. They displayed better communication skills with their mothers and with their friends (KM 622 "*My son communicates easily with me about his school work. He talks to me about anything, even HIV*" and KM 388 "*He can now play friendly with other children, even his school performance has increased positively*").

The mothers mentioned that the children now listened to them more, as indicated by KM191 "*I have a good relationship with my son now, we spend a lot of time together and he listens when I talk to him. Nowadays he cares much about me and prefers to spend more time with me rather than with his friends. He even makes me tea and pours me bathing water*", showed more respect for others (KM 358 "*His behaviour has improved a lot and he now shows a lot of respect for me and other people*"), had a more trusting relationship with them (KM 545 "*He is more easy to communicate with. He received my disclosure to him with understanding*") and were more obedient (KM 421 "*Because my child can now listen to me when I give him advice*"). The mothers reported that their children's self-confidence had improved (KM 297 "*She was shy, but ever since we came to KM she is now open, she told her teacher that we are in the KM project, she told me that she is seeing improvement in my daughter, she is now open*") as well as their behaviour (KM320 "*His behaviour of stealing money and food at home is getting better*"). Changes in the children's behaviour, as described by the mothers, were that their children took more responsibility at home (KM 202 "*Her school performance has improved. My daughter is more responsible, she washes her clothes when I am not at home, she cooks and cleans, she didn't do this before we came to KM*") and they were more caring (KM 580 "*He is more responsible and more caring. He is no longer rough at play, he is now softer*").

Other aspects that emerged in the mother evaluation forms are that their children's schoolwork showed improvement (KM 269 "*Her concentration at school has improved and now she even listens to me*") and their children's behaviour changed, in that they rather chose to stay at home than to play in the streets (KM 149 "*He used to be away from home for the whole day an did not listen when I talked to him, but now he listens and prefers staying at home*").

Some mothers reported that their children were less aggressive (KM 414 "*She was an angry child before coming to KM. Now she has improved a lot*") and less stressed (KM 157 "*He has become more open and is now able to talk to me about anything. He does not seem to stress a lot about his brother's behaviour of abusing substances like before*"). Some mothers evaluated their children's social behaviour as more appropriate (KM 701 "*My child no longer fights with other kids as he used to do before he started attending KM support groups*") and they described their children's behaviour as more emphatic (KM 411 "*He is more understanding and cares about other's feelings*"). The impact of the Kgolo Mmogo support sessions were seen in the children's behaviour at home and at school.

5.1.8. Group setting – Findings

The group setting was discussed in Chapter 3, p.172.

6. Qualitative interpretation

6.1. Qualitative interpretation of the behaviour and adaptive functioning displayed by children affected by HIV/Aids in a group-based intervention

The findings of the group session report data, the careworkers' observations, careworker's focus group, the mother evaluation questionnaires and the child evaluation questionnaires are incorporated and triangulated in the following interpretation to answer the research question 'What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?'

The child support group intervention sessions were based on theories of resilience and aimed at enhancing the adaptive behaviour of children affected by maternal HIV/Aids (refer to Chapter 1, p.5). Children exposed to maternal illness, low socio-economic circumstances and violence are at risk for developing psychological problems, including internal and external behaviour problems (Dutra et al. 2000).

An intervention programme provides an opportunity to prevent the development of problems and to enhance children's resilience to cope with their adverse circumstances. Murphy et al. (2010) states that there is an intervention need for mothers and their school-aged children, other than medicine adherence and prevention interventions.

The findings of the Child Support Group Evaluation Study indicated that the mothers found it difficult to cope with their illness and their own emotions regarding their illness (refer to par. 5.1.2.10., p.243 & Fig. 4.6). The mothers didn't know how to approach their children and to disclose their illness to them. They were unsure of how their children would cope with this knowledge. The findings indicated that the mothers were not used to communicate with their children and they were also afraid that their children would disclose their HIV status to others (refer to Fig.4.6).

Although the mothers generally did not disclose their HIV status to their children, their children showed awareness (expressed in verbalisation and behaviour) that their mothers were ill. This awareness caused emotional distress for the children. One of their coping strategies was to avoid the situation by either taking part in pleasurable activities or to withdraw. This emotional coping mechanism is aligned with Helseth and Ulfsæt's (2003) and Korneluk and Lee's (1998) findings. Children often hide their emotional stress in order to protect their mothers from further distress, according to Helseth and Ulfsæt's (2003). The children in this study displayed the same type of masking behaviour.

The ability to handle intense emotions is often difficult for children and they may need an adult to support and guidance them in managing these emotions effectively. There is a point up to where a child's strategies to maintain well-being is sufficient but then the burden becomes too heavy and they experience extreme stress levels (Helseth & Ulfsæt, 2003). The group provided support to the mothers and children in this regard. The careworkers and the intervention groups facilitated trust, information exchange and good communication. The group provided a safe environment for these children to vent their emotions, as proposed by Bronfenbrenner (1990). The data indicated that the identification of own and other's emotions, communication and support were the themes that occurred most frequently during the group sessions (refer to Figure 4.20) and that these skills helped them to display adaptive behaviour.

The careworkers often reported that the children enjoyed the sessions. They also attended the group regularly (refer to Figure 4.21) and in some instances they even attended the groups by themselves, without their mothers. This may be indicative of a child who wanted to escape from his/her unpleasant circumstances but it may also have been that the group provided emotional relief because he/she could share his/her emotions regarding their situation with other children in the same circumstances. This shared experience created a feeling of belonging and it built friendships in the group. Peer relationships are important for a child in the latent-phase (Werner, 1995). They want to feel that they belong and focus emotional energy on competent relationships (refer to Table 2.1). This study showed that their increased interpersonal understanding and their identification and verbalisation of other's emotions enhanced their ability to establish friendships.

The group provided a safe context where friendships could be established and the study indicated that the children evaluated this as one of the most outstanding attributes of the group. Positive social relationships with other people gave the children an opportunity for communication and to feel somebody is listening to them (Condly, 2006).

Betancourt et al. (2012) indicate that intervention groups assist children to talk to supportive friends and to seek help from adults in the community. The children in this study were able to move away from their own egocentricity to being able to understand other's emotions and recognising that other people can have different emotions (refer to Table 2.1). The support group offered them the opportunity to achieve the developmental task of moving away from egocentricity to accommodate other people's emotions (emotional intelligence). This developmental task may perhaps not be adequately addressed at home as the mother may be emotionally unavailable due to her illness.

The group provided the children in this study with the opportunity to practice this adaptive behaviour which is particularly important where children have to support their mothers. A stable, caring relationship with a mother (or other adult) is an important protective factor for a child to cope adequately with the demands of life and in some instances to even thrive in the face of adversity (Masten & Coatsworth, 1998). The joint group sessions enhanced the mother-and-child relationship for the participants in this study and thus the child's adaptive behaviour.

Religious practices were an important coping strategy, frequently used by the children in the child support groups. Masten and Obradović (2006) and Dutra et al. (2000) list religious practices as one of the adaptive systems that has to be available and working for a child to have a better chance of being resilient in his/her environment. Spirituality provides strength and a strong sense of connectedness where the child believes in something bigger than just his/her immediate situation (Williams et al., 2001). Latent-phase children often believe that God can be influenced through their promises, prayers and deeds (refer to Table 2.1) because they are cognitively on a concrete level of reasoning and realise that actions do have consequences (refer to Table 2.1). Coping can be a child's cognitive and behavioural effort to manage a difficult situation such as a mother's illness either consciously or unconsciously.

A child can find it difficult to express his/her feelings regarding their parent's illness, according to Johnston et al. (1992). The child appraises the situation according to his/her developmental stage by giving it a meaning that is based on personal experiences, values and beliefs. The children in this study used religious coping skills as part of their coping repertoire.

On a normative level the children furthermore used group rules as a coping and problem-solving mechanism. Clear boundaries are promoted by Janas (2002) as important for a child to feel secure. This absolutist and inflexible thinking style aligns with their developmental level where they see 'right is right and wrong is wrong' without any mitigating considerations (refer to Table 2.1). In a context where rules and regulations are violated either in their families or their environment, these children are in need of boundaries (rules) to provide them with security.

Comparison of their strengths took place in the social environment of the group (sessions 5–7). Children in this age group often compare themselves to others and evaluate themselves according to academic, physical and social areas of competence (refer to Table 2.1). An intervention must thus aim to use the strengths of the vulnerable population to overcome adversity, according to Luthar, Cicchetti and Becker (2000).

Lanyado and Horne (2009) refer to the company of children with diverse personalities displaying different weaknesses and strengths in the group which gives a child the opportunity to rediscover aspects of him or herself. In the group they had the opportunity to work as a team to complete activities where they could evaluate their own strengths or weaknesses. The findings indicated that they helped and supported each other to solve problems and, as a result, they explored their undiscovered strengths and put it into practice. This process enhanced respect for each other.

The life skills they acquired through their experiences in the group gave them self-confidence to assist their mothers at home and to support them. The children showed a basic knowledge of household chores (life skills) but the group provided practice opportunities for communication between the mothers and the children, which enhanced their emotional intelligence to deal with the emotional situation at home (Janas, 2002). Murphy and Marelich (2008) indicate that a resilient child displays a higher self-esteem than a non-resilient child. The child has, in effect, a greater efficacy to cope with his/her mother's HIV-infection and he/she shows enhanced interpersonal problem-solving skills. A high self-esteem often results in better social and school adjustment.

According to Urbis (2011) an integral part of resilience development for a latent-phase child to develop self-confidence, is an affirmative sense of self and positive recognition from other people. The child has to experience a sense of belonging in a supportive relationship. The child has to feel competent and this is achieved through activities where he/she can learn and achieve. The activities have to furthermore elicit opportunities where he/she feels listened to and where the child can make his/her own choices. The group provided the children with a sense of belonging where they received positive recognition from their facilitators, the other group members and their mothers during the joint sessions. The activities were developed to provide the children with the opportunity to achieve and to learn new skills in a safe and supportive setting. The findings from the children's quality assurance questionnaires indicated that the children appreciated the many questions posed to them in the group where they could answer them and therefore be listened to. Data from this study showed that their self-confidence was hereby enhanced as they felt that their opinion as children were valued. This measurement of the satisfaction of the participants in the intervention is important to ensure quality delivery, according to Geldard and Geldard (2001).

The latent-phase child is in the phase where children want to think independently from their parents (refer to Table 2.1). The child becomes more independent and needs more opportunities to be independent in places that are outside of the immediate arena of the family (Urbis, 2011). Werner (2005) indicates that sociability with a sense of independence is an important resilience characteristic of school-aged children. Resilient children display independence, appropriate behaviour, the ability to process information and are able to sustain social relationships. In this study it was found that they experienced a conflicting dualism at home as their mothers expected them to perform household chores independently, but they were not allowed to voice their opinion or make their own choices (refer to par. 5.1.2.9., p.242). This need was met through the group, which empowered the children to think independently and solve problems as a coping skill.

The adverse circumstances (poverty, violence, mother's illness) as experienced in their families and community contributed to the children's quest to change their future. According to Rochat and Hough (2007) children who display adaptive behaviour have a positive outlook on the future. A purpose in life and a positive future orientation help children to succeed in life, despite all the barriers he/she may experience in his/her present situation, according to Williams et al. (2001). With the support of the group and the help of the mothers the children in this study discovered their own strengths and they could plan for their future. The ideals the children pursued gave them direction but also it also gave hope to their mothers. A mother's positive future expectation for her child is a direct mediator for resilience, according to Condly (2006).

A child facing trauma is re-evaluating his/her position in the world and the child's reaction to the trauma is reflected in the behaviour he/she displays, according to Condly (2006). Trauma affects every person in a different manner and to a different extent. The children in the Child Support Group Evaluation Study experienced multi-dimensional risk factors. They were exposed to intra- and interfamily violence, abuse, poverty, maternal illness, broken families and negative mother-child relationships. Despite all of this, some children not only 'survived' according to Condly (2006), but they also 'thrived'. The children in the support group in this study displayed adaptive behaviour in the group, at home and some teachers reported improved behaviour at school (refer to par. 5.1.6.2., p.286).

The groups not only enhanced the children's adaptive behaviour, but also increased the children's ability to reach the latency phase's developmental tasks (refer to Table 2.1). Bailey (2004) emphasises the importance of successful adaptation for a given developmental phase. The cumulative value they gained from their participation in the groups was extrapolated to their direct environments. Adaptive behaviour as a protective factor has been taught and encouraged in the support groups. The intervention aimed to enhance as many protective factors available as possible (Masten & Coatsworth, 1998) and to enhance resilience opportunities and adaptive behaviour, as suggested by Gilgun and Abrams (2005).

6.2. Qualitative interpretation of the Child Support Group Evaluation Study content, methods and process

6.2.1. Content

The content of the Child Support Group Evaluation Study was specifically selected to enhance the adaptive behaviour of vulnerable children (Thompson & Henderson, 2006). This enabled the modification of non-adaptive behaviour and support of adaptive behaviour. The group provided the children with the learning opportunity to unlearn and relearn by practicing life skills. The content of each session had a specific purpose in order to reach the overall goals. The content reflected the children's real life situation because they could identify with it and it was culturally familiar to them, for example the 'masekitlana' and 'morabaraba' games. Pillay (2007) proposes the use of culturally friendly methods such as storytelling and projective techniques to address and approach the psychological challenges of children affected by maternal HIV/Aids. The topics and activities were age-appropriate, for instance board games, role-play, painting and drawing (Janas, 2002).

The cultural adaptability of the group sessions was furthermore enhanced by the group facilitators who were members of the same cultural group and thus also spoke the language of the group (Kerig, Ludlow, & Wenar, 2012). The children enjoyed the singing activities, but the song choice in session 10 was not age-appropriate as the older children felt it was only for younger children (refer to refer to par. 5.1.4. [session 10], p.262). The children were unfamiliar with the children charter referred to in session 8 (p.259) and they therefore found it difficult to discuss.

The three activities that were invaluable to the intervention programme were the 'masekitlana', 'morabaraba' and sock puppet activities. The 'masekitlana' activity (session 5) elicited deep-grounded emotional projections from the children (refer to par. 5.1.4. [session 5], p.253). It provided the opportunity for the children to cope with stressors in their situation and vent their feelings, fears and anxieties as they were not allowed or encouraged to talk freely at home and school about their emotions (refer to par. 5.1.2.1., p.233). The mothers and children could more easily relate to the sock puppet activity (session 17) and the culturally appropriate game of 'morabaraba' (refer to par. 5.1.4. [session 21], p.275) because they could experience the joy of sharing, communication, team work and eventually bonding with each other.

The children indicated that they enjoyed the activities where they played with puppets, the feeling thermometer activity, preparing lunch for their mothers, the body mapping activity, the 'don't talk to strangers' board game, the 'Finding Nemo' DVD and dancing and singing activities the most. Although the children indicated that they enjoyed these activities the most, it was the 'masekitlana', 'morabaraba' and sock puppet activities that elicited the most communication, participation and emotional sharing, according to the facilitators' observations. These three activities facilitated the projection of underlying emotional and behavioural problems and by doing this the child's psychosocial well-being was addressed.

The content facilitated the children's realisation that they had common needs and problems shared by other children in the same situation. The main aims of a support group are for children to receive mutual support in a safe environment, to share coping strategies, to share information and to develop confidence in dealing with the shared stressor at hand, according to Geldard and Geldard (2001). Support groups enrol children who experience specific challenges and the children may exhibit behavioural and emotional symptoms because of the life challenge. The activities required the children to work together and through this process their need for belonging and peer support were addressed (refer to Fig. 4.15). This elicited self-confidence, empathy, cooperation and altruism (refer to par. 5.1.7., p.289 & par. 5.1.4. [session 13], p.262). Peer support is important, according to Hughes-d'Aeth (2002), because peers provide information, life skills to cope with high-risk situations and practical ways to support behavioural changes. The activities enhanced the children's social skills where they had to relate to others (refer to par. 5.1.4. [session 9], p. 260).

Making friends is a priority for the latency-phase child (refer to Table 2.1). The content encapsulated all the resilience (adaptive behaviour) modalities (refer to Fig. 4.20) as envisaged in the theory-based intervention. The theory-driven content of the intervention provided direction and focus to the intervention programme, as indicated by Geldard and Geldard (2001).

6.2.2. Methods

Various methods were used to address the emotional, cognitive and social needs of the children. A variety of methods kept the sessions interesting for the children (Thompson & Henderson, 2006). The methods were determined by the aims of each session and the activities supported it, as indicated by Thompson and Henderson (2006). The methods were predominantly age-appropriate and flexible, as recommended by Sharry (2004). The age appropriate interests informed the structured activities, as supported by Janas (2002).The methods allowed the facilitators to be flexible in their choice of activity sequence to fit the specific group dynamics.

The methods used included:
- Role-play – for example, sock puppet activity, culturally friendly puppet play and real-life scenarios.
- Drawing/painting – for example, 'Feel good quilt', body mapping and family exercise
- Board games – for example, 'Don't talk to strangers' board game, 'Emotions' board game and morabaraba game.
- Physical activities – for example, Marschack Interaction Method activities, blind snake game and falling game.
- Bibliotherapy activities – for example, 'Man in the hole' story, 'Finding Nemo'-DVD and Metaphorical story.
- Memory box making – for example, 'Creating a family legacy' activity.
- Projective methods – for example, 'masekitlana'.
- Ice-breakers – for example, 'Ring and string' activity, 'Wool web' activity and 'The safe place' activity.

In order to extrapolate the aim of the group sessions, homework was given where the mother and child had the opportunity to work together. The homework enhanced this practice opportunity for the group members, but it was limited as pointed out by Leeper et al. (2010) to the willingness of the child to do the homework and the mother's support. Parental involvement is important, according to Sharry (2004), and the homework activities aimed to involve the mothers in the children's separate sessions. The mothers were more willing to assist their children to complete homework tasks after they (mothers) had completed their separate session where they focused on their coping with HIV/Aids. The shift in the mothers' separate sessions to parenting and child development topics brought about the improvement in completion of the homework activities.

The group cohesion was enhanced by three activities, namely 'climbing down the tree', the 'feeling thermometer', and homework activities, that became routine in the group sessions. This routine gave them structure and safety. Although flexibility is crucial in children support groups, Sharry (2004) emphasises the importance of routine and structure in a group to ensure that the groups run smoothly. The various methods employed in the group sessions contributed to reaching the aim of the intervention.

6.2.3. Process

An overwhelming number of children indicated in their group evaluations that they understood the group process, the content and what was expected of them (refer to Figs. 4.10 & 4.16). The children who found it difficult to comply with the session expectations might have had difficulty in completing the tasks because they didn't have the required skills, or they might not have been adventurous or they might have been too young (refer to par. 5.1.6.4., p.288). The topics and themes have to take into account the developmental level and aim of the intervention group, according to Geldard and Geldard (2001). The group process and content were thus age appropriate for most children and they were able to meet the expectations set by the sessions.

According to Kmita, Baranska and Niemiec (2002), support groups for parents have a positive impact on a child's psychosocial development.

Sharry (2004) proposes parallel parent support groups in a bid to involve parents in the group process, but also to maximise the positive results of the group intervention. Interventions that involve more than one family member have an added benefit of improving communication in the family (Korneluk & Lee, 1998; Spath, 2007). The intervention included both separate, parallel-run child and parent support sessions and joint sessions for the mothers and children.

The separate sessions offered mothers the opportunity to deal with their own emotions regarding their HIV-infection and gain parental skills (refer to Appendix 10), whereas the children were given the opportunity to learn and practice adaptive behaviour skills. In the joint sessions the mothers and children had the chance to play and communicate with each other. This enriched the mother-child relationship (refer to par. 5.1.5. [stage 2], p.282). The activities used in the children's separate sessions were aligned with the mother's separate sessions. Parental involvement in children support groups is suggested by Sharry (2004) to maximise the positive results of the group intervention.

The child support group intervention used the parallel-run separate sessions and joint sessions to maximise the positive results (for instance, naming of own and other's emotions, communication, sharing, help and support, respect, coping, problem-solving, positive future orientation and life skills) of the intervention.

Thompson and Henderson (2006) indicate that the topics and themes of a programme have to be sequenced to fit the anticipated, logical stages of the group. The intervention programme followed a logical sequence, from learning to know each other to trusting each other to such an extent that the group members were able to verbalise their feelings. The sequence of the children's separate sessions initially focused on the exploration of the self together with strengths and the focus then moved on to the child in relation to his/her family, friends and community. The joint sessions followed a sequence of activities, progressing from those requiring less emotional involvement, to those appealing to more intense emotional involvement (memory box activity). Provision was made, in advance, to allow for thorough debriefing after the sessions where intense emotional involvement was required. The group stages did seem to overlap and to a certain extent re-occur.

The groups had to re-establish themselves in the joint sessions after the separate sessions ended, which could have led to the preparation, forming, storming, norming and adjourning stages re-occurring (refer to par. 5.1.2, p.280).

The initial welcoming and the final termination sessions need special consideration in the planning phase, according to Thompson and Henderson (2006). The initial welcoming session in the children's separate sessions focused on establishing structure and children had the opportunity to get to know each other.

The first joint session gave the mothers and children the opportunity to get to know each other better and to set the scene for further communication and interaction. The last session of the children's separate sessions prepared them for the upcoming joint sessions with their mothers as they were not used to engaging with their mothers in an informal manner (play and communication) (refer to par. 5.1.4. [session 14], p.266). The last joint session was a festive occasion where they received certificates in acknowledgment of their contribution and completion of the sessions. A child's efforts to reach certain goals must be appropriately acknowledged and celebrated in the group (Janas, 2002). The mothers and children were encouraged to share their contact details with each other for future support.

6.2.4. Training of careworkers (group facilitators)

Geldard and Geldard (2001) and Thompson and Henderson (2006) mention that a facilitator has to have certain basic counselling skills, for instance observation skills, active listening skills, the ability to give feedback, the ability to make use of questions and the ability to confront participants. Observation skills are of particular importance because the facilitator must be able to identify problems in the group and with participants, but also able to give feedback on the group process (Geldard & Geldard, 2001; Thompson & Henderson, 2006). The careworkers received a year's formal and informal (as needed) training as child group facilitators (refer to par.13.2, p.191). The content of the group facilitator training included training in basic counselling skills, observation skills and reporting skills. They received supervision on a daily basis from the social workers and the project coordinator.

Weekly debriefing sessions were scheduled with the careworkers, where they could vent their frustrations and ask for guidance (refer to par. 13.2, p.191). The facilitators were furthermore guided in appropriate referral practices, as discussed in paragraph 13.2, p.191.

6.2.5. Application of the intervention by the careworkers

In addition to counselling skills, Geldard and Geldard (2001) recommend that facilitators develop facilitation skills. The facilitator thus has to be able to give clear directions and instructions. The facilitator has to remind the group of group rules, confidentiality rules and responsibilities of the group participants.

Facilitating discussions, teaching, giving advice, protective behaviour and modelling are some of the facilitation skills required from a group facilitator. The careworkers' training as group facilitators is deemed to have been adequate as they were able to:

- Facilitate the group activities to reach the intended goals of each session.

- Incorporate the various methods appropriately.

- Follow the group process and be flexible when necessary.

- Relate to the children in a warm and emphatic manner and engage with them on their own level, while still be respected as facilitator.

- Identify and reflect the children's emotions.

- Manage difficult behaviour (for example, hyperactivity and aggression) and maintain discipline on a mutually respectful manner. The facilitator has to be able to manage difficult behaviour and reinforce positive behaviour, according to Geldard and Geldard (2001).

- Identify children who were in need of referral and thus give extra support to children who need it, as proposed by Thompson and Henderson (2006).

- Reflect on the group dynamics and their own behaviour as facilitator. They connect ideas generated in the group, according to Thompson and Henderson (2006).

Their experience as facilitators had an added advantage for the careworkers. They were able to extrapolate the knowledge and skills they had gained to their own families.

The facilitators in this study were chosen from the same community and culture as the group members. They were thus able to communicate with the group members in their own language. Cultural adaptability is increased if the group facilitator is a member of the same cultural group and able to speak the language of the group, according to Kerig, Ludlow and Wenar (2012). Specific cultural differences may have an impact on the success of an intervention programme and therefore the facilitators were chosen from the same community as the group members. Geldard and Geldard (2001) emphasise the importance of finding suitable facilitators who are available for the full duration of the intervention session and co-facilitators who can be a substitute if a facilitator goes on leave. A facilitator and co-facilitator were assigned to each group for further observation and as support.

The facilitators in this study displayed and verbalised adequate skills and knowledge to facilitate a child support group. They did however indicate that they needed additional information regarding the emotional life of children and child development, to supplement what they had learnt in their training sessions.

6.2.6. Response of the children and mothers (in joint sessions) to the intervention

6.2.6.1. Children's response to the intervention (session reports, child evaluation questionnaires, and careworker focus groups)

The children felt comfortable in the group because they experienced as sense of belonging and acceptance from the group members and careworkers. This is aligned with children in this age group's need for positive regard from others (refer to Table 2.1). They could communicate their feelings and they felt safe enough to share positive and negative emotions. Kmita, Baranska and Niemiec (2002) mention that children are able to safely express their fears and anxieties in a secure environment with a caring facilitator and supporting group members. The group facilitators were able to explain the goals of the sessions and model appropriate behaviour in order for the children to understand what was expected of them in the group and the group process. Group contexts provide children with modelling opportunities to observe and imitate positive behaviour and problem-solving of their peers, according to Akos (2000).

They experienced their friends as supportive and they cared about their friends. The children indicated that they enjoyed the challenges given to them through the games and the questions asked in the group. They placed specific importance on the respect they learnt for other people in the group. Data show that the respectful behaviour modelled in the group seemed to enhance the behaviour.

Their enjoyment of writing, reading, painting and board game activities indicate that the methods chosen in the support sessions were predominantly age appropriate. Sessions have to be structured using age-appropriate activities. Activities such as bibliotherapy, DVDs, board games, puppets and role-playing have the ability to stimulate discussion and problem-solving, according to Thompson and Henderson (2006).

These types of activities are seen as age appropriate for a latency-phase child. The children indicated the play activities with their mothers in this study as their best experience in the group, with specific reference to puppet play, the 'feeling thermometer' exercise, the 'making food for mothers' session, body mapping with mothers, 'don't talk to strangers' board game, the 'Finding Nemo' DVD, singing and dancing activities. The children received lunches after the sessions and toys after completion of the 24-week support sessions. The children experienced the support sessions as positive and voiced enjoyment. Some children wanted to share this positive experience with their siblings and friends and brought them with to the groups.

6.2.6.2. Mothers' response to the intervention (mother evaluation questionnaires, session reports [joint sessions], careworker focus groups)

The mothers in this study reported that they experienced the Kgolo Mmogo support sessions as positive because they learned how to communicate positively with their children and these newly-found skills helped them to get to know their children. Rolland (1987) argues that for a family to cope with illness they have to be able to communicate with each other. They felt more comfortable in sharing their emotions with their children after getting to know them better through play activities. Some mothers could disclose their HIV status to their children because of their closer bond. Bronfenbrenner (1990) indicates that trust, information exchange and good communication are necessary for effective relationships.

