THE GENERAL AND EMOTIONAL DEVELOPMENT OF A SAMPLE OF SOUTH AFRICAN CHILDREN IN RESIDENTIAL CARE

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DECLARATION OF AUTHENTICITY

I hereby declare that the content of this thesis represents my own work and that any significant assistance I have received from other sources, are identified in my acknowledgements.

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Dedicated to Johan, Tubby and Johlene
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ABSTRACT

The main aim of this study was to explore and describe the general and emotional development of a sample of South African children between the age of five and eight years in residential care. More specifically, the study aimed to explore and describe the general level of development of a sample of children in residential care; to explore and describe the development of a sample of children in residential care in six areas of development; and to describe the emotional wellbeing of children in residential care. A non-probability, purposive sampling method was applied as the participants were comprised of children between the ages of 5 and 8 years housed at the residential care facility. The sample consisted of 11 children.

The multiple case study method was used to achieve the aim of the study, using both qualitative and quantitative data. The quantitative data consisted of scores obtained from the administration of the Griffiths Mental Development Scales - Extended Revised (GMDS-ER). The qualitative data was obtained from the Human Figure Drawing (HFD), participants’ scholastic progress reports, case reports from the residential care facility and clinical observations during the assessment period. The data was analysed according to thematic analysis.

The results highlighted the pervasiveness of delays in all domains of child development of children housed in residential care, specifically that of language, social and emotional development. An important finding of the study was that decrements in these domains of development underpinned delays in the other domains of development since they form the foundation of learning and relating to the world.

The study served to emphasize the importance of consistent developmental assessment in order to ascertain whether these children present with developmental delays and, if so, to
identify which areas of development are most affected. Information from the developmental assessments could assist in the early identification of developmental delays and allow for individually tailored interventions to overcome such delays.

KEY WORDS: Residential Care, General and Emotional Development, Developmental Assessment, Griffiths Mental Development Scales Extended Revised; Human Figure Drawings.
CHAPTER ONE
INTRODUCTION

“Most people can look back over the years and identify a time and place at which their lives changed significantly. Whether by accident or design, these are the moments when, because of a readiness within us and collaboration with events occurring around us, we are forced to seriously reappraise ourselves and the conditions under which we live and to make certain choices that will affect the rest of our lives” (Flack, 2009, P22).

The experience of childhood is different for children in residential care compared to that of children reared by their parents. Children housed in residential care facilities have characteristically been removed from their homes due to poverty, neglect or because they were orphaned. In South Africa it is estimated that forty percent (16,333,349) of the population are children. South Africa is geographically a predominantly rural country and as such 55% of its children live in rural areas (of which 62% are under the age of 10 years) and 45% live in urban areas (Meintjes et al., 2005). South Africa is characterised by high levels of poverty ¹ and 7 out of every 10 children live in poverty with children in rural areas (70%) being more likely to live in poverty than those in urban areas. The HIV/AIDS pandemic has also had a significant impact on family and community life in South Africa. The rate of infection has increased in prevalence from 22.4% in 1998 to 24.5% in 2000 (Meintjes et al., 2005). The obvious result of the continued escalation of the HIV/AIDS pandemic is the negative impact that it has on children. It was projected that by the year 2005 there would be one million orphans in South Africa and two million orphans by 2010. These were conservative projections. Key poverty indicators identified for South African children indicate that six out of every 10 children live in poverty, mostly in rural areas. School

¹ ‘poor’ is defined as the poorest 40% of households
enrolment is high at primary and secondary levels but an estimated 5% of children between the ages of 10 and 16 years are not in school. It was found that 42% of children under 7 years of age live only with their mother and 20% do not live with either parent. In 1998, the Child Protection Unit and specialist personnel dealt with 37 352 crimes against children, of which 57% were sexual offences. In April 2002, there were 2 334 children awaiting trial in South African prisons and 1 812 serving sentences. It could therefore be said that these children are faced with continuously changing environments and circumstances that children raised by their parents do not face.

The adversity that these children face at an early age could have a detrimental effect on their development both physically and emotionally. A better understanding of child development and the development of this population group is therefore necessary in order to attempt to minimise the extent of the damage suffered by these children and to try and provide them with opportunities to live healthy lives in which they can contribute to society in a meaningful way. In order to contextualise, grasp the developmental needs of this population group and measure the extent of damage incurred, an understanding of human development or developmental psychology is required.

Developmental psychology, also known as human development, is the scientific study of systematic psychological changes that occur in human beings over the course of their life span (Bruner, 1966). Originally concerned with infants and children, the field has expanded to include adolescence, adult development, aging, and the entire life span. The field examines change across a broad range of topics including motor skills and other psycho-physiological processes; cognitive development involving areas such as problem solving, moral understanding, and conceptual understanding; language acquisition; social, personality, and emotional development; and self-concept and identity formation (Bruner, 1966).
Developmental psychology includes issues such as the extent to which development occurs through the gradual accumulation of knowledge versus stage-like development, or the extent to which children are born with innate mental structures versus learning through experience. Many researchers are interested in the interaction between personal characteristics, the individual's behavior, environmental factors including social context and their impact on development; others take a more narrowly focused approach and as such developmental psychology informs several applied fields, including educational psychology, child psychopathology, and forensic developmental psychology. Developmental psychologists who are interested in social development examine how individuals develop social and emotional competencies. For example, they study how children form friendships, how they understand and deal with emotions and how identity develops. Research in this area may involve study of the relationship between cognition or cognitive development and social behavior.

Two of the more highly debated issues in life-span development psychology today are continuity versus discontinuity and nature versus nurture (further discussed in Chapter 3). At the heart of the **continuity versus discontinuity** debate lays the question of whether development is solely and evenly continuous, or whether it is marked by age-specific periods. Developmentalists who advocate the **continuous model** describe development as a relatively smooth process, without sharp or distinct stages, through which an individual must pass. Meanwhile, supporters of the **discontinuous model** describe development as a series of discrete **stages**, each of which is characterized by at least one task that an individual must accomplish before progressing to the next **stage**. Proponents of stage theories of development also suggest that individuals go through **critical periods**, which are times of increased and favoured sensitivity to particular aspects of development. For example, early childhood (the first 5 years) is a critical period for language acquisition (Vygotsky, 1986).
Thus, most adults find it difficult or impossible to master a second language during their adult years while young children raised in bilingual homes normally learn second languages easily during childhood.

Experts from a variety of disciplines continue to argue over the roles that biology and the environment ultimately play in development. This centuries-old nature-versus-nurture debate concerns the relative degree to which heredity and learning affect functioning. Both genetic traits and environmental circumstances are likely to be involved in an individual's development, although the amount each express, depends on the individual and his or her circumstances. For example, some identical twins that are separated at birth develop similar personality, cognitive and social characteristics, while other twins who are separated at birth do not. Likewise, many non-twin siblings raised in the same household develop similar characteristics, although this similar development of characteristics is not always the case with non-twin siblings. This interactional nature-versus-nurture or biology-versus-environment approach to the study of human psychological development exemplifies the multifaceted makeup of the biopsychosocial perspective (Bruner, 1966). In the present study, the researcher focussed on the discontinuous model as well as the impact that the children housed in residential care’s past as well as present environments may have had on their development. As such, the theories of Piaget and Erikson were used as the theoretical context for the study. The prominent theoretical perspective that attempts to explain development is Piaget's Stage Theory. To a lesser extent, historical theories continue to provide a basis for additional research, among them being Erikson's eight stages of psychosocial development.

Jean Piaget's stages of cognitive development had an enormous impact on developmental psychology as well as education. He was a biologist who originally studied molluscs but
moved into the study of the development of children's understanding, through observing them, talking and listening to them while they worked on exercises he set (Piaget, 1990). His view of how children's minds work and develop has been enormously influential, particularly in educational theory. His particular insight was the role of maturation (simply growing up) in children's increasing capacity to understand their world believing that they cannot undertake certain tasks until they are psychologically mature enough to do so. His research has spawned a great deal more, much of which has undermined the detail of his own, but like many other original investigators, his importance comes from his overall vision. He proposed that children's thinking does not develop entirely smoothly, instead, there are certain points at which it "takes off" and moves into completely new areas and capabilities. He saw these transitions as taking place at about 18 months, 7 years and 11 or 12 years. This has been taken to mean that before these ages children are not capable (no matter how bright) of understanding things in certain ways and has been used as the basis for scheduling the school curriculum (Piaget, 1990).

There are two major aspects to his theory: 1) the process of coming to know and 2) the stages we move through as we gradually acquire this ability. As a biologist, Piaget was interested in how an organism adapts to its environment (Piaget described it as intelligence). Behavior (adaptation to the environment) is controlled through mental organizations called schemes that the individual uses to represent the world and designate action. This adaptation is driven by a biological drive to obtain balance between schemes and the environment (equilibration). Piaget hypothesized that infants are born with schemes operating at birth that he called "reflexes." In other animals, these reflexes control behavior throughout life. However, in human beings as the infant uses these reflexes to adapt to the environment, these reflexes are quickly replaced with constructed schemes.
Piaget described two processes used by the individual in its attempt to adapt: assimilation and accommodation (Piaget, 1990). Both of these processes are used throughout life as the person increasingly adapts to the environment in a more complex manner. Assimilation is the process of using or transforming the environment so that it can be placed in pre-existing cognitive structures. Accommodation is the process of changing cognitive structures in order to accept something from the environment. Both processes are used simultaneously and alternately throughout life. An example of assimilation would be when an infant uses a sucking schema that was developed by sucking on a small bottle when attempting to suck on a larger bottle. An example of accommodation would be when the child needs to modify a sucking schema developed by sucking on a pacifier to one that would be successful for sucking on a bottle. As schemes become increasingly more complex (i.e., responsible for more complex behaviors) they are termed structures. As one's structures become more complex, they are organized in a hierarchical manner (i.e., from general to specific). Piaget identified four stages in cognitive development which are discussed in more depth in chapter 3 pertaining to child development.

Many preschool and primary programs are modeled on Piaget's theory, which, as stated previously, provides part of the foundation for constructivist learning. Discovery learning and supporting the developing interests of the child are two primary instructional techniques. It is recommended that parents and teachers challenge the child's abilities, but not present material or information that is too far beyond the child's level. It is also recommended that teachers use a wide variety of concrete experiences to help the child learn (e.g., use of manipulatives, working in groups to get experience seeing from another's perspective, field trips, etc).
One of the main elements of Erikson’s psychosocial stage theory is the development of ego identity (Erikson, 1964). Ego identity is the conscious sense of self that we develop through social interaction. According to Erikson, our ego identity is constantly changing due to new experience and information we acquire in our daily interactions with others. In addition to ego identity, Erikson also believed that a sense of competence also motivates behaviors and actions. Each stage in Erikson’s theory is concerned with becoming competent in an area of life. If the stage is handled well, the person will feel a sense of mastery, which he sometimes referred to as ego strength or ego quality (Erikson, 1964). If the stage is managed poorly, the person will emerge with a sense of inadequacy. In each stage, Erikson believed people experience a conflict that serves as a turning point in development. In Erikson’s view, these conflicts are centered on either developing a psychological quality or failing to develop that quality. During these times, the potential for personal growth is high, but so is the potential for failure.

The sample for the present study consisted of children housed in a specific residential care facility. The facility in question houses children between the ages of 3 to 18 years who have been removed from their parental homes due to neglect as well as children who are orphaned. The children are housed in cottages according to their age and developmental needs. Every cottage has a housemother who acts as the primary caregiver. The residential care facility is also equipped with access to specialized education, a speech therapist and social workers. The multidisciplinary team at the residential care facility have case discussions to discuss the treatment plan of each child based on their scholastic progress reports, results from the speech therapist when applicable, treatment plan to be reunited with their families and any other information which might be relevant to the well-being of the child. All these reports are referred to as the case reports in the present study.
Many research studies still need to be conducted on this topic to improve the life chances of children in residential care. To refine such studies cognizance needs to be taken of the extent of neglect in the home environment, whether the child had been exposed to psychotherapy or has received counselling, duration of stay in the residential care facility, whether there is ongoing contact with the family of origin and specific developmental needs identified both in the classroom and in the cottages. Early detection of trauma and possible developmental delays could result in early intervention for these children. However, the researcher of the present study only included age and nationality as variables since the primary aim of the study was to explore and describe the general and emotional development of a sample of children between the age of five and eight years in residential care. More specifically, the study aimed to explore and describe the general level of development of a sample of children in residential care; to explore and describe the development of a sample of children in residential care in six areas of development; and to describe the emotional wellbeing of children in residential care. All children for the sample were selected from the same residential care facility as they had all been exposed to the same living circumstances in the residential care facility. It is also important to be cognizant of the fact that all the children in the sample happened to be Afrikaans speaking and that no English speaking children were eliminated due to a language variable.

The present study has described the general and emotional development of children between the ages of 5 and 8 years in residential care by conducting a multiple case study. This allowed for a holistic description of the development of each child in the study by making use of quantitative and qualitative data. The information gained benefitted the children directly as it served to highlight their developmental strengths and weaknesses, information which could assist their teachers and primary caregivers to develop individualised and appropriate interventions when necessary. Furthermore, the results of the
multiple case studies could be examined in the context of existing research and theories. Studies which in any way contribute to the understanding and support of children housed in residential care facilities are relevant.

In order to contextualize the present study, Chapter 2 introduces the reader to South African legislation regarding the process of removing a child from the family of origin, the function of residential care facilities and highlights how this process could cause emotional distress.

Chapter 3 provides an overview of theories of child development and child development according to the child development domains, with consistent reference to children housed in residential care.

Chapter 4 details the emotional world of children housed in residential care. It focuses on theories of emotion, factors in emotional development, the impact that long term abuse and consequent placement in residential care has on the emotional development of children.

Chapter 5 details how the aims of the study were met. The methodology used for collecting and analyzing data is described. The results and discussion thereof are presented in Chapters 6 and 7 respectively. Chapter 6 illustrates the results whereas Chapter 7 is a discussion thereof followed by the limitations inherent in the present study and recommendations for future studies.
CHAPTER TWO

CHILDREN IN RESIDENTIAL CARE

2.1 Introduction

The family is regarded as the central institution of society and is the primary medium through which the socialisation of children is achieved. The home ought to be the source of stability in the lives of children. It is from this basis that children develop their identity and where their physical, emotional, and social well being is developed (International Convention on the Rights of the Child 1989: Art 18). There are, however, many instances where families, for a variety of reasons, are not able to take care of their children and fulfil their needs. These children may then be removed from their parents’ care and be placed in residential care facilities until the family circumstances have improved.

Albert Cumus (1962) once stated that separation is characteristic of the human condition and that it is often the rule of the world. He believed it is in the essence of things that all who love should be separated. In this sense Camus is speaking of the separation that inevitably accompanies all growth and development and is therefore impossible to resist: birth, infancy, childhood, adolescence, adulthood, old age, and death. Throughout each stage of growth and development, from birth to death, there is a gradual giving-up of the old for the new in an orderly sequence within which there may be great variation but where the pattern follows a major form. Separation through growth and development is a process whereby parents and child learn to differentiate themselves from each other and to part gradually – a process made possible by the satisfactions experienced by each individual in the family which bring a sense of growth, achievement, and contentment. The transition from one developmental period to the next during the early years is smoothed by the ever consistent, ever present parents, who create a sense of outer continuity, predictability, and harmony which helps the child to
develop a sense of inner security. Erikson (1968) has described this as essential for giving the child an identity and a sense of inner goodness and basic trust (Weber & Haberlein, 1972). Children housed in residential care, however do not have an ever present parent or parental figure. As a result they present with a plethora of missed experiences which could affect them in adverse ways.

This chapter aims to facilitate a holistic understanding of all aspects of residential care and the children placed therein. Before we can begin to understand the way these children are affected both emotionally and developmentally, we need to understand residential care within the South African context, the children’s experience of being removed from home and being placed in residential care, the process of placement, and the challenges these children face, what makes them vulnerable, and the concept of emotional well-being. These areas will form the focus of this chapter.

2.2 Residential Care

In South Africa, the policies and practices of apartheid prior to 1994 resulted in severe and widespread violation of children’s rights. Since the beginning of democracy, the country has made remarkable progress in addressing the historical inequities of apartheid and their consequences for children’s survival, development and well-being (Smith, 2009). The Constitution and a series of new laws and policies provide the enabling frameworks for children’s health, care, development and protection.

Despite these marks of real progress, inequity persists. Forty percent (16 million) of the South African population consists of children from birth to 18 years of age (Skelton, 1998). Seven out of ten of these children live in poverty. Although the proportion of children living in low income households appears to have decreased over the last five years, child poverty
continues to be pervasive and the proportion of poor South African children has remained constant.

Accounts of childhood adversity and extreme deprivation are not new to psychological literature. Intensive case studies of children raised in isolation or extreme deprivation have provided developmental psychologists with a better understanding of the effects of the early environment on later development. The influx of children adopted from impoverished residential care has provided a more recent opportunity to investigate the long-term adjustment and outcome of children who endured a circumscribed period of deprivation (Gunnar, Bruce & Grotevant, 2000).

2.3 Residential Care And The South African Government

Unlike many other developing world governments (Tolfree, 1995), the South African government has a clear regulatory framework for residential care. This is primarily detailed in the Child Care Act of 1983 and its associated regulations, as well as in a Minimum Standards for Child and Youth Care policy (released in draft form in 1998, but never formally finalised despite instructions from the government that it be implemented). This set of legislation is almost entirely concerned with the legal provisions associated with the protection of children who are not – or are not able to be – in the care of their biological parent(s). South African law currently sub-divides the broad category of residential or ‘institutional’ care into a set of different kinds of facilities, on the basis of the function they fulfil and the needs of the children they serve. These are as follows (Child Care Act of 1983, s.1.1):
a. **Children’s home:** A children’s home can be described as any residence or home maintained for the reception, protection, care and bringing-up of more than six children apart from their parents, but does not include any school of industries or reform school.

b. **Institution:** Defined as a reform school, school of industries or children’s home established under section 29 or children’s home registered under section 30.

c. **Place of care:** Place of care means any building or premises maintained or used, whether for profit or otherwise, for the reception, protection and temporary or partial care of more than six children apart from their parents, but does not include any boarding school, school hostel or any establishment which is maintained or used mainly for the tuition or training of children and which is controlled by or which has been registered or approved by the State, including a provincial administration.

d. **Place of safety:** Can be described as any place established under section 28 and includes any place suitable for the reception of a child, into which the owner, occupier or person in charge thereof is willing to receive a child.

e. **Reform school:** A school maintained for the reception, care and training of children sent thereto in terms of the Criminal Procedure Act, 1977, or transferred thereto under this Act.

f. **Shelter:** Is any building or premises maintained or used for the reception, protection and temporary care of more than six children in especially difficult circumstance. That is, place of care for children who are living in circumstances which deny them their basic
needs, such as children living on the streets or children exposed to armed conflict or violence.

The purpose and functions of each of these types of facilities is slightly different. Reform schools are aimed at children who have been convicted, while places of safety perform a much broader range of functions but are intended specifically to provide short-term placements for children who are awaiting trial or sentence or until appropriate longer-term arrangements can be made for them (such as their return to families, or placement in foster care or a Children’s Home) (Child Care Act, s.21(1)). In contrast, the general purpose of Children’s Homes is for the “reception, care and bringing up of children” (Child Care Act, s.29 (1)). There are slightly different provisions and regulations associated with each. The vast majority of Children’s Homes are run by welfare organisations; only a small handful country-wide are managed entirely by the government.

By law, a court inquiry is required in order for children to be placed in any of these facilities. Based on a series of criteria which define a child in legal terms as being ‘in need of care’ (Child Care Act, s.14(4)), the court may order that he or she be placed in a residential facility of some kind. In addition, any care arrangement in which more than six children are resident with a caregiver who is not kin is required by law to be registered as an official facility with the Department of Social Development and to conform to a series of criteria articulated in the Child Care Act and its regulations. Registration as a children’s home or other residential facility establishes the maximum number of children that may be cared for at the facility at any given time, and or as well as and the legal age-range of children that may be resident, among other things. In addition, registration as a residential facility with the Department entitles the facility to apply for a government subsidy of its services. This is
allocated on a per-capita basis, although a new financing policy – currently being piloted – aims to change this approach in the future.

In other words, in terms of current South African law, it is illegal to care for more than six unrelated children without court orders or legal emergency-placement orders. Concomitantly, any group-care set-up that does not consist (solely) of kin (grandchildren, siblings, nephews or nieces etc.) is illegal unless approved by the Department of Social Development.

New children’s legislation that will ultimately replace the Child Care Act of 1983 has been in preparation for many years. The Children’s Act no. 38 was passed by parliament in 2005, but in order to operate in full requires the finalisation of the Children’s Amendment Bill no. 19 of 2006. Unlike the Child Care Act of 1983 which focuses primarily on children’s protection, the new Act and its Amendment Bill attempt to legislate for a continuum of care for children: in other words, it includes provisions for so called ‘prevention’ and ‘early intervention’ services for children (some of which are referred to as ‘home- and community-based services’ in other policies) as well as specifically articulating that a child may only be placed by the courts in a residential care facility “if another option is not appropriate” (Children’s Amendment Bill 2006, s 158(1)).

The new legislation aggregates the range of types of residential care settings under the single title of “Child and Youth Care Centres”. These it defines as follows (Children’s Amendment Bill, s.191(1)): a child and youth care centre is a facility for the provision of residential care to more than six children outside the child’s family environment in accordance with a residential care programme or programmes suited for the children in the facility, but excludes:
a. a partial care facility;

b. a drop-in centre;

c. a boarding school;

d. a school hostel or other residential facility attached to a school; or

e. any other establishment which is maintained mainly for the tuition or training of children other than an establishment which is maintained for children ordered by a court to receive tuition or training.

The legislation requires residential facilities – Child and Youth Care Centres – to provide therapeutic programmes as appropriate to the targeted children’s developmental and other needs (Children’s Amendment Bill, 2006 s. 191(2-3)). This contrasts with the current context, in which the requirement for developmental and therapeutic programmes is located at policy rather than legislative level, in the Minimum Norms and Standards for Child and Youth Care Centres (National Department of Social Development, 2009). The Amendment Bill therefore explicitly frames residential care not only as a last resort for children’s care, but also as an intervention that requires more than simply addressing children’s basic physical needs (see section 6.7). Implied within the requirement for therapeutic programmes is a focus on short-term care for children in residential facilities. In addition, it positions Child and Youth Care Centres as ideally providing community-based services in addition to residential care. In addition to reconceptualising residential care, the Children’s Act of 2005 and its Amendment Bill provide substantially more detailed provisions for the sector. These include more detailed registration and operational requirements, specific provisions regarding the Department of Social Development’s responses to unregistered homes, provisions for ‘quality assurance’ and a requirement that the Department ensures that there is a strategy in
place to ensure “an appropriate spread” (s. 192(1)) of Child and Youth Care Centres in every province to cater for the range of children’s needs.

Other ‘alternative care’ options in the Children’s Act no. 30 and the Children’s Amendment Bill draw on but adjust those outlined in the Child Care Act of 1983. Formal court-ordered foster care placement of children ‘in need of care and protection’ with people other than their biological parents remains a key alternative care option, and is in particular being implemented as a response to the increasing numbers of orphans resulting from the AIDS pandemic (Meintjes et al., 2005). No more than six children can be legally placed in the care of a foster parent.

Official data about the state of residential care in South Africa is extremely sketchy. There are no consolidated national statistics illustrating the number and types of residential care facilities for children in the country, despite efforts on the part of the national Department of Social Development over the past year to collate data. Similarly, it is not known how many children are resident in such facilities. Publicly available official national statistics date from 2003, providing a total of 204 registered Children’s Homes countrywide (see Table 1).
Table 1

Registered Children’s Homes In South Africa, 2003

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Number of children’s homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>53</td>
</tr>
<tr>
<td>North West</td>
<td>4</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>4</td>
</tr>
<tr>
<td>Limpopo</td>
<td>8</td>
</tr>
<tr>
<td>Free State</td>
<td>14</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>48</td>
</tr>
<tr>
<td>Western Cape</td>
<td>40</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>24</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>204</strong></td>
</tr>
</tbody>
</table>


However in a study conducted one year later by Southern African Development Planning Evaluation and Research (2004), 21 of these homes were found either to have been incorrectly classified or to no longer exist. No data regarding the number of children in Children’s Homes or other residential care facilities are provided by either of the above studies. In a subsequent report compiled for the Department of Social Development, Skelton (2005) provides an estimate of 10 361 children resident in 181 registered Children’s Homes countrywide at the time of her study. This figure does not include children in secure care facilities, in places of safety or other residential care settings.

In early 2006, the Children’s Directorate in the national Department of Social Development initiated an audit of residential care facilities countrywide. By May 2007, the audit was still not complete, with data on some districts in provinces outstanding. Draft findings from the audit revealed at minimum 193 registered Children’s Homes across the country, at least half of which were located in KwaZulu-Natal and Gauteng provinces. In
addition, five state-run Children’s Homes were recorded. For this incomplete list of children’s homes, the registered capacity was 12920 children, substantially more than the numbers recorded in the Skelton (2005) study. Thirty-five percent of registered homes were documented to have a capacity of more than 60 children, with a quarter of these having a capacity of over 120. No data were collected regarding the actual number of children resident at the time of the audit. It is important to be cognizant of the fact that Department of Social Development is unable to render reconstructions services in the communities from which the children are removed. This then serves to explain the reasons why so many of the children have been placed in residential care for prolonged periods of time. The breakdown of traditional religious and cultural values as well as the increased incidence of HIV/AIDS has left most communities unable to cope with and absorb the large numbers of orphaned children. Additionally, many different types of children are still being abandoned (e.g., mentally and physically disabled children as well as HIV positive children). These incidences thus gives rise in the number of children housed by residential care facilities in South Africa and strengthens the increasing need for residential care facilities in South Africa.

2.4 Residential Care Defined And Process Of Placement

Phillips (1997) stated that residential care can be defined as a group living arrangement for children in which care is remunerated by adults who would not be regarded as traditional carers within the wider society. From a young person’s point of view, residential care might be described as being looked after ‘away from home by people who are not (their) parents’. If residential care means being cared for by generally unrelated people, and we believe that the essence of family life is the nurture and unconditional acceptance of children by adults in
an individual adult-child relationship, then we can see that residential care may fail to provide this. In fact the larger and more institutional the residential care, the less likely such individual nurture and unconditional acceptance is. Not all children are resilient enough to cope with damaging family behaviour in its extreme form. Some can become psychologically and even physically traumatised as a result (Phillips, 1997). They may then need to be removed from their family environment. The Child Care Act has been amended by the Child Care Amendment Act 96 of 1996, which brought changes to the criteria on which a finding that a child is in need of care must be based. The Amendment Act changed the test of whether the child is in need of care.

As stated previously, a variety of reasons exist as to why a family is not able to take care of their children and fulfil their needs. The Children’s Court may then find a child in need of care and decide the period of separation from the parents is the best for the child. A child is found in need of care and protection in the following circumstances if the child (Children’s Act 38 (2005) (s.150(1)):

a. has been abandoned or orphaned and is without any visible means of support;
b. displays behaviour which cannot be controlled by the parent or care-giver;
c. lives or works on the streets or begs for a living;
d. is addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency;
e. has been exploited or lives in circumstances that expose the child to exploitation;
f. lives in or is exposed to circumstances which may seriously harm that child’s physical, mental or social well-being;
g. may be at risk if returned to the custody of the parent, guardian or care-giver of the child as there is reason to believe that he or she will live in or be exposed to circumstances which may seriously harm the physical, mental or social well-being of the child;

h. is in a state of physical or mental neglect; or

i. is being maltreated, abused, deliberately neglected or degraded by a parent, a care-giver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is.

A designated social worker will then investigate the circumstances and if, after investigation, a social worker finds that a child referred to above is not a child in need of care and protection, the social worker must where necessary take measures to assist the child, including counselling, mediation, prevention and early intervention services, family reconstruction and rehabilitation, behaviour modification, problem solving and referral to another suitably qualified person or organisation. It is important to note that the social worker’s primary focus in these instances is on prevention and early intervention. Only if those two strategies have proved to be unsuccessful or the child is found to be in need of care and protection, will the social worker remove the child and enter the statutory process and the continuum of care. This process is diagrammatically reflected in the figure on the next page.
If a child is believed to be in need of care and protection, the social worker involved may remove the child with or without a court order. According to the Children’s Act 38 (2005) (s.151(1)) a child who is in need of care and protection that is removed by court order, will undergo the following process:

a. If evidence is presented that the child is in need of care and protection, the presiding officer will send a designated social worker to investigate the situation.

b. The same presiding officer may also issue an order that the child be placed in temporary safe care if it appears that it is necessary for the safety and well-being of the child.

c. A person authorised by a court order may, either alone or accompanied by a police official (a) enter any premises mentioned in the order; or (b) remove the child from the premises. A police official may use such force as may be reasonably necessary to overcome any resistance against the entry of the premises, including the breaking of any door or window of such premises: Provided that the police official shall first audibly demand admission to the premises and notify the purpose for which he or she seeks to enter such premises.
d. The person who has removed a child in terms of the court order must:

(a) without delay but within 24 hours inform the parent, guardian or care-giver of the child of
    the removal of the child, if that person can readily be traced; and

(b) within 24 hours refer the matter to a designated social worker for investigation and

(c) report the matter to the relevant provincial department of social development.

A designated social worker or a police official may remove a child and place the child in
temporary safe care without a court order if there are reasonable grounds for believing:

a. that the child-

   1. is in need of care and protection; and

   2. needs immediate emergency protection;

   3. that the delay in obtaining a court order for the removal of the child and placing the
      child in temporary safe care may jeopardise the child’s safety and well-being; and

   4. that the removal of the child from his or her home environment is the best way to
      secure that child’s safety and well-being.

b. If a designated social worker has removed a child and placed the child in temporary safe
   care, he/she must:

   1. without delay but within 24 hours inform the parent, guardian or care-giver of
      the child of the removal of the child, if that person can readily be traced; and

   2. not later than the next court day inform the relevant clerk of the children’s
      court of the removal of the child; and

   3. report the matter to the relevant provincial department of social development.
c. If a police official has removed a child and placed the child in temporary safe care
   1. without delay but within 24 hours inform the parent, guardian or care-giver of
      the child of the removal of the child, if that person can readily be traced; and
   2. refer the matter to a designated social worker for investigation
   3. without delay but within 24 hours notify the provincial department of social
      development of the removal of the child and of the place where the child has been
      placed; and
   4. not later than the next court day inform the relevant clerk of the children’s
      court of the removal of the child.

According to the Children’s Act 38 (2005), the best interests of the child must be the
determining factor in any decision whether a child in need of care and protection should be
removed and placed in temporary safe care, and all relevant facts must for this purpose be
taken into account, including the possible removal of the alleged offender from the home or
place where the child resides, and the safety and well-being of the child as the first priority.

In most cases a children’s court will issue an order placing a child in the care of a child
and youth care centre only if another option is not appropriate. If a children’s court decides
that a child should be placed in the care of a child and youth care centre, the court must -

a. determine the residential care programme best suited for the child; and
b. order that the child be placed in a Child and Youth Care Centre offering that
   particular residential care programme.

The provincial head of social development in the relevant province must place the
child in a Child and Youth Care Centre offering the residential care programme which the
court has determined for the child, taking into account -

a. the developmental, therapeutic, educational and other needs of the child;
b. the permanency plan for the child which was considered by the court, and any
   instructions issued by the court with regard to the implementation of the permanency
   plan;
c. any other instructions of the court;
d. the safety of the community and other children in the centre, in the case of a child in
   need of secure care;
e. the distance of the centre from the child’s family or community; and
f. any other relevant factors.

The provincial head of social development must, as a general rule, select a centre offering
the programme ordered by the court which is located as close as possible to the child’s family
or community. In many cases, the child will be removed from the home after every other
avenue of intervention has been exhausted. This implies that the child would have had
contact with the designated social worker and that he or she would, to some extent, know
what is happening in his or her world. However, in the case of small children, they may lack
the cognitive capacity to fully understand the situation thereby increasing their anxiety. It is
also important to note that when the designated social worker presents the case to the court,
all children involved enter the court proceedings, are made to hear why they are being
removed from the home. In most cases the children are expected to partake in the court
proceedings. In cases where the child is removed without a court order, little time remains to
orientate the child to the court proceedings and what is expected of him or her. And seeing
that the court is not a ‘child friendly’ environment, this experience could traumatisethechild
even before he or she has entered the residential care facility. The child thus has the
experience of being taken from home (at times by force), being placed in a temporary place
of safety, appearing in court (at times not being orientated to the process), and then being
placed in a residential care facility where he or she does not know anyone.

The duration of the stay for the child at the residential care facility may vary between the
following:

a. two years from the date the order was made (which is usually the case); or
b. such shorter period for which the order was made; and
c. may be extended by a children’s court for a period of not more than two years
   at a time.

When deciding on an extension of the period of a court order in the court must take
cognisance of the views of:

a. the child;
b. the parent and any other person who has parental responsibilities and rights in respect
   of the child;
c. where appropriate, the management of the centre where the child is placed; and
d. any alternative care-giver of that child.

No court order referred to in this subsection extends beyond the date on which the child in
respect of whom it was made reaches the age of 18 years.

Hatchuel (1985) outlines the following needs of a child who enters a residential setting,
which are essentially not unlike the developmental needs of any child: basic material needs;
physical growth needs; security and nurturing needs; educational needs; need for acceptance
and self-worth; self-actualizing and spiritual development. These needs are based on Abraham Maslow’s (1970) Self Actualisation theory and Erik Erikson’s (1968) theory of Psychosocial Development.

However, due to the fact that children are often admitted to residential care because of child abuse, traumatic experiences and severe neglect, they also enter the children’s home with diverse special needs due to traumatisation as a result of separation from the parent or caregiver, neglect or abuse. Sladde (2003) states that these children are victims of their circumstances and are therefore in need of some human understanding and support to overcome the barriers that lie before them. They also need a conducive environment which will prepare them for the eventual return to their parents or guardians. Therefore the alternative care situation needs to make provision for supportive services and specialized programmes in order to attend to previously damaged social, psychological, environmental and educational facets. Taking the diverse needs of children into account, it is therefore imperative that a child and youth care worker understands the child as a unique human being (Sladde, 2003, p.21).

A significant number of troubled children and young people are best helped by the provision of residential care. Residential care is essentially a safe haven for children who may for the time being not be able to live with their families, children who find the intensity of family relationships too much to bear, and those for who, as a consequence of past experiences, the notion of family life is too threatening. Residential care provides children with a safe, secure and structured environment. It meets their basic material needs, physical growth needs; security and nurturing needs; educational needs; need for acceptance and self-worth; self-actualizing and spiritual development. Children in residential care often attend school more consistently than when living with their family of origin. This regular
attendance allows for the early identification of developmental delays. The primary care
givers in the facility act as parental figures and model appropriate behaviour to the children.
This is a positive exposure since many of the children have been removed from their homes
due to unsafe living circumstances, abuse or abandonment. The residential care facility also
creates a treatment plan for the child which would, in most cases, include the possibility of
returning to the family or origin. In many cases a social worker would work with the family
to teach the parents better parenting skills etc. while the child is in residential care. This then
ensures that the child returns to a stable and nurturing home environment. There are,
however, areas of concern when it comes to the placement, adjustment and services rendered
by residential care facilities. These will be discussed below.

2.5 Areas Of Concern

The situation of residential care ‘on the ground’ in South Africa is demonstrated to be
much more complex than is acknowledged in policy discourse and debate both locally and
internationally (Kellmer Pringle, 1986). Data from studies document how residential care
settings for children vary substantially across multiple axes, and how in many instances
negative features associated with residential care settings do not apply. These include
concerns about children’s routine dislocation from family, community, and cultural
background; their marginalisation from everyday society; and the absence of opportunities to
develop secure, long-lasting attachments. A great deal of evidence has been collected from
around the world which shows that residential care is an extremely poor way of providing
include:
a. Children and young people who grow up in institutions often fail to develop their own cultural identity. They may feel alienated from their community. They often lack networks of friends and relatives and may lack the social skills needed to develop these. Adults who grew up in institutions form an 'underclass' in some societies.

b. A reduced potential to form secure, long-lasting attachments as well as reduced access to individuals who take a real personal interest in the child’s problems and achievements (Weber & Haberlein, 1972).

c. Overcrowding and a lack of privacy.

d. Reduced or no possibility to maintain contact with family members and friends.

e. A lack of preparation for future life when leaving the institution. There may be inadequate resources to assist them in finding accommodation and employment, developing relationships, and getting access to services. It may or may not be possible for the young person to remain in contact with the institution (Whittaker, Archer & Hicks, 1998).

f. Children and young people from institutions often lack interpersonal skills. Some may develop anti-social forms of behaviour (Weber & Haberlein, 1972).

g. Institutions are very poor at providing for children's psychosocial needs.

h. Institutions may promote stigma and discrimination. Children and young people in such institutions may be seen as 'different' from other children and young people and stigmatized as a result. Levels of physical care above and beyond those in the local community may also promote stigma (Whittaker, Archer & Hicks, 1998).

i. Many institutions lack staff members that are skilled in providing child care.

j. Children and young people rarely have the opportunity to participate in decisions that affect them in residential care.
In a small number of cases, children may be unable to face living in a family home so that even alternative foster care may not be appropriate. These children are then identified as vulnerable children. The next section deals with this.

### 2.6 Vulnerable Children

The reasons why children have to live apart from their families range from parental inadequacy and intractable pathology to inability to cope with overwhelming circumstances; and from temporary crisis to permanent abandonment. Kellmer Pringle (1986) states that three major advances have been made in our understanding of the implications of substitute care for children. They are well supported by research even though none have been translated into action. The first is that adequate physical care is not sufficient to ensure satisfactory emotional, social, and intellectual growth; secondly, that prolonged institutional life in a children’s home can have damaging effects on a child’s all-round development; and thirdly that many, if not a majority, of all children could remain in their own homes if effective and sufficient supportive services within the community were available.

Children who have been institutionalized have lost their mother and she has not been replaced. For such children, loss of the external regulation that a responsive mother provides and the absence of any substitute results in increased levels of stress hormones and alters and retards brain development (Ladd et al., 2000; Schore, 2001). Removal from the home and the transition to an institution poses enormous challenges for the child’s coping resources. It is reasonable to assume that all the stages of the period of transition to the institution embody a whole range of stress factors for the child: the period that precedes the intervention of the welfare authorities, during which abuse or neglect create a difficult environment for the child; the interim, countdown period of uncertainty until he leaves home, when he does not know
anything about the institution or what awaits him; and finally, the period of his arrival at the residential care facility, where he feels alien and must, in addition to being separated from his parents, cope with and adjust to the new place, peer group, and staff members who serve as alternative caregivers (Shechory & Sommerfeld, 2007).

Research has indicated that children placed in residential care can recover, at least somewhat, from the impact of such deprivation (O’Conner, Bredenkamp & Rutter, 1999). It is possible that some of the damage caused by early loss can be ameliorated if children are supplied with care that provides an opportunity to participate in earlier missed experiences. However, the experience of neglect or abuse is likely to influence a child’s emotional, intellectual, and social development and it could be that that influence is long-term, extending well into adolescence and adulthood. Studies show that there is a greater risk that children who have experienced neglect or abuse will develop various psychological disturbances during their lives, including problems in the areas of behaviour (aggressive or antisocial), learning, and social adjustment (Shechory & Sommerfeld, 2007).

In this context, vulnerability implies that a particular child or group of children who are at risk in a probabilistic sense for manifesting a certain behaviour or set of behaviours are susceptible to decrements in well-being. Risk factors are those biological and environment conditions known to be associated with decrements in well-being. The behaviours in question are those in which children are exhibiting a developmental delay or a decrement in well-being (Rogers & Ginzberg, 1990).

Rogers and Ginzberg (1990) state that many different approaches have been taken to measure the well-being of children. In this context, well-being can be defined in terms of social, physical, cognitive or academic, and emotional or mental health and development. For the purpose of this study, the focus will primarily fall on emotional well-being and how a
potential lack in emotional well-being may influence the general development of vulnerable children. This will now be discussed.

2.7 Emotional Well-being

Emotional functioning, emotional self-regulation, psychopathology, behaviour problems, and self-esteem are all measures of emotional well-being. Emotional well-being involves adaptation ability to draw upon inner and environmental resources to achieve an appropriate developmental outcome, which is often termed behavioural competence. Emotional well-being and behavioural competence are important elements in assessing the need for special educational services; mild mental retardation and developmental failure are defined in terms of both intellectual functioning and adaptive behaviour in everyday situations (Rogers & Ginzberg, 1990).

Middle-childhood behaviour problems are associated with later behaviour problems, specifically conduct disorder and delinquency (Whittaker & Trieschman, 1972). Few studies have been conducted on how environmental change influences behaviour in children. Almost no early intervention studies have measured behaviour problems, instead relying on cognitive outcome measures (Whittaker & Trieschman, 1972). The effect of institutionalisation on the general and emotional development of children in residential care will be further explored in the next two chapters pertaining to general development and emotional development.

2.8 Conclusion

Finally, it is important to take note of the important role that the residential care facility plays in rectifying the impact that the adverse family environment and consequent removal of
the child from the environment has had on the child both emotionally and developmentally. The focus therefore shifts not only to the impact that the home environment and removal has had on the child emotionally and developmentally, but also to how the residential care facility could go about maximising the child’s developmental potential.

The focus of this study is primarily on the emotional development of children in residential care. From the information provided in this chapter it is evident that key themes emerge when exploring the various factors which influence both the vulnerability and resilience of individual children. These key themes include the impact of the event or set of life circumstances which dictate the way in which a particular child is likely to be affected. Whilst the chronology of events is of importance, of even greater salience is the age and the stage of development at which these events occurred, as the child’s responses will be influenced by their cognitive capacity to make sense of the events. It is the particular conflux of individual personality factors, the nature of supportive relationships available to the child and the relative vulnerability of resilience at the time, as shaped by the influence of past history, which is most likely to inform the child’s need for support. These themes illustrate that we should not only be providing what each child needs at the time, but anticipating what they might need to develop a coherent story of life events and circumstances for themselves at later stages of development. This can be invaluable in influencing carers’ preparedness to identify and support the child’s later needs for additional help. These themes suggest that emotional experiences could affect emotional development which, in turn, affect the child’s general development. It is therefore important to explore theories of child development, issues in child development and the expected path of development for children to better understand the challenges that these children face. The next chapter will aim to do this.
3.1 Introduction

There are some universal characteristics of childhood that can be observed, the most obvious being the complete dependence on others from birth and into early childhood. The psychological and sociological study of children has yielded a vast amount of information about development. Many studies in the literature describe either stages of development or age-related maturational tasks. Those working in child care and protection must have some knowledge of such developmental milestones. However, it would not be possible or appropriate for them to become experts in this wide field but they need an overall awareness of physical, cognitive and emotional development in children. It is important to be cognizant of the fact that each child is born with potential and successful childhood can be seen in terms of achieving this potential. There can be different routes to this potential and different ways to encourage it. Some aspects of adult behaviour will support the development of potential, others will inhibit it and some aspects will have a negative effect. The experience of adverse life events and socio-economic deprivation may also affect development.

Thus each child, whatever the physical or intellectual capacity, has a potential which can be promoted. With information about what can be expected at any given age if a child’s development is supported and healthy, it should be possible to assess the extent to which an individual child’s potential has been undermined by adverse circumstances and events (Daniel, Wassell & Gilligan, 1999). The aim of this chapter therefore is to shed light on the study of child development, theories of child development, issues in child development and child development according to the domains of child development.
3.2 The Study Of Child Development

3.2.1 The Nature Of Development

The term ‘development’ refers to the process by which an organism (human or animal) grows and changes through its life-span. Craig and Baucum (2002) state that development refers to the changes over time in body and in behaviour due to both biology and to experience. Normal human development can therefore be viewed as a continuous process of growth and change which occurs from conception to death. This process takes the form of a series of progressive stages through which individual development evolves. Each stage holds with it a set of tasks that need to be mastered in order for the person to grow and develop. Human development can therefore be seen as a predictable pattern of development. The study of child development is multi-disciplinary and focuses on examining developmental trends, principles and processes in this pattern throughout the childhood years (Craig, 1999).

Due to the fact that biological and environmental factors interact with one another, normal child development can be viewed as taking place in a predictable pattern. However, children that are currently in residential care facilities are expected to follow a different developmental path due to their limited exposure to parental modelling, a nurturing environment and poor attachment (Craig & Baucum, 2002).

3.2.2 Principles Of Development

Gottlieb (1983) and Hinde (1983) have developed seven principles of development which will be discussed below. It is important to be cognizant of the fact that although these references are dated, they still provide a good point of departure to understand the nature of development.
The first concept of development is that of **forward reference**, or the pre-adapted quality of newborns (Gottlieb, 1983). Some behaviours of newborns (sucking and grasping reflexes) are present prenatally so as to maximize the probability of early survival. This concept states that early neural and behavioural development affect later development. An example of this principle is the extent to which the grasping and sucking reflexes are incorporated into later cognitive development in Piaget’s (1970) theory.

The second concept of development is that of **differentiation and hierarchical organization**. This concept states that organs and organisms undergo differentiation as they move from homogeneous states to heterogeneous states. The concept can be and has been applied to the development at organ level and at the organism level. At the latter level, children’s motor skills become more differentiated with age, as does their interaction with the environment.

The third concept is that of **optimum stage** or **critical/sensitive periods**. This concept holds that there are certain periods in development that are critical to development of specific behaviours. A familiar example is that of infant attachment in which early theory holds that if infants do not securely attach to the mother, they would suffer from subsequent personality abnormalities.

The fourth concept of development involves **individual differences**. This concept suggests that individual variations exists within species (for example, some boys may be physically active while others are passive). These differences are often accounted for by biological differences.

The fifth concept, sequence of behaviour stages, suggests **regularity despite individual differences**. Regularities relate to the specific sequence, or order, in which behaviours
appear. This well-known concept is best illustrated in Piaget’s (1970) theory of cognitive development, wherein children progress from sensorimotor, to preoperational, to operational levels of intelligence. Although the ages may vary for each stage, they appear in the specified order.

The sixth developmental concept relates to **functional considerations**, that is, the use of specific behaviour. The important point to stress here, which is related to the fifth concept, is that specific behaviour may serve different functions at different periods of development. For example, crying is an appropriate behaviour for an infant’s request for food; it would not be appropriate for a child currently in middle childhood.

The seventh developmental concept relates to **discontinuity/continuity** in development. This concept, like the fifth and sixth concept, explores the extent to which behaviour, traits, or skills are stable or unstable across the life span.

These seven principles have some correlation with existing theories of child development and also lay the foundation on which anomalies in development of children in residential care can be explained since these children may have difficulty attaching to individuals in their lives, display inappropriate behaviour (developmentally and socially) and have a tendency of not negotiating stages of development successfully (Hinde, 1983). Theories of child development will now be discussed in order to illustrate various ways in which childhood development can be viewed and understood.

### 3.3 Theories Of Child Development

Jean Piaget (1896-1980) was a Swiss cognitive theorist that significantly contributed to the understanding of children’s thinking by means of his Cognitive-Developmental Theory.
Child development was conceptualised by Piaget as gradual changes in cognitive organizations and structures which occur as the child encounters and adapts to new situations. He believed that the aim of all behaviour and thought was to adapt to the environment in effective ways. He thus viewed the mind as an active participant in the learning process. If information or an experience the person encounters fits within an existing mental framework, it is assimilated. Assimilation is viewed by Piaget as the process of making new information part of existing schemas (Craig & Baucum, 2002). If the information does not fit, the mind may reject it or accommodate the new information or experience. In this context accommodation refers to the act of changing our schemas when a new object or event does not fit (Craig & Baucum, 2002). Piaget holds that most learning situations involve an interaction between both processes. He believed that development occurs in an ordered sequence of qualitatively distinct stages which are distinguished by their increase in complexity. Four stages of cognitive development were identified, namely sensorimotor, preoperational, concrete operations and the formal operations stage. The preoperational stage takes place from approximately the age of two to seven years. The concrete operations stage occurs between the ages of approximately 7 years to 12 years of age. These two cognitive stages will be discussed in the section 3.5 pertaining to cognitive processes later this chapter with the focus primarily falling on the preoperational stage as the children who participated in this study fell predominantly within this age range.

Erikson’s (1964) theory postulates that individual development is the result of two simultaneous and complex influences, namely genetic and social factors (Schultz, 1990). Genetic factors determine development through the manifestation of characteristics that develop according to a genetically determined ground plan (Meyer, Moore & Viljoen, 2002, p.193). However, he also postulates that social influences are present and that they place
demands on the individual while at the same time providing the individual with opportunities for growth. These demands and opportunities are in accordance with, and complementary to, the developmental potential and needs of the individual at each stage of development.

Erikson believed that development occurs as individuals move through different psychosocial stages, each with its own developmental crisis. Successful resolution of the developmental crisis would result in optimal development. Erikson promoted eight psychosocial stages of development. The stages that fall within the focus of this study are the Initiative versus Guilt stage and the Industry versus Inferiority stage, since they span from ages three to six years and ages six to twelve years respectively and the sample of this study falls within these two stages. These stages will be elaborated upon in the section 3.5 pertaining to psycho-social development.

Vygotsky (1987) was the first psychologist to emphasize the social context in which much of children’s cognitive development takes place. Like Piaget, he saw the child as an active constructor of knowledge and understanding. But he differed from Piaget in his emphasis on the role of direct intervention by more knowledgeable others in this learning process. Vygotsky argued that it is as a result of the social interactions between the growing child and other members of that child’s community that the child acquires the ‘tools’ of thinking and learning (Smith, Cowie & Blades, 2003). In fact, it is out of this cooperative process of engaging in mutual activities with more expert others that the child becomes knowledgeable. Instruction, according to Vygotsky, is the heart of learning. Vygotsky defined two levels of cognitive development. The first is the child’s actual developmental level, as determined by independent problem solving. The second is the child’s level of potential development, as determined by the kind of problem solving the child can do under adult guidance or in
collaboration or play with a more capable peer. The distance between what a child can do alone and what a child can do with help is called the zone of proximal development.

A major challenge to Piaget’s theory comes from the more recent emphasis, within the field of developmental psychology, on the intricate and reciprocal relationship between the individual person and the social context. Piaget viewed the child as an ‘active scientist’ who interacts with the physical environment and develops increasingly complex thought strategies. This active child, constructing child often works alone at solving problems and forming concepts. According to Craig and Baucum (2002), Vygotsky’s and Piaget’s approaches are not opposite but rather complement one another in understanding cognitive development as a whole. Just as children at times learn from others, they also learn on their own at times. It is therefore apparent that some of the theorists had consistent ideas with regard to child development even though some theoretical concerns persisted. What seems to overlap is the impact of others in the child’s process of learning and how this may impact on both the cognitive and psychosocial development in the child. This overlap is important since, as stated in Chapter 2, children in residential care often lack the input from primary caregivers. This creates a void since these children may not be exposed to the experiences upon which they can challenge themselves and develop their identity and problem-solving skills. This could result in an insecure child who is stuck in earlier stages of development which were not negotiated successfully. In the current study, the researcher did not make use of one particular developmental theory as the primary theory since there are aspects of each theory which are valuable to the understanding of the development of children in residential care. The next section investigates issues in the study of child development in order to illustrate the differing viewpoints in this area.
3.4 Issues In The Study Of Child Development

Mussen, Conger and Kagan (1980) state that there are some theoretical concerns in addition to the practical applications of developmental child psychology. That is, there are questions about the fundamental nature of children and of human development. We will briefly examine five such issues, namely: the goals of development, nature versus nurture, the child’s activity or passivity, continuity versus discontinuity in development and stability of characteristics over time.

a. The Goals of Development

This theoretical issue revolves around whether the child is developing toward some ideal goal. On the one hand the psychological development of a child could be seen as representing progress toward a ‘most mature’ level of functioning or on the other hand, development could be viewed simply as a series of changes, without assuming that there is some final goal (Mussen, Conger & Kagan, 1980, p.5).

b. Nature versus Nurture

Mussen, Conger and Kagan (1980) state that one of the best-known controversies in developmental psychology concerns the relative effects of environmental factors and of biological forces on behaviour. Put more simply, this is the nature-versus-nurture, or heredity-versus-environment, issue. It is generally concluded that all development depends on both biological and environmental factors. The general consensus is that as the interaction between heredity and environment is so complex, it is ineffective to regard one as more important than the other and it is more advisable to focus on how these factors interact to influence development.
c. The Child’s Activity or Passivity

A third issue that has been found to be controversial revolves around the question of whether the child is naturally active or passive with respect to the world of people and objects. Is the child a passive product of experience or does the child actively select and influence the experiences she undergoes (Mussen, Conger & Kagan, 1980)?

d. Continuity versus Discontinuity in Development

The issue of how to best characterise developmental change has been a topic of debate for some time. Two contrasting positions have dominated this debate. Some theorists assume that the course of development is continuous, with changes and progress toward maturity taking place gradually, so that the curve of behavioural development shows a smooth, upward movement. Other theorists feel that the course of development is segmented, or divided into stages, and that development advances through a series of rather abrupt