AN OBSERVATIONAL ANALYSIS OF PSYCHOSOCIAL BEHAVIORS AND CAREGIVER RESPONSES IN THE DURBAN CHILDREN'S HOME

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December 2007

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ACKNOWLEDGEMENTS

I would first like to thank my project, Professor Arvin Bhana, for providing his opinions, suggestions, and assistance in the product as well as for sharing his expertise in the field of psychology and in research.

I would also like to thank Joshika Ramlall of Big Brother, Big Sister: South Africa for connecting me with the Durban Children's Home, despite her busy position and duties.

Also a special thanks to my academic director, Zed Mcgladdery, who devoted so much of his time and energy to discuss logistics, research strategies, and findings with me, and remaining so enthusiastic and supportive of my project.

I would like to extend my sincere gratitude to the staff that I have met through the Durban Children's Home, who allowed me so graciously into their workspace. As an entirety, the staff was supportive and flexible in assisting with my project while continuing to give their energy and time to the children. A special thanks to Premie Pillay, who met with me daily to discuss my experiences and to organize which part of the Home I was most needed on any given day. Her kindness was endless and her assistance has been greatly appreciated.

Finally, I would like to thank the children who allowed me so genuinely into their environment and provided me with perspectives of those who have faced such hardships at such a young age. Nonetheless somehow so many of them continue to go throughout life so optimistically and with so much passion, attitudes that many people in this world can learn from.

ABSTRACT

In South Africa, many children find themselves in at risk situations arising from issues like HIV, abuse, and poverty, which highly impact their mental well being by forcing them into unlivable situations. The Durban Children's Home, located in Glenwood, Durban, works to tackle this problem, providing facilities, meals, and care for 75 homeless, abused, terminally ill, and/or poverty stricken children. Yet in coming from situations where children no longer have support of their primary caregiver or environment, these children require quality psychosocial attention in the Home. However when basic needs of so many children must be met in an institutional setting, the issue is posed of whether or not these crucial psychosocial needs of the children are being met.

To answer this, children's symptoms suggesting psychosocial stress were observed, as were interactions between children and caregivers. Those observations were then compared to interviews of caregivers about their primary roles to understand the discrepancies between caregivers' perspectives and actions. These were then triangulated against views of experts through personal discussion and current research and literature.

Psychosocial stress was observed in some of the children and was displayed in very different forms. Though all caregivers were equipped with training to assist the psychosocial needs of the children, there was inconsistency of attention to the psychosocial needs of the children due in part to burnout and the constant demand of the children's needs.

INTRODUCTION

Worldwide, about one in ten children suffer from childhood mental disorders.[1] Yet in developing countries, the role of mental health is often not a great focus when many individuals are struggling to meet their basic needs. Poverty remains one of the greatest challenges in South Africa as individuals struggle to correct the unequal distribution of resources established through the Apartheid regime. With poverty comes increased exposure to malnutrition, abuse, disease, and a number of other stressors that compromise a child's ability to obtain and rely on a supportive environment. This therefore largely heightens their risk of psychological problems.

[1] Bhana, Avin. Mental Health in a Developing Country Context, lecture. 10/16/07

The problem is also exacerbated by the HIV/AIDS epidemic, which is rapidly increasing in sub-Saharan Africa, housing ¾ of the 4.3 million new infections worldwide in 2006.[2] HIV/AIDS creates horrific problems in South Africa, with the highest amounts of infection per capita worldwide. In 2006, 360,000 AIDS orphans, defined as children under 18 without a mother, existed in Kwazulu Natal alone.[3] Growing numbers of children are becoming infected as well. In 2006, South Africa had 294,000 cases under 14 years, exposing these children to the complexity of illness, the rigorous scheduling of treatment, and early confrontation with death.[4] As a result of HIV/AIDS, increasing numbers of children are drastically physically and mentally impacted in South Africa, through infection, orphanhood, elevated poverty, poor living conditions, and inadequate quality of care as the virus wipes through families, tearing them apart.

These infected and affected children have flooded children's homes, which work to provide facilities, meals, care, and support to homeless, abused, terminally ill, and poverty stricken children. As children come into the homes with such traumatic pasts, they carry with them memories and challenges that must be dealt with that are not solved by solely filling the basic needs of food, clothing, shelter, and education. As described by Unicef,

> There is a need to develop coordinated systems of services for children that allow

[2] Knight, Steven. *The Epidemiology of Tuberculosis*, lecture. 10/9/07.
[3] Day, Candy and Andy Gray. Health and Related Indicators of South Africa 2006. Pg 428.
[4] Day, Candy and Andy Gray. *Health and Related Indicators 2006.* Produced by Health Systems Trust, 427.

> us to support the whole child—physically, socially, emotionally, spiritually and cognitively—within the context of the family, the home, and health-care settings.[5]

Yet when the basic needs of so many children are working to be met, it leaves little room for focus on the psychosocial worlds of the children.

Durban Children's Home, located in Glenwood, Durban, is one such home that works to assist children in need. The Home provides care to orphans and vulnerable children, including children infected, orphaned, or otherwise affected by HIV/AIDS, children struggling from substance abuse, homeless children, and children who have had to be removed from their previous homes due to unsafe or unsupportive environments.[6]

Because one of the challenges of institutions such as the Durban Children's Home is providing intimate, one-on-one attention to the children[7], the observer offered her time, support, and energy to volunteer at the Home, assisting children with homework and playing and interacting with them. This work enabled an environment conducive to observation of the children and the caregivers' involvement with the children. Through observation and interviews of caretakers and academics in the field, the role of psychosocial behaviors and caregiver responses to these psychological needs were examined. Therefore this study works to understand the relationship between the children's psychosocial behaviors and caregiver roles. To accomplish this, symptoms suggesting possible psychological issues are observed and explored in the contexts of their histories and pasts. Then, the skills that the caregivers obtain and their perceptions of their roles in the children's lives are examined primarily through interviews. Finally,

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[5] Rochat, Tamsen, Mitchell Carol, and Linda Richter. *The Psychological, Social and Developmental Needs of Babies and Young Children and their Caregivers Living with HIV and AIDS.* HSRC and Unicef. 2007. 9.

[6] Pillay, Premie, Interview. 21/11/07.

[7] Pillay, 21/11/07

through observing interactions between the children and caregivers, one can explore how successful the caregivers are at identifying and providing possible interventions for these symptoms. This allows us therefore to come to some conclusion of the success and needs for improvement of a particular home working to achieve an extremely difficult task, to support the children on a multidimensional level.

Definitions of Major Terms and Abbreviations

Contextual Terms

HIV- Human Immunodeficiency Virus

AIDS- Acquired Immune Deficiency Syndrome

Opportunistic Infections- "Infections that arise when the immune system is suppressed. Opportunistic Infections are responsible for up to 90% of all AIDS-related deaths."[8]

Orphan- An orphan is defined by UNAIDS as a child under fifteen who has lost his or her mother (maternal orphan) or both parents (double orphan). However many researchers and intervention groups generally increase the age range to encompass children up to 18 years of age.[9] For the purpose of this study, the term "orphan" will include children up to 18, because the home has children up to that age.

Vulnerable Children- Vulnerable children are children who have been exposed to one or more of the following:

- loss of a parent through death or desertion
- illness of a parent or caregiver
- poverty, hunger, lack of access to services
- overcrowding or deficient caretakers
- disability
- physical or sexual violence
- chronic illness

Trauma- The impact of extreme stressors, either physical or psychological, that overwhelm an individual's ability to cope[10]

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[8] Ward, D.E. *The AmFAR AIDS handbook: The complete guide to understanding HIV and AIDS.* New York: W.W. Norton & Company, 1999. 417.

[9] Skinner, Donald, Tshele, N., Mtero-Munyati, S., Sewabe, M., Chiatamoto, P., Mfecane, S., Chandiwana, B., Mfecane, S., and N. Nkomo. Towards a Definition of Orphaned and Vulnerable Children. *AIDS Behavior* (10), 2006. 620.

[10] Lieberman, Alicia and Kathleen Knorr. The Impact of Trauma: A developmental Framework for Infancy and Early Childhood. *Psychiatric Annals,* 37(6), 2007. 416.

Psychological Terms

Depression- Depression is a psychological disorder influenced by biological and environmental factors. Symptoms include

- depressed mood
- reduced interest in activities
- sleep disturbances
- loss of energy
- concentration difficulties
- suicidal thoughts or intentions[11]

Anxiety- Generalized Anxiety Disorder is a psychological disorder in which feelings of excessive worry, heart palpitations, and dizziness become difficult to control and are unrelated to a particular past event. [12]

Posttraumatic Stress Disorder- a psychological disorder following a traumatic even which causes intense feelings of fear and/or hopelessness. This includes

- experiencing trauma through nightmares, obsessive thoughts , and flashbacks
- avoidance of situations, people, and/or objects that serve as reminders
- increased overall anxiety[13]

Description of Durban Children's Home

The Durban Children's Home, located in Glenwood, Durban, was established in 1905 by civic citizens to accommodate white children whose mothers were working or ill. Then in 1995, after the break from Apartheid in 1994 and the establishment of a Democracy, an affirmative action policy was created to meet the needs of the now apparent struggles of South Africans. The mission is as follows:

> The Durban Children's Homes is committed to providing children, youth and their families, from the Ethekweni Metropolitan communities, with child care programmes, which ensure a relevant and effective service. These programmes meet the individual developmental needs of children and youth, thereby ensuring that new skills are learnt, existing strengths are enhanced and a sense of well being and security is experienced by every young person in our care.[14]

[11] All Psych Online. http://allpsych.com/disorders. Accessed 1/12/07.
[12] All Psych Online. http://allpsych.com/disorders. Accessed 1/12/07.
[13] All Psych Online. http://allpsych.com/disorders. Accessed 1/12/07.
[14] Durban Children's Home Websight. www.dch.org.za. Accessed 1/12/07

The Home is currently for children who are orphaned, abused, neglected, or too ill or poverty stricken to be cared for in their current homes. As HIV/AIDS, teen pregnancies, and drug dependencies have demonstrated to be great challenges, the Durban Children's Home has adjusted its programs to focus on addressing these issues. Currently, The Durban Children's Home is made up of Siyakhula Treatment Center, a residential program for youth ages 11 to 17 with drug dependencies, the Isibindi Community Project, which provides support to child headed households, and the Residential Care Program. The Residential Care Program consists of a residential unit for young children ages two to ten, a residential unit for girls ages 11 to 18, Khayalisha or "Our Home" in Zulu which is a residential unit for boys ages 11 to 18, and Amaqhawe Care Centre meaning "Little Heroes", a unit for the terminally ill. All of Amaqhawe's current residents are HIV positive. All of the units have 20 children each, except for Amaqhawe which has 16. Childcare workers work two at a time with a child to caregiver ratio of 10:1. They generally work half the day and then switch with two others who work the remaining part of the day. Funding resources consist primarily of a monthly per capita head subsidy as a registered childcare facility. [15] Funding also comes from donations, annual fundraising, funding for specific projects, and interest from investments.[16]

The Children's Home recognizes the importance of family and that institutional care is not ideal for a child. Thus the Home's main goal is to reunite the children, if available and safe, with their families as soon as possible. Reintegration with family is

[15] McIntyre, Morag. *The History of the Durban Children's Homes.* Durban Children's Home. 2005

[16] Durban Children's Home Websight. www.dch.org.za. Accessed 1/12/07

encouraged during holidays, even if the child cannot go home permanently. This way the children have some contact with caregivers outside the Home and have a concept of family. [17]

The Pasts of the Children

The Durban Children's Home provides a safe environment for orphans and vulnerable children. This may be due to orphanhood from parents who have lost their lives to the HIV pandemic, desertion by families and therefore children are currently living in the streets, caregivers who are too ill to care for their children, children who are physically or sexually abused, or families who can no longer provide for their children due to poverty, especially those who have to be on treatment for HIV.

In all cases, an agency social worker identifies the case that is in need of removal from the current situation. The child is then taken to court where there is a court order for the child to be admitted into a home. In cases where there are siblings, an important goal is to keep the siblings together. The social worker then finds an appropriate home where the order is to last two years, if necessary. Meanwhile the Home does investigations of the family situations that the child has left and is in communication with the caretaker who continues to stay in contact with the family and child. However, if the social worker or organization feels that the children and family are unfit to reunite after two years, they can extend the order. The main goal is to get the children out of the Home in as short of a time period as possible so to provide space in the Home for other children in need and because of the importance of the role of families in the lives of young people. However, for some children who are orphaned or have no safe environment outside of the home,

[17] Pillay, Premie, Interview. 21/11/07.

reintegration with family is not possible. Therefore, some children remain in the home for a few months while others stay their entire childhood until they are old enough to live independently.[18]

METHODOLOGY

In constructing a view of psychosocial behaviors and the caregiver's role in those behaviors, data consisted of an array of primary and secondary data. Primary data consisted of a fusion of observations of the children and caregivers, interviews of the caregiver, as well as meetings and discussions with professionals in the fields of psychology and childcare in the Durban area.

Because the researcher volunteered at the home for two hours every day between the dates of 8 November 2007 and 29 November 2007, close observation of the children's daily lives was possible. Volunteering consisted primarily of afternoon times. Time was spent assisting and tutoring the older boys who were residents of Khayalisha, supervising the children from all four units for a morning, individual supervision of children in need, and visiting and interacting daily with terminally ill children in Amaqhawe.

At first, the observer was looking for symptoms of depression, yet when few symptoms presented themselves, the scope of symptoms had to be widened to encompass behaviors suggestive of any psychosocial problems. Personal moods and behaviors suggestive of psychosocial stress and problems were observed. Interactions between

[18] Pillay, 21/11/07.

children and caregivers were observed as well. The observer is currently perusing an undergraduate degree in the field of psychology, which sheds lights on these observations. While practical training or experience has not yet been completed, sufficient theory has been learned to make informed psychosocial observations. In cases where more complex symptoms were observed, the observer consulted with Dr. Arvin Bhana, a professor of psychology and a researcher for the Human Sciences Research Counsel.

Observations were then compared to perceptions of the caregivers. The social worker of the Home and the nurse were interviewed, who both have substantial interaction with all of the caregivers and children on a daily basis. Therefore their information and perspectives were extremely valuable to understand issues around the home on a broader level. Two childcare workers, one working in Khayalisha and one working in Amaqhawe, were interviewed as well, who discussed specific children and challenges of the particular home that they worked at.

Interviews were conducted in the manner of guided questions, focusing on training and the role of the childcare worker as well as their perceptions of the prevalence of emotional and psychological issues existing in the Home. Unfortunately, the Childcare Workers who were most willing to be interviewed were the ones who were generally more enthusiastic, while the ones less involved in the children's lives showed little interest in being interviewed. This suggests self-selecting bias in the particular subjects interviewed. Therefore the other childcare workers had to be solely observed. Brief meetings with researchers at the Youth, Family, and Social Development department at the Human Sciences Research Counsel in Durban were held as well, to learn about their

most recent research on caregiving for HIV positive children in a hospital setting. This provided a professional perspective both on similar work in the field of psychology as well as a second opinion on symptoms observed in this particular project.

Primary data was then triangulated against secondary data, which included psychological papers concerning the role and perception of psychology in South Africa generally as well as epidemiology of psychopathological disorders. Secondary data also contained recent research about the well-being of orphans and vulnerable children, the different residential options for these children, and how HIV, both through personal infection and infection of parents, affects the psychosocial lives of these children.

Ethics

Because the Durban Children's Home houses children still struggling to cope with past issues and histories, the well-being of the children and of the Home in general was of primary concern throughout the study. The social worker gave written consent for the observer to volunteer and simultaneously use the Home as a base for the study. This enabled reciprocity for as the observer was obtaining valuable data, she was also volunteering her time and energy to assist these young people. Unfortunately, questions could not ethically be asked directly of the children themselves because they were already experiencing stressful and sometimes unstable situations. Therefore, to bring up their pasts was not an ethical option without immediate trained support systems or debriefing. Due to lack of training of the observer and the inability to ask questions of the children, diagnosis was impossible and thus avoided in all situations. If incidents or behaviors were of particular concern, they were raised in daily discussion with the social worker. Yet in these situations, the observer reiterated her inability to diagnose.

In interviews, oral consent was given. Caregivers were only told to disclose only the information they felt comfortable with and were welcome to drop out of the interview if at any point they felt uncomfortable. They were also told that is they decided at a later date that wanted to leave out any statements that they said, that was fine as well. Pasts of the individual children were not asked for the children's privacy. Therefore throughout this project, the number one goal was neither to harm the organization, including their system and reputation, nor to harm the children and caretakers' well being.

FINDINGS AND ANALYSIS

Past and Current Challenges presenting psychological stress.

Though the children have different backgrounds and reasons for needing to leave their environments, all have undergone stressors beyond what most children experience. As many of the children in the Home have experienced major trauma and often multiple stressors, psychological issues become much more likely to arise.[19] They are particularly at risk for these issues because young children especially have limited coping skills and therefore have different reactions from adults.[20] Therefore through examining the different backgrounds and the symptoms present in these children, we gain insight into how varied the issues of the home are.

[19] Cluver, Lucie, Gardner, Frances, and Don Oberario. Psychological Distress amost AIDS-orphaned chidren in Urban South Africa. *Journal of Child Psychology and Psychiatry.* 48(8), 2007. p. 755-763.

[20] Lieberman, 416-422.

Poverty

Many children in the home have been driven to the home by poverty.[21] Worldwide, poverty is preventing over 200 million children under five years old from reaching development potential, more than 60 percent of these children located in Sub-Saharan Africa.[22] This can have substantial effects on the child cognitively. Poverty creates a number of stresses like physical stress from malnutrition, lack of material resources and access to adequate education, and exposure to violence. It puts stress in relationships between parent and child as well, as sensitive and responsive care becomes difficult. Poverty also heightens one's exposure to HIV/AIDS. [23] Simultaneously, poverty prevents many children from acquiring life sustaining drugs, which is a factor causing a number of children to come to Amaqhawe.[24]

In an interview with Childcare Worker B, she explained that returning home is an incredibly stressful time and consequently a time when many children have behavioral and emotional issues. When they go home, they are not guaranteed that their basic needs and therefore do not have the security or structure that they receive at home. "They don't know if they will get enough food and if they will be hungry," Childcare Worker B explained.[25] As a result, due to the returned threat of poverty, the children become noticeably anxious.

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[21] Pillay, 21/11/07.
[22] Rochat. 36.
[23] Rochat, 35-6.
[24] Pillay, 3/10/07.
[25] Childcare worker B, 27/11/06.

HIV/AIDS

South Africa holds the highest amounts of HIV/AIDS per capita worldwide. This has affected a number of children, with 294,000 cases under 14 years in 2006, exposing these children to the complexity of illness, the rigorous scheduling of treatment, and early confrontation with death.[26] Even for those children who are not personally infected, HIV/AIDS leaves a devastating number of children orphaned, with 360,000 AIDS orphans in Kwazulu Natal in 2006.[27] In a study examining psychological distress in 1,025 AIDS orphans in urban townships in South Africa, research found that AIDS orphans were more likely to report symptoms of depression, peer related problems, delinquency, and conduct problems than children orphaned from other sources and non orphaned controls.[28] Yet the amount of orphans does not account for the number of children who live with terminally ill parents, who still suffer similar hardships of forced early independence, and who are exposed to traumatic situations, including seeing their parents in such terrible physical shape.

In the Durban Children's Home, this exposure to HIV/AIDS is a reality for many of the children, both in terms of personal infection and family infection. The nurse of the home explained in an interview, "Even if a child is not *in*fected, he's still *a*ffected."[29]

For the children living in the terminally ill unit, Amaqhawe, all are HIV positive. Therefore, due to their status, they are exposed to a number of challenges. There are a number of biological challenges as the HIV virus has biological effects on the brain and

[26] Day, Candy and Andy Gray. *Health and Related Indicators 2006.* Produced by Health Systems Trust.
[27] Knight, Steven. *The Epidemiology of Tuberculosis,* lecture. 10/9/07.
[28] Cluver, Gardner, and Operario, 755.
[29] Nurse, interview, Durban Children's Home. 20/11/06.

body, which make the victim more susceptible to psychological issues. The virus attacks the central nervous system, which is the most frequent and serious target. This develops risk of psychiatric illness. Also 8 to 13 percent of HIV-infected children and 19 to 31 percent of children with AIDS are neurologically affected. With more advanced HIV infection, brain growth, motor function, and developmental progress is all impaired. These impairments create more stress for the children as they find themselves behind their class and playmates.[30] Therefore these biological factors, though unable to be observed in the Amaqhawe children due to lack of time and training, are important in understanding the complexity of HIV's impact on the psychological wellbeing of these children.

As HIV attacks the immune system, the child often finds him or herself sick with opportunistic infections. Being ill so often is psychologically damaging as well. Childcare worker A, who works daily in Amaqhawe, explained, "The children feel bad about always being sick. They wonder 'why do I always feel like this? Why if I'm not sick today will I be sick tomorrow?'" She explained that this can be very distressing for the children.[31] Informant A1, a three-year-old girl, suffers from tuberculosis, and was observed coughing at one point so hard that she began to cry.[32]

Not only are opportunistic infections exhausting and stressful, they are also more apparent than the virus alone, which can be embarrassing for children.[33] Informant A2, a

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[30] Rao, R, Sagar, R, Kabra, SK, and R Lodha. Psychiatric Morbidity in HIV-infected children. *AIDS Care*. Routledge, 16(9), 2007. 829

[31] Childcare Worker A, female in mid 30s, interview, Durban Children's Home. 23/11/07.

[32] Informant A1, 3-year-old female, resident of Amaqhawe. Durban Children's Home. 29/11/07.

[33] Rao, 829.

twelve-year-old resident of Amaqhawe, exhibited this insecurity when the Home social worker inquired about the bandages on her hands. In response, Informant A2 dropped her head and muttered that she had sores, hiding her hands behind her back. For the remainder of the day, she was shy and quiet, remaining separate from most of the other children.[34] This behavior demonstrates unconfident and ashamed feelings toward her condition.

Informant A2's reaction suggested that there was an expectation that she would be made fun of, stigma of HIV/AIDS being a major source of this insecurity. Similar findings were found in another study in which a boy, when asked to describe a challenging part of his situation, described, "When someone is shouting at me and when people are gossipin about me or laugh at me or beat me up. When people swear at my mother…"[35] It becomes clear that many react in unsupportive ways when they find out that an individual is HIV positive, which becomes especially traumatic when a child is at a point in his or her life when so much value is placed on social contact and status. Therefore stigma and fear negatively influence support and social interaction within communities.[36]

Therefore, it becomes different and helpful in some ways when the children are surrounded by other children who are all experiencing the same symptoms. Informant A2 was not embarrassed about her sores until outsiders came into the unit and questioned

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[34] Informant A, 12-year-old female, resident of Amaqhawe. Durban Children's Home. 12/11/07.

[35] Cluver L. and F. Gardner. Risk and protective factors for psychological well-being of children orphaned by AIDS in Cape Town: a qualitative study of children and caregivers' perspectives. *AIDS Care.* Routledge, March 2007; 19(3). 323.

[36] Loewnson, R. Exploring equity and inclusion in the response to AIDS. *AIDS Care.* Routledge. 19(Suppliment1). 2007. S4.

her. However, this also makes one question whether or not it is difficult for a child to be completely surrounded by other terminally ill children, constantly exposed to illness and hints of death from others on top of their personal struggles.

Abuse

A number of children come to the Durban Children's Home to escape abuse present in their current environments. [37]Informant B, a fifteen-year-old boy who is a resident of Khayalisha, was found curled up in the middle of the sidewalk outside the entrance to the house in a fetal-like position, while other residents and childcare workers stood around him, unaffected. [38] When questioned what was wrong with him, Childcare worker B explained that he was fine. He had just fallen in play and had receded into a fetal position like he often did when he was even mildly hurt.[39] On a later date, Childcare worker B mentioned in an interview the traumatic past of this boy and that he had experienced abuse.[40]

Yet through discussion with a trained psychologist, the fetal position proves to be a significant action especially considering abuse in his past. Curling up in this position resembles a time in his life when he was the safest and most secure—when he was in his mother's womb. Therefore in a time when there was no parent, childcare worker, or other individual to comfort him, he was comforting himself by going back to a time when he

[37] Pillay, 21/11/07.
[38] Informant B, 15 year old male, resident of Khayalisha. Durban Children's Home. 11/11/07.
[39] Childcare worker B, female in early 30s working at Khayalisha. Durban Children's Home. 11/11/07.
[40] Childcare worker B, interview. Durban Children's Home. 27/11/07.

did feel comfortable and cared for. The fetal position is also an important survival technique in abuse, because it exposes the least amount of surface area to be attacked, protecting oneself physically. Informant B's action was additionally a submissive position, which in his past would more likely cause the perpetrator to stop the abuse.

This behavior seems to have been normalized by the staff and residents because it is a common occurrence. This is dismissing a sign of clear difficulty with coping, which because has occurred so often, has been normalized. Because there might be no obvious psychological stresses in the child and it may seem like he is just shutting down and then coming back to be fine, does not mean that he is alright psychologically. He may be struggling with a number of issues which he has no other way to cope with than to close himself to the rest of his environment. Instead this shows signs of coping difficulty and a need to intervene. [41]

Abuse has been found to have a tremendous effect on its victims long after the actual occurrence of abuse has ended. Similar symptoms to Informant B are found in many children that have undergone abuse. Children exposed to violence have elevated difficulty coping with later frustration, fear, crying, temper tantrums, and aggression.[42] Informant C, a five-year-old HIV positive girl who is a resident of Amaqhawe, in several instances showed signs of this coping difficulty. In one instance, Informant C was observed trying to take a set of keys out a volunteer's hands, at first as a game. When told that she could not have them, the game turned into a desperate mission for the keys as she began to dig her nails into the volunteer and the smile disappeared from her face. She

[41] Bhana, Dr. Avin, HSRC. 16/11/07

[42] Lieberman, Alicia and Kathleen Knorr. The Impact of Trauma: A developmental framework or infancy and early childhood. *Psychiatric Annals.* 37(6). 2007. 417.

stopped pursuing the keys and started clawing and hitting the volunteer, despite the volunteer's attempt to calm her down with her words. When the volunteer more forcefully held Informant C's hands from her own body, Informant C melted into a ball in which she curled up and began crying, unresponsive to her environment and surroundings. She remained curled in a fetal like position, crying until she finally calmed herself and stood up with no apparent expression and walked away. [43] Thus Informant C conveys coping difficulty with frustration in the inability to have an item that she desired and later aggression. Yet as soon as a more physical intervention was made, Informant C receded in the fetal position, suggesting a possible history of abuse, with similar characteristics as Informant B.

While boys tend to have more externalizing behaviors as a result like oppositional behavior, aggression, impulsivity, and substance abuse, girls are more likely to display internalizing behavior like depression, anxiety, posttraumatic stress disorder, and suicidal thoughts or pursuits.[44] The observed differences in coping strategies between Informants B and C are interesting as they are opposite from what the text reiterated, that females tend to internalize while males tend to externalize. Though this might often be true, these instances provide a reminder that the findings are not absolute.

In a study of 49 women, subjects who had experienced abuse as children and currently had been diagnosed with major depression were six times more likely to have higher hormone responses to stressors than controls.[45] Thus this study illustrates that

[43] Informant C, 5 year old female, resident of Amaqhawe, Durban Children's Home, 26/11/07.
[44] Walker, 115.
[45] Chapman, Daniel, Dube, Shanta, and Robert Anda. Adverse childhood events

abuse can have a chemical effect on the body that changes psychological responses to certain stimuli, suggesting an explanation for why these children reacted in those ways.

Informant D, a 14-year-old girl, exibits signs of major psychological struggle due to both physical and sexual abuse. Informant D has since been conflicted by a fear of her mother while simultaneously possessing a deep-rooted love and desire to obtain a mother-to-daughter bond. These conflicting thoughts provide her with much confusion and frustration. Since her time at the Durban Children's Home, she has attempted suicide. In one instance, directly after her mother forbid her to come home for a weekend, she acted up at school and cut her wrists. Immediately after this behavior, her body was rigid and her teeth were chattering, as though in shock. Yet about forty-five prior, she was extremely animated and seemingly happy, in a mania-like state. Yet her mania state would stop momentarily to ask the observer questions like, "Why do people have to hurt other people?" and other questions completely unrelated to the current conversation. Then she would jump back to the discussion.[46] Thus, the episode could be directly linked with a particular recent interaction with her mother. She acted out in this manner directly after her mother rejected her for a weekend visit. This action could be influenced by the need for attention. In an environment where there is no parental attention and little attention from childcare workers due to the amount of children, cutting one's wrists requires immediate attention.[47]

Sexual abuse can leave serious impacts on its victims as well. Consequences of childhood sexual abuse are guilt, low self-esteem, self-blame, delinquency, substance abuse, impaired sexual functioning, and vulnerability to repeated victimization. They

[46] Informant D, 14-year-old female resident of …… Durban Children's Home. 21/11/07.
[47] Bhana, discussion, 1/12/07.

have elevated lifetime rates of mood, anxiety, attention deficiency disorder, borderline personality, and somatization disorders.[48]

Many residents of the Durban Children's Home have been victims of sexual abuse, much have which has been indirectly associated with HIV, according to the Home's nurse. She explained that a lot of the HIV positive children have been infected through HIV positive community members who believe the widespread rumor that HIV can be cured through sleeping with a virgin. In many of these sexual abuse situations, the children do not always believe that these actions are wrong, because the perpetrator may "tell the child that this is love and it's ok. The child will tell me, 'Sister, I enjoyed it' because this is what they think love is, because they didn't get a lot of attention besides this." [49] Therefore the children come into the Home with a warped perception of sexuality and love, which they work to deal with throughout much of their lives.

Returning Home

The pasts and families of these children remain a focus in their lives throughout their times at the Home. During holiday, many of the children go home to stay with their parents, with extended family, or with friends. However, some children remain at the home throughout the entire holiday. This creates a vast amount of stress and tension within the Home.[50] Those children who are going home do not know what to expect from their families, whether they will have stable relationships with their families, and whether

[48] Walker, J., Carey, P., Mohr, N., Stein, D., and S. Seedat. Gender differences in the prevalence of childhood sexual abuse and in the development of PTSD. *Archives of Women's Mental Health.* (7) 2007. 115.
[49] Nurse, interview, 20/11/07.
[50] Childcare Worker B, 27/11/07.

or not their basic needs will be met. On one day upon entering Amaqhawe, the children who were going home for the holiday were packing their belongings and the house was extremely chaotic, with clothing scattered throughout the entire downstairs. Attitudes of a number of the children were completely different.

Informant F was asked casually how he was doing that day and he put his head down and responded that he was not well. When asked why, he explained that he was not going home and he wished he could. Throughout the next half hour he kept repeating that he wanted to go to his uncle's house. Then he was noticeably quiet the remainder of the day, keeping to himself during playtime while the other children interacted with one another.[51] This demonstrates the frustration and impact of not having a place to go to for the holiday, especially as other children in his immediate surroundings are getting ready to leave.

However, Informant G who was going home permanently the following that day acted forlorn and reserved as well. When asked if she was excited to return home, she nodded but then shortly thereafter shook her head. By the time the observer left she was sitting on the couch with her head in her arms, not responding to anyone that tried to interact with her. [52] Thus she illustrates these mixed feelings about going home. On one hand she was excited to return home and be with her family, yet on the other she was leaving the environment and schedule that she had gotten to know that always provided the basic needs, and though not her parents, provided caregivers who were at least accepting of her.

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[51] Informant F, 9 year old female, resident of Amaqhawe. Durban Childrens Home 27/11/07.

[52] Informant G, 12-year-old female, resident of Amaqhawe. Durban Children's Home. 27/11/07.

In Khayalisha, Childcare Worker B explained that Informant H was returning home permanently, but that since he found out he had been having behavior issues, disrupting the rest of the residential unit. She explained that he had started stealing and had to be constantly told to behave himself. "He has completely changed since he found out he was going home," she said.[53] Therefore he seemed to be having a similar struggle as Informant G, but expressed himself very differently, in the form of externalization. This fits with the finding that while girls are likely to exhibit more internalizing behaviors, boys are more likely to exhibit external ones. Girls are much more likely to show signs of depression, anxiety, Post Traumatic Stress, and suicide attempts, while boys are more likely to show oppositional behavior, aggression, impulsivity, and substance abuse.[54] Therefore there is a range of ways that this stress and anxiety is exposed.

Roles of Caregivers

Thus with all of these factors and pasts of the children at the home, having a supportive and nurturing environment is essential. In development, children have both exploration motives, which are to explore the environment and eventually become independent, and attachment motives, which are to protect the children in case of danger. A secure base is necessary for a child to feel comfortable to explore. Therefore, when this secure base does not exist because a parent can no longer support a child in this way, it becomes very emotionally traumatic and foundations of early mental health are

[53] Childcare Worker B, 27/11/07.
[54] Walker, 115.

damaged.[55] According to a study on the role of caregivers, orphaned children require more emotional nourishment from new primary caregivers than from their biological ones to balance the traumatic and emotional experience of the parents' deaths.[56]

Thus, the role of the caregiver is extremely important because at the Home, fulfilling the basic needs of the children is crucial and often lacking in many of the children's previous environments. Yet because of the traumatic and emotionally challenging times both that their previous environments caused and the stress of coming to a new environment and leaving the old ones behind, psychosocial care is a necessity for the children as well.[57]

However, meeting the psychosocial needs of the children is surely a challenging and exhausting goal, especially as basic needs have to be taken care of primarily. Therefore, a lack of time and energy becomes a major challenge in doing this. Through investigation of how the caregivers at the home are equipped, how they perceive their primary roles, their awareness of the psychosocial lives of the children, and the engagement with the children, we can gain insight into how successful they are in aiding the psychosocial needs of the children.

The childcare workers have the most contact with the children on a day-to-day basis. If there is any concern about a specific child, they will be referred to the nurse or to

[55] Lieberman, 418.
[56] Freeman, M. and N. Nkomo. Guardianship of Orphans and Vulnerable Children: A survey of current and prospective South African Caregivers. *AIDS Care.* 18(4), 2006. 303.
[57] Freeman, 303.

the social worker. The social worker will then decide if further treatment is necessary, and if a child needs to be referred to a psychologist of a local hospital.[58]

The Social Worker

The social worker is in communication with the children prior to their arrival and throughout their time at the home. The social worker is in contact with staff, teachers, and family to see how each child is progressing and doing emotionally and physically. She also decides if the child needs outside assistance from psychologists or doctors. The social worker is responsible for deciding when a child is or is not ready to leave the Home as well. When a particular child is having difficulty with a social or emotional issue, he or she may meet with the social worker. The social worker therefore serves as a line of referral between childcare workers, families, and children to make sure that the child's needs are met. [59]

The Nurse

The nurse is on site daily to treat any ailments that a child may have and if not possible, will refer the child to a hospital. The Durban Children's Home Nurse is often referred to as "Sister." She is often busy with minor injuries as well as treating a range of sores and various other symptoms caused from the HIV virus. Yet not only does she do these basic care duties, she is extremely involved in the lives of the children as well. She leads a number of education classes, such as sexual education and nutrition classes, and therefore gets to know the children on a personal level. She does both group learning and

[58] Pillay, 21/11/07.
[59] Pillay, 21/11/07.

individual counseling, enabling for more one-on-one contact which is so crucial when children do not have parents to support them.

The sister also goes around throughout the facility to check up on the kids herself in their environments outside of her office. She explained that when she sees a child sitting in the corner or obviously upset or troubled, she will approach him or her and ask what is wrong. She makes these rounds daily and considers them a necessary and important element of her position. When asked what her primary role was, she explained, "I must maintain happiness. A child must be jolly."[60] Therefore the sister obviously thinks of her position as greater than treating solely the physical selves of the children but the "psychological and spiritual ones" as well.[61]

Childcare Workers

Childcare workers are the caregivers that see the children most consistently and in the children's most intimate environments. Therefore their roles in the children's lives are crucial. They most closely resemble the roles of original caregivers as they spend the most intimate times with the children. They are the first adults the children see in the morning and the last ones they see before going to sleep. They are present during meal times, bath times, and homework times.

Training

Most Childcare workers are trained through programs by the National Association of Childcare Workers, a non-profit organization that prepares and trains people to work in the field. While several Childcare Workers have their degrees, the majority does not have

[60] Nurse, 20/11/07.
[61] Nurse, 20/11/07.

the financial ability due to low salary of the job and high cost of education. The training program involves practical care, developmental, and psychosocial elements. Training involves basic qualification, which mainly focuses on providing the basic needs for the kids. There is also self-awareness, with the notion that in order to care effectively for others, one must first care for oneself on a psychosocial level. They must also take restorative conferencing, which involves Childcare Workers learning to resolve serious conflict between the child and family member, other child, staff, or other individual. In this particular element of the course, ways of finding balance and understanding between the victim and perpetrator are learned. They also have to take behavior management, family preservation, peer counseling, and ARV training classes. [62]

ARV training not only discusses procedures of how to medicate but also describes techniques to make it physically and emotionally easier for the children. For example, Childcare Worker B shared that in her ARV training session she learned about how unpleasant a lot of the medication tastes and that if given a strong tasting food immediately with it, such as peanut butter, it makes it much easier for the child to take the medication comfortably. The ARV training class also taught the childcare workers to be aware of the stigma and social discomfort around HIV. Therefore a childcare worker must be sensitive to this and do what he or she can to make it easier for the child in this respect. After learning this, Childcare Worker B described that she allowed one of the HIV positive boys in her house to shower privately, away from the other boys, due to

[62] Pillay, 21/11/07.

embarrassment of his sores that he had.[63] Therefore the training provides more subject matter than basic care alone but incorporates psychosocial elements as well.

Fulfilling More Than Basic Needs

According to a study that looked into how caregivers perceived care, important elements mentioned beyond basic care included support, honestly, praise, closeness, help with homework, reading and storytelling, and advice on schooling.[64] When Childcare Worker A was asked what she considered her primary role to be, she responded by explaining that it was "to heal the children physically, mentally, emotionally. I have to give them love and care."[65] Therefore she described her primary concern for the children to be greater than fulfilling their basic needs but rather to encompass the whole of the child. She explained that because she is in such an intimate environment with the children she gets to know them very well, and can generally tell fairly easily when a child is not feeling well physically or emotionally.[66]

At certain points she was seen playfully interacting with one of the two year olds, tickling him. He was laughing and obviously enjoying himself. This kind of interaction with the childcare worker provided him with important tactile contact. Cuddling and touching children, a recent study showed, despite a sometimes disturbing physical appearance, makes a child feel loved and has been shown to be beneficial to development.[67]

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[63] Childcare Worker B, 27/11/07.
[64] Cluver, L and F Gardner, 321.
[65] Childcare Worker A, 23/11/07.
[66] Childcare Worker A, 23/11/07.
[67] Report on Experts Meeting: Psychosocial care and support of HIV-positive babies and young children on ART in South Africa. 8 December 2005.

Childcare Worker B also expressed an interest in the psychosocial lives of the children. She explained that at the beginning of the year she and one other childcare-worker took ten of the boys into the bush for three days on a camping trip. There, they sat in a circle and went around sharing stories of their pasts. She described it as an opportunity for them to send wishes to their parents or families, to apologize for situations that they blamed themselves for, or to simply share their experiences with the other boys and adults present. The childcare workers then shared their own pasts with the boys as well. She explained that this created a strong bond between them, knowing that they could express their feelings to her and the group if desired. [68] This created an opened space for the boys to express themselves, and showed the importance of externalizing their feelings in a positive way.

When asked if the children come to her often to talk to her, Childcare Worker B explained that they often do not and that as a childcare worker, she always needs to be observing their behaviors to see if there are symptoms of emotional, social, or personal problems. When there are, she tries to take their mind off of whatever is bothering by telling them a joke or having them come help her in the kitchen.[69] Though it is certainly a positive attribute that she is consciously watching out for the psychological well being of the children, it seems that simply taking their mind off of their problems might not necessarily be the best way to cope with them. Instead of putting these feelings away, it might be beneficial to expose them by asking what is wrong and actually working to confront these feelings.

The Challenge of Caregiving for 20 children

[68] Childcare Worker B, 27/11/07.
[69] Childcare Worker B, 27/11/07.

However, in the interviews, both childcare workers expressed the hardest part of the job was to work to split time and energy between twenty children. Childcare Worker A explained, "They are desperate for love and care, but there are so many of them."[70] Childcare worker B described the jealousy that occurs if some children are getting more attention from others.[71] This is reiterated in a study working to understand factors affecting psychological wellbeing of AIDS orphans through a sample of 60 orphans, 42 caregivers, and 20 social care providers in South Africa. Data found that children were particularly unhappy and at risk for emotional problems when they felt that they were being discriminated against or getting less attention than other children.[72]

In a study of nurses in pediatric settings, they have found that as the number of terminally ill children are growing, so are the caseloads. Therefore, the demands of the nurses have skyrocketed, without the training, support, skills, and management to match those demands. Thus the care systems become more rigid and the nurses burn out quickly, having less desire to engage with the patients.[73] A similar phenomenon is occurring with childcare workers with the surge of orphans and vulnerable children needing homes.

In the Durban Children's Home, evidence of such burnout is apparent through observations where childcare workers were not as invested in the children's immediate environments. For example, when the volunteers entered Amaqhawe, there was sometimes little interaction seen between childcare workers and children. Childcare workers were often seated in desks facing the rest of the room while the children were

[70] Childcare Worker A, 23/11/07.
[71] Childcare Worker B, 27/11/07.
[72] Culver, L and F Gardner, 321.
[73] Rochat, 47.

playing amongst themselves. When the volunteers came, the childcare workers often left the room completely to let the volunteers take over with the children.[74]

Childcare worker C exhibited burnout behaviors on three different occasions. She was observed lying face down on the floor while the children were outside, [75] sitting with her back facing the children,[76] and at one point dozing at her desk while the children played around her.[77]

In research investigating the role of caregiving in hospitals for HIV positive children, researchers found that there are a number of painful procedures which can be made much more pleasant for children with simple tricks. For example, massage in young children can help to calm them in uncomfortable procedures. Also, eating can be undesirable for many HIV positive children on medication, even though proper nutrition is extremely important in maximizing health while on anti-retrovirals. The researchers found that relaxing the rigid eating times and by having the nurse present throughout the meal make the eating process more manageable for the children. [78] However, in Amaqhawe, flexible eating times are difficult when there are so many children sharing an environment, many of which are two young to make their own meals. During meals, childcare workers are rarely present. They generally remain in the kitchen while the children eat amongst themselves in the dining room. [79] If childcare workers were more present at this time, this might more closely resemble a family and a time for social

[74] Observation, 22/11/06.
[75] Childcare Worker C, working at Amaqhawe. 12/11/07.
[76] Childcare Worker C, 23/11/07.
[77] Childcare Worker C, 23/11/07.
[78] Observation, Durban Children's Home. 11/11/07- 29/11/07.
[79] Observation, Durban Children's Home. 11/11/07- 29/11/07.

bonding. Therefore mealtime would be less of a chore and more of an enjoyable experience for the children.

In circumstances like this, one also must consider the circumstances in which the childcare workers are working. Childcare work is thoroughly exhausting and especially when caring for children who have to be under strict medication regimens, one can become burnt out quickly. The volunteers provided an opportunity for relief so it seems that the childcare worker's occasional lack of immediate interaction with the children was really just utilizing this time to themselves because there was other assistance. Though it would have been beneficial to see how the childcare workers and children interacted without the presence of the volunteer, this was not possible due to lack of time and opportunity. Therefore one must look at the hours in which the childcare workers work and if it is possible to provide quality care for that entire period of time. Childcare Worker B explained that some weekends she works from 8pm on Friday to 8am on Monday.[80] One thus wonders how present a childcare worker can be for this entire period of time.

To put this into perspective, we must ask how many biological parents provide consistent care. Though this was not a focus in this study, it seems that few parents are able to provide quality care all the time. Therefore to expect childcare workers to provide this, who are also playing similar roles but for 20 children, it seems an unreasonable expectation to provide quality care for such long periods of time. Thus, working shorter shifts seems to be the most logical option.

[80] Childcare Worker B, 27/11/07.

However, this poses yet another problem, for as caregivers work fewer hours, this would also require more switching of caregivers, with less resemblance of a natural caregiver and perhaps weaker connection between childcare worker and child. Thus this introduces the argument of what is more important, fewer hours of caregivers to avoid burnout versus continuity of care.

CONCLUSIONS

In conclusion, the observed symptoms of psychological stress illustrate how the traumatic pasts of the children continue to affect them even after removal of these situations. The children have an array of pasts and therefore a range of problems and struggles. Poverty is one of the great challenges exposing children to stressors, as well as HIV/AIDS and abuse. Reintegration with original families and environments, one of the main missions of the home, is also surprisingly a major stressor as well. Holidays are often times when children want to be with families yet often cannot be. Those who can go home become conflicted with excitement and with stress of the indefinite environments and situations that they will be exposed to when home.

While some children deal with these stresses internally, providing risk for depression, anxiety, posttraumatic stress disorder, and suicidal thoughts or pursuits, others have more externalizing behaviors resulting in oppositional behavior, aggression, impulsivity, and substance abuse.

Thus in coming to the Durban Children's Home, the children require both basic needs and psychosocial care. The caregivers including social worker, nurse, and childcare workers, spend a substantial amount of effort working to prevent and deal with these issues as they present themselves. Caregivers go well beyond the basic needs of the

children in many cases. For example, the nurse does rounds to make sure students are content, Childcare worker B took a group of children on a camping trip, and Childcare Worker A was seen interacting with the children in a way that fulfills their needs for tactile feedback from the power of human touch. Childcare worker training also involves training in psychosocial elements of care.

However due to the constant, complex, and exhausting needs of the children, consistent care does not seem possible. The most feasible solution seems to be to have the childcare workers work shorter hours so as to ensure quality of care. Yet this provides a dilemma for if caregivers work fewer hours, this would also require more switching of caregivers, with less resemblance of a natural caregiver and perhaps weaker connection between childcare worker and child. Thus the dilemma becomes what is more important, fewer hours of caregivers to avoid burnout versus continuity of care.

This is clearly an important issue and one that could have significant impact on the psychological wellbeing of so many children tragically faced with hardships of poverty, abuse, and illness. Nonetheless, the Durban Children's Home provides a nurturing environment on so many respects for these children and helps to aid them in their psychosocial lives.

LIMITATIONS OF THE STUDY

Due to time and logistical limitations, some areas of this study that would have provided important and significant data was not possible. First of all due to ethics, questions could not be asked of the children about their feelings, symptoms, or perceptions of the caregivers. If psychological surveys could have been filled out by

children, these could have provided more diagnosable results which would have been helpful in learning about specific impacts of the children's pasts on their psychological states. This was not possible also due to the observer's lack of diagnosis training.

Also, lack of time prevented more caregiver interviews to be carried out, which would have provided more depth in the variety of perceptions and actions of caregivers. Those observed who showed less investment in the psychosocial lives of the children were unable to be interviewed partly due to time and also because of their lack of enthusiasm when they were asked to be interviewed. This would have been an important factor in the study if possible.

RECOMMENDATIONS FOR FURTHER RESEARCH

Further research that would be hugely interesting would be to look more closely at psychopathological symptoms of the children in Durban Children's Home, or another children's home if the researcher had more excessive training in diagnosis.

Another topic of study would be to further investigate the presence of burnout in childcare workers of the Home, which seemed to have a large effect on the interaction between childcare workers and children.

It would be fascinating to see in what ways the findings in this particular study vary in other homes in South Africa. Though the Durban Children's Home still struggles with finances, it is considerably well funded compared to a number of other homes in the country. Therefore through investigating how caregivers' availability and interactions with children differ depending on funding would be largely important and interesting.

LITERATURE REVIEW

Cluver L. and F. Gardner. Risk and protective factors for psychological well-being of children orphaned by AIDS in Cape Town: a qualitative study of children and caregivers' perspectives. *AIDS Care.* Routledge, March 2007; 19(3).

- *This text looks at how interviews and focus groups are used in the context of orphans and caretakers. This focuses on what types of factors play into an orphan's risk of mental illnesses including poverty, education, stigma, and family. This study uses qualitative measurements.*

Skinner, Donald, N. Tshekp, S. Mtero-Munyati, M. Segwabe, P. Chibatamoto, S. Mfecane, B. Chandiwana, N. Nkomo, S. Tiou, and G. Chitiyo. Towards a Definition of Orphaned and Vulnerable Children. *AIDS Behavior.* 2006 10: 619-26

- *This text considers the discrepancies of various definitions of "Orphans" and "Vulnerable children" to point out significant variation occurring even in the academic context. This study uses focus groups of leaders and the community, service providers, orphaned and vulnerable children, and their caretakers to understand more deeply the different thoughts behind these definitions. These focus groups take place in various locations throughout South Africa, Zimbabwe, and Botswana.*

Rao, R., R. Sagar, S.K. Kabra, and R. Lodha. Psychiatric Morbidity in HIV-infected children. *AIDS Care.* Routledge, July 2007: 19(6).

- *This text discusses the biological, psychological and social factors that may predispose an HIV positive child to develop psychological illnesses. It explains therefore how depression, anxiety, disruptive disorders, and hyperactive disorders become such major battles for HIV positive children. It goes into detail to explain why this is.*

Hugo, Charmaine, Dorothy Boshoff, Annelene Traut, Nompumelelo Zungu, and Dan Stein. Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry Epidemiology.* 2003, 38.

- *This text researches and discusses the role of mental illness in South Africa generally. It explains that many South Africans who suffer from psychological disorders are unaware of the various types of treatments available. Therefore this looks deeply into perceptions of South Africans regarding mental illnesses. It used questionnaires to examine stigma around mental disabilities as well.*

Day, Candy and Andy Gray. *Health and Related Indicators 2006.* Produced by Health Systems Trust.

- *This text provides overall health indicators including those relevant to HIV/AIDS epidemic.*

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Informant A1, 3-year-old female, resident of Amaqhawe. Durban Children's Home. 29/11/07.

Informant A, 12-year-old female, resident of Amaqhawe. Durban Children's Home. 12/11/07.

Informant B, 15 year old male, resident of Khayalisha. Durban Children's Home. 11/11/07.

Informant C, 5 year old female, resident of Amaqhawe, Durban Children's Home, 26/11/07.

Informant D, 14-year-old female resident of …… Durban Children's Home. 21/11/07.

Informant E, 3 year old female, resident of Amaqhawe. Durban Children's Home. 29/11/07.

Informant F, 9 year old female, resident of Amaqhawe. Durban Childrens Home 27/11/07.

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APPENDIX A

DAILY LOG

Date	Hours	Location / Volunteering
8 November 2007	2:30-5 pm	Khayalisha, assisting/ tutoring with matriculation examination studying
9 November 2007	2:30-5	Khayalisha, assisting with matriculation examination studying
12 November 2007	2:30-5	First Half: Khayalisha, assisting with matriculation examination studying Second Half: Amaqhawe, supervising Art project with children
13 November 2007	3-5	First Half: Khayalisha, assisting with matriculation examination studying Second Half: Amaqhawe, supervising Art project with children
14 November 2007	3-5	Amaqhawe, games and interaction with children
15 November 2007	3-5	Amaqhawe, games and interaction with children
16 November 2007	3-5	Amaqhawe, games and interaction with children
19 November 2007	3-5	Amaqhawe, games and interaction with children
20 November 2007	3-5	Amaqhawe, games and interaction with children
21 November 2007	10:30am-1pm, 3-5	Morning: Assisting with

		girl having emotional difficulties Afternoon: Amaqhawe, games and interaction with children
22 November 2007	3-5	Amaqhawe, games and interaction with children
23 November 2007	3-5	Amaqhawe, games and interaction with children
26 November 2007	9am-2pm	Supervised residents from all four homes while staff at holiday lunch
27 November 2007	3-5	Amaqhawe, games and interaction with children
28 November 2007	3-5	Amaqhawe, games and interaction with children
29 November 2007	3-5	Amaqhawe, games and interaction with children

Appendix B

Interview Questions

Interview Questions for Social Worker

- What does your position entail?
- What is the training process for childcare workers like? How are they hired?
    - Are they taught to focus on psychosocial elements of the children as well as caring for the basic needs?
- What are the backgrounds of the children?
- What is the process in being admitted into the Home?
- Are psychological disorders an issue at the Children's Home? What kinds of symptoms do you see? Are psychological symptoms more common in a particular unit?
- Who can they speak to/ how can they get treatment?
    - Role of nurse
    - Role of psychologist
- Are any of the children on psychological treatment?
- What do you think some of the strengths of the home in regards to tackling psychosocial issues are and what are some of the weaknesses?

Interview Questions for Nurse

- what are the backgrounds of the children?
- What does your position entail?
- What do you view as your primary role?
- How often do children come in with psychological issues?
- What kinds of issues/ symptoms?
- What resources do the children have?
- What do you feel the childcare workers role in the psychosocial lives with the children is?
- Are the children with HIV aware of their status? How does this affect their psychosocial wellbeing?

Questions for Childcare Workers

- What was your training process?

- What do you see as your primary role?
- Aside from yourself, are there other people to support the children?
- What do you consider your relationship with the children to be?
- Do the children have psychological issues or emotional issues that they are dealing with? What symptoms do you see?
- How do you respond to these issues?