The group provided the necessary opportunities for the mothers and children to develop effective relationships. The mothers indicated that they enjoyed playing with their children and this gave them the opportunity to share positive (planning for the future) and negative experiences (memory box exercise) with their children. Most of the mothers indicated that their children's behaviour improved significantly after attending the support sessions. The children displayed less aggressive behaviour (externalised behaviour problems) and they were able to cope better with problems. Akos (2000) supports the idea that through group work a child can unlearn negative behaviour and learn new ways of coping with problems in a safe environment with their peers.

Children in the latency phase are more vulnerable to stressors than children of other age groups, according to Collins, Madsen and Susman-Stillman (2008). The sessions helped them to cope better with the stressors they experienced in their situation. The mothers noticed that their children showed improved communication and listening skills (refer to par. 5.1.7., p. 289). These skills improved their friendships with peers and their relationships with their mothers.

The respect and subsequent obedience they had learned in the group was noticed by the mothers in their observations of their children's adaptive social engagements outside of the group. Children in the latency phase want to feel that they belong and therefore the group gave them the opportunity to make new friends and experience a sense of belonging (Refer to Figs. 4.7 & 4.8). Aldridge and Becker (1999) assert that children in the latent-phase who are exposed to illness in the family or have to take over care-giving roles in their family can experience educational, social, and emotional problems. The mothers in this study reported that their children displayed more self-confidence and their school work improved (refer to par. 5.1.7., p.289). The mothers also indicated that the teachers commented on the positive behavioural changes of the children. The group thus provided a buffer for the children and supported them in coping with their mother's illness. The mothers in the study observed that their children's caring behaviour extended to them wanting to be at home and to help their mothers with household chores. The responsible behaviour and empathy they showed made it easier for the mothers to disclose their HIV status to their children.

6.2.7. Group setting (session reports, careworker focus groups, group attendance, project coordinator observation notes)

Geldard and Geldard (2001) indicate that group composition and group size are decisions that can impact on the effectiveness of a group. The group composition was dependent on the randomised allocation of group members. In one wave only boys were in the group and they functioned particularly well. This is aligned with the latency phase where children of one gender (refer to Table 2.1) tend to divide themselves into same-sex groups. Mixed-gender groups are preferred though, according to Thompson and Henderson (2006), as this type of group is more productive than same-gender groups. This was the case with 11 of the 12 groups in the Child Support Group Evaluation Study. The ages of the children in the groups ranged from 6 to 10 years (latency years). The group facilitators indicated that the six year-old children found some of the activities too difficult.

The careworkers indicated that the group size was important for a group to function effectively. According to the careworkers, the optimum group size was more than two members but not more than 12 members. They were not able to complete some of the activities in instances where the groups were too big or too small. Akos (2000) indicates that a large group (10–12) of children is more suitable for empathy development and a smaller group (4–6) is more appropriate for remedial prosocial behaviour. The average attendance of group sessions was eight children and it is aligned with Thompson and Henderson's (2006) idea that a support group is most effective with eight children. Two group facilitators were available for each group and this complied with Thompson and Henderson's (2006) opinion that the number of facilitators should inform the group size.

The careworkers in this study mentioned that they supported including children who were ill and children with mental and other types of disabilities. The children with mental disabilities and other disabilities were a challenge in the group but the other group members and the careworkers were able to accommodate them effectively in the group. The groups had to be all-inclusive, according to the careworkers, in order to be representative of real life. They were of the opinion that children should be given the opportunity to learn skills to cope with different children in the groups. Malouff and Schutte (1998) support the idea that the group has to be representative of the wide social environment.

Geldard and Geldard (2001) mention the importance of intake procedures, confidentiality, safety of the group intervention site, conduciveness of the site to the group activities, average length of the sessions and overall duration of the sessions as indicators for planning a successful group intervention. The intake of the child support group sessions in this study took place in safe environments. The group sessions took place in non-descript buildings and therefore attributed to confidentiality (refer to par. 10, p.172). The group sessions at both sites took place in a secure area and it was easily accessible for the mothers and the children. In some instances the children had to attend the group sessions by themselves and it was necessary that the locations were chosen carefully to assure safety and accessibility. The rooms were big enough for the children's activities and the joint sessions. There was enough space for chairs and tables to be arranged in a circle, as proposed by Thompson and Henderson (2006). The rooms were situated far enough from each other in order to limit disturbance.

The outside area was big and safe for the children to play in and for the outside joint session activities (refer to par. 10, p.172). Having regard for all of these factors, the locations and buildings of both the Mamelodi and Atteridgeville sites were conducive to the group process.

6.2.8. Duration of support group sessions

The six-month duration of the group sessions seems to have been adequate, with reference to the good group attendance (refer to Table 4.4). Tudge et al. (2009) and Bronfenbrenner (1979) state that for optimum development, the interaction must happen on a regular basis over long periods of time. The children's sessions were scheduled weekly and it stretched over a six-month period. External factors did influence the group attendance, for instance where mothers were employed during the group sessions or fell ill. These factors could not be controlled. The mother, child and careworker evaluation indicated that they experienced the group sessions as adequate and in many instances they proposed more sessions. The children specifically expressed this idea (refer to par. 5.1.4. [session 24], p.279).

The child support group sessions had a definite structure where the themes followed on each other and they had a direct correlation with the mothers separate sessions (refer to Appendix 10). Each session was planned for an hour and a half (excluding lunch time).

The sessions were not too long and adhered to Thompson and Henderson's (2006) proposal that sessions for children must be short enough to keep the children's attention. The careworkers indicated in their group session reports that some children were not able to be on time at the start of the sessions. The reasons for coming late ranged from extra-mural school activities and school finishing late to unreliable transport (taxis coming late or not at all). The careworkers proposed a larger time gap between the starting time of the group sessions and the time the school adjourned.

6.2.9. Timing of support group sessions

The success of a support groups additionally depends on the time of year (taking into account the school calendar) when the sessions are presented. The timing of the support group makes a difference in how well the group is received and attended (Geldard & Geldard, 2001). The timing of the group sessions in this study was dependant on the completion of each wave group. The timing of the support groups seemed to have worked well, but the careworkers did however indicate that the December holiday break was too long. The children lost interest and their attendance rates were poorer.

6.2.10. Cost effectiveness of group sessions

Geldard and Geldard (2001) place emphasise on the cost effectiveness of support groups. The group session cost effectiveness is described in paragraph 14, p.192. Masten and Coatsworth (1998) indicate that if a stressor occurs during the intervention, efforts have to be made to reduce its impact. Resources can be added or improved to enhance the effects of the intervention. This intervention programme thus had made provision from the start to distribute food parcels to families in need. The food parcels were donated and the intervention personnel only administered its distribution. Muindi (2003) emphasises the importance of a programme to tend to the physical needs of children who are hungry or malnourished. Masten and Coatsworth (1998) support the idea of first identifying the risks (hunger) before an intervention commences. According to them, if a stressor occurs during the intervention, efforts have to be made to reduce the impact and resources can then be added or improved to enhance the effects of the interaction.

7. Quantitative interpretation of the Child Support Group Evaluation Study (child focused questionnaires)

The data findings (refer to Tables 4.3 & 4.4) of the baseline and six-month interviews (pre- and post-treatment) of the child self-report psychological instruments suggest that the children did not display a significant difference in their report of anxiety on the Revised Child Manifest Anxiety Scale (RCMAS), depression on the Child Depression Inventory (CDI), emotional intelligence on the BarOn EQ-i: YV™ and self-concept on the Self Descriptive Questionnaire (SDQ) after attending a six-month intervention that aimed to increase their adaptive behaviour.

The difficulties associated with the use of the child psychological instruments in the Promoting Resilience in Young Children Study were that the instruments were not standardised on the South African population, the instruments were not developed for the diverse South African cultural groups they were intended to be used for and the instruments had to be translated from the English language into four local languages.

The translated instruments produced its own set of challenges as the languages the instruments were translated into have a limited emotional vocabulary compared to the larger emotive English vocabulary. The child instruments were ultimately used in the study because there was a limited selection of instruments available for measuring resilience of young children in South Africa. Leong, Qin and Huang (2008) caution that "*measures of social and psychological constructs are usually culturally relative and their equivalence in meaning and application should not be assumed*" (p.66). Moletsane (2004) furthermore refers to the possible methodological difficulties that may be encountered when psychometric assessment is done cross-culturally. The absence of meaningful normative data for specific cultural groups is one such a difficulty.

According to Moletsane (2004) most tests used in South Africa are standardised adaptations of tests developed in other countries. No standardised psychological instruments for the different culture latency age groups have been validated for the South African population (Cluver & Gardner, 2007). This was subsequently also true for the Promoting Resilience in Young Children Study.

The cultural context of the children requires specific attention in a developing and complex country such as South Africa (Moletsane, 2004). Jackson and Abosi (2006) indicate, for example, that in certain South African cultures children demonstrate a moderate expression of emotions and a high respect for their elders. These specific cultural traits might have had an impact on the way some of the children in the study answered the emotionally laden questions and how they reacted to the research assistants who asked them the questions.

The questionnaires in the study were translated into the Sepedi-, Setswana-, Isizulu- and Sesotho languages. Each language group has a different ethnic and cultural background that has to be taken into consideration in order to adhere to cultural fairness (Hall & Maramba, 2001). Dawes (2006) cautions that even with translational adaptation of questionnaires to fit the terminology, cultural and linguistic differences of the population the instruments are intended for, it is still difficult to distinguish if the participants really understand questions related to emotions and behaviour. Dawes (2006) questions if these types of instruments truly reflect the local understandings of well-being and distress. Swartz (2002) pointed out that the possibility of "*the impossibility of finding a perfect translation*" (p.41) has to be taken in consideration. The standardisation of the instruments used, the cross-cultural adaptation of the instruments and possible translation concerns in the assessment battery thus have to be considered in the interpretation of the data.

The non-significant scores as indicated on the RCMAS, CDI, BarOn EQ-i: YV™ and SDQ self-report instruments could be further explained by the fact that some of the children were not aware that their mothers were HIV positive. Only 12.2% mothers (refer to Fig. 4.6) indicated that they or somebody else had disclosed their HIV-status to their children. Letteney (2010) and Corona et al. (2006) refer to the reason why mothers are reluctant to disclose their status to their children, as fear of stigmatisation. Hough et al. (2003) and Brandt (2007) allude to clinical research focusing on the psychological health of HIV-affected children, indicating that they are extremely vulnerable and at great risk for developing psychopathology. Heightened levels of externalising behaviour and internalising problems were reported by the mothers in these studies. Korneluk and Lee (1998) do however caution that the presence of parental illness *per se* does not inescapably lead to psychopathology and adjustment problems in children.

The Kidcope psychological instrument, however, showed a significant difference between the baseline interviews and the six-month follow-up interviews, in terms of the frequency the child participants in this study used both the coping styles of approach and avoidance. They reported that they used both coping mechanisms more often after they had completed the six-month intervention sessions. The children perceived the approach coping style after the six-month intervention sessions as efficacious. They did not report a significant change in their perception of the efficaciousness of avoidance coping after completing the intervention sessions. They were thus able to employ different coping styles more often and distinguish between the efficaciousness of the approach coping style and avoidance coping style.

Billings and Moos's (1981) childhood coping model indicates that a child can use either active or avoidant coping strategies. Active coping strategies are used in an attempt to actively focus on the stressor, whereas avoidant coping is where cognition and behaviour are used to draw the child's attention away from the stressor. Avoidant coping is more closely linked to child adjustment problems. The data of the children in the Child Support Group Evaluation Study indicated that the frequency of using both types (approach and avoidance) coping styles increased after attending a group-based support intervention. Helseth and Ulfsæt (2003) indicate that there is a point up to where a child's avoidant coping strategies to maintain well-being are sufficient and then the burden becomes unbearable and they experience acute stress levels. The children in this study were able to judge the effectiveness of the two different coping styles and after attending the intervention sessions they employed both coping skills in an effort to cope with their complex environment.

The intervention enhanced the children's range of coping skills to cope with the stressor at hand, as proposed by Harbeck-Weber, Fisher and Dittner (2003). It furthermore enabled them to make a meaningful choice in their decision of which coping mechanism to employ. The intervention addressed coping and problem-solving skills that are beneficial to non-resilient children, according to Murphy and Marelich (2008), as they are taught how to label their feelings, how to solve problems and use other life skills.

The Child Spiritual Coping Scale (CSCS) data indicated that the children reported that they used spiritual coping strategies more frequently after attending the support group intervention but that they did not perceive the spiritual coping skills as more efficacious than before the intervention. Children in the middle childhood years are in the concrete operational phase of cognitive development (refer to Table 2.1) and therefore might have experienced more difficulty in evaluating the efficacy of the coping mechanisms of the spiritual realm.

Religious coping has received less attention than other types of coping, according to Folkman and Moskowitz (2004). Spirituality provides strength and a strong sense of connectedness where the child believes in something bigger than just his/her immediate situation (Williams et al., 2001).

The children in the Child Support Group Evaluation Study thus indicated that they made more frequent use of spiritual coping mechanisms after they completed the intervention sessions, but did not indicate a difference in the efficacy of the spiritual coping skills they employed before the intervention and thereafter.

A possible explanation for the discrepancy between the significant differences indicated by the child participants on the Kidcope and CSCS self-report instruments and the non-significant differences indicated on the CDI, RCMAS, BarOn EQ-i:YV™ and SDQ self-report instruments after completion of a six-months intervention, could perhaps be the structure of the questionnaires. The Kidcope and the CSCS instruments are the only two instruments in the assessment battery that had a two-tier answering structure where the children had to indicate the frequency they used a specific coping mechanism and then subsequently evaluate the efficacy of the coping mechanism they employed. The child had to engage in the question in order to answer it. In addition, both instruments focused on coping mechanisms and the questions concentrated more on coping behaviour and less on emotions as the other instruments in the assessment battery. The translations furthermore could translate words describing behaviour more easily than words describing emotion, because more 'behaviour' words than 'emotion' words were available in the translated languages' vocabularies.

Studies furthermore indicate that internalised problems such as childhood depression is difficult to diagnose reliably even with standardised questionnaires and clear diagnostic criteria (Carr, 2006; Borner, Braunstein, St.Victor, & Pollack, 2010). The children in the Child Support Group Evaluation Study also had no previous experience in answering questionnaires or using Likert-type scales to indicate their answers. The unfamiliarity of the activity could further have had an impact on the data findings.

The mother participants indicated on both the Child Behavior Checklist (CBCL) and Vineland II child-focused questionnaires, improvement in their children's behaviour and adaptive functioning after attending a six-month support group intervention. The children were reported as displaying less internalised behaviour problems, such as depression and less externalised behaviour problems, such as aggression.

Children often do not have the ability to verbalise their feelings in the same way adults do and their behaviour may be viewed as inappropriate by outsiders because they have a tendency to act out their anxiety and fears.

A child could react with internalising stress responses (depression and/or anxiety), externalising stress responses (acting out and difficult behaviour) and/or with somatising stress responses in a way to cope with stressful life events, according to Eloff and Ebersöhn (2002). Children who are affected by maternal HIV/Aids are prone to elevated levels of psychological distress, depression, loneliness, negative self-esteem, anxiety and withdrawal, according to Betancourt et al. (2012); Forehand et al. (1998); Forehand et al. (2002) and Forsyth, Damour, Nagler and Adnopoz (1996). These internalising problems could have a major impact on the psychological development of this vulnerable group of children. The HIV-infected mothers in the group intervention reported that the intervention improved the internalised and externalised behaviour problems of their children and moreover it enhanced their children's adaptive behaviour. Their children did not only display less problematic behaviour but they showed improved communication, daily living and socialisation skills after attending a six-month group-based intervention.

The child group findings indicate that the intervention had a significant impact on the frequency the children used different coping mechanisms and that they were able to distinguish between the efficacy of the approach and avoidance coping styles. The children's adaptive behaviour was significantly enhanced by the intervention sessions as reported by the mothers.

8. Summary

The quantitative and qualitative data findings of the Child Support Group Evaluation Study were discussed in detail in an attempt to answer the research question of 'How efficacious is a group-based intervention in enhancing adaptive behaviour of young children affected by maternal HIV/Aids?' In order to provide background to the aforementioned question the study reported on the population characteristics of the study participants. Two prominent characteristics of the study population were that a large group of mothers were unemployed and not married. In addition only a small percentage of mothers (12.20%) indicated that they or somebody else had told their children that they (the mothers) were infected with the HIV virus.

The quantitative data findings and analysis focused on two distinct, although closely-related, data sets, the child self-report questionnaires and the child-focused questionnaires where the mothers reported on their children's behaviour and adaptive functioning. The child self-report questionnaire data indicated that **the intervention sessions enhanced the children's use of approach, avoidance and religious coping skills** as reported on the Kidcope and Child Spiritual Coping Scale instruments. The children furthermore indicated that they could distinguish between the efficaciousness of the approach coping style and avoidance coping style. Non-significant scores were indicated on the Revised Child Manifest Anxiety Scale, Child Depression Inventory, BarOn EQ-i: YV™ and Self-Description Questionnaire self-report instruments.

Reasons attributed to this inconsistency between the indicators were that only a small number of mothers disclosed their status to their children and the children were thus not aware of their mothers' illness; the self-report instruments were not standardised for the South African population or unique culture groups; the translation in itself could have been problematic (although great care was taken to ensure that the questionnaires were culturally adapted to fit the population it was intended to be used in); and the structure of the two coping self-report questionnaires differed significantly from the other instruments in the assessment battery.

The mothers of the child participants reported **improved internalised and externalised behaviour** on the Child Behavior Check List. The mothers indicated that their children displayed **enhanced daily living, communication and socialisation skills** after completing the group support six-month intervention sessions, on the Vineland-II adaptive behavior instrument.

The qualitative analysis phase of the support group intervention entailed an in-depth exploration of the careworkers' group session notes, careworkers' observations, group attendance statistics, programme content and process, group stages, careworker focus groups, child evaluation questionnaires, mother evaluation questionnaires and assessment of the group setting.

The data of 75 individual participants were initially selected and analysed as the careworkers indicated that these individual participants displayed noticeable observable adaptive behaviour or non-adaptive behaviour. Adaptive behaviour (protective factors) and non-adaptive externalised behaviour and internalised behaviour (risk factors) were identified.

The qualitative data analysis of the support group sessions indicated the resilience indicators that emerged in the group sessions and referred to specific risk factors that had an impact on the resilience of children. Resilience indicators that most often transpired in the group support sessions were the **identification and verbalisation of own and others' emotions, sharing and communication indicators.**

Help and support, life skills, problem-solving, positive future, respect and coping were also addressed in the child support groups as proposed in the goals set out in the manual. The findings indicated that maternal illness, violence and poverty had particularly debilitating effects on the children's adaptive behaviour.

In the aforementioned findings **the children in the support group intervention displayed normative values by exhibiting religious coping skills, a pursuit for and display of respect and drawing a definite distinction between what is right and wrong, despite the chaotic life circumstances of enduring poverty, violence, single parenting and the uncertainty of maternal illness to which they were exposed**.

The children's attendance of the group sessions was also analysed. An average of 8.5 children attended the group sessions in this study. Eight children are indicated in the literature review as an ideal number of participants (Geldard & Geldard, 2001). The largely constant group attendance rates from session 1 to session 24 of the total 12 waves additionally pointed towards a low attrition rate.

The group content of the Promoting Resilience in Young Children manual was analysed by referring to the goals and subsequent outcomes of each session. The implementation of the group intervention sessions and the group stages of preparation, forming, storming, norming and adjourning were evaluated in detail in an effort to provide a detailed evaluation of the theory-based group intervention programme under investigation. The goals of the sessions were reached in each session. Activities that did not succeed in helping to reach the initially planned outcomes were identified and revisions were proposed. Most of the activities were successful, except for the 'If you are happy and you know it' activity in session 10 and the 'Child Charter' activity in session 8.

The careworkers' experiences of their role as group facilitators; their evaluation of children's behaviour in the group sessions; their experience of the group process and suggestions for future groups; what they thought the children gained from the sessions; specific difficult situations they had to deal with; added benefit of the sessions for the facilitator's own life and other issues became apparent in the analysed data from the focus group discussions.

While this was not a primary focus of the study, the experiences of the careworkers were included to provide a nuanced understanding of the efficaciousness of the child support group intervention.

The intervention programme findings were triangulated with the mothers' and children's evaluations of their experiences of the group sessions. **The mothers experienced that their parenting skills were positively enhanced by attending the support group sessions and they reported that their children displayed improved behaviour**. The children indicated that the group gave them the opportunity to make new friends and to learn new skills. Their experience of the group sessions was positive and they indicated specific group session activities they enjoyed.

The specific content, methods and processes employed in the intervention were analysed and evaluated for effectiveness and age-appropriateness in the Child Support Group Evaluation Study**. The data indicated that the content, methods and processes employed in the group-based sessions were effective and adequate for the latency age group the intervention was intended for.** According to the analysed data, the training of the careworkers was adequate and they received sufficient support that enabled them to facilitate group sessions focusing on the enhancement of adaptive behaviour. **The application of the intervention, duration of the support group sessions, timing and cost-effectiveness of the sessions were satisfactory, according to the qualitative data findings.**

In summary, the quantitative data findings indicated an improvement in the children's use of coping skills. The mothers indicated a significant improvement in their children's adaptive behaviour after they had attended the six-month support group intervention. The mothers furthermore reported a decline in internalised and externalised behaviour problems.

The qualitative data findings indicated an improvement in the group members' adaptive behaviour as displayed by the children in the group sessions, evaluated by the mothers and children and reported by the mothers and careworkers. The children exhibited adaptive behaviour despite the adversities they had to face. Poverty, maternal illness, single-parent families and violence were adverse risk factors prevalent in the children's lives.

An interpretative integration of the qualitative and quantitative data findings of the Child Support Group Evaluation Study propose that the six-month child support group intervention was efficacious in enhancing the adaptive behaviour of children affected by maternal HIV/Aids.

Chapter 5 consists of a summary of the research, conclusions and recommendations following from this study.

CHAPTER 5

Summary, Conclusions and Recommendations
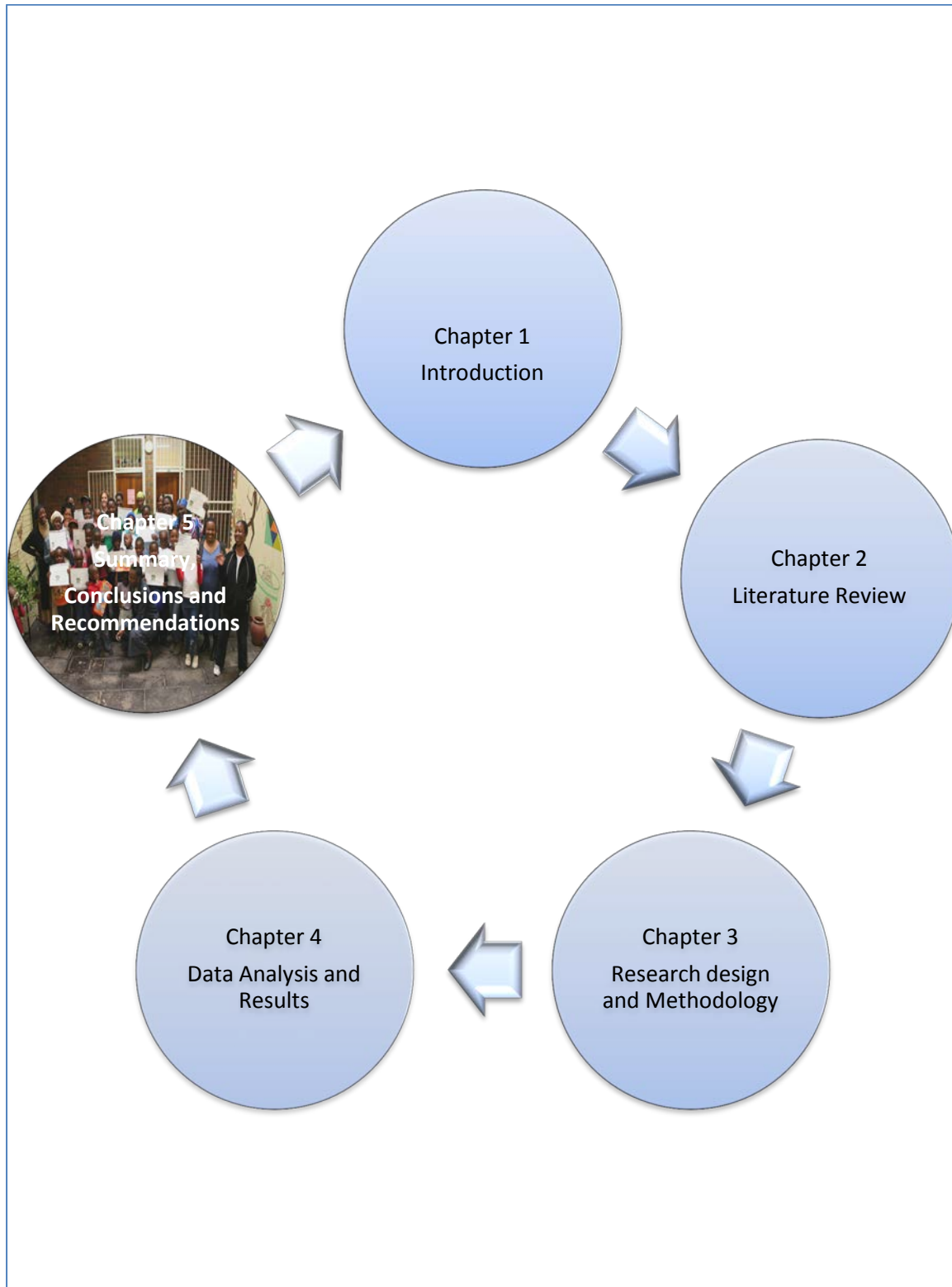
1. Introduction

> *"Never doubt that a small group of thoughtful, committed citizens*
> *can change the world. Indeed, it is the only thing that ever has"*
> (Margaret Mead in Goldman, 2005, p.271).

A large group of South African children are exposed to the psychosocial and economic effects of HIV/Aids. The children who live in families where their mothers are infected with HIV, experience the same kind of anxiety and fear as children who live in families disrupted by other life-threatening diseases such as cancer. However, there is often an added burden on them – stigmatisation, discrimination and related economic stressors accompany their daily struggle to adapt to their living circumstances. Stigmatisation by itself has the possibility of increasing the impact of HIV/Aids on children's lives. In various cases the parents do not disclose their HIV status to their children because of the associated stigmatisation involved in disclosure. Furthermore, the symptoms of the illness and possible negative family dynamics, for instance maternal depression, make it difficult for the child to make sense of his/her situation. In South Africa the effects of HIV/Aids on victims and their families, often living in single-parent households and poverty and experiencing high levels of violence, are exacerbated by the limited support they receive from the community. The children of HIV-positive mothers consequently experience immense uncertainty in their environment, compounded by the added insecurity brought on by their mother's state of health.

Fortunately, HIV is no longer an early death sentence as current antiretroviral medicine and new treatment options make it possible for HIV-infected patients to have a near-normal life expectancy. These medical advances make it even more important for researchers to support mothers and children in managing their HIV diagnoses and prognoses to such an extent that the family can adapt to their new circumstances and experience a fairly normal family life.

Rigorous research focussing on the evaluation of programmes designed to enhance the adaptation of children to maternal HIV/Aids and psychosocial support for families in these circumstances over an extended period are scarce. Research regarding the impact and effect of the different bioecological systems of the child and his/her family affected by HIV/Aids are of particular importance, to ensure that a programme is holistically evaluated.

Betancourt et al. (2012) state that *"The mental health and wellbeing of children and families affected by HIV/AIDS must be viewed as a dynamic process involving a number of ecological levels, from the biological to the family to the larger community and culture, with each level presenting risks"(n.p.)*. The change of emphasis in HIV/Aids programmes, shifting from focussing on the physical support to children to the added psychosocial support to children in their context, had an impact on current research regarding the planning and evaluation of programmes to support children affected by maternal HIV/Aids.

The Child Support Group Evaluation Study reported in this thesis aimed to deliver a contribution to the limited number of mixed-method evaluation studies focussing on children's adaptive behaviour in adverse circumstances. The study furthermore aimed to contribute to the planning, process and evaluation of a culturally-appropriate theory-based intervention programme to enhance latency-phase children's adaptive behaviour in a group context.

This chapter contains a summary of the study findings, conclusions drawn from the literature and empirical research, limitations, strengths and contribution of the study as well as recommendations for improvement of the intervention programme and proposed further research. A synopsis of the key findings for the Child Support Group Evaluation Study is presented at the end of Chapter 5.

2. Summary

Chapter 1 contains the introduction and background to the Child Support Group Evaluation Study, which includes a description of the randomised controlled trial, Promoting Resilience of Young Children Study, the rationale, assumptions, limitations, research questions, research methodology and procedures of the study.

In this chapter it was argued that latency-phase children affected by maternal HIV/Aids are exposed to psychosocial and economic difficulties and prone to developing behavioural problems. Although maternal HIV could have a pronounced impact on a child's development, it is posed that adaptive behaviour or resilience can be promoted in children through a culturally-appropriate intervention programme focussing on the child and his/her context holistically.

The main research question can be stated as follows: How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour? This question implies more questions, such as the quantitative question: To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour? and the qualitative questions: What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display? What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent-phase child? An overview of the proposed evaluation study was furthermore presented in Chapter 1.

In **Chapter 2**, a literature review was undertaken of the theoretical concepts that were deemed critical to the understanding of the underlying assumptions for the evaluation of the theory-driven group-based intervention for latency-phase children affected by maternal HIV. A summarised outline of this chapter includes theoretical assumptions referring to the latent child's experience of maternal illness and the psychosocial effects of maternal HIV. Resilience and adaptive behaviour of children in the context of HIV and Aids were furthermore examined. For the purposes of this Child Support Group Evaluation Study, resilience served as the umbrella concept for adaptive behaviour. Finally, literature pertaining to the planning, content and process of group-based intervention programmes for HIV-affected children was presented.

Chapter 3 contains the methodological approach to the evaluation of the intervention programme. A concurrent nested mixed-method research design was used in this study to evaluate the efficaciousness of a theory-based support group intervention to enhance children's adaptive behaviour. The intervention programme evaluation follows integration of the knowledge gained from a literature review, as well as questionnaires, focus group interviews, observations and content and process evaluation of the programme manual. The programme evaluation is presented as the Child Support Group Evaluation Study. The ethical guidelines that were adhered to in the study are furthermore discussed in this chapter.

Chapter 4 presents an account of the evaluation and the findings of the Child Support Group Evaluation Study and the data analysis.

A theory-driven evaluation study was conducted in order to come to an understanding of the efficacy of a support group intervention to enhance the adaptive behaviour of children who are affected by HIV/Aids in a low-resource environment.

The quantitative findings of the Child Support Group Evaluation Study indicate that the intervention sessions enhanced the children's use of approach, avoidance and religious coping skills. The children could distinguish between the efficaciousness of the approach coping style and avoidance coping style. The mothers of the child participants reported that their children displayed improved internalised and externalised behaviour and they furthermore indicated that they displayed enhanced daily living, communication and socialisation skills after completing the group support six-month intervention sessions.

The qualitative findings indicate that the resilience indicators that most often transpired in the group support sessions were the identification and verbalisation of own and others' emotions, sharing and communication indicators. The children in the support group intervention displayed normative values by exhibiting religious coping skills, a pursuit for and display of respect and drawing a definite distinction between what is right and wrong, despite the effects of maternal illness, violence and poverty to which they were exposed.

The data indicated that the content, methods and processes employed in the group-based sessions were effective for the latency age group the intervention was intended for. According to the analysed data, the training of the careworkers was adequate and they received sufficient support that enabled them to facilitate group sessions focusing on the enhancement of adaptive behaviour. The application of the intervention, duration of the support group sessions, timing and cost-effectiveness of the sessions were satisfactory, according to the qualitative data findings.

An interpretative integration of the qualitative and quantitative data findings of the Child Support Group Evaluation Study propose that the six-month child support group intervention was efficacious in enhancing the adaptive behaviour of children affected by maternal HIV/Aids. An executive summary of the quantitative and qualitative analysis of the results obtained in the Child Support Group Evaluation Study are presented in section 5.6 of this chapter.

3. Further limitations of the study

The limitations for this thesis study are as follows:

- The subjective nature of self-reporting questionnaires lends itself to questioning the validity of the answers given by the participants. The participants may for instance want to portray themselves in a better light or attempt to please the research assistant.

- The self-report questionnaires used in this study were not validated for the South African population.

- The complexity of the translated instruments could have had an influence on the collection of data.

- Due to the nature of qualitative research, the data obtained in the qualitative phase of the study may be subject to different interpretations by different readers.

- The complexity of the variables being measured could have influenced the assignment of cause and effect.

- Two data collection points for two members of the same family in the study over a six-month period posed a challenge for retention of participants and follow-up interviews.

- The attendance of group sessions fluctuated due to the mothers' health problems, mothers' working, weather conditions, holidays and transport problems.

- The study was limited to urban sites and did not include rural areas.

- A further limitation of the study is that it reports the observations of what the careworkers chose to report.

4. Strengths of the study

The strengths of the study included:

- The Child Support Group Evaluation Study used a mixed-method approach to increase the validity and credibility of the study. The mixed-method approach offered different lenses to capture the different dimensions of the child support group intervention sessions and the experiences of the participants.

- The study was prospective and data was collected at different time points.

- The team of careworkers, who facilitated the group sessions were well trained, worked well in a team and were motivated to make a success of the project.

- The careworkers could converse with the participants in their home language.

- The group sessions were cost-effective to enable group facilitators in low-resource settings to repeat the intervention without major cost implications.

- In this study the researcher's role as Research Coordinator for the Promoting Resilience in Young Children Study made it possible for her to be part of the developmental phases of the intervention study. This role additionally provided the opportunity for the researcher to be integrally involved in the intervention on a daily basis and this insider insight enhanced her understanding of the study. However, there was the possibility of potential for bias in the qualitative results interpretation because of previous involvement in the study as research coordinator. Therefore, the researcher in this study compensated by utilising member checking, external auditing and triangulation to counteract this potential bias in the PhD-study.

- The researcher had a prolonged engagement (five years) in the study field.

- Two pilot studies of both the intervention and the instruments used in the study preceded the Promoting Resilience in Young Children Study.

- A variety of instruments were used for collecting data in the study.

- Data were collected from both the mothers and children.

- The instruments and the activities used in the child support group intervention sessions were adapted to be culturally appropriate.

- Clear selection criteria were set for the participants and they were strictly applied by the research team.

- The intervention was uniquely designed to incorporate both separate and joint sessions.

- All the instruments used in the study were back-translated to ensure reliability.

5. Conclusions

The researcher of this study has intentionally presented the conclusion paragraphs in bullet-point form for the purposes of clarity and synthesis.

5.1. Chapter 1

- There is a need for rigorously researched, theory-based programmes that place emphasis on culturally-appropriate programmes that focus on the psychosocial needs of young children.

- Research, monitoring and the evaluation of programmes focussing on the impact of HIV on families and communities, are important.

- Research is critical in the South African context to investigate the protective processes of children who are affected by HIV/Aids as the 'disease burden' in South Africa is high.

- The Child Support Group Evaluation Study is nested in the Promoting Resilience in Young Children Study. The latter study was a longitudinal randomised controlled study which aimed to enhance resilience of young children living in families affected by maternal HIV/Aids.

- The Child Support Group Evaluation Study focuses on the evaluation of an intervention programme for young children affected by maternal HIV and followed a mixed-method design that includes elements obtained from both a quantitative and a qualitative approach.

- The mixed-method approach of this study might prove significant in contributing to the underdeveloped area of research relating to the evaluation of an intervention to enhance adaptive behaviour (resilience) of latent-phase children affected by maternal HIV/Aids across all ecological levels.

- This study aims to investigate the contextual complexities in a low-resource setting and to rigorously assess the intervention content, methods and process applied in the intervention programme.

5.2. Chapter 2

- It became apparent in the literature review that latent-phase children are in a developmental period of relative stability where they have the opportunity to develop and practice their physical, cognitive, emotional and social skills. These life skills are important for adjustment in later developmental phases.

- The contexts of the child in which development occurs and interaction takes place are of significance in understanding the latent phase.

- Certain general milestones, spanning across cultures, are necessary for a child to reach in the middle-childhood years.

- The research literature indicated that maternal illness has an impact on a latent child's development. Individual factors such as age, gender, child and parental coping styles and protective variables/resilience are identified as possible factors that may influence a child's adjustment to parental illness.

- Bronfenbrenner's ecological systems theory can be used as a framework to explain the phenomenon of maternal illness and to provide insight into the impact of maternal HIV/Aids on children's adaptive behaviour and development.

- Children of HIV-infected mothers are vulnerable for developing emotional and psychological problems, according to the literature review. The social support structures of the mother, the socio-demographic characteristics of the family, the child's social support structures, the HIV-associated maternal stressors, the mother's coping strategies, the child's coping strategies, the associated stigma and the quality of the mother-child relationship are factors than can have an effect on the child's psychosocial adjustment.

- Mothers infected with HIV and their children often stay in low socio-economic surroundings and they experience poverty.

- Mothers infected with HIV face numerous challenges on a physical level and psychological level, for example depression, but also on a parental level. Maternal stress may have a negative impact on parenting and negative parenting skills may have an effect on the behaviour of children.

- Maternal HIV-disclosure to children is a complicated process and current research is reporting mixed results. The disclosure rate in South Africa is very low because of possible discrimination against the family.

- Parentification is the act of children taking over parental role behaviour and can have positive and negative effects for children.

- Research indicates that South Africa, in specific, is lacking indigenous HIV counselling interventions that are specifically focused on the psychosocial needs of children living with HIV/Aids.

- Risks and resilience are multifaceted and expressed in different behaviours where resilience refers to the interaction between a child's genetic predisposition and the support he/she receives. Resilience is furthermore not a fixed attribute of a child and not universal across domains, but it is changeable over time as the child develops.

- Risk factors, for example maternal illness, can be described as stressors in a child's life that may result in emotional, social or behavioural problems. Protective factors are ameliorating factors assisting a child to adapt successfully to a stressful situation or chronic adversity.

- The literature review shows that resilience skills are teachable in a group situation and the social-emotional domains and skills and knowledge domains are important in assisting a child to deal with difficult life situations.

5.3. Chapter 3

- A research design was decided upon in the Child Support Group Evaluation Study that could guide the research questions as posed in this study and evaluate the empirical data.

- The nested multiple case study and quasi-experimental designs were chosen to answer the qualitative and quantitative questions and are aligned with the pragmatic and critical realism paradigms for the study.

- The use of both a quantitative and qualitative design provided the opportunity for a holistic evaluation in the Child Support Group Evaluation Study.

- The Child Support Group Evaluation Study includes data extracted from the Promoting Resilience in Young Children Study pertaining to the baseline interviews, intervention and six-month interviews of the participants who received treatment.

- The theory-driven outcome evaluation approach was deemed appropriate to study the qualities and processes of the intervention programme.

- The triangulation process in the programme evaluation used multiple methods of data collection. The use of multiple methods had the objective of increasing the reliability of observations and as a result the evaluation in the context of the Child Support Group Evaluation Study.

- The instruments for the study were translated from English into four African languages, namely Sepedi, Setswana, Isizulu and Sesotho.

- The true validity of the instruments remain in doubt as the research literature indicates that even with translational adaptation of translated questionnaires to fit the terminology, cultural and linguistic differences of the population, it is still difficult to ascertain if the participants really understood questions related to emotions and behaviour.

- The research team developed a concrete visual aid for the mothers and children to choose between the different scale options of the instruments.

- The intervention was grounded in a systematic review of accrued evidence on compelling vulnerability and protective processes that tend to modify the effects of maternal HIV-infection. The intervention was developed to improve children's maladaptive patterns as well as to build their strengths.

- The content of the intervention programme manual was purposefully selected and the sessions addressed coping, optimism, emotional intelligence, social skills and the identification of meaning and purpose of life.

5.4. Chapter 4

- The Child Support Group Evaluation Study quantitative sample consisted of 139 children (76 boys and 63 girls) from the Mamelodi and Atteridgeville areas in the Gauteng province, South Africa.

- At the time of the data collection the mean age of the children was 8 years. The socioeconomic data indicated that a large group of mothers were unemployed at the start of the intervention sessions. Only a small number of the mothers were married and almost half of the mother participants were not married but had a partner. A small group of mother participants (12.20%) indicated that they (or others) had disclosed to their children that they were infected with the HIV-virus.

- The children did not report a significant difference in their anxiety on the Revised Child Manifest Anxiety Scale (RCMAS), depression on the Child Depression Inventory (CDI), emotional intelligence on the BarOn EQ-i: YV™ and self-concept on the Self Descriptive Questionnaire (SDQ) after attending a six-month intervention that aimed to increase their adaptive behaviour.

- The child participants in the Child Support Group Evaluation Study showed a significant difference on the Kidcope psychological instrument, from the baseline interviews to the six-month follow-up interviews, in the frequency they used both the coping styles of approach and avoidance. They reported that they used both coping mechanisms more often after they had completed the six-month intervention sessions. The children did, however, perceive the approach coping style as more efficacious, after the six-month intervention sessions.

- The Child Spiritual Coping Scale (CSCS) data indicated that the children reported that they more frequently used spiritual coping strategies after having attended the support group intervention but that they did not perceive the spiritual coping skills they employed as more efficacious than before the intervention.

- The mother participants indicated on both the Child Behavior Checklist (CBCL) and Vineland II child-focused questionnaires, significant improvement in their children's behaviour and adaptive functioning after attending the six-month support group intervention. The children were reported to have displayed less internalised behaviour problems, for example depression, and less externalised behaviour problems, for example aggression. The children also displayed significantly improved communication, daily living, and socialisation skills, according to their mothers.

- Children who displayed adaptive behaviour in spite of being exposed to poverty, maternal illness and violence in their immediate surroundings had the advantage of a good mother-and-child relationship. They furthermore displayed a sharing of emotions; good communication skills; positive religious coping skills; a positive future orientation; could extrapolate skills learned in intervention to real-life situations; participated in the group sessions; had a sense of responsibility; displayed life skills; could discern between right and wrong; independent; displayed and sought respect; observed intelligent behaviour; a positive predisposition; helped others; showed problem-solving skills, tenacity and a good relationship with a family member other than the mother.

- The children who displayed non-adaptive behaviour experienced a problematic mother-and-child relationship, exposure to violence and poverty; not feeling respected; hyperactivity; withdrawal; anxiousness; insecurity and inattentiveness. They indicated that they had family secrets which they had to keep to themselves and could not talk about it with somebody else.

- The identification and verbalisation of own and others' emotions, sharing and communication transpired most often in the group sessions. Help and support, life skills, problem-solving, positive future, respect and coping were also addressed in the child support groups.

- Additional aspects in the study were: the impact of maternal illness, violence and poverty on the child participants.

- The careworkers identified skills and knowledge as important for a facilitator. They were able to accurately observe and report on the children's behaviour in the support sessions. The careworkers were furthermore able to identify children who were in need of further referral. They pointed out important aspects for future intervention planning. The careworkers indicated that they applied the skills and knowledge gained as facilitators at home with their own children and in the process gained knowledge in how to manage difficult behaviour.

- The majority of children reported that they felt comfortable in the group and that they understood what was expected of them. The children indicated that they learnt new skills in the group and that these skills were experienced as helpful. The children indicated that they saw the opportunity to play with new friends as the most important benefit of the group. They especially enjoyed the activities where they could play with their mothers.

- The majority of mothers reported that they experienced their parenting to be easier after the group support sessions and they experienced their children's behaviour more positively. The mothers indicated that the support sessions improved their communication with their children to such an extent that they were able to discuss their illness with them, as they were emotionally closer to their children after the sessions. The mothers mentioned that their children's schoolwork had improved.

- The cultural adaptability of the group sessions was enhanced by the group facilitators who are members of the same cultural group and their ability to speak the language of the group participants.

- The group cohesion was enhanced by three activities, namely, climbing down the tree, the feeling thermometer and homework which became a fixed routine in the group sessions. This routine may have provided additional structure and safety to the children.

- The group process and content were age appropriate for most children and they were able to comply with the expectations set by the sessions.
- The six-month duration of the group sessions seems to have been adequate, with reference to the group attendance.

6. Executive summary

A theory-driven group-based support intervention to enhance adaptive behaviour of young children affected by maternal HIV/Aids was evaluated in the Child Support Group Evaluation Study. Quantitative and qualitative data of 139 child participants in 12 groups, or waves, who participated in a six-month intervention, were used.

The quantitative evaluation phase of the nested mixed-method approach of the Child Support Group Evaluation Study indicated a significant improvement in the children's adaptive behaviour after the completion of the six-month intervention, according to reports by the mother participants on the Child Behavior Check List and the Vineland-II instruments. The children specifically displayed improved communication, daily living and socialisation skills. The mothers furthermore indicated that their children displayed significantly less internalised and externalised behaviour disorders after they had attended the six-month intervention.

A non-significant difference in the improvement of adaptive behaviour was indicated on the Child Depression Inventory, Revised Child Manifest Anxiety Scale, Self-Description Questionnaire and BarOnEQ-i:YV child self-report questionnaires. This stands in direct opposition to the significant difference in behaviour and adaptive behaviour the mothers indicated on the child-focused questionnaires and raises concerns regarding the applicability of self-report child-focused instruments that were not developed in South Africa for the South African population.

Possible explanations presented for this indication of non-significant improvement on the child self-report questionnaires are that the children in the study sample were not previously exposed to answering questions on a Likert-type scale or answering emotional-focused questions and this was a learning experience for them.

At the six-month interview they could possibly have been more familiar with the research assistants and these types of questionnaires. The support group intervention furthermore focused *inter alia* on emotional intelligence which aimed to teach the children how to express their emotions. The children could have given a more realistic evaluation of their own emotions at the six-month interview. In their culture, the sample population is expected to respect adults (Jackson & Abosi, 2006). The children therefore could have answered the questions asked by the research assistants in a way they thought were expected of them or given culturally-acceptable answers. The questionnaires were not standardised for the South African population and consequently the norms of the questionnaires were not used in this study. The researchers of the Promoting Resilience in Young Children Study went to great lengths to ensure that the questionnaires were culturally tailored and translated accurately in the four languages pre-identified for the study (refer to par. 8.2., p.161).The questionnaires were translated into Sepedi, Setswana, Isizulu and Setsotho. A specific difficulty that was identified during the translational process was that the English language had significantly more emotive words than the languages the questionnaires were translated into.

An additional explanation for the non-significant difference the children reported on the Revised Child Manifest Anxiety Scale (RCMAS), Child Depression Inventory (CDI), BarOn EQ-i: YV™ and Self Descriptive Questionnaire (SDQ) after attending a six-month intervention that aimed to increase their adaptive behaviour, is that most of the children were not aware that their mothers were HIV-positive and consequently did not experience increased anxiety, depression, self-description concerns or emotional intelligence problems. Only 12.2% mothers indicated that they or somebody else had disclosed their HIV-status to their children.

The child participants did, however, indicate a significant difference in the frequency they used both the approach and avoidance coping styles on the Kidcope psychological instrument. They were able to distinguish between the efficacies of the two coping styles and indicated that they experienced the approach coping style as more effective. Although the children could indicate which coping style was more effective, they used both the approach and avoidance coping mechanisms to cope with their complex environment and its diverse stressors.

The intervention enhanced the children's broad range of coping skills to cope with the stressors at hand, as proposed by Harbeck-Weber, Fisher and Dittner (2003). It furthermore enabled them to make a meaningful decision regarding which coping mechanism to employ.

The children in the study sample indicated on the Child Spiritual Coping Scale that they more frequently used spiritual coping strategies after having attended the support group intervention but that they did not perceive the spiritual coping skills they employed as more efficient than before the intervention. Children in the latent-phase are in the concrete operational phase of cognitive development (refer to Table 2.1) and therefore might have experienced more difficulty in evaluating the efficacy of spiritual coping mechanisms. A possible explanation for the discrepancies in information reported by the child participants on the different self-report questionnaires could be ascribed to the two-tier construction of the Kidcope and Child Spiritual Coping Scale self-report instruments. These two instruments were the only two instruments in the Promoting Resilience in Young Children Study assessment battery where the children had to indicate the frequency with which they used a specific coping mechanism and then subsequently evaluate the efficacy of the coping mechanism they employed. The child had to engage with the question in order to answer it. This increased engagement in the instrument items could possibly explain the discrepancy. The two coping questionnaires furthermore used less emotive language and focused more on the cognitive appraisal of the stressor at hand.

A qualitative analysis was employed to evaluate the behaviour and adaptive functioning of children with HIV-infected mothers who attended a group-based intervention. The programme content and methods used during the support sessions were subsequently qualitatively evaluated.

Betancourt et al.(2012) state that "*The mental health and wellbeing of children and families affected by HIV/Aids must be viewed as a dynamic process involving a number of ecological levels, from the biological to the family, to the larger community and culture, with each level presenting risks*" (n.p.). Research on psychological wellbeing and adaptive behaviour in children affected by maternal HIV/Aids is extremely scarce and Betancourt et al. (2012) indicate that they have yet to find research that is able to adequately, quantitatively examine the contributing resilience factors at various ecological levels.

A more comprehensive understanding of these factors can contribute to a more targeted, 'strengths-based' intervention for children and their families affected by maternal HIV/Aids, according to Betancourt et al. (2012).

The child's micro-system consists of relationships closest to the child, whereas the meso-system consists of a number of micro-systems. These systems can support or oppose each other. The exo-system has a direct influence on the developing child although the child is not situated in the system. The macro-system spans across all the systems and refers to the society the child lives in (Bronfenbrenner, 1994; Christensen, 2010; Tudge et al.,2009).

The group-based intervention focused on all of the above systems in its development and outcomes and thereby adheres to Betancourt's et al. (2012) recommendation that a comprehensive understanding of all the systems affecting the child must be studied, in order to examine resilience factors adequately. The individual child's adaptive and non-adaptive behaviour were examined and risk and protective factors were identified. The risk factors identified in the intervention study were intra- and interfamily violence, abuse, poverty, maternal illness, broken families and negative mother-and-child relationships. The protective factors identified in the study during and after completion of the six-month intervention were a close mother-and-child relationship where they were able to play with one another, support from friends, enhanced communication skills, ability to share and identify emotions of self and others, the willingness to help others and to ask for help, showing respect, positive religious coping skills, adequate problem-solving skills, a positive future orientation, a supportive relationship with another adult (caregiver) other than the mother and life skills. The support group sessions provided an opportunity for the children to practice adaptive behaviour in a safe environment. They were thereby able to enhance their protective factors. This assisted them in coping with the risk factors they faced.

The meso-system studied different systems the children are part of. The mother-and-child interaction system was studied in relation to other mother-and-children interactions in a group setting. The child participating in his/her school system was reported on by the mothers and some teachers reported on the children's behaviour in school. The group sessions focused on the identification of additional support systems in the child's context and how this support could be elicited by them.

The exo-system of the child included their mothers' experience of their illness and the health system that took care of them. The attendance of the group sessions were affected by the mother's illness where they could not attend certain sessions because of scheduled appointments at the clinic.

The group sessions supported the children by enhancing their communication skills and ability to talk about their emotions. The children could therefore voice their opinions and discuss their feelings with their mothers. The joint sessions assisted the mothers in listening and playing with their children. Both the children and the mothers benefited from the support sessions and indicated that they not only enjoyed the sessions, but also recognised the importance thereof. This two-way communication enhancement made it easier for mothers to discuss situations with their children and to model positive coping skills. The children's anxiety levels regarding their mothers' illness were lessened as this could now be discussed. The child was also able to choose from a repertoire of new coping skills to cope with their adverse circumstances. The mothers reported that their children showed more self-confidence and that their school work had improved. The group thus provided a buffer for the children and supported them in coping with their mothers' illness.

The evaluation of the content and methods used in the Child Support Group Evaluation Study indicated that they were age-appropriate, with the exception of three activities, and positively experienced by all interested parties. The six-month duration of the intervention study was also seen as adequate, as indicated by the data collected. The group facilitators did, however, indicate that the six year-old children found some of the activities too difficult and needed extra support. The culturally sensitive content and methods used in the support group sessions were important factors in achieving the aim of enhancing adaptive behaviour. The masekitlana and morabaraba games used in the session were particularly well received by the group members. These cultural games furthermore had important behaviour moderating effects. It provided an opportunity for the children to cope with stressors in their situation and vent their feelings, fears and anxieties as they were not allowed or encouraged to talk freely about their emotions in their community. The cultural adaptability of the group sessions was furthermore enhanced by the group facilitators who were members of the same cultural group and their ability to speak the language of the group.

The activities enhanced the children's social skills where they had to relate to others. The content covered all the resilience (adaptive behaviour) modalities as envisaged in the theory-based intervention. The theory-driven content of the intervention provided direction and focus to the intervention programme.

Group size, group setting and cost effectiveness were subsequently assessed to evaluate the theory-based support sessions as indicated by Chen (2005). The group size was on average eight members and this is proposed to be an effective size group since the results from the study indicate that the groups functioned optimally when they included eight children. Groups with less than four members and more than 12 members are considered ineffective for reaching the set session goals as indicated by the careworkers. The group setting, where safety, accessibility and functionality were taken in consideration, was experienced as adequate by the group participants and the group facilitators. The child support groups were cost effective and it involved the community by asking for help with extra costs incurred.

The different data sets used to evaluate the group sessions in the Child Support Group Evaluation Study indicate that the careworkers were adequately trained to fulfil the requirements set for a group facilitator. They were able to apply the manual in the group according to intervention prescriptions and they displayed facilitation skills necessary for child groups. They could relate to the children in a warm and emphatic manner. The careworkers could identify and reflect the children's emotions and manage difficult behaviour (for instance, hyperactivity and aggression). They could furthermore identify children who were in need of referral. Their experience as facilitators had an added benefit because they were able to extrapolate the knowledge and skills they had gained to their own families. The experiences of the group facilitators could be considered in-depth in an ensuing study.

The response of the children and the mothers to the intervention was positive. An overwhelming number of children indicated in their group evaluations that they understood the group process, the content and what was expected of them in the group. The children felt comfortable in the group because they experienced a sense of belonging and acceptance from the group members and careworkers. They could communicate their feelings and they felt safe enough to share positive and negative emotions.

The mothers reported that they experienced the Kgolo Mmogo support sessions as positive because they learnt how to communicate positively with their children and these newfound skills helped them to get to know their children. They felt more comfortable in sharing their emotions with their children after getting to know them better through play activities. Some mothers could disclose their HIV status to their children because of their closer bond. The group provided the necessary opportunities for the mothers and children to develop effective relationships. Most of the mothers indicated that their children's behaviour had improved significantly after attending the support sessions. The children displayed less aggressive behaviour (externalised behaviour problems) and they were better equipped to cope with problems.

Murphy et al. (2010) indicate that there is an intervention need for mothers and their school-aged children, other than medicine adherence and prevention interventions. The main areas identified to be addressed through intervention programmes are information on how psychological distress can affect child outcomes, how to deal with stress, how to implement family routines and how mother-child communication can be improved. Murphy and Marelich (2008) further suggest that an intervention programme can provide a child with strong adult and peer attachments which are reported in resilience research to be an indicative protective factor. The intervention addressed coping and problem-solving skills that were beneficial to children displaying non-adaptive behaviour as they were taught how to label their feelings, how to solve problems and other life skills. An organised and predictable environment created an opportunity for the child to practice and enhance their resilience skills. The intervention programme environment combined warmth and care with clearly defined structures and boundaries in order to facilitate the enhancement of adaptive behaviour. The support group succeeded in that the group members supported each other. The group-based intervention programme for young children with HIV-affected mothers was thus efficacious to enhance adaptive behaviour.

A specific finding of this study, after examining the data as presented, was that the children showed a strong need for order in their lives. The children in this study were exposed to a chaotic environment of single-parenting, family unemployment, relationship instability, persistent poverty and violence. The uncertainty of the mother's illness, as most of the children were not told about their mother's illness and they only observed the symptoms of the illness, caused further chaos in the children's lives.

Their experience of a lack of control over their mother's illness contributed to this uncertainty. The children in the groups displayed normative values through their religious coping styles, their quest for and display of respect and their unambiguous assertion of what are right and wrong. Latent-phase children are furthermore developmentally inclined to exhibit a "black and white", rule-driven thinking style (refer to Table 2.1). Norms provide guidelines, boundaries, safety and control in uncertain circumstances (Benson, Leffert, Scales, & Blyth, 1998).

Goldman (2005) indicates the important role of children's individual and meaningful belief systems that *"can create a strong framework to positively cope with life issues"* (p.252). Adaptive behaviour or resilience is actualised in adverse circumstances when a child creates, through inner strength, a sphere or space to order his/her thoughts, behaviours and emotions that provides him/her with the parameters wherein he/she can function adequately. The children thus created their own inner safe sphere in which order is possible amidst chaos.

The intervention programme created order in their minds and emotions. Pedagogically it is well documented that ordered thinking subsequently creates order in a child's emotional life (Ivcevic, Brackett, & Mayer, 2007; Santrock, 2011).The researcher in this study asserts that order is an essential protective factor created by the children, enabling them to cope with chaos. Order was an implicit goal of the programme, not actively sought, but the effects thereof added value to the programme. Order was established through the implementation of specific activities, for instance the climbing the tree, emotional thermometer and homework activities to establish a routine in the group sessions. The group session dates were pre-planned to allow for the sessions to take place on the same day, at the same time and for activities to be presented in the same order in every session.

In the first session of the group intervention the session contents were discussed with the children and the sequence, as presented, remained constant throughout all the sessions. At the beginning of every session the activities and order in which they would take place were first explained to the children before the sessions commenced. Park and Folkman (1997) refer to the tendency of people to believe they can influence life outcomes and that there is a correlation between their actions and outcomes. A traumatic event in a person's life violates a person's sense of control and the attempt a person makes to regain this control is an effort to reduce the stress related to the trauma.

People can experience a perceived level of control over stressful life events by using different attribution styles. A factor causing ongoing trauma for children in adverse situations is often the sense of loss of control in their lives (Goldman, 2005). The researcher in this study is of the opinion that order was a crucial skill for the children to integrate, in order for them to feel that they had gained some control over their stressful life events and consequently their adaptive behaviour was enhanced. The importance of the group sessions to create order is thus posed as a significant factor in the development of a support group intervention for children.

In conclusion, if a person is not exposed to adverse circumstances it is not possible to ascertain if he/she is resilient or not (Luther, Cicchetti, & Becker, 2000). The children in the support groups had limited to no protective factors working in their favour and despite this they presented with factors such as respect, religious coping skills and a value system of knowing right from wrong that helped them to survive in their environment. The programme supported the children in enhancing their 'self-created protective factor' by means of an ordered process in which the session, program content and other time factors were presented. By creating protective spheres they ordered their life worlds which had been thrown into chaos because of the presence of cumulative risk factors such as their mother's unknown and indefinite illness and the violent and poverty-stricken environment they were exposed to. The resilient child has to be able to negotiate the multiple risks in his/her environment to be able to adapt competently, despite the presence of significant risks and adversity. With this sphere as protective factor there is order in their circumstances and thoughts which furthermore help stabilise negative effects. Moreover, these findings attest to the importance of the role children themselves play in actively architecting their outcomes and influencing their ultimate adaptation to adverse life events, as indicated by Cicchetti and Rogosch (1997). The distinction made between external and internal protective factors and the presence of both are not necessary for building a child's resilience. Generalisability of the intervention findings to other areas or age groups affected by maternal HIV/Aids should be made with caution. However, in this sample of children the study poses that inner factors could have a dominant role to play in enhancing adaptive behaviour and subsequently resilience. The origins of this internalised norm-driven behaviour and whether it was because of upbringing, culture, a person's own inner striving for boundaries or another reason could ultimately not be established in this study. Further research in this area is proposed.

7. Contributions of the study

Although the aim of this study was not to construct a programme, the researcher in this study was a member of the team who developed the Promoting Resilience in Young Children Study. The aim of this study was to evaluate the efficacy of the Promoting Resilience in Young Children Study using a mixed-method approach to evaluate if this programme realised its proposed aim of enhancing adaptive behaviour in children.

- The study provides convincing evidence of the intervention programme's ability to enhance a child's adaptive behaviour and to strengthen the bond between mothers and their children.

- The mixed-method approach of this study support the randomised control study findings of the Promoting Resilience in Young Children Study.

- The study furthermore places emphasis on the importance of religion as a coping mechanism for the children who indicated that they did not trust their community structures and therefore they placed their trust in religion. The findings might be specific to the context of this study.

- Structures and processes were moreover established and evaluated to train careworkers as group facilitators.

- The study indicates that the foremost risk factors the children in the group were exposed to are violence, abuse, poverty and uncertainty because of their mother's illness.

- The intervention programme supported the child participants to create an inner protective sphere of order through the ordered manner in which the session, program content and other time factors were presented. By creating a protective sphere of order the children could order their life worlds which were thrown into chaos because of the presence of cumulative risk factors such as their mother's illness, single parent families and the violent and poverty-stricken environment where to they were exposed.

- This study contributes to the understanding of latency-aged children's adaptation to stressful life circumstances.

Proposed reasons for the success of the intervention programme:

- The project was specifically tailored to address the identified needs of the community.
- A balance was maintained between the aims of the research and the needs of the research participants.
- The project was delivered through a process of continuous monitoring, change of course and revised planning where necessary.
- The project was delivered by members in the community who understood the cultural practices of the group participants and their language. The careworkers received comprehensive training and mentoring that enabled them to facilitate the child group sessions.
- An intervention supports children by providing a meaningful relationship with at least one caring adult. In this study the group facilitator fulfilled this role.
- The intervention groups assisted children in making new friends, talking to supportive friends, and seeking help from adults in the community.
- The intervention programme used age-appropriate content and methods.
- The parallel parent support groups aimed to maximise the positive results of the group intervention.
- The joint sessions included the mothers and followed a family-centred approach to enhance mother and child communication.

8. Recommendations

In the recommendation section the focus is placed on the programme design, the training of the group facilitators and the group process before more general recommendations are made.

8.1 Programme design

8.1.1. Homework activities

- It is recommended that the homework exercises for the children commence after session 8, where the focus shifts away from the mother's experience of HIV/Aids to the discussions focussing on parenting skills and child development.

- The mothers have to receive a thorough briefing of the importance of the homework activities, their role in the process has to be emphasised and the mothers have to be shown examples of how to help their children to complete the specific homework exercises.

8.1.2. Age-appropriate activities

- The 'Happy Song' activity in session 10 has to be replaced by a more age-appropriate activity.
- The younger children (6 year-olds) in the sessions indicated that the 'child's rights' activity in session 8 and the 'drawing of strengths' activity in session 5 were too complicated. The underlying premise of the activities is deemed appropriate for children aged 6–10, but it is proposed that the methods used be adjusted in future programmes to be appropriate for all the age groups or for the programme to start at age seven.

8.1.3. Group size

- The size of the group is an important factor in the success of the group intervention.
- Caution has to be taken that the size of the group is not too small or too big. An average number of eight children per group seem to be an ideal number of children to allow for adequate participation of all the group members.

8.2. Careworker (group facilitator) training

- Group facilitators have to acquire the skills to be able to identify underlying problems in sessions, to deal with the problem at hand and to refer where necessary.
- Group facilitators have to be able to work with children in the group contexts but also with individual children displaying difficult behaviour, for example, hyperactivity.
- Sensitivity in identifying possible sexual abuse is important as indicated, for example, in the body map activity. The group facilitator must be able to identify problematic behaviour and provide alternatives to children who may experience certain activities as negative.

- The study indicated that the careworkers from a community could be trained to adequately facilitate a group-based intervention to enhance adaptive behaviour of children, if they received sufficient training, supervision and debriefing. Investment should be made in the training of the careworkers as group facilitators.

8.3. Group process

- Children who were absent for too many sessions have to be encouraged to join a following wave. They miss out on essential aspects and continuity of the programme if they continue with the group sessions without having had the background of the previous sessions. The sessions are developed to build on the previous session.
- A multi-disciplinary team at or nearby the site of intervention is advisable in order to guide the careworkers and to refer the group participants if necessary.
- Participation of children with disabilities is recommended as they represent the real-world population. Their participation subsequently provides the children with the opportunity to learn how to communicate with and show empathy to children with disabilities.
- It is recommended that a child with a mental disability is accompanied by another sibling to ensure the group process is not disrupted too much.
- Extra support or referral is proposed in severe cases where mother participants do not participate in the session activities because of possible psychological problems, for example, depression or medical reasons.
- Visitors to the group sessions had a negative influence on the group coherence in this study. However, the mother participants are often unable to leave their other children unattended at home. A separate area with enough space and equipment for these children to play and to do their homework under supervision is recommended.
- The age spectrum of the group has to be taken into consideration. The ages of the participants have to be well dispersed for the group sessions to be successful.
- Mothers have to commit in the recruitment phase to bring their children to the group sessions, particularly the joint sessions.
- Separate group sessions on Saturdays are proposed for mother and child participants who are unable to attend the group sessions during the week.

- The group process is disrupted if children attend the joint sessions without their mothers. Mothers have to be encouraged to accompany their children to the joint sessions.

- The group process is complicated if a mother is accompanied by more than one child to the joint sessions (in particular younger siblings). A day-care facility is recommended during the joint sessions.

8.4. Additional recommendations

- A comprehensive referral system has to be in place where participants can be referred to, in case of medical emergencies or where they require psychosocial intervention.

- Follow-up group sessions or 'drop-in' centres are recommended where mothers and children can receive additional support.

- An extra informal 'meet and greet' session for the mother participants is recommended at the beginning of the intervention programme to prepare them for the support sessions. Participants in previous waves may provide support during this session and could share their experience of the intervention with the new participants. During this session the mothers additionally have to receive information on how they must prepare their children for the sessions. The children indicated in the first session that they were anxious as they did not know what to expect from the group.

- Additional but related support sessions are recommended for present fathers of the child participants and partners of the mother participants.

- The positive effect of the joint sessions on the mother-and-child relationship, as reported in the support group intervention, has to be made available to the rest of the population. Parental guidance sessions in the community are furthermore advised.

- The use and development of child psychological questionnaires standardised for the South African population is proposed.

- Further data analysis of the correlations between the pre-and post-test measures are recommended.

- The immense psychosocial need of HIV-affected families in South Africa necessitates educational psychologists to train careworkers in the community to be able to use the intervention programme effectively. They furthermore have to be available to act as mentors for the careworkers.

- A study that follows the participants who were referred to external support systems has to be undertaken.
- Observational studies that follow the effect of the intervention on parenting (beyond self-report) are recommended.

9. Further research

The research yielded the following areas for further research:
- A study to assess the prior knowledge, experience and training a volunteer careworker has to receive to be an adequate group facilitator for children is recommended. This theoretical framework for training future group facilitators will be able to provide guidance for future studies.
- Further research to clarify the role of the careworkers' and research assistants' personal characteristics as confounding factors in terms of the research results.
- Further research on the type of 'parameters' children use to create a space where they can function adaptively in difficult circumstances. This research can subsequently be extended to other challenging life circumstances, for instance children in war and abusive situations.
- Longitudinal research on the children who attended the support group intervention to establish the efficacy of the intervention on later adolescent risk-taking behaviour/scholastic achievement/general behaviour.
- Research to establish the efficacy of the group-based intervention on an HIV-positive child population.
- Research to establish the efficacy of the group based intervention on a non-HIV infected population with specific consideration of the group's effect on the enhancement of the mother-and-child relationship.
- Research to establish the role and engagement of the fathers in the child participant's lives.
- Theoretical research concerning the value of culturally-specific games (such as 'masekitlana'and 'morabaraba' games) as projective media and therapeutic medium.
- Longitudinal research of the careworkers' experience as group facilitators and the impact they have on their community because of their involvement in the intervention.

- Further research, using a similar study design but applied to different contexts, is suggested.
- Research to interrogate the effects of translated instruments is recommended.

10. Synopsis of key findings

A synopsis of the key findings is presented in Figure 5.1.

Figure 5.1 Synopsis of the key findings

SYNOPSIS OF KEY FINDINGS

How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?

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To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?

- Intervention sessions enhanced approach-, avoidance and religious coping skills.
- Children could distinguish between the efficaciousness of the approach and avoidance coping style.
- Non-significant differences were observed on the questionnaires measuring anxiety, depression, emotional intelligence and self-concept.
- Enhanced internalised and externalised behaviour.
- Enhanced daily living-, communication- and socialisation skills.

What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?

- Resilience indicators that most transpired in group support sessions were: identification of own and others' emotions, sharing and communication.
- Maternal illness, violence and poverty were risk factors.
- Normative values displayed despite chaotic life circumstances: religious coping skills, pursuit and display of respect, distinguish between right and wrong.
- Mothers experienced the intervention positive and reported that their children's behaviour improved.

What programme content and methods could be developed to appraise and enhance the adaptive behaviour of a latent phase child?

- Content, methods and processes employed in the group-based sessions were effective, adequate and culturally sensitive.
- Training of the careworkers was adequate.
- The application of the intervention, duration of the support group sessions, timing and cost-effectiveness of the sessions were satisfactory.

Concurrent nested (QUALquan) mixed-method strategy

How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?

- Risk factors identified in the intervention study were intra- and inter family violence, abuse, poverty, maternal illness, broken families and negative mother-child relationships.
- Protective factors identified in the study were close mother-and-child relationships where they could play with one another, support from friends, enhanced communication skills, ability to share and identify emotions of self and others, willingness to help others and ask for help, showing respect, positive religious coping skills, adequate problem-solving skills, a positive future orientation, a supportive relationship with another adult and life skills.
- Group provided a buffer for the children and supported them in coping with their mother's illness.
- Children in group sessions showed a strong need for order in their lives. Children group participants were exposed to a chaotic environment (poverty, single-parenting, family unemployment, relationship instability, violence, uncertainty of mother's illness).
- Children displayed normative values (religious coping styles, respect, assertion between right and wrong). Adaptive behaviour or resilience is actualised in adverse circumstances when a child creates through inner strength, a sphere or space to order his/her thoughts, behaviours and emotions that provides him/her with the parameters wherein he/she can function adequately. The intervention programme created **order** in the group participants' minds and emotions.

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TABLE OF CONTENTS

APPENDICES

Appendix 1. Research design and data-collection method

Research Design: Evaluation research	How efficacious is a group-based intervention programme for young children with HIV-infected mothers in enhancing adaptive behaviour?				
			Data collection method		
		Instru-ments	Texts	Inter-view	Obser-ve
	1) To what extent is a group-based intervention programme for children with HIV-infected mothers effective in enhancing adaptive behaviour?	✓			
	2) What qualitative observed and reported behaviour and adaptive functioning do children with HIV-infected mothers attending a group-based intervention display?		✓	✓	✓
	3) What programme content and methods could be developed to appraise and enhance the resilience modalities of a latent phase child?		✓	✓	✓

Data-collection instruments				Authenticity and trust
Psychological instruments	Select/ analyse data texts	Interviews	Observations	
1. Psychological instruments pre- and post- child intervention groups. 2. Psychological instruments of mothers pertaining information on their child's development and behavior pre- and post- child intervention groups.	3. Group session notes (careworkers/ group facilitators). 4. Group quality assurance questionnaires (mothers and children).	5. Focus group interviews with careworkers.	6. Researcher field notes, observing the child in intervention groups. 7. Careworker observations of individual children in intervention groups.	• Translated and back-translated questionnaires. • External coder. • Multiple qualitative and quantitative data-collection methods used to triangulate data findings. • Mixed-method design of study.

Appendix 2. Data-collection instruments

	Evaluation study – Theory-based support group intervention for children affected by maternal HIV/Aids											
Research design	**Evaluation study** – Theory-based support group intervention for children affected by maternal HIV/Aids											
When administered	**Baseline interview**		**Group-based resilience intervention**			**6 month interview following group intervention**						
Data collection methods	Psychological instruments		Content analysis	Obser-vation	Interviews	Psychological instruments			Content Analysis	Interviews	Observation	
Data collection instruments	-BarOn Emotional Intelligence question-naire (BarOn EQ:i) -Kidcope -Revised Child Manifest Anxiety Survey (RCMAS) -Child Depres-sion Inventory (CDI) -Child Spiritual Coping Scale (CSCS) -Self Descrip-tion Question-naire (SDQ)	-Vineland -Child Behavior Checklist (CBCL) -Socio-demographic question-naire	Group session notes	Reflect-ive notes	Focus groups	-BarOn Emotional Intelligence questionnaire (BarOn EQ:i) -Kidcope -Revised Child Manifest Anxiety Survey (RCMAS) -Child Depression Inventory (CDI) -Child Spiritual Coping Scale (CSCS) -Self Description Questionnaire (SDQ)	-Vineland -Child Behavior Checklist (CBCL) -Socio-demographic questionnaire		Quality assurance questionnaires	Focus groups	Reflective notes	Reflective notes
Data source	Child	Mother	Child groups	Child groups	Care-workers	Child	Mother		Mother Child	Care-workers	Child groups	Child
Who conducted	Research assistant	Research assistant	Care-workers	Re-searcher	Re-searcher	Research assistant	Research assistant	Re-search assistant	Re-search assistant	Re-searcher	Re-searcher	Care -worker
Ethical considerations	Obtained assent Caregiver consent Anonymity	Informed consent									Gained trust	

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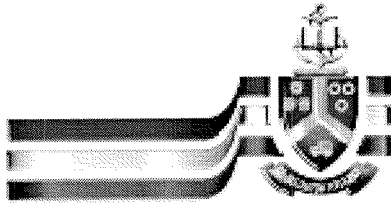
University of Pretoria

KGOLO-MMOGO
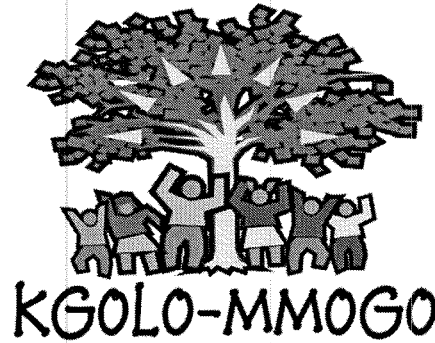
Form A

CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT

A RESEARCH PROJECT OF
THE UNIVERSITY OF PRETORIA AND YALE UNIVERSITY SCHOOL OF MEDICINE

Study Title:　*Promoting Resilience in Young Children*
Principal Investigators: *Irma Eloff, PhD & Brian Forsyth, MB ChB*
Funding Source: *National Institute of Mental Health (USA)*

Parent Form

Invitation to Participate:
You and your child are invited to participate in a research project that is aimed at finding out whether a program that provides information and support to women who have HIV can help build resilience in their children. When we use the term building resilience, we mean helping their children to feel better about themselves and giving them greater strength and abilities to cope with stresses. You and your child have been invited to participate in this project because of your experience with having HIV and because your child is the right age for the study.

In order for you to decide whether or not you wish to be part of this research study, you should know all about the possible benefits and risks. This consent form gives you detailed information about the study. A member of the research team will discuss it with you, and this discussion will include all aspects of the study: its purpose, what will happen, and the possible benefits and risks. Once you understand the study, you will be asked if you wish to participate; and if so, you will be asked to sign this form.

Description of the Project
If you agree you will be assigned to one of two groups. The group you are in will be assigned by chance. This means that you will be given a number and through a random process, you will have a 50-50 chance of being in one group or the other.

If you are in the <u>first group</u> we will ask you to take part in an individual interview at 4 different times (standard care group).You will have access to the standard care that will be provided to all people participating in the study. If you are in the <u>second group</u> we ask you to come for the interviews and support groups.

❏　**Description of the interviews**
　　Whether or not you participate in the support groups, we would ask you to take part in an interview at three different times -- at the beginning, then again after 6, 12, and 18 months. The interview takes about two to three hours and includes questions both about yourself and also about your child. The questions include such things as how much support you feel you are getting and how you are coping. If for any reason you find the interview too long to do at one time, you are free to choose to stop in the middle and continue it at a later time. If your child is aged six to ten years, we will invite your child to participate in interviews at the same time as you. The interviews will include questions considered appropriate for young children, and will last about 1½ hours. Most of the questions come from other studies and are asked in ways that allow children to express their emotions and other feelings that have to do with their self-esteem. We realize that children may find it difficult to participate in something that takes a long time and therefore have a number of techniques to improve this experience. Both you and your child will be given the option of declining to answer any individual questions. During the interview with your child your HIV status will not be mentioned. The person completing the interview will tell your child that this is a study looking at "how children develop strengths" and there would be no mention of HIV.

We usually call by phone to let you know when to come back for the follow-up interviews but sometimes we have difficulty making contact. If we do have difficulty, we may wish to visit you at home but if we do this we would protect your confidentiality and would not tell anyone what this is about. We also would like to call you between each interview, at 9 and 15 months to check up on how you are doing. This will be a very short interview (about 5 minutes). If you are in the standard of care group, we will also call you 3 months from today.

Because it is helpful to get information from other people who know your child well, we would also invite you to have others, such as a relative and your child's teacher, complete separate evaluations. We are sensitive, however, to the fact that you might not want this to be done, and we would only request this if you wish it to happen and you give separate consent for this to happen. If this were to be done, the person completing the evaluation would be told this is a study looking at "how children adapt and develop strengths" and there would be no mention of HIV. You are free to participate in the study whether or not you invite others to complete evaluations about your child.

If you are in the second group we would ask you to take part in the interview process as described above. In addition we would ask you and your child to attend a weekly support group.

☐ **Support program**

If you are invited to participate in the support program, this would involve you attending weekly support groups with other HIV positive women over six months. Each session lasts about two hours and covers a specific topic. Group leaders help members talk about things that affect them and help members understand the needs of their children and how children may be helped to be more resilient. Children between the ages of 6 and 10 can also attend a group with other children at the same time as their mothers, and there will be a daycare for younger children. Some of the sessions will be joint sessions where mothers and children get the opportunity to do activities together. If you were unable to attend the group because of illness, a staff member of the Kgolo Mmogo project will visit you at home and provide you with similar support and information. Your child would still have the opportunity to join the group.

Whether or not you participate in the support groups, we will review your medical record from the clinic or hospital you attend, for information regarding your CD4+ count, as well as your HIV progression and medications. We may refer you to medical, psychological, or social services as needed. If you currently have a health provider in your community, we may ask you to sign a Release of Information to give us permission to communicate about your care, if necessary. Receiving any of these services will not affect your eligibility or involvement in the study.

Risks regarding confidentiality

There are no known risks to being in this study except those that relate to confidentiality of information. All information obtained during the course of this study is strictly confidential. Once information is collected, your name and your child's name and other identifying information such as addresses will be removed and the form and any computerized information will be identified by a code number only. The list of names and code numbers will be kept in a locked cabinet to which only the researchers will have access.

We won't give out any names or contact information to anyone who is not directly working on this study unless there is concern about a serious psychiatric problem, the threat of violence to yourself or others, or concern about child abuse. If such a concern arises we will make every effort to discuss the action with you before taking action.

During group discussions some people may reveal personal information to others in the group. Study participants will be instructed to keep private all information that has been shared. Because this project includes helping parents communicate with their children in an age-appropriate manner about important things in their lives, we expect that some parents will tell their children about their HIV and children might share this information with others. Disclosure about your own HIV status, however, is something for you to decide upon. Program staff will not disclose or discuss your HIV status, except in instances in which you wish this to happen and have provided your written permission. Staff is trained in how to maintain confidentiality when children raise questions about HIV. If you are selected to participate in a support group but do not want your child to attend the children's group, you can choose to do this and then, if you change your mind your child could join the group later. Any scientific reports using data from this study will not include information that identifies you as a subject.

Benefits

The study is designed to find out whether this type of program benefits parents and children but we do not know whether you or your child will benefit personally from participation in the study.

Financial Considerations

To reimburse you for your travel costs and the time spent doing the interviews, you will be given 50 rands for completing each interview and your child will be given a small toy worth about 10 rands.

What are my rights as a participant in this study?

The participation of you and your child in this study is entirely voluntary and either you or your child can refuse to participate or stop at any time without giving any reason. If you decide not to participate or withdraw from the study this will not affect you in any way and will not affect the care you or your child receives. If you decide to be in the study, you can leave blank or refuse to answer any questions that you don't want to answer.

Has this study received ethical approval?

This study has been approved by both the Health Sciences Ethics Committee of the University of Pretoria and the Human Investigation Committee of Yale University School of Medicine.   The study is in accordance with the declaration of Helsinki (Last update: October 2000), which deals with recommendations guiding biomedical research involving human subjects.

Questions

Please feel free to ask about anything you don't understand and consider this project and the consent form carefully – as long as you feel is necessary – before you make a decision.

Informed Consent

I hereby confirm that I have been informed by the study personnel, ... about the nature, conduct, risks and benefits of this study. I have also read or have had someone read to me the above information regarding this study.

I am aware that the results of this study will be anonymously processed into a report.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study and agree to the participation of my child.

Child's name   _____   (Please print)

Name of Subject (parent)   _____   (Please print)

Subject's signature   _____Date _____

I, ... herewith confirm that the above person has been informed fully about the nature, conduct, and risks of the above study.

Investigator's name_____ (Please print)

Investigator's signature _____Date _____

If you have any further questions about this study, you can call the study investigator, Dr. Irma Eloff, PhD at: 012-420-3751. If you have a question about your rights as a participant, you can contact the University of Pretoria Health Sciences Ethics Committee at 012-339-8612.

IRB NUMBER	00002235	
FWA	00002567	

THIS FORM IS NOT VALID UNLESS THE FOLLOWING BOX HAS BEEN COMPLETED IN THE HIC OFFICE

© University of Pretoria

THIS FORM IS VALID ONLY FROM:
10/27/07 UNTIL: 10.26.08
University of Pretoria PROTOCOL #: 144/2005
Yale University HIC#: 0510000762
INITIALED:

APPROVED BY THE
OCT 2 6 2007
Yale University
Human Investigation Committee

10/19/2006

KGOLO-MMOGO PROJECT
Tel no: 012 373 1077
Fax no: 012 373 1078
Kalafong Hospital,
Clinical Building,
MRC-Unit for Maternal and Infant
Health Care Strategies,
Private Bag x396,
Pretoria, 0001

KGOLO-MMOGO

Form D

Child's Assent for Being in a Research Study
The University of Pretoria and Yale University School of Medicine

<u>Title</u>: *Helping Young Children Learn to Cope*

To be read to children aged seven years and older.

<u>Why am I here?</u>

Sometimes when we want to find out if something really works or not, we ask people to join something and then later ask them questions, so that we can know if things have changed. We want to invite you to be part of something that we will call a study and want to tell you all about it first.

This study gives a chance for parents to get together regularly with other parents in a group to talk about things about themselves and their children, and for children to get together with other children. Sometimes the parents and children will get together in a group. We are asking you to be in the study because your mother has agreed to do this study.

<u>Why are they doing this study?</u>

We are doing this study to find out whether giving information and support to mothers can help their children feel better about themselves and give them greater strength and abilities to cope with stresses.

What will happen to me?

If you agree to be in our study you will spend some time with one of us answering some questions. This would be done at four different times -- once sometime soon, then again every six months for one and half years. The questions will be about you and how you are feeling. There are no right or wrong answers, just what you feel is best.

You may also be asked to join other children in a group, just like at school, except this time it would be playing games and talking. To find out if it really makes things better or not, some mothers and their children get a chance to join the groups but others will not. I don't know whether you and your mother will be invited to join groups – the choice is kind of like tossing a coin to decide who goes to the support group.

Will the study hurt?

No, the study will not hurt. The questions can take a long time but you can take a break if you are feeling tired or don't want to answer them all at one time. If you don't want to answer a question you don't need to. All of your answers will be kept private. No one, not even someone in your family, will be told your answers.

Will the study help me?

We hope the study will help you feel good about yourself, but we do not know if this will happen.

What if I have any questions?

You can ask any questions that you have about the study. If you have a question later that you didn't think of now, you can call Dr. Irma Eloff, PhD at: 012-420-3751 or ask me next time.

Does my mother know about this?

This study was explained to your mother and she said that you could be in it. You can talk this over with her before you decide.

10/6/06

<u>Do I have to be in the study?</u>

You do not have to be in the study. No one will be upset if you don't want to do this. If you don't want to be in this study, you just have to tell them. You can say yes now and change your mind later. It's up to you.

Writing your name on this page means that that you agree to be in the study, and know what will happen to you. If you decide to quit the study all you have to do is tell the person in charge.

_____ _____

Signature of Child Date

_____ _____

Signature of Researcher Date

If you have any further questions about this study, you can call the study investigator, Dr. Irma Eloff, PhD at: 012-420-3751. If you have a question about your rights as a participant, you can contact the University of Pretoria Health Sciences Ethics Committee at 012-339-8612.

IRB NUMBER	00002235
FWA	00002567

THIS FORM IS NOT VALID UNLESS THE FOLLOWING BOX
HAS BEEN COMPLETED IN THE HIC OFFICE

THIS FORM IS VALID ONLY FROM:
10/2[?]/07   UNTIL: 10.26.08
University of Pretoria PROTOCOL #: 144/2005
Yale University HIC#: 0510000762
INITIALED:

APPROVED BY THE
OCT 26 2008
Yale University
Human Investigation Committee

Appendix 5: Examples of bar diagrams used as visual aids

KIDCOPE (e)
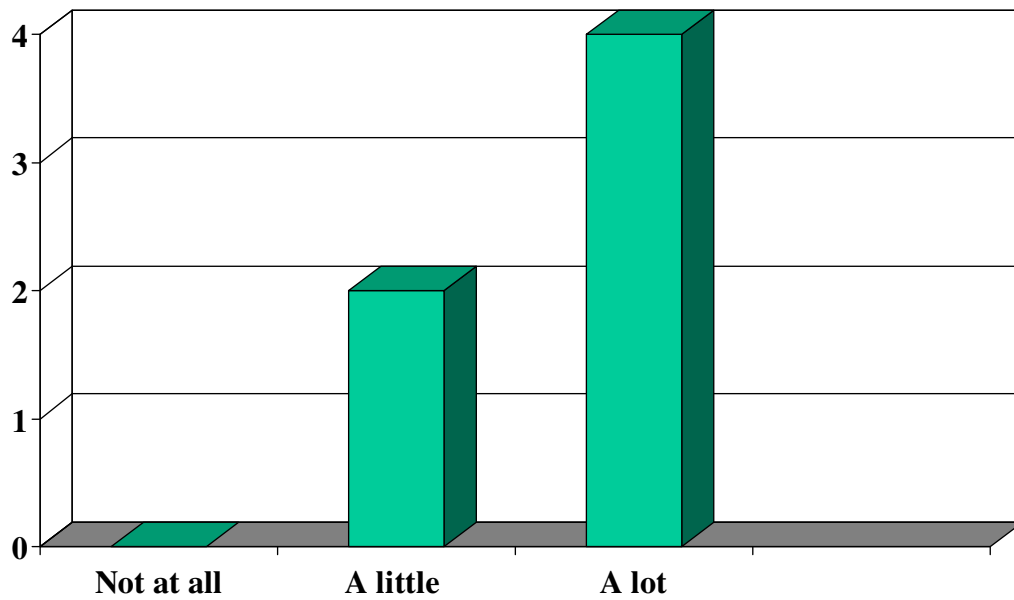
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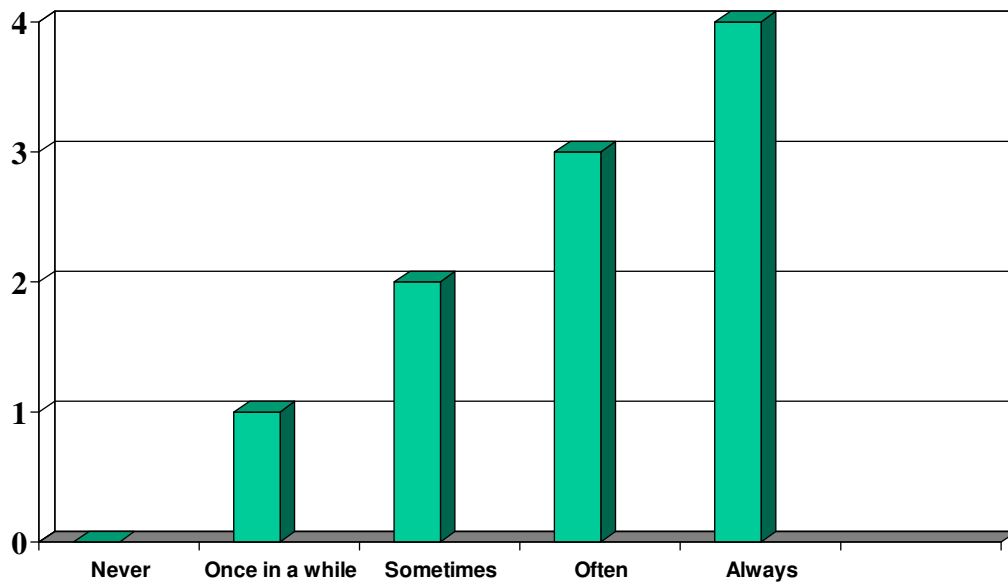
BarOn EQ-I: YV (e)
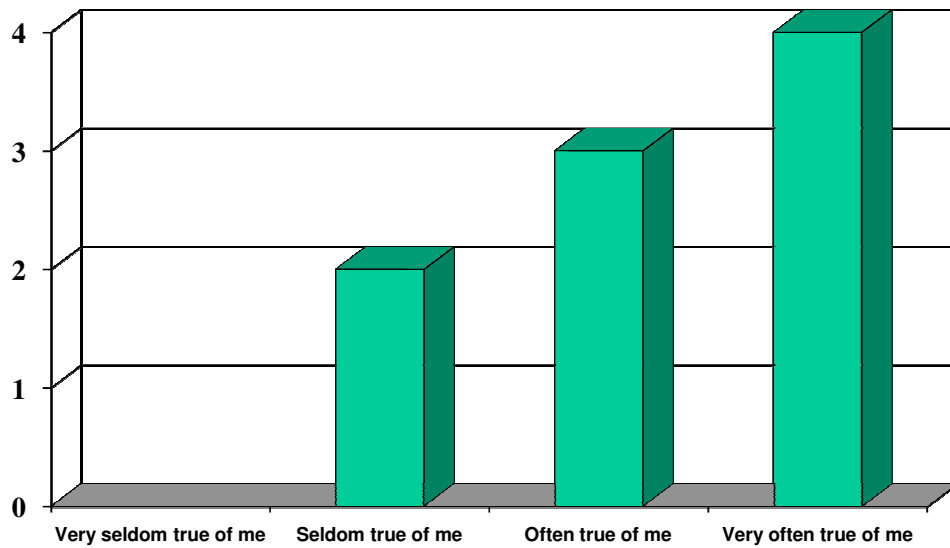
KM ID: _____co | **GROUP SCALE– C** |

INTERVIEW 6 MONTHS – FOR INTERVENTION CHILDREN

Did this child attend the intervention group: | Yes | | No |
If yes, please complete the group scale for children

The following questions are about the group that you were part of. Would you say the following questions are not true, a little true, a lot true or very true?

	Not True	A Little True	A lot True	Very True
1. I felt comfortable in the group.	0	1	2	3
2. I made friends in the group.	0	1	2	3
3. I learned new things in the group.	0	1	2	3
4. I understood what I was supposed to do during the group.	0	1	2	3
5. Children in the group quarrelled and fought too much.	0	1	2	3
6. My friends from group care about me.	0	1	2	3
7. It was hard to understand what was happening in the group.	0	1	2	3
8. The things I learned in the group helped me.	0	1	2	3
9. My friends and I helped each other in the group.	0	1	2	3
10. I could easily do what I was asked to during group.	0	1	2	3
11. I care about my friends from group.	0	1	2	3
12. What did you like best about the group?				

_____
_____
_____

Appendix 7: Mother evaluation form

You were part of the Kgolo Mmogo project for the past 6 months. During this time you came for interviews and you were also part of a group. We want to ask you a few questions of how you experienced your time with us.

1a. What effect do you think your involvement with the Kgolo Mmogo project has had on your life?
- ☐ Positive effect
- ☐ No effect
- ☐ Negative effect

1b. Why?
_____
_____
_____
_____

2a. What effect has your involvement in Kgolo Mmogo had on your ability to be a parent?
- ☐ Made it easier
- ☐ Made it more difficult
- ☐ No difference

2b. Why?
_____
_____
_____
_____

3a. What effect has your involvement in Kgolo Mmogo had on your child's behaviour?

- ☐ Positive effect
- ☐ No effect
- ☐ Negative effect

3b. Why?
_____
_____
_____
_____

P.T.O

4. What have you liked about Kgolo Mmogo?

_____
_____
_____
_____

5. What have you disliked about Kgolo Mmogo?

_____
_____
_____
_____

6a. Would you suggest to another person to join the Kgolo Mmogo project?
   ☐   Yes
   ☐   No

6b. Why?

_____
_____
_____
_____

Thank you for taking part in the Kgolo Mmogo project. We appreciate all your effort!

Evaluation questions for child

You were part of the Kgolo Mmogo project for the past 6 months. During this time you came for interviews and you also were part of a group. Do you remember this? We want to ask you a few questions of how you experienced your time with us.

1) What was the best part of Kgolo Mmogo?

_____
_____
_____
_____

2) What was the worst part about Kgolo Mmogo?

_____
_____
_____
_____

3) Are you and your mother talking more after being part of Kgolo Mmogo?
    ☐ Yes
    ☐ No

4) Are you and your mother playing more after being part of Kgolo Mmogo?
    ☐ Yes
    ☐ No

5a) Would you tell another child to be part of Kgolo Mmogo?
    ☐ Yes
    ☐ No

5b) Why?

_____
_____
_____
_____

Thank you for taking part in the Kgolo Mmogo project. We appreciate all your effort!

Appendix 8: Group session report form
Session 1 – child intervention (6-10 years)

Session checklists

Group#: _____   Total Intervention Period: _____

Facilitators: _____   Date:_____

Group Members:	Reason for Absence (If Not Present)	Amount of participation		
		Not at all	Minimal	Appropriate
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Session 1 Title: Introduction and getting to know each other

Content discussed and/ or practiced:	Fully	Partially	Not at all
"Name of the game" exercise			
General understanding of how the group will function			
Group rules (emphasis on confidentiality)			
Building of trust (blind walk and blink snake)			
Listening skills			
Feeling thermometer exercise			

Process notes:

(1) Was the session goal reached? (Whether session goal was achieved and how well it was achieved?)

_____

_____

_____

(2) Interaction and communication

_____

_____

_____

(3) Facilitator's (careworker's) observations

_____

_____

_____

_____

_____

(4) Other/unexpected topics

_____

_____

(5) Problems and concerns

_____

_____

(6) Notes to self

_____

_____

_____

(7) Other

_____

_____

_____

_____

Appendix 9: Materials needed for the children groups

Session 1
• Paper and pen to take the register and for notes on the session
• Materials needed for the ice-breaker (cuddly toy)
• Blindfolds and identification of obstacles for the 'Blind walk with directions' or 'Blind snake' game
• Feeling Thermometer
• Cardboard for each group member and colored pens for name card.
• Prestik
• Soccer ball

Session 2
• Paper and pen to take the register and for notes on the session
• Tennis Ball
• Soccer ball
• Whistle
• Ties for 'paired soccer'
• Finger-paint
• Pencils
• Newspaper
• A3 paper for each child
• Masking tape
• Refuse bags (apron for children)
• Pegs (to hold apron)
• Prestik
• Animal pictures
• Card board

Session 3
• Large piece of paper (for each child in the group)
• A4 piece of paper (for each child in the group)
• Koki's
• Crayons
• Newspaper
• Piece of cloth (one for each group member)
• Paint
• Brushes
• Refuse bags (aprons)

Session 4
- 3 pieces of paper for each group member
- Family drawing made in Session 3
- Photocopy with community outlines
- Crayons
- Old magazines
- Scissors
- Glue
- UNICEF booklets 'The little Hare'
- Pieces of newspaper

Session 5
- Ball of wool
- Story board of Little Peter Bear
- Paper and crayons

Session 6

- Paper or cardboard
- Pen or felt tip pen
- Magazines
- Glue
- Scissors
- Body map of each child (Crafted in session 3)
- Puppets
- Cards with scenarios

Session 7
- Story board of The Man in the Hole and The Fire (picture of the events on one side and story on the other)
- Puppets
- Egg
- Bowl
- Glass of water
- Match
- Candle
- Newspaper

Session 8
- Bean bags
- Poster of Children's Charter
- Don't talk to strangers-board game (Arlenco® toys and games)

Session 9
•   Roll of string (wool)
•   A ring (can be made out of a two liter juice top, i.e. make a whole through the middle of the top and thread the string through it).
•   Metaphorical story and drawings 'The lion, hyena and tortoise' - story

Session 10
•   A dice +/- 40 cm X 40 cm made from felt, fabric and filled with stuffing, with different emotions glued on to each of the six sides.
•   Paper/card
•   Glue
•   Scissors
•   Crayons
•   Emotions-board game

Session 11
•   Puppets
•   'What am I doing?' - Scenarios on cards
•   Scenarios for puppet play
•   Puppet play stage (e.g. table with blanket in front)

Session 12
•   Worksheet 1
•   Paper
•   Crayons/pens/pencils
•   Materials for demonstration of skills: Piece of clothing for washing, washing powder, pegs and plastic basin   Kettle, teaspoons, mugs, tea/coffee, milk sugar   Diaper, baby powder, Vaseline, baby doll   Broom, duster   Washcloth and soap

Session 13
•   Picture of butterfly cycle (ice-breaker)
•   A raw potato for each child
•   Water crest seed
•   Cotton wool
•   Water in a jug
•   Koki's
•   Coloured paper
•   Pins
•   Pipe cleaners
•   Scissors

- Ingredients for vegetable soup (depending on availability: carrots, onions, tomato, soup packets, pasta, marrow bones, celery, potato, tin of vegetables, water, salt)
- Grater
- Peelers
- Vegetable knife
- Pot for soup
- Hot plate
- Black refuse bags for aprons
- Flowers for table
- Serviettes

Session 14
- Paper
- Crayons
- Scissors
- Glue
- 'Future train'-story

Session 15
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Blankets or chairs
- Pre-baked muffins/cupcakes
- Decorating ingredients – smarties, astros, vermicelli, hundreds-and-thousands,
- Bread
- Smears, cheese, polony etc. for sandwiches
- Cool drink
- Glasses
- Plates
- **Games**:
- Potatoe/ Egg Races (potato or egg, spoon, old stoking or rope, prize)
- Balloon Popping Races (ballons, old stocking/rope, prize)

Session 16
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Blankets and chairs
- Clay for both children groups - first 20 minute group
- Big white paper and tape for body mapping
- Crayons, pencils or Koki's for body mapping
- Pre-written instructions for the M.I.M activity on numbered pieces of paper for every child-mother pair
- Cotton wool

- A4 paper
- Water
- Balls of cotton wool
- Paint and paint brushes
- Hand lotion
- Bubbles
- Toilet paper
- Towels
- Newspaper
- Small packets of 'Smartie' chocolate for each child/mother pair (for every child in the pair)

Session 17
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Flip board paper
- Koki's and pencils
- One pair of white socks for every child/mother pair
- Buttons and beads
- Glue

Session 18
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- A4 paper boxes (one for every mother-child pair)
- Koki pens, crayons and coloured pencils
- Magazines
- Coloured paper
- Scissors
- A3 paper
- Glue
- Finger paint
- Ball of cotton wool
- Prestik
- Refuse bags

Session 19
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Decorated A4 paper boxes (one for every mother-child pair) which were made in session 19
- Koki pens, crayons and coloured pencils
- Glue

- Magazines
- A3 paper
- A4 paper with fine lines and without
- Coloured paper
- Scissors
- Finger paint
- Newspapers
- Water
- Photos taken in session 19
- Prestik
- Refuse bags

Session 20
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Beads
- Elastic for beading
- Flour
- Water
- Bowls
- Salt
- Oil
- Food colouring
- Newspaper

Session 21
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Paper plates (2 for every mother/ child pair)
- Crayons
- Scissors
- A4 paper (2 for every mother/child pair)

Session 22
- Paper and pen to take the register and for notes on the session.
- Invoice book and money for travelling expenses.
- Flip chart and koki's
- Pre-written instructions for discussion
- Finding Nemo DVD
- DVD player

Session 23
• Paper and pen to take the register and for notes on the session. • Invoice book and money for travelling expenses. • Magazines • A3 paper • A4 paper • Paint and brushes • Scissors • Glue • White board paper • Pencils

Session 24
• Paper and pen to take the register and for notes on the session. • Invoice book and money for travelling expenses. • Certificates for mothers and children • Food, cooldrink and cake

**Appendix 10: Content of the Kgolo Mmogo intervention programme manual**

Weeks	Children sessions (1-14)	Mother sessions (1-14)
Week 1	Introduction and getting to know each other 'Let's get to know one another'	Introduction, orientation and relationships of trust
Week 2	Developing relationships within the group 'Let's get to know one another'	Living positively 'How do I look after myself' (Basic HIV info)
Week 3	Describe self and self in family 'Who am I?'	Disclosure
Week 4	Describe self and family within community 'My community'	HIV and relationships
Week 5	Identify strengths within self 'What do I look like? I have, I am, I can!"	The emotional experience of having HIV 'How do I feel?' – part I
Week 6	Identify coping that is linked to strengths identified 'What can I do/ What am I good at?'	The emotional experience of having HIV 'How do I feel?' – part II
Week 7	Problem solving 'How can I do it?'	Coping, problem solving and stress management
Week 8	Protecting self and identifying boundaries 'Protecting myself'	HIV in the household, human rights and stigma
Week 9	Social skills 'Socializing with peers'	Knowing and understanding myself as parent (parenting skills) Part I
Week 10	Identifying emotions (focus on self) 'How do I feel?"	Knowing and understanding myself as parent (parenting skills) Part 2
Week 11	Identifying emotions (focus on other and communication) ''How do others feel?'	Knowing and understanding my child (development of children) Part I
Week 12	Survival skills (Part 1) 'Look and learn'	Knowing and understanding my child (development of children) Part II
Week 13	Survival skills (Part 2) 'Let's practice our skills'	My child and HIV
Week 14	Identifying meaning, purpose and future orientation 'Let's live life'	Life planning and goal setting
Joint group sessions for mothers and children (Sessions 15 -24)		
Week 15	Mother and child getting to know each other 'Knowing me, knowing you' (Part 1)	
Week 16	Mother and child getting to know each other 'Knowing me, knowing you' (Part 2)	
Week 17	Mother and child getting to know each other 'Knowing me, knowing you' (Part 3)	
Week 18	Creating a legacy. 'Let's make a family memory' (Part 1)	
Week 19	Creating a legacy. 'Let's make a family memory' (Part 2)	
Week 20	Interaction between mother and child 'Let's have fun' (Part 1)	
Week 21	Interaction between mother and child 'Let's have fun' (Part 2)	
Week 22	Mother and child sessions revisited 'Where are we at now' (separate session)	
Week 23	Planning for the future 'Let's dream together'	
Week 24	Family celebration 'Let's dream together'	

Appendix 11: Cue card for group facilitator/careworker

Important resilient characteristics to facilitate and encourage
1) **Naming** and **identification** of emotions
2) Appropriate expression of **own emotions**
3) Appropriate response to **others' emotions**
4) **Communication** with group members
5) **Sharing** with group members
6) **Supporting** group members
7) Asking for **help**
8) **Respect** for group members
9) **Coping** with stress
10) Appropriate **problem solving**
11) A **positive future perspective**
12) Life skills

KGOLO MMOGO PROJECT

Appendix 12: Lunch menu
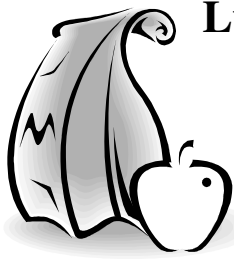
Lunch menu for groups

Session	
1	Rice and chicken (including carrots, potatoes and onions)
2	Bread rolls, ham, lettuce and tomato
3	Chicken a la king (Chicken and pasta)
4	Bread and tin beans baked with onions, tomato and minestrone soup packet
5	Chicken livers, pap and spinach
6	Bread rolls, tinned tuna, mayonnaise and tinned sweet corn
7	Rice and beef stew
8	Chicken mayonnaise sandwich
9	Cabbage, mince and pap
10	Bread rolls, ham and lettuce
11	Pap, wors and gravy
12	Fruit salad (summer) / vegetable soup (winter) *Children help with preparation*
13	Bread rolls, polony and lettuce
14	Rice and mince
15	Bread rolls, lettuce, polony and tomato. Cupcakes. *Moms and kids prepare food for picnic in joint session*
16	Stamp, brown beans, potato and beef stock
17	Chicken livers, pap and spinach
18	Bread rolls, tinned tuna, lettuce and sweet corn
19	Mixed vegetable stew (carrots, cabbage, potato and peas)
20	Chicken mayonnaise sandwich
21	Rice and chicken
22	Tuna salad (tinned tuna, mayonnaise, tomato, sweet corn and pasta) (summer) / vegetable soup(winter)
23	Pap and pilchards
24	Boerewors rolls, cake, chips and cool drink. *Last session party.*

University of Pretoria

Certificate of Achievement

Being Resilient

The child receiving this Kgolo Mmogo certificate has shown courage, strength and survival skills. Over the course of 24 weeks this child attended weekly group sessions and displayed all the requirements of being resilient.

Given to _____

Date   _____   Place _____

KGOLO-MMOGO

University of Pretoria   Yale University

RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE	**CLEARANCE NUMBER :** EP 11/11/01
DEGREE AND PROJECT	PhD An evaluation of a theory-based support group intervention for children affected by maternal HIV/AIDS
INVESTIGATOR(S)	Michelle Finestone
DEPARTMENT	Educational Psychology
DATE CONSIDERED	24 July 2013
DECISION OF THE COMMITTEE	APPROVED

Please note:

For Masters applications, ethical clearance is valid for 2 years

For PhD applications, ethical clearnace is valid for 3 years.

CHAIRPERSON OF ETHICS COMMITTEE	Prof Liesel Ebersöhn
DATE	24 July 2013
CC	Jeannie Beukes Liesel Ebersöhn Prof. B Forsyth Prof. I Eloff

This ethical clearance certificate is issued subject to the following conditions:

1. A signed personal declaration of responsibility
2. If the research question changes significantly so as to alter the nature of the study, a new application for ethical clearance must be submitted
3. It remains the students' responsibility to ensure that all the necessary forms for informed consent are kept for future queries.

Please quote the clearance number in all enquiries.

Appendix 15: Findings of individual group members as observed by the careworkers

Girl

> *When we were discussing some of the questions about the previous session **KM 116** said what makes her laugh is when her mother is well because her mother was sick for long (1:16)*
>
> *KM 116 - She is a dedicated child who is always willing to help those in need. She made friends easily because she is always welcoming new group members. At first she had low self esteem but when time goes on she was better. She played with others. She participated well. During joint session she was close to the mother and communicated well (Careworker observation)*

The mother's illness had a direct effect on the child's emotional well-being. KM 116 showed adaptive behaviour by reaching out to others. Her communication skills and self-esteem enhanced in the group. She had as a protective factor a good relationship with her mother.

Girl

> *KM 146 – She like to fight. She was the youngest in the group and she was protecting herself form the older ones by fighting. She is disrespectful .She is disrespectful to her mother (Careworker observation)*
>
> *KM 146 did not want to continue the activity with the mother because she came late (1:17)*

KM 146 displayed external behaviour problems. As the youngest group member it could have been a protective factor against the older children as she learnt how to fend for herself. This child did however display a problematic relationship with her mother that could be a risk factor for resilience.

Girl

> *KM 122 decorated her box with care and she said she is working she will buy her mother big house and car (1:18)*
>
> *KM 122 wants to become a doctor to help sick people (1:23)*
>
> *KM 122 – She is an intelligent child with leadership skills. She is always helping and does activities properly. If her mom couldn't come, she would come alone to group. She attended all the sessions (Careworker observation)*

KM 122's observed intelligent behaviour and leadership skills were protective factors of resilience. She displayed resilience and adaptive behaviour by attending alone all the group sessions when her mother did not attend certain of the sessions. This girl also had positive and realistic (taking into account her intelligent behaviour) future expectations. She displayed an inclination to help others.

Boy

KM 143 is having a burnt wound in the face, when we asked him about it he started to cry and didn't want to talk about it. Abuse is very possible, aunt reported (1:11)

KM 143 in his memory box he wrote a message to his mom telling her how much he loves her and she is a special mom (1:18)

KM 143 when said he wants to be soldier and he want to shoot those who disrespect him (1:23)

KM 143 – The child was hitting some children at times, but he was overall okay. He showed he loved his mom (Careworker observation)

KM 143 displayed contradicting behaviour. The boy expressed a caring attitude towards his mother and experienced her as a positive attribute in his life which points to a resilience. On the other hand he was indicating a tendency for aggressive behaviour. The possibility of abuse and his need for respect were pronounced in his expression.

Boy

After playing games outside, one of the children (KM 147) had pains in his hip because the mother was dragging him. She wanted to win the game and didn't care about him (1: 15)

KM 147 was not comfortable when we were doing balloon between two bodies, he did not play with his mother he wanted to play alone (1:15)

KM 147 was birthdaying. His mommy brought cake and he was very happy to eat it with his friends. He was dancing. (1:24)

KM 147 – He is a cute boy. He communicated very well with his mother in later sessions (Careworker observation)

The relationship of KM 147 and his mother was negative when the joint sessions started. The mother did not give him adequate attention and he was not comfortable with being in close proximity with her. The mother-child relationship was a risk factor for KM 147, but the joint group sessions helped their relationship to develop into a more positive relationship where the mother saw her child's needs. The mother brought a cake to the group in order for the rest of the group to celebrate her son's birthday with them. She thus saw his needs and responded to it.

Boy

> *KM 163 came alone and he was freezing cold. He said he didn't have something warm to wear (1:12)*
>
> *KM 163 unable to decorate his memory box, he wanted to decorate his box with alcohol and with guns. When we ask him why he uses this he said he likes fighting (1:18)*
>
> *KM 163 – Most of the time he will withdraw form the group and he was full of stories. He could tell a lie and he won't feel guilty about that even if you confronted him he won't apologise he will just look at you (Careworker observation)*
>
> *KM 163 – the family received food parcels and other material help such as blankets from KM (Careworker observation)*

The poverty KM 163 experienced was a risk factor for him. He communicated a tendency to choose negative elements such as alcohol and guns. He also showed he experienced a negative relationship with his mother in the memory box decoration session. The session was a 'family legacy'-exercise where children had to cut positive pictures out of magazines depicting their family life in particular their relationships with their mothers. The child told lies and did not show remorse if he got caught out on a lie. The negative tendencies could have been indicative of external and internal behaviour problems. The child and his family received physical aid to alleviate the food scarcity in their household.

Girl

> *KM 199 understands happy face only when singing 'if you are happy and you know it'. Could not in other sessions (2:10)*
>
> *KM 199 did not want her mother to help her decorate the cup cake with caramel, she waited for the group to finish decorating then she decorated hers without her mother (1:15)*

> *KM 199 told her mother she does not like wrapping activity and she wanted to stop playing (2:16)*
>
> *KM 199 – At first she was crying. When time goes on and others accommodate her she stopped crying and participated well. Group members helped her a lot. During joint sessions she had good communication with mom. They were close towards session 18 and later session (Careworker observation)*

The mother-child relationship seemed to be a risk factor for KM 199. She could not express her emotions in the separate sessions. A factor could have been her age as she was six years old at the time of the intervention. The group supported her during the separate sessions and this support gave impetus for her to participate in the group. During the first joint session she negated her mother's help and indicated that she wanted to complete the activity by herself. She directly communicated to her mother that she did not want to complete the tasks with her. As the joint sessions progressed she developed a better relationship with her mother.

Boy

> **KM 206** *said he wanted to work with guns because if you have a gun you can protect your family and no one will mess with you (2:13)*
>
> *KM 206 said he wanted a gun to protect his family (2:23)*
>
> *KM 206 – He is sometimes talkative. At first sessions he said he liked guns and boxing but later he said he does not like it because they are not good (Careworker observation)*

At first KM 206 wanted to protect his family against violence that he perceived in his close environment and he wanted to be protective *"no one will mess with you"*. He indicated that he did not trust his environment and he felt threatened. He wanted to have control over his circumstances. The child displayed that he was aware that guns and violence was not the appropriate choice. This indicated resilience. He was able to reflect on his thoughts and expressions.

4

Girl

> *When doing puppet plays* **KM 213** *was very happy to play. She also gives some of the children things to role play. She was quiet but now she is like a director (2:6)*
>
> *When naming social rules KM 213 said don't interrupt or shout while there are visitors at your home. (2:9)*
>
> *KM 213 said if someone is sick at home and went to hospital, she is afraid that of maybe s/he will die (3:10)*
>
> *KM 213 said that the best place for her child is at KM , because her child is more active and enjoy life when here (3:18)*
>
> *KM 213 – She was talkative always giving an idea during discussion. She was always first one to answer question. She had good communication with mother. She cried in session 24 saying she wants to continue with group (Careworker observation)*

KM 213 displayed protective factors in her communication and behaviour. She displayed a cheerful disposition and was also aware of social rules. She did however indicate anxiousness when illness was mentioned in the group. She equated hospitalisation with the possibility of death. She displayed a catastrophic thinking tendency. The child's mother reported that the group had a positive effect on her child. KM 213 was more active and positive in general after attending the group according to the mother. The mother-child communication was good and contributed to the child's protective factors.

Girl

> *KM* **134** *said she help her mommy by cleaning the house. KM 214 said she made tea for her mommy and she was participating well in the group (2:12)*
>
> *KM 134 said that she learnt that if her mommy is sick, she will be able to make food for her. She loves her mommy because she takes care of them (2:13)*
>
> *KM 134 – She was an older girl who was very neat but sometimes wanted to show others that she is little 'miss'. During the joint she communicated well with her mother (Careworker observation)*

5

KM 134 showed with life skills and good participation (communication skills) in the group. She experienced her relationship with her mother as positive and indicated responsibility towards her mother in the case of her mother becoming ill. She mentioned that the group enhanced her life skills *"if her mommy is sick, she will be able to make food for her"*.

Boy

KM 170 does not know his grandfather name because they don't stay with them or his father and he does not understand his father's language (2:3)

When doing activity of tow of making bracelet KM 170 refuse to make it because he is a boy (2:20)

KM 170 and 209 and their mothers told us that every time when there are at home before supper they discuss about the session and do some of the activities with the other siblings(2:21)

KM 170 – He participated well during separate sessions. He didn't know Sotho well but he tried and he seemed eager to learn. He spoke Venda. He and his mother had a strong bond (Careworker observation)

A risk factor in KM 170's life was an absent father. He did however indicate a good relationship with his mother. He showed with protective resilience factors in that he participated well in the group although he spoke a different language than the rest of the group. The group accommodated this difference. The family experienced the group activities as positive and helpful to such an extent that they practiced the session activities at home with other siblings.

Girl

*KM 170 and **209** and their mothers told us that every time when there are at home before supper they discuss about the session and do some of the activities with the other siblings(2:21)*

KM 209 said that if someone is sick she will pray for him/her and she will be happy if she will be healed. (2:10)

KM 209 – She was always smiling but shy. She was younger in the group. She participated well in the sessions (Careworker observation)

KM 209 showed resilience by participating well in the group despite being the youngest in the group. She showed that she utilised religious coping strategies to cope with illness. The mother and child experienced the group as positive. They practiced the group session activities at home with other siblings.

Boy

> *KM **179** he was bullying other children and he said he feels pain when somebody passed away and he is worried when is mother is sick, he thinks she is going to die. (2:10)*
>
> *KM 179 said he is experiencing problems about his mom being sick and he understands that she is very sick (2:10)*
>
> *KM 179 asked 173 what will happen when his friend died and he answered he is going to cry and the group said yes he should cry. (2:10)*
>
> *When playing masekitlana most of the children did not want to use their families as characters but they preferred their friends. KM 179 likes fighting. In his story he was beating his friend and also another group member complained about him and said that he bullies him at home when he visits. (2:5)*
>
> *KM 179 – He was a dedicated child and would ask his mother to ask his brother to bring him to the group when the mother was not feeling well (Careworker observation)*

KM 179 displayed external behaviour problems in direct response to his experience of his mother's illness. He expressed his anxiousness about his mother's health. He did show despite his external behaviour problems and anxiousness resilience in that he attended the group sessions on a regular basis and asked his mother to do so as well.

Boy

> *KM **173** and 214 when doing dislikes and likes game said they dislike beers and liquor because it makes trouble in a family (2:6)*
>
> *KM 179 asked 173 what will happen when his friend died and he answered he is going to cry and the group said yes he should cry (2:10)*
>
> *KM 173 – He participated well during separation. He didn't know Sotho well but he tried and he seems eager to know the language, he was also understandable. They speak Venda language. He always gives an idea when asked something. During joint session he did very well with his mother. They had a strong bond (Careworker observation)*

7

The positive mother-child relationship, the child's ability to identify negative behaviour and his ability to express his emotions were protective factors. Although he was shy in the separate sessions he was able to share in the group and share his emotions. The positive mother-child relationship was shown by the betterment of his communication during the joint sessions.

Girl

> **KM 214** *isolates herself. She didn't want to play with other children, she want to be alone. (2:5)*
>
> *KM 173 and 214 when doing dislikes and likes game said they dislike beers and liquor because it makes trouble in a family (2:6)*
>
> *KM 214 said at home they don't like to talk about death (2:10)*
>
> *KM 214 said she made tea for her mommy and she was participating well (2:12)*
>
> *When decorating the body maps KM 214 said "I love you my child". We explained to the mother that what their children said is what and how you talk to them. The puppet sock exercise was very good and both mother and child enjoyed it (2:17)*
>
> *KM 214 – She was isolating herself from the group. She was always shy and quiet. She did not share her feelings with the group. She will just say she is fine but you could see she is not. She was not comfortable with other children coming close to her especially boys. She was not so happy; she tried to hide her feelings (Careworker observation)*

The behaviour and expressions of KM 214 during the group sessions indicated that there were risk factors in her life. The facilitators identified KM 214 with a possible emotional problem after observation and referred the child. KM 214 did not share her feelings with the group or communicated in the group. She preferred to isolate herself and thereby she did not need to communicate with other group members. Her behaviour could have been indicative of a deeper problem or 'secret'. She showed with internalised behaviour problems. The mother-child relationship could have been a protective factor in the child's life, but her *"I love you my child"* response could have been an expressive need for a good relationship with her mother and not necessarily indicative of a good existing relationship.

Girl

> *My concern is that KM169 come late around to 4 before we dish up. She missed a lot and could not participate because she was too late (2:10)*
>
> *KM 169 – She was sometimes very playful and seems as she having emotional problems. She usually interrupts even if you are talking to someone. During the joint sessions her behaviour changed for the better and her mother encouraged her to participate (Careworker observation)*

The facilitators observed that KM 169 displayed attention-seeking behaviour that was not age-appropriate. The mother and child wanted to be part of the group as they attended the group sessions very late even though they knew the group were almost finished with the day's session. In the joint sessions the mother had a positive effect on the child's behaviour which could have been indicative of a possible protective factor for the child.

Girl

> *KM 256 said she want us to teach them the Bible (3:2)*
>
> *KM 256 did not want to participate; she said she is feeling sad (3:10)*
>
> *KM 256 did not want her mother to use a black colour during the puppet sock making. She said black is too dark and she chose orange (3:17)*
>
> *KM 256 said she will be a good girl and listen to her mom (3:22)*
>
> *KM 256 – She was very beautiful and very neat every time. She participated very well and communicated well with other group members. She was an intelligent girl who does things her own way. She had good relationship with her mother and helped others in group (Careworker observation)*

KM 256 showed according to the facilitators' observations with an internalised behaviour problem. She withdrew when the session focussed on the identification of emotions. She verbalised that she was sad. She did show protective factors through her displayed religious coping skills, helpfulness to others and her intelligent behaviour as observed by the facilitators. During the later joint sessions she expressed her need to move away from 'darkness' "*She said black is too dark and she chose orange*" and she wanted to change her behaviour to be a 'good girl' and listen to her mother. She showed a positive relationship with her mother.

9

Boy

*When **KM 219** was doing family exercise he drew only him and his mother. He said I didn't draw my father and brother because I don't love them (3:3)*

KM 217 tried to discipline KM 219 by not giving him a chance to place a round during the 'Don't talk to strangers game' because he was disturbing the group members when trying to answer some of the questions (3:8)

KM 219 was singing 'when I remember what the Lord has done. I will never forget anymore' (3:19)

KM 219 – was very active. Sometimes he just wanted to go out and play alone. He sometimes communicated well with group members. During joint sessions he wanted to lead the mother when doing activities. He is always disturbing the group (Careworker observation)

KM 219 displayed hyperactivity and this had a negative influence on his group behaviour and how the group experienced him. A further risk factor in his life was his poor relationship with his father and brother as verbalised by him. His mother also showed she had difficulty in dealing with his hyperactive behaviour. He displayed a protective factor in his religious coping skills in the later joint sessions.

Boy

*KM **236** said he love his mommy and dad because they care for them and their mothers make for them food (3:3)*

KM 219 was kicking others and during masekitlana he was fighting with KM 236 over the stones. We tried to give him a break, but he refused (3:5)

I noted that KM 263 was playing with KM 236 and then 263 badly hurt 236. We asked him to say sorry. When we go to put their names on thermometer KM 263 put his name on unhappy face, and when asked he said because for what he did to KM 236 was wrong. (3:10)

KM 236 invited his sister to sit on the table and have food because she is the one who brought him to the group, she was representing his mother (3:12)

KM 236 – He was very interested in the group because his mother was working and he came along with his sister (Careworker observation)

The behaviour displayed towards KM 236 was indicative of bullying behaviour and he was the victim of two bullies. The child did however show tenacity and resiliency in staying in the group even though his mother was not attending because she was working. A protective factor in KM 236's life was his positive relationship with his sister and with both his parents.

Boy

> ***KM 216***- *He is a shy child when asked questions but he is too playful and he does not like doing activities, he only wanted to play (Careworker observation)*
>
> *KM 216 not participating and he is unable to give answers. He is always laughing or repeating what the facilitator says. He said he wants to go to the little one group. He is a very young 6 year old (3:3)*
>
> *Most of the time KM 216 does not participate well but this time he wanted to finish playing board game, he was very courageous and at last he finished. He was very happy. (3:8)*

KM 216 experienced the group activities as difficult as he was only six years old. He could not complete the activities in the separate sessions. He verbalised his wanting to attend the smaller group where there would be less expectations put to him. He did however show resilience in his tenacity to complete the board game in session 8.

Boy

> ***KM 248*** *said he needs a gun to protect his family from criminals (3:20)*
>
> *KM 248 said he is going to make a gun so that he can shoot people who are stealing cars (3:5)*
>
> *KM 248 said he is going to make a gun so that he can shoot people who are stealing cars (3:20)*
>
> *KM 248 during the board game he was asked when a special person is sick what is it that you are scared of and he said he is scared the person will die and he does not want his mother to die because he is still young and he needs her. (3:10)*
>
> *KM 248 – He is a dedicated guy who is always doing his task very well. He was a disciplined child and won't take anything without asking permission. He helped others in the group. He shared with group what happens with him at school at every session (Careworker observation)*

KM 248 verbalised his need several times during the group sessions to control his environment by 'making a gun' to protect what belongs to him. He verbalised anxiousness about his mother's health and expressed his need for her in his life. He showed dedication, discipline and he helped others in the group (protective factors). Another protective factor indicated was his ability to share his experiences with the group.

Girl

> Father passed away **KM 217** *said her father passed away and she is staying with her mom and sisters (3:3)*
>
> *KM 217 said I sit on my grandmother's lap and the others said they sit on their mothers' laps (3:4)*
>
> *KM 217 tried to discipline KM 219 by not giving him a chance to place a round during the 'Don't talk to strangers game' because he was disturbing the group members when trying to answer some of the questions (3:8)*
>
> *KM 217 – She is a beautiful and neat girl. Always gives own ideas in the group. She participated well with others. She was always happy (Careworker observation)*

The risk factors in KM 217 life was an absent father (father deceased) and she indicated that she has a better relationship with her grandmother than her mother. She displayed protective factors in that she participated well in the group, shared and communicated her ideas with the group and she had a positive attitude. She internalised the group rules and used it as a problem solving skill.

Girl

> **KM 227** *is also having a problem, she looses control and beat the tables and screams and after sometime she becomes quiet and she will not say anything and if you ask her to talk se will just looks at you (3:2)*
>
> *KM 227 she is having difficulties in understanding what you are saying to her. She listens to what her younger sister is saying to her and only then can she participates (3:2)*
>
> *KM 227 – She was intellectually disabled. Sometimes she participated well but if you gave her work to do she wanted to take her own time. She was quick to fight and you couldn't always understand her. She did well in joint sessions with her mom (Careworker observation)*

12

KM 227 was intellectually disabled and displayed external behaviour problems in the group. The group accommodated her behaviour and the facilitators understood that they had to give her more time to complete tasks. A protective factor for KM 227 was her little sister who helped her to cope with the demands set by the session activities. A good mother-child relationship as indicated in the joint sessions is also a protective factor for KM 227.

Girl

> **KM 302** *said she liked to be in the group (4:2)*
>
> *KM 302 said God makes her happy and she loves Him (4:2)*
>
> *KM 302 asked if she could include the tenants in 'My family'-exercise because they are helping them with money (4:3)*
>
> *When playing masekitlana KM 302 was talking about her brother"because his mother gives him money to buy bread and he didn't bring change. It shows that he robbed his mother" (4:5)*
>
> *KM 302 is uncontrollable and wants only to play outside. She seems too young for the group (4:3) Spoke to mother. Mother says she is hyperactive at home as well.*
>
> *KM 302 said she won't sit with her mother alone, she need to have one of the facilitators with her because her mother will pinch her* (4:14)
>
> *KM 302 – She is too playful. She does not listen to the instructions given to her. You have to call her to order every time. She likes playing more than doing the activities in the group (Careworker observation)*

KM 302 displayed hyperactive behaviour, but her behaviour could also be indicative of an inability to cope with the activities in the group because she was only six years old. The mother conferred that the child was showing with hyperactive behaviour at home as well and therefore the conclusion could be drawn that she displayed hyperactive behaviour. KM 302 indicated a financial need in her family and also exhibited that she could differentiate between right and wrong. She displayed an inability to describe her family members and her relationship with her mother seemed problematic according to the careworkers' descriptions. A lack of support from significant others in her life could be suggestive of a risk factor in her life. A protective factor in her life was her religious coping skills where she seek the love that was absent in her family from God.

13

Girl

> *KM 319* told the group about her brother who is a thief and the grandmother is angry about it. She hates him (4:2)
>
> *KM 319 said she likes God and she dislikes the devil. KM 302 said God makes her happy and she loves Him (4:2)*
>
> *KM 319 she was not interested in the balloon popping activities. She said does not enjoying doing that with her mother and rather play alone (4:15)*
>
> *KM 319 and her mother were comfortable with each other and they shared some of the information. They are showing strong bond because each pair want to express themselves (4:21)*
>
> *KM 319 – She is always asking questions before she could do the activities. She will ask you to make sure that she understands. She enjoyed coming to the group because she said it is where she made friends and there was no fighting (Careworker observation)*

KM 319 displayed strong preferences and she indicated that she knew right from wrong (protective factors). She felt comfortable sharing in the group. She also showed a religious coping style and enjoyment in being with her peers where there is peace ('no fighting'). KM 319 might have been exposed to a family life where there was upheaval. She expressed her negative experience of her mother in the first joint session, but as the group sessions progressed the mother and child showed a closer relationship.

Girl

> *KM 290 said she like reading, do school work. 'Peter Bear'- story (4:5)*
>
> *KM 290, 323 and 297 want the group to help each other about their school work during the session. The facilitator asked them to come early so that they can be able to do some work before the group starts (4: 6)*
>
> *KM 290 said she is not afraid of ghosts because she doesn't belief it is real. She believes in God (4:8)*
>
> *KM 290 – She is intelligent child who is able to do things on her own and she is willing to help others during the sessions. She shares what happens at home and school with other group members. She was older than the other group members. Sometimes her mother did not come to group, then she came alone (Careworker observation)*

14

KM 290 is a conscientious girl who showed responsibility in completing her homework. She displayed a religious coping style. She is described by the group facilitators as a child who displayed intelligent behaviour. Her willingness to share during the group and her attendance of the group when her mother sometimes did not attend the group, were indicative of protective resilience factors.

Boy

KM 280 said he will keep quiet when there is a fire and won't tell his parents (4:7)

KM 280 when he said he is going to smoke drugs with friend, KM 285 said drugs kills and we die young if one smokes. (4:8)

KM 280 said during the 'Don't talk to strangers' board game negative remarks. Like if his friends are playing with knives, he will take the knife and stab them. (4:8)

KM 280 when we started at first shy and bored, because he was the only boy. After seeing everyone expressing themselves when singing he said I can sing alone and he did it well. We encouraged him. All children sang praise and worship songs. They participated well (5:11)

KM 280 said my mother ignores me when I talk to her and his mother said his is speaking the truth (4:21)

KM 280 and 269 did not come to the group, their mothers were ill (4: 23)

KM 280 - He keeps quiet and didn't want to share with group his problems. He doesn't like questions. Sometimes the mother didn't feel well but he forced her to go to group (Careworker observation)

KM 280 displayed and verbalised external behaviour problems. A further risk factor was the negative mother-child relationship. The child indicated that his mother did not give attention to him and the mother agreed with his observation. His mother's illness could have a negative impact on his behaviour. He did not share his feelings with the group. Although he displayed negative behaviour (internalised and externalised behaviour problems), he experienced the group as positive for him and his mother *"Sometimes the mother didn't feel well but he forced her to go to the group"*. KM 280's behaviour improved in the later separate sessions and he participated in the group.

> *KM 290, 323 and **297** want the group to help each other about their school work during the session. The facilitator asked them to come early so that they can be able to do some work before the group starts (4: 6)*
>
> *Most of the time KM 297 is shy and not expressing herself but on this activity of specific skill was she the one who was showing others how to make tea (4:12)*
>
> *KM 297 improved a lot. She showed she is resilient because at first she was shy but now she can express herself (4:13)*
>
> *Mother of KM 297 said she is thankful because her child was shy but now she can socialise with peers even at school because a teacher told the mother that she is improving especially in communication (4:24)*
>
> *KM 297 - She was very shy at the beginning during separate session. She improved during sessions starting to communicate with others and even her mother said the teacher asked what she did because she sees improvement in the child. During joint sessions she communicated well (Careworker observation)*

KM 297 displayed improvement in her communication- and socialisation skills. The child's mother and teacher commented on the change they observed in her behaviour after she started to attend the group sessions. She is a diligent child who wanted to do her homework and she asked for help from the rest of the group. She was able to identify and utilise the assets in her environment. She showed adaptive behaviour.

Boy

> ***KM 285** said drugs kills and we die young if one smokes (4:8)*
>
> *KM 285 pasted his box with beautiful shoes and clothes and said he wants his mother to look beautiful in those clothes. He wants to buy it for her (4:18)*
>
> *When doing likes and dislikes exercise KM 285 said he doesn't like liqueur because it's not good and he saw many people who are drinking alcohol and they are disrespecting (4:19)*

> *KM 285 – He is a responsible person, he takes care of what he uses for the activities and he makes sure that everybody brings back what they used. He was always taking care of his little sister when coming to the group. He would make sure that his sister is playing with other children every time before he attends the group. He was sometimes quiet in the group, but answered questions (Careworker observation)*

KM 285 verbalised his disapproval of negative behaviour. He displayed adaptive behaviour in the group. KM 285 demonstrated responsibility towards his younger sister and the group. His relationship with his mother was a further protective factor.

Boy

> *KM 331 when feeling the thermometer he said he is not happy because the whole group is not there. KM 331 said he likes to go to church and he dislikes disrespect (5:2)*
>
> *KM 331 said he likes going to church and pray for crime to stop because there are too many killings and rape in the country (5:2)*
>
> *KM 331 made a big note about the group and gave it to his mother so that she does not forget about the next group (5:2)*
>
> *KM 331 – He is a dedicated person if you give him a task. He will do it with his all. He makes sure that he understands before doing the task. He is always happy and helping other children. He always tries to say positive things about other children. The bond between him and his mother is very strong (Careworker observation)*

KM 331 displayed a pleasant disposition and was fully immersed in the group process. He supported the other children in the group and showed a positive attitude towards the members in the group. He enjoyed being part of the group and demonstrated a positive religious coping style. The positive mother and child relationship and respect shown by the child were further protective factors in KM 331's life.

Boy

> *KM 350 said he don't like to sing especially this song 'if you happy' because his is older and song for pre-schoolers (5:9)*
>
> *KM 350 was pinching his mother after she could not play hand clapping game correctly. He was just doing it in a funny, joking way (5:16)*

17

> *KM 350 was the mother telling her child that he is first born; he must do some house chores because his sibling is still young. At the end their mothers was surprised because they were not aware that is the way they talk with their children at home (5:17)*
>
> *KM 350 said he want to be a fire-fighter to help people who life in informal settlements when their shacks are burning (5:23)*
>
> *KM 350 – He is always willing to help and he is participating in the group. He is not afraid to take chances when he does not know how to do a thing. He is a caring child. He would take care of small children in the group when nobody was there to help them. He likes playing. He communicated well with his mother in the joint sessions. He was always smiling (Careworker observation)*

KM 350 displayed a pleasant disposition and he participated well with the group members. He had a caring attitude and showed a willingness to help others. He exhibited a sense of humour and good communication skills. The positive relationship exhibited between KM 350 and his mother is a further protective factor.

Boy

> **KM 407** *he is a young 6yrs old and it is difficult for him to follow instructions. He only wants to play (5:2)*
>
> *KM 407 is far behind his age and has difficulties with activities (5:2)*
>
> *KM 407 and 358 were unable to draw there families. When doing 'people sorting' activity (5:3)*
>
> *KM 407 is improving. He was doing the activity by himself, he enjoyed cutting. He said he is happy because he had lunch today at school (5:5)*
>
> *KM 407 said he learnt everything but enjoyed having lunch here because sometimes at home there is nothing to eat (5:8)*
>
> *KM 407 come with his brother and they did the activities together, it was not difficult for them to play together*
>
> *KM 407 played very well with puppet. He was the mother and telling the child to switch off TV because it's too late*
>
> *KM 407 – He was the smallest in the group and most of the time he did not want to do the activities and just wanted to play. He fought with other children in the group (Careworker observation)*

KM 407 experienced difficulties with the group activities as he was the youngest in the group and tried to escape the situation by playing. He also displayed external behaviour problems as a possible further indication of his inability to cope with the group activities.

He was exposed to food scarcity and that might have had an effect on his attention span. He showed he was unsure of who was part of his family and thus his support system. He did show improvement as the sessions progressed during the separate group sessions. His brother was a protective factor in KM 407's life as he was able to participate better with the brother's help.

Boy

> *KM 373 and **376** on their play told us what is going on at home. He said his friend does crime but he doesn't. They also said a parent must not beat you, but talk to you* (5:5)
>
> *KM 376 in his play uncle is abusing them. He beat his sister if there is no food if the mother is not around. The uncle is not working and the mother has to lock the food for him (5:5)*
>
> *KM 376 on his play includes abuse (emotionally) because he said his uncle is fighting against his father. His mother is seeking job because she is financially abused. The child is taking care of his sibling especially at school* (5:5)
>
> *KM 376 said he does not feel safe when he is with a policeman because the police have guns and they shoot people (5:8)*
>
> *KM 376, 350 and 373 said they feel unsafe with their uncles because they are drinking. They don't trust them. They trust their friends more than their uncle* (5:8)
>
> *KM 376 said if there is someone at home and he/she very sick, he will pray for him/her (5:9)*
>
> *KM 376 said he liked decisions and consequences because he learnt that everything you are doing you must expect the results (5:24)*
>
> *KM 376 – He was able to share with the group what happened at school. He was sometimes not himself because of the problems at home. He was a full time group member and participated fully. He made friends in the group and visited them at home (Careworker observation)*

KM 373 displayed exposure to poverty and abusive life circumstances. He described his uncle, who was supposed to protect him, as aggressive and he placed more trust in his friends more. The insecurity he experienced was amplified by his verbalisation that he did not even trust policemen. The police are generally seen as the safe keepers of a community.

The child indicated that he had to take the responsibly for the safety of his younger sibling although he experienced feeling unsafe himself. The child showed protective factors in that he was able to share with the group and he displayed positive religious coping skills. He made friends with the group members and utilised their support outside the group context. He further displayed resilience and a need for group support by attending all the support sessions.

Boy

KM 358 asked his mother to come and look what he did during the session (5:2)

KM 358 is shy and sometime withdraws himself from the group (5:4)

KM 358 is participating better in the group, I think it didn't go well last week because he walked far from school and it was very hot (5:5)

KM 407 and 358 were unable to draw there families. When doing 'people sorting' activity (5:3)

KM 358 – He is a shy boy and does not always take part in the group activities (Careworker observation)

KM 358 displayed a need for his mother's approval (or affection) and his inability to identify his family members were a further indication of his feeling of insecurity. The careworkers were able to identify internalised behaviour problems displayed by KM 358 but were subsequently (following session) able through observation to supply a plausible reason for this behaviour.

Boy

KM 399 cried when we ask him to spell and write. The group comforted him (5:5)

KM 399 said he is happy to play with his mother and he will ask his mother to do it again at home (5:15)

During the decorating of memory box KM 399 pasted 2 fathers and one mother and said he is having two dads (uncle and father) (5:18)

KM 399 brought cake because it was his birthday. We celebrated together (5:21)

KM 399 had tears in his eyes when Nemo's father tried to fight the men to save Nemo and group members comforted him (5:22)

20

> *KM 399 – He was the smallest in the group but he was competitive with them. He would do the activities and he will make sure about what he is doing is the best. He was always happy to be in the group and because his mother was always on his side. He would not hurt anybody (Careworker observation)*

The group supported KM 399 and he felt safe to share his emotions in the group. Although he was the youngest in the group he showed resilience in taking part and even being competitive in the group. He showed good communication skills. His positive relationship with his parents and uncle was a protective factor. KM 399 enjoyed the group sessions with his mother. His birthday was celebrated with the rest of the group that could indicate the established cohesion of the group.

Boy

> *KM **373** and 376 on their play told us what is going on at home. 373 include himself, police and friends. He said his friend does crime but he doesn't. They also said a parent must not beat you, but talk to you* (5:5)
>
> *KM 373 said he want to have one (gun). When asked about it he became shy and said not for his own family but another family KM 376, 350 and 373 said they feel unsafe with their uncles because they are drinking. They don't trust them. They trust their friends more than their uncle (5:8)*
>
> *KM 373 said he likes the whole group because they were able to play together and do activities together. He felt having his younger brothers in the group (5:14)*
>
> ***KM 373** was the mother saying why you came later from school, I am going to beat you (5:17)*
>
> *KM 373 said he liked don't talk to strangers game because our lives are very important and we must watch out on our ways.*
>
> *KM 373 said she is going to save money for her son so that he may go to University (5:23)*
>
> *KM 373 – He knew himself especially when talking about future dreams. If he missed session he will asked what we did in previous session. He was talking like an adult. If you put topic on floor he will be the first one to give idea. He was older than rest of group but he accommodated others. During joint sessions he participated well with mother, but was cross with her one day when she was late (Careworker observation)*

KM 373 felt unsafe in his family, specifically with his uncle. He explicitly indicated that he wanted a gun for protection, but he was able to discern this type of behaviour as negative. He was overly aware of his safety and the unsafe environment of his home was amplified in this overt expression. He expressed a need for communication and respect from his parents. He experienced the group as a supportive system and indicated that he enjoyed the group sessions to such an extent that he wanted his younger siblings to join in. He participated fully in the group and showed a high level of responsibility. The responsibility could be imposed on him at home because of his unstable family situation. Although the child showed a problematic relationship with his mother the sessions helped to improve the mother-child relationship. The future planning session (session 23) made the mother aware that she needed to take care of her son's future by saving money for a tertiary education.

Girl

> *I was impressed with **KM 467** when we asked them if they are ever dishonest she said that yes I sometime don't give my mom change when I am from the shops. What is good is that after hearing what happened to Peter bear because of cheating she promise to never be dishonest again (6:5)*
>
> *KM 467 said that she don't trust uncles because they are naughty. She said she was in the newspaper that uncle raped a child (6:8)*
>
> *KM 467 said she had lack of respect but now know she knows how. She learnt if from others in group (6:24)*
>
> *KM 467 – She was the leader of the group. She was helping where necessary. She wanted to do her work properly, she is neat and intelligent. She is always playing with her mother and the mother is happy with her because she supports the mother with everything (Careworker observation)*

The child displayed a range of protective behavioural attributes. She was able to learn from the sessions and to extrapolate the sessions to her personal life. She felt safe to share in the group. She showed leader capabilities, intelligent behaviour and supported other group members during the group sessions. Her relationship with her mother was playful and positive. Her mother communicated her appreciation for KM 467. KM 467 did however felt unsafe in the presence of her uncle. This insecurity could have been either personal experience or general insecurity as experienced reading reports of rape in the media.

22

Boy

> **KM 112** *in his family exercise he coloured his mother's face black and said it is because she is ugly (6:3)*
>
> *KM 112 said he didn't want to do feel thermometer (6:4)*
>
> *KM 112 – He needs to much attention and he disturbs the group, he does things that will make other children loose focus and he wants to do things is own way, if he does not want to do the activity he will withdraw himself form the group. He does not listen to his mother. He is sometimes aggressive and start fights with others (Careworker observation)*
>
> *KM 112 asked to go to the toilet and did not come back to the group. When we went to look for him he was sitting outside and said he was afraid of KM 441. That is far from the truth as KM441 is bullied by KM 112, he is lying (6:5)*
>
> *KM 441 and KM 112 during the previous sessions they were not getting along but this session they helped each other with picture cutting, when someone needed a picture the other will give them the picture. Definite improvement in KM 112 behaviour (6:6)*
>
> *After the body mapping KM 112 (better) and his mother were enjoying play with puppets and the child was doing what his mother do when they are at home and they were laughing about it (6:17)*

KM 112 displayed an array of external behaviour problems ranging from hyperactivity, lying to overt aggressive behaviour towards other children. He did not want to take part in the separate sessions but he showed improvement in the later separate sessions. The mother-child relationship also seemed problematic. The joint sessions were indicative of definite improvement in the child's behaviour and relationship with his mother. The mother and child were able to communicate with each other through the group platform.

Boy

> **KM 516** *cut Bible picture and said that he love to go to church. He also said he saw KM 492 at the same church (6:6)*
>
> *KM 516 said he is happy because his father attends church with them (6:10)*
>
> *KM 516 – He always gave an idea. If you don't understand him, he will explain until you do. He communicated well. The mother said his teacher was praising him after he joins the sessions because he improved. His bond with his mother looks very strong (Careworker observation)*

KM 515 displayed protective factors. He showed positive religious coping and a good relationship with both of his parents. Het communicated well in the group. KM 515's teacher indicated that she saw improvement in his behaviour after he joined the support sessions.

Girl

> *KM 492 said she don't want to participate at all .The problem is that her mother is not feeling well most of the time and she tells us that she is sad about it (6:8)*
>
> *KM 492 usually she is shy she does not say why she is happy. She will say just because she is, but today she said she was happy because she is going to play with her mother. She is looking forward to it, because they don't do it at home (6:15)*
>
> *KM 492 – She is a shy child and she won't give you answers when you need them. She will first smile at you and hide her face. She does not want to try during the group sessions even if she knows the answer (Careworker observation)*

KM 492 displayed internal behaviour problems and at times withdrew from the group. She was influenced by her mother's illness to a large extent and well aware of her mother's health status. She displayed anxiousness when her mother fell ill. She showed a longing for closeness with her mother and indicated that they do not play at home with each other. The group gave the child and mother the opportunity to play, communicate and to get to know each other.

Boy

> **KM 441** *is bullied by KM 112 (6:5)*
>
> *KM 441 and KM 112 during the previous sessions they were not getting along but this session they helped each other with picture cutting, when someone needed a picture the other will give them the picture (6:6)*
>
> *KM 441 was not respecting group rules he was making noise and he said he is not interested but the group asked him to go outside and he can come back when he is ready, he did so and came back to group (6:11)*
>
> *KM 441 said he wants to be professional soccer star and he already started. He also said he want to be a responsible man and father for his family when he grows up (6:23)*

> *KM 441 – At the beginning he was not communicating with others well. One day he tried to fight with one. During joint session he did very well. He was close to his mother (Careworker observation)*

KM 441 was the victim of bullying, but he showed resilience in playing with the bully in the following session. He acted out in one of the sessions, but he was able to acknowledge that he was in the wrong. The group as a whole acted as a rule keeper and kept the cohesion of the group in tact when they disciplined KM 441. KM 441 showed a positive future orientation in the following joint sessions. His behaviour showed improvement in the joint sessions with his mother who he had a good relationship with.

Girl

> *KM 453, KM 500 and KM 414 they came alone because their parents are working and they promised to come to every session without their parents because they enjoy being part of the group and the things we do here helped them even at school e.g. how to communicate with peers and talk about your feeling (6:13)*
>
> *It was good. They interacted with each other following instructions. They were able to share with us what makes them happy KM 453 said it is because her mom is healthy (6:21)*
>
> *KM 453 said if she gets lost she will call her mother because she knows her contact numbers. She was the one who told others that everything which is happening in Nemo we did in previous sessions e.g. she said we did don't talk to strangers and survival skills where we practiced household chores (6:22)*
>
> *KM 453 said she want to be a social worker she is aware that her mother save money for her for further studies. She said the reason is she wants to help family in need and children who don't have parents. She want to open centre for orphans and say thank you for God for protecting her on future path and keeping her mom healthy (6:23)*
>
> *KM 453 – She was participating and helping other children with activities when they have difficulties but she is shy and does not like talking a lot. She enjoyed coming to the group even if the mother was no longer coming (Careworker observation)*

KM 452 displayed resilience by participating in the group sessions alone. Her mother was working and could not attend the sessions. Although she was shy, she was able to share her emotions in the group and she enjoyed the support she received from her peers in the group.

KM 452 was able to learn from the group sessions and extrapolated skills learnt in previous sessions. She showed independence by attending the group sessions alone when her mother became ill. She was positive in her expectations of her future and indicated that she wanted to help others. KM 452 related her own happiness to her mother's health and showed positive religious coping. She displayed a good relationship with her mother.

Girl

KM 453, KM 500 and **KM 414** *they came alone because their parents are working and they promised to come to every session without their parents because they enjoy being part of the group and the things we do here helped them even at school e.g. how to communicate with peers and talk about your feeling (6:13)*
KM 414 – She is an active child and she can see if someone is not happy and she will ask that person what is wrong. She is always happy and enjoying the group. She also shares with the group what happened at home or school (Careworker observation)

KM 414 displayed a cheerful disposition and showed resilience by attending the sessions without her mother. She easily shared with the group her experiences and emotions. She was able to identify other's emotions and indicated that she enjoyed the group sessions. She utilised the group as a support system.

Boy

*When doing activity of safe place **KM 470** and 502 said they don't trust their uncles because they drink alcohol and smoke. They sometimes asked them to buy but these children refuse because at school taught them it is illegal for them to have alcohol and cigarettes (7:8)*
KM 470 did a very strange thing. She did not want to guide her child in planning future. She refused to. She is behaving like child herself and children walked over her (7:23)
KM 470 – He could not participate in the group properly because of the social needs at home. Most of the time there was not food at home and the only place he could get food was in the support groups (Careworker observation)

KM 407 experienced difficult life circumstances where there was food insecurity in his family. The group was able to provide food to him and his family during the sessions and food parcels were additionally given to the family.

The child indicated that he felt unsafe in the presence of his uncles and that he was pressurised buy them to take part in illegal activities. He was able to discern between right and wrong behaviour. The mother of KM 407 displayed inappropriate behaviour. The mother-child relationship was a risk factor for KM 407.

Boy

> *When doing masekitlana KM 412 and **502** refused to play it. KM 502 said he doesn't like swearing people and there is someone in his family who does and he does not want to mention his name (7:5)*
>
> *When doing activity of safe place KM 470 and 502 said they don't trust heir uncles because they drink alcohol and smoke. They sometimes asked them to buy but these children refuse because at school taught them it is illegal for them to have alcohol and cigarettes. 502 says he is afraid of his uncle, he threatens him (7:8)*
>
> *KM502 said he will eat his friend's food when he is asked to take care of them because he will be hungry (7:9)*
>
> *KM 502 said he can see his mother on her face if she is not happy, after that all agreed with him. They then try and make her happy. They don't feel happy if their mothers are not feeling happy (7:10)*
>
> *KM 502 – He was participating and trying to do best, but some times he was shy or sad because his mother was not nice to him (Careworker observation)*

KM 502 experienced difficulty in the 'masekitlana' session as he first refused to play it, but later he did play. He was afraid to play the game in case he shared his family or family 'secrets' with the rest of the group. He did however indicate that there was 'someone' in his family that swears at him. He indicated that he did not approve of this behaviour and wanted respect from this person (the possibility is that it was his mother). He expressed his need for food and the possibility existed that his family experienced food insecurity. The group did provide the family with food parcels. He felt unsafe in his family environment, specifically with his uncles who pressured and threatened him to take part in illegal activities. He was able to discern between right and wrong. Although he had difficulty with sharing in the group, he did share with the group in some instances. He did participate in the group, although he showed with internalised behaviour problems.

He expressed a need for a good relationship with his mother, but her behaviour towards him was very negative. The negative mother-child behaviour could be indicative of the child's internalised behaviour problems he displayed.

Boy

> **KM 419** *said he never failed his exams/ tests if the know that he is going to write he practice. They said their mothers and brothers helped them with their home work (7:5)*
>
> *KM 419 said he is happy to be in the group because he can learn at the group in a very calm place. They say it is not like school and they like the fun atmosphere (7:5)*
>
> *KM 419 said he tell/share with his mother. He also brings homework we gave them last week. The mother's message was "he is meaningful and supportive to me". He read it to group and said he loves his mother (7:7)*
>
> *KM 419 said if there is someone in the family like your mother, very sick, he will pray for her and accompany her to hospital (7:10)*
>
> *KM 419 drew breasts of mother on emotion drawing and said he put breasts because he didn't drew face only, he drew the whole body. He said he put breasts because it is picture of mother (7:21)*
>
> *KM 419 –He was not shy but sometimes he was quiet and we could not understand what is wrong with him because when you asked him he will tell you he is fine and nothing wrong (Careworker observation)*

KM 419 showed with a range of protective resilience factors. He displayed a positive attitude and responsibility towards his school work and he did the homework given to him during the group sessions. He displayed a positive relationship with his mother and experienced her as supportive. The mother overtly expressed her love and support for her child. He displayed positive religious coping skills. He experienced the group sessions as fun and a place that was calm (in contrast with the school atmosphere and possible anxiety experienced at home because of his mother's illness). He did show with some degree of internalised behaviour problems when he sometimes withdrew from the group. He expressed awareness of his mother being ill. His drawing that included his mother's breasts could be indicative of an over-dependency (nurturing indication) on his mother or an anxiousness of losing her in reference to his knowledge of his mother's illness.

Boy

> *KM **491** when asked what he will do when our food is finished on the island he said he is going to kill himself because he is afraid of hunger (7:12)*
>
> *KM 491 said he want to be careworker's body guard when he grows up (7:14)*
>
> *KM 491 said he is happy to be in the group because they are not fighting here they play together and they are friends (7:15)*
>
> *During the decoration of the memory box most of the children decorated their box on things they wish to have, some they don't have enough food and they pasted their boxes with food (7:18)*
>
> *KM 491 refused to mix clay, when asked why he said that I am a boy and I can't touch girls stuff. But when his mother finished mixing, he wanted to play with it and enjoyed it. Saying I didn't believe it will be like this and his mother laughed. They played and enjoyed it (7:20)*
>
> *KM 491 – Has a good relationship with his mom and he had his own ideas. He worked well in the group with the other children (Careworker observation)*

KM 491 indicated a food scarcity at his home. The group was able to provide food parcels to the family. He experienced the group as positive where he can get support from friends. He saw the group as a peaceful place where he is accepted and he showed affection toward the careworkers. The child showed that he had definite ideas what was acceptable as activities for the different genders, but he showed flexibly in his willingness to partake in the activity which he originally equated with a girl's activity. The joint sessions presented a situation where the mother and child could bond and communicate.

Girl

> *KM **504** did not want to mime or act. She was shy but the group did not force her to do he activity and said to her she can do it in her own time if she feels ready (7:11)*
>
> *KM 504 – She was very shy; she could not share her feelings with the group. She will keep quiet and give a smile. She knew the answers, but didn't speak up in the group (Careworker observation)*
>
> *KM 504 improved a lot. She was very shy during children sessions, but now she is playing and talking with her mother and other group members. She is like a new person (7:19)*

KM 504 showed improvement in her communication skills and willingness to share her emotions. The group gave her the opportunity to practice her skills and did not pressurise her in doing an activity which she did not feel comfortable with. The careworkers monitored her behaviour closely.

Boy

> **KM 329** *and 419 their story with puppet play was playing in the park and other start to fight with him and he reminds the child about the Kgolo Mmogo room rules. He also told him what we must behave the same, if we are at home and at school (7:7)*
>
> *KM 329 said he didn't respect his father as Nemo is not listening to his father, he does respect his mother and listen when she talks to him (7:22)*
>
> *KM 329 mother is deciding for her son what to do, the child has no say, he has to agree with the mother. She did the collage and future path herself. The child was not happy (7:23)*
>
> *KM 329 had tears in his eyes and he said this place made him laugh and enjoy playing so the will no one to play with at home because his mother does not allow him to play with other kids (7:24)*
>
> *KM 329 – He participated and he knew how to answer the questions. His problem is that his mother is overprotective. She does not allow him to make friends at home. She thinks he will get out of control. He only had friends in the group (Careworker observation)*

KM 329 indicated that he could extrapolate the group rules he learnt in session 1 to a real life scenario. He showed he had respect for his parents. He participated well in the group and he specifically appreciated the opportunity of making friends, having the company of peers and getting support from the group. KM 329's mother did not allow her son to have friends as she was overprotective of him. She did not take her son's plans for the future in consideration and decided for the boy. The group gave the boy an opportunity to make friends, but also to share his feelings of unhappiness with his mother. KM 329 was able to voice his unhappiness about his mother's over-protectiveness and her tendency of taking decisions for him without taking him in consideration. The group empowered him.

Boy

> *When doing masekitlana **KM 412** and 502 refused to play it. KM 412 said he doesn't want to talk about his family. We gave him chance to play by himself and saw how he threw the stones hard on the floor (7:5)*
>
> *KM 412 have missed a lot of sessions , but after playing with his mom he said this type of sessions he will never miss .He liked it so much to play with his mom (7:15)*
>
> *KM 412 – He was not interested to be in the group. He will not come to the group and told his mothers he wants to play with his friends. He only enjoyed the group after the joint sessions started (Careworker observation)*

KM 412 expressed an inability to speak about his family in front of the group. The facilitators accommodated his behaviour and gave him a change to play by himself. The facilitators did however observed that the boy showed forceful behaviour when he depicted his family with the stones game. The 'masekitlana'-game facilitated his ability to express his emotions regarding his family in a non-verbal manner. The child did not want share his feelings or take part in the separate sessions, but he enjoyed the joint sessions with his mother. The group gave him an opportunity to play and communicate with his mother.

Boy

> *KM **434** said he is sad and angry when his mother is sick, but he will pray for her and ask her to go the doctor (7:10)*
>
> *KM 434 said she is happy because her son was very shy at the beginning but now he can share with others even at home. Every mother child pair exchanged contact details to contact each other (7:24)*
>
> *KM 434 – At first he was very shy but when time goes by he became alright especially during joint session. His mother told us that he is now free to confront her if he wants something. At the end he was comfortable to share in front of the group members (Careworker observation)*

KM 434's communication skills improved after attending the group sessions. He specifically showed improvement in the joint sessions with his mother. The mother expressed her gratitude to the group for helping her child to communicate.

She mentioned that he did not just show improvement in the group, but he also showed improvement at home. KM 434 was aware that his mother is ill and he was able to describe his emotions as anger. In relation to his mother's illness he showed positive religious copings skills.

Girl

> **KM 561** *said with feeling thermometer she is not happy, because one child at school beats her. The group encouraged her to go to the teacher and talk about it (8:1)*
>
> *KM 561 said she want to be a nurse. And she also said she remind her mother to take her medication every day, she needs her medication every day otherwise she will become ill (8:10)*
>
> *KM 561 was old self after last week. Mother was ill, but better now (8:10)*
>
> *KM 561 – During separation, sometimes had a fear to answer question were as she knew. When goes on she was always participated well and if she don't know she tell you. During joint session she did well with her mother. She was a soft speaker (Careworker observation)*

KM 561 was able to share her emotions and experiences with the group. The group was able to support and give her guidelines how to deal with a bullying situation. Her choice of a future path was in direct relation to her experience of her mother's illness. She helped her mother in reminding her to take her pills everyday. This responsibility may have had an effect on her emotionally (anxiety). She might have felt a responsibility towards her mother to remind her to take her pills every day which is a immense responsibility for a child. The child showed in her behaviour how she experienced her mother's illness. If her mother felt better, she felt better and *vice versa*. Protective factors could have been her positive relationship with her mother and the support of the group she received.

Girl

> **KM 545** *said she likes her family because they pray together and go to outing together. They love each other (8:6)*
>
> *With role play KM 545 and 576 said their father got accident with his car, he called his wife to call ambulance and informed her we he is. When the mother inform their child she cried a lot thinking that her father will die (8:7)*

> *KM 545 said the story of hyena, lion, taught her to be like tortoise, helping each other because it's important. (8:14)*
>
> *KM 545 said if I get lost I will make a plan to survive and use skills I learnt. KM 545 said if I get lost I will call my mom because I now know her contact details (8:22)*
>
> *KM 522 and 545 they knew in order to be a successful person you must not have children first and have finished your studies (8:23)*
>
> *KM 545 – is a child that showed good behaviour in the group, always helped the other children and we didn't have any problems with her (Careworker observation)*

Protective factors in KM 545's life are her good relationship with her family, their support for each other and her positive religious coping skills. The child displayed helping skills and she was able to extrapolate the skills she learnt in the sessions to real life scenarios. She showed with life skills and a positive outlook on the future.

Girl

> **KM 576** *said she feels special because her mom brought her to the group (8:4)*
>
> *KM 576 said it is wrong because you can be thief for rest of life (8:9)*
>
> *KM 576 said that she learnt that strangers are both men and women. They said it is important to come to group, because it is fun and you learn important things (8:14)*
>
> *KM 576 said we must be safe (8:22)*
>
> *KM 576 said she want to be a teacher and have lovely family. She also said she want to do small agricultural because she want to have sheep so that her family will not suffer and they will not have to buy meat from butcher (8:23)*
>
> *KM 576 – During discussion she sometimes disagree with others decisions. She did very well. She always has an answer for each question. During joint sessions she did well with her mother but sometimes she wanted her mother to listen to her. She was very intelligent and was always smiling. She always seems happy and she has lover for other children, and the relationship with her mother was strong. During the joint sessions her and her mother made the group laugh (Careworker observation)*

KM 576 showed with a cheerful disposition and the facilitators described her behaviour as intelligent. She felt comfortable enough in the group to challenge the opinions of other group members and displayed good communication skills.

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The child was able to express her emotions in the group and was able to differentiate between adaptive and non-adaptive behaviour. She experienced the group as a place where she could learn as well as a place where she could have fun. She displayed appropriate life skills and a positive outlook on the future. She had a definite workable plan for taking care of her family in the future. She had a good relationship with her mother (protective factor).

Boy

> *KM **570** and 536 said sometimes they take their mother/father's change after buying something for them (8:9)*
>
> *KM 570 was playing with his brother because their mother was not feeling well and he looked a bit sad (8:16)*
>
> *KM 570 was not very active in the group and he was very shy and sometime he was afraid to take part in the group. When his younger brother came along with KM 570 and he started to be better and he seems very happy and the relations with his mother were good (Careworker observation)*

KM 570 displayed internalised behaviour problems and withdrew from the group. He did however felt save enough in the group to share a negative situation with the group where he took his parent's change without permission. He was aware of his mother not feeling well and that had an impact on his behaviour. A protective factor for KM 570 is his good relationship with his mother and brother.

Boy

> *KM **580** usually says minimum, but this session he is participating very good. He was also able to relate story to others (8:9)*
>
> *KM 580 said he doesn't like to sing, he is bored with Happy song (8:10)*
>
> *When doing broken telephone KM 580 was very playful and passed the incorrect message. The group members asked him to be serious and after that he listened well and were able to pass the correct message (8:11)*
>
> *KM 580 said he didn't enjoy body mapping and I think maybe there was no communication between him and mom (8:16)*
>
> *KM580 said that he has nothing to do with his father's family, because he doesn't love them (8:19)*

> *I was surprised about KM 580 by telling us that he wants to go to mountains for circumcision in order for him to become a man and have 10 children (8:23)*
>
> *KM 580 –At first this child was not participating in the group, he was very quiet and little bit shy and after being in the group and he was now the one who was giving answers, especially when we were doing story telling and he was the youngest of all the children in the group and the relationship with her mother was very good. Most of the time he came early to the group and his mother joined the group later (Careworker observation)*

KM 580 was the youngest in the group and that had an impact that he did not take part in the group in the beginning sessions. He only started to take part in session 9 ('socialising with peers' – session). In certain of the activities he showed with inattention and hyperactivity. The group accommodated his behaviour but also guided him to display better behaviour. He expressed a disliking in the bodymap activity with his mother, but the mother-child relationship showed generally to be a protective factor in the child's life. He showed life skills and independent behaviour when he used transport by himself to attend the group sessions directly after school. He showed punctuality. He experienced his father's family as negative. He indicated that he wanted to be circumcised according to cultural traditions and hereby he declared his independence. This wish could have been in reaction to his experience of being the youngest in the group.

Boy

> **KM 539** *said if there is someone sick in the family, he will ask her what she needs (8:8)*
>
> *KM 539 said he will kill himself on island and the food is finished. The will kill himself before hungers kills him (8:12)*
>
> *KM 539 – At first he was shy, when you asked him a question he will just say: "I don't know" from session 5 he changed, no more shyness, he started participating well. During joint sessions he was closer to careworkers than to mother. Sometimes didn't want to go on with activities with mother but after encouragement he did. What I liked in session 24 when we asked them what they learnt he said "I like don't talk to strangers and I learnt I must not play at street until late because it is not a good thing, it is dangerous" (Careworker observation)*

KM 539 displayed a possible food scarcity in his family and the group provided the family with food parcels. He indicated that he was aware of illness in his family and immediately personalised the gender of the ill person he referred to as female. He showed internalised behaviour problems in the beginning of the separate sessions and withdrew from the group. In session 5 ('identify own strengths') his behaviour changed and he took part in the group. He experienced his relationship with his mother as negative and rather wanted to work with the careworkers in the group. He showed life skills and were able to extrapolate the skills he learnt in previous sessions to his current situation.

Boy

> *KM 552 says his mom cry over 'a secret', she is ill (8:15)*
>
> *KM 552 said he want to be soccer star and have thousands. He also said he will go to UNISA and study business skills, commercial science to do business well (8:23)*
>
> *KM 552- He used to come alone to the group without his mother due to family problems. But towards joint sessions the child started to come with his mother. He was always participating (Careworker observation)*
>
> *KM 552 – He was intelligent boy. He participated well during activities. At first session he was attending he was talking English and we asked him to speak in Sotho language that others can understand. During joint session he communicated well with his mother when she came to group, sometimes he wanted to control his mother (Careworker observation)*

KM 552 was aware that his mother was ill and he was also aware that he must keep her illness a secret. A burden of secretiveness was placed on him. He participated well in the group despite problems he experienced in his family and for a long period he attended the group without his mother. He did however show a positive relationship with his mother when she attended some of the sessions. He showed adaptive behaviour, a positive future orientation and intelligent behaviour. These are all protective factors for KM 552.

Boy

KM **525** is a very intelligent guy, he has a very good reasoning capacity and he is very open and not shy (9:1)

KM 525 was the leader in discussing the feeling good quilt (9:2).

KM 525 says teacher you were honest when saying there will be more than us two attending this week (9:2)

KM 525 identified his asset as a clinic next to his house (9:3)

KM 525, 590 and 637 said they don't trust their uncles because they drink alcohol and sometimes asked them to go and buy cigarettes and alcohol and that is illegal (9:8)

KM 525 said he is unhappy because his teacher punished him because he didn't do homework but he blamed himself (9:9)

KM 525 says he is happy on feeling thermometer because he did his home work this week (9:10)

KM 525 said he wishes that illegal businesses must be stopped because some people don't have future because of that. He gave example of drug sellers (9:10)

KM 525 helped a lot in the session and helped to make tea for everyone (9:12)

KM 525 missed to play with his mother and sometimes she is not able to as she is physically disabled, but this made the boy unhappy, but we careworkers assisted him (9:16)

KM 525 said he say thank you so much because he was not aware of this strengths but now he is sure about it (9:24)

KM 525 and 550 brought their photos while still babies and Baptist certificates. KM 525 brought photos (9:24)

KM 525 put his name on a sad face, he said he is sad the group is ending and he wishes the group can go on (9:24)

KM 525 always participate in the group sometimes help smaller ones to say something. If you ask him question he gave you more than you wanted. He was always neat. During joint session he did very well with his mother. Their bond was very strong. You could see that even at home their bond and relationship was good (Careworker observation)

KM 525's behaviour was described by the facilitators as intelligent. He displayed good reasoning in the group and leadership skills. He showed adaptive behaviour skills by indicating that he wants to do well in school; he took responsibility for his own behaviour and he easily shared his emotions with the group members.

He displayed good morality and he could distinguish between right and wrong behaviour. He did however display apprehension when referring to his uncle. He experienced his uncle a negative influence in his life. He experienced his mother's disability as difficult, but he was able to cope with the situation. He played well with the careworkers in situations where his mother could not physically take part in some of the activities. KM 525 and his mother displayed a positive relationship and they communicated well with one another (protective factor). KM 525 enjoyed the group sessions and indicted he wanted to continue with the group sessions.

Girl

> **KM 590** – *She was interested in the group. Her mother was working and she came alone. She participated well during the separate sessions. During the joint sessions she did well with the careworkers. Sometimes her mother came from work and the communication was good. The child showed aggressive behaviour in the separate sessions (early sessions) (Careworker observation)*
>
> *KM 590 said we must respect our parents when they asked us to help them (9:5)*
>
> *KM 525, 590 and 637 said they don't trust their uncles because they drink alcohol and sometimes asked them to go and buy cigarettes and alcohol and that is illegal (9:8)*

KM 590 displayed externalised behaviour problems in some of the separate sessions and she indicated that she did not trust her uncles. She disliked the situation where they expected her to engage in illegal behaviour. She was able to distinguish between right and wrong. KM 590 showed resilience in attending the group sessions without her mother.

Girl

> **KM 637** – *She was smaller girl than others. She always was laughing even if you ask her questions. Her mom missed a lot of sessions, because she gave birth in the middle of the sessions. She kept attending the session with another mother of the group. She participated well when her mother joined the sessions again. She was playful and very naughty (Careworker observation)*
>
> *KM 637 is very busy in the group and she is disturbing the group with difficult behaviour (10:4)*
>
> *She is doing much better with her mother and she is not so disturbing in the group (10: 20)*

KM 637 displayed behaviour that is associated with a younger child. She exhibited regressive behaviour when her mother gave birth to a new baby, but showed improvement when her mother re-joined the group. KM 637 showed positive behaviour in attending the group with another mother.

Boy

> *KM 567 said in masekitlana play that the father who didn't give the mother money to buy something to eat. When he come back he was complaining because they give him pap and water and they inform him that it's because nothing he leave when he goes to work. Father was swearing and they were afraid (8:5)*
>
> *KM 567 said he don't trust uncles because his uncle is drinking alcohol and thereafter disrespect others. He also said he will not be safe if she is with his uncle only (8:8)*
>
> *KM 567 said he liked lion because he did revenge to his friend and if he was lion he would also do that (8:9)*
>
> *KM 567 – very quiet and he seems anxious in the group (Careworker observation)*
>
> KM 567 said he does not like being a police man because policeman is being killed in the community, he wants to be a doctor to help those who are shot (8:14)

KM 567 verbalised his fear for his father and uncle figures in his life. He displayed internalised behaviour problems (anxiousness) and was not very active in the group. His anxiousness was further amplified by his reference to policemen that are killed and his feeling of unsafety transpired in the behaviour he showed in the group.

Boy

> *KM 526 – He participated well during separation sessions when you asked questions he was always the first one to give an answer. He usually came alone or accompanied by his father because his mother was working, she sometimes came late after work. He was happy and worked well in the group. He worked well with the facilitators if his mother was not in the group (Careworker observation)*
>
> *KM 526 during the future train activity. He was enjoying the activity and he was living the dream because after the activity he encouraged other to talk about their future dreams and also asked advice fro the parents on which subject he needs to take in school (9:14)*

> *KM 526 said when he grow he want to be a doctor and he is going to marry and live together with her granny and his mother must go to the old age centre (9:23)*

The child participated well during the group and showed adaptive behaviour by participating in the group even though his mother could not attend the group on a regular basis. His father showed commitment in bringing him to the group. KM 526 showed adaptive behaviour during the separate sessions but also accommodated the careworkers during the joint sessions when his mother could not attend the sessions. He displayed a cheerful disposition during the group sessions. He showed a positive future orientation and he asked for help from adults to attain his goals. The 'future train' exercise facilitated the child's discussion and questions regarding his future plans. He did show a positive relationship with his grandmother, but experienced his mother's absence as negative.

Boy

> **KM 648** *because it is a cool guy when coming to answering he is quick. He said he enjoyed a lot and wish he could be here until midnight (10:1)*
>
> *KM 648 is the leader of the group. He said he was happy because it was his birthday (10:2)*
>
> *KM 648 when doing family exercise he drew his mother acting showing with an arrow that this is my daughter and this is my husband (10:3)*
>
> *KM 648 is very active in terms of participation and volunteer to lead the game e.g. being the sun (10:4) He said it felt good to be the sun, he enjoyed seeing the other children fall into the*
>
> *He takes his anger by doing gardening and after that he feels better (Careworker observation)*
>
> *KM 648 is still on top of the group, he can always give a different and suitable answer. When feeling thermometer he said he is happy, because he has finished writing his exams. He is the leader of the group. He said he doesn't like pink because it is for girls (10:4)*
>
> *He spoke about his shot-put and discus medals he won (10:5)*
>
> *He says the husband is always drunk and comes home very late (10:5)*
>
> *KM 648 told a story of a father who goes to work and goes to the beer drinking after being payed he drinks the money and comes home late and shouts for the mother to open the door, after demanding food and when the mother gives him pap he demands meat and beat her. All the stories talked about aggression and scolding (10:5)*
>
> *KM 648 said that uncles can rape children (10:8)*

> *KM 648 said if there is someone special at home and very sick, he will tell him/her that he will be healed and he will also ask him/her what s/he wants (10:10)*
>
> *KM 648 says that he works and works very hard when he is angry (10:10)*
>
> *KM 648 he wants to be a pilot, in terms of being a pilot he said that he must first pass matric and include the following subjects: social sciences and mathematics. (10:14)*
>
> *He won balloon popping and he was very happy telling the other winner that he is also a winner (10:15)*
>
> *KM 648 you can see mother and child communicate well (10:16)*
>
> *KM 648 – This boy was suffering from the swollen feet, but always attending the group. His feet were on and off, and when it hurts he had difficulty in moving. But he was concentrating in the group and was one of our best members in group. And they come from Zimbabwe but that didn't bother him because he can communicate very well in Sotho. He always does his homework and when you ask him a question he always answers a good one. And the relationship with the mother was very strong. The mother was always supportive when the child was in pain (Careworker observation)*

KM 648 showed with a physical problem but he was not discouraged to take part in the group sessions. He even took part in sports despite the physical pain he experienced. He displayed leadership skills and the other children put trust in him. His quick and accurate responses in the group were indicative of intelligent behaviour. He shared his emotions and experiences with the group. He showed with positive problemsolving skills where he indicated that he coped with anger by working hard. He showed good communication skills. He verbalised his negative experience of the father figure in his life and he also indicated that he is afraid of 'uncles that could rape children'. He illustrated good life skills, a positive future orientation and compassion with other people who are ill. The good mother-mother child relationship between KM 648 and his mother is a further protective factor in this child's life. The children in the group accommodated KM 648 illness and also his culture which was not South African.

Boy

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*KM **679**- The child had previous health problem, the mother said he was hit by a car and that makes that the child is slow in the group (Careworker observation)*

KM 679 said "I felt like I was alone and dizzy, but I enjoyed". He said "I felt like suffocating in the dark" (10:1)

KM 679 said that when he is afraid or scared he will tell his mom and he feels safe when mom is there to protect him (10:2)

KM 679 was not happy about his copy because KM 648 didn't draw him nicely. He said he will not take his copy home, because they will laugh at him because it is not beautiful (10:3)

KM 679 has difficulty in maths homework and asks KM 648 to help him (10:6)

KM 679 said sibling makes him angry because he wakes up early in the morning and makes noise (10:6)

KM 679, 630 and 602 their story was about child who invited her friends to home and they stole some food and when mother and father came back form work they went to friend's homes and demand their food and they gave them money. They were doing crime, housebreaking at he shops stole money and got arrested – role play (10:7)

Most children said they do not trust their uncles. KM 679 said that their uncles beat them when drunk (10:8)

KM 679 said if someone did something wrong e.g. beating him he do revenge. He said he like to fight. He also said he is like "Lion in the story because lion kicked hyena and vulture" (10:9)

KM 679 says he watches TV or fight when he is angry (10:10)

KM 679 said that while he was in the future train he was going to Boksburg seeing dog chasing hare. He also said he likes revenge (10:14)

KM 679's mother said to son colour red to her means the blood of her son, because her son likes fighting (10:20)

KM 679 said he was not happy because they will not come to the group anymore to be able to go on learning the good things from the group (10:24)

KM 679 was always early. He usually gives answer when you asked. He played well with the other children. During joint he did activities well some with his mother. They communicated with each other and developed a strong bond (Careworker observation)

KM 679 displayed an intellectual disability because of an accident he was involved in. The group accommodated his behaviour. He verbalised an inclination for showing external behaviour problems where he wanted to fight and take revenge as he described it in the group. The mother indicated that KM 679 was prone to fighting. He was additionally exposed to violence when he accompanied his family to an illegal dog race. He did display a low impulse control but he showed adaptive behaviour in not being involved in any physical altercations in the group. He was able to vent his feelings and the careworkers were instrumental in helping this child to deal with his emotions. The child showed fear for his uncles and indicated that they beat him. He felt safe with his mother and they displayed a good mother-child relationship (protective factor). The group was positively experienced by KM 679 and he indicated that he learnt new things in the group.

Girl

> **KM 616** – *The child seems unhappy and she was always quiet and sometimes when we ask her questions you could see that her mind was far away. And she had that fear and most of the time she was not participating well in the group, she was always quiet but the relationship with her mother was very good (Careworker observation)*
> *KM 616 said she loves her grandmother because she takes care of them (10:3).*
> *KM 616 says she is scared of her uncle because he raped her (10:8). Child was referred KM 616 was very quiet and did not participate well (10:22)*

KM 616 displayed internalised behaviour problems. She showed an inability to concentrate and escaped to her a world of her own. She showed anxiousness in her behaviour in the group and did not participate well in the group. She displayed a good relationship with her grandmother and with her mother (protective factor). A risk factor for KM 616 is her fear for her uncle that raped her and the sexual assault in itself. She had not received any counselling before the group started. She was referred to a therapist at an outside agency.

Girl

> *KM **630** refuse to be in the middle and said she is afraid of falling down (lack of trust) (10:2)*
>
> *When playing balloon popping I liked the way KM 630 protected herself because the mother concentrated on only to pop the others balloons forgetting to protect her own child (10:15)*
>
> *KM 630 first refused to draw her child. She was not confident to do that (10:17)*
>
> *KM 630 pasted a very beautiful linen for her moms special bedroom, and you could see how she makes her mom proud (10:18)*
>
> *KM 630 – asked her mother to write down her favourite song and she didn't and the girl started to cry and I comforted her and help her writing it and thereafter she sang for us and her mother was embarrassed (10:19)*
>
> *KM 630 feeling bored because her mother was not communicating with her about their emotion faces that their children drawn. It was sad to the children (10:21)*
>
> *KM 630 and 622 were feeling left out because their mothers were not communicating with them. The mothers doesn't look energetic (10:21)*
>
> *KM 630 – The child was very innocent and she is very clever, she was always smiling and is not a talkative somebody, she is sweet and nice and she was always giving us answers when we ask her. Her relationship with her mother was not that good, because most of the time during join session her mother was not interested in playing with her, but the child did everything the facilitator was doing. She was always early in the group. When the mother didn't want to participate in the joint session, she didn't give up. She always went to the careworker saying come and help me (Careworker observation)*

The child displayed a positive attitude towards life in general and her mother. She showed positive coping skills in asking the careworkers for help when her mother did not want to participate in the group activities. Her mother displayed negative behaviour towards the child (the mother might have felt ill during the session). The child was not deterred by her mother's negative attitude. The facilitators experienced KM 630 as a likeable child and displaying intelligent behaviour.

Girl

> **KM 602** *was able to say that her mom is the one that make her feel better because she put him on lap and told him that he was special. She also said that her mom makes her to feel special because she always compliments her for doing duties at home. She also happy she makes new friends in group (10:4)*
>
> *After reading the story of the little hare KM 602 said her mother told her that she is special especially when she asked her to buy something at the shop and she choose the correct things (10:4)*
>
> *KM 602 said she has lot of friends and if one of them beat her, she turn to others and play with them (10:9)*
>
> *KM 602 was not her best, she was sucking her thumb and not concentrating very well (10:11)*
>
> *KM 602 I am not happy about KM 602 she is still not participating well (10:13)*
>
> *KM 602 participation dropped and worried about her (10:14)*
>
> *KM 602 and her mother did not communicate well (10:16)*
>
> *KM 602 was very much happy to play with her mom but her mom disappointed her because she didn't want to do the activities with saying that she is lazy and painting will make her dirty (10:16)*
>
> *KM 602 – She is an intelligent girl. She always participated in the group when you ask questions. She always told us what they did at school; she shows us her books and reports. During the joint sessions her mother sometimes was not interested but the girl didn't give up, if she need help, she comes to one of the facilitators and asks help (Careworker observation)*
>
> KM 602 - *This child was active in the group, every time when we ask question she was the first one to raise her hand. And she was always explaining or sharing to us about the things she did at school (Careworker observation)*

KM 602 displayed a range of protective behaviours. Her behaviour was described by the facilitators as intelligent. She did well in school and brought her books and reports to the group. A protective factor in this child's life is the child's tenacity and her problem solving skills. Her mother did complement her, but in the joint group sessions the mother did not want to take part in the activities with her daughter saying that *"the painting will make her dirty"*. The child showed adaptive behaviour in asking one of the careworkers to help her with the activities.

KM 602 did display internalised behaviour problems (attention problems, thumb sucking, and withdrawal from group) in some of the joint sessions when the mother was not willing to take part in the activities.

Girl

> **KM 699** *comes to group with careworker, mother passed away during group sessions. She told careworkers that her mother passed away.*
>
> KM 699 *she is a very hyperactive child and sometimes she was little bit problematic not listening to the facilitator. She was older than all the girls but act like 6yrs old child. She will just keep quiet. Most of the time she was too playful. Her mother passed away during the group. The sister came along with and assists her during joint session (Careworker observation)*

KM 699's mother passed away while they were still attending the group sessions. The child displayed internalised behaviour problems when her mother passed away. She showed hyperactivity, attention problems and acted younger than what was expected from her age. The child showed resilience in attending the group sessions with her sister even though her mother passed away. Her sister, the careworkers and the group were protective of her. The group gave support and structure to a child's whose life was irrevocably changed by the loss of her mother.

Boy

> **KM 660** – *He was very talkative boy and sometimes overactive. He liked jokes even if we do serious activity he sometimes just stand up and start dancing (Careworker observation)*
>
> KM 660 *said if his friends brought lunch boxes they all open and share together. Team spirit. KM 660 was honest saying he associated himself with lion because sometimes his friends tease him and he do revenge (9:11)*

KM 660 displayed hyperactivity and inappropriate behaviour in the group. He showed honesty in his association with the lion character and he could identify with the story. The story facilitated an opportunity for him to communicate in the group and to share with the group members.

Boy

> **KM 193** *was not feeling good, because he said he had been circumcised and he just wants to sit (12:2)*
>
> *During ice breaker 'the den' KM 193 said he don't trust his uncle because all uncles are naughty, they abuse children. He doesn't feel safe with him (12:8)*
>
> *KM 193 says he fears most of all that if his mother gets sick or if she can pass away that is his biggest fear. He said he can't live without her (12:10)*
>
> *KM 193 says he applies group rules outside at home and at school and he also taught others to behave good (12:14)*
>
> *Last week KM 193 said he won't help his friends because they also don't help him. After saying he want to be a doctor I asked him why and he said he want to help sick people. He is taking out his anger on other children while mother is sick (12:23)*
>
> KM 193 – *This boy is very serious person and he don't talk much unless you question him and he is very good child and he never gives us a problem. He loves her mother very much, they are always smiling and communicating and they always come together (Careworker observation)*

The child adhered to the cultural tradition of circumcision. He showed adaptive behaviour in attending the group although he underwent circumcision and culturally he was now seen as an adult. KM 193 expressed fear for his uncle and said that 'all' uncles abuse children. 'The Den'-exercise facilitated this disclosure. He showed awareness of the possibility that his mother might become ill and that she could pass away. He shared his anxiety with the group. He verbalised that he was able to extrapolate the group rules to other situations outside the group. He displayed internal and external behaviour problems in certain sessions (mother was ill during these sessions) that might be ascribed to his mother's illness during these sessions. He displayed a positive attitude, a positive future orientation and a good relationship with his mother when she attended the sessions. He indicated he wanted to be a doctor in order to help sick people.

Boy

> **KM 719** *also said he love his mom so much and the think he can't survive without his mom (12:3)*
>
> *KM 719 mother said they are happy because they now are able to talk to their children with love and understanding (12:24)*
>
> *KM 719 – He was the youngest in the group. They accommodated him in the group. He was always smiling when you speak to him. Sometimes his intention was to play not doing activities. During joint session we thought he will not co-operate but he communicated well with his mother (Careworker observation)*

KM 719 displayed a cheerful disposition. As the youngest in the group he received support from the other group members. He displayed playful behaviour when he perceived some of the activities of the sessions as too difficult. He did however display improvement in the joint sessions where he did activities with his mother. KM 719's positive relationship with his mother is a protective factor for him. His mother indicated that the joint sessions taught her how to communicate with her child.

Boy

> **KM 707** *drew only his grandmother who passed away and said "I love her even if she is dead because she took care of me" (12:3)*
>
> *KM 707 was not himself yesterday even when filling the thermometer, he put his name on the unhappy face, when we asked him what makes him unhappy he was biting his finger nails and said I don't know. And he participated only on the ship exercise and goes outside to be with his brother. We didn't force him to come back. KM 707 looks unhappy and he came with his brother because his mother is sick (12:12)*
>
> KM 707 – *Some of the times this child didn't want to participate and he will keep quiet until we finish the session. And he skipped lot of sessions because the mother was not feeling well. And he also had a reading problem and was very shy, and he was some other time where he is very shy, and he was some other time where he comes with his brother. And his mother did not finish the session, the child attended (Careworker observation)*

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KM 707 displayed internalised behaviour problems. He shared his loss of his grandmother with the group. He showed anxiousness and he experienced more anxious behaviour when his mother was ill. The child did however display resilience in attending the sessions when his mother could not attend because of illness. KM 707 could have experienced the group as a support system (and a place to escape) when attended the sessions without his mother. A protective factor for KM 707 was his relationship with his brother.

Boy

> ***KM 71**3 said he is not happy because other child was hit by a car next to his home and they took him to the hospital (12:13)*
>
> *KM 713 didn't include mom but uncle in his family picture (12:18)*
>
> *KM 713 – He is very intelligent and he usually takes care of siblings before the group starts. He participated very well in the group. He usually gave the answers when asking questions. He was very cooperative and he liked discussing better than writing and drawing. During the joint session he did well with his mother (Careworker observation)*

KM 713 was able to express his emotions in the group when he was exposed to a traumatic life event (child was hit by a car and KM 713 saw the accident). He fully participated in the group and the facilitators described his behaviour as intelligent. At first he did not include his mother and rather his uncle on a family drawing but as the joint session progressed he showed with a good relationship with his mother.

Girl

> ***KM 168** was complaining about neighbours who usually ask money though her mom is not working. Their neighbours said "you don't want to borrow us money and we know you are getting support grants". She says it makes her worry a lot (12:5)*
>
> *KM 168 child talk like the mother with puppet sock and said "I will beat you to bits if you do not do the house chores" (12:17)*
>
> *KM 168 – This child was very sweet and she always looks happy and usually early in the group. Her relationship with her mother was good and she was a Shangaan speaker. She is a very intelligent girl. Older than the others and accommodated the others. She said she wants to be a lawyer (Careworker observation)*

KM 168 was able to share her emotions with the group. She felt a responsibility towards her family. She indicated during session 17 that her mother was using verbally abusive language towards her. The child showed with a cheerful disposition, a positive future outlook and the facilitators experienced her behaviour as intelligent. She demonstrated a willingness to help other children in the group. She showed adaptive behaviour in being part of a group where she does not fully speak the language of the other group members. The group accommodated and supported her although she could not fluently speak their language. A protective factor was her good relationship with her mother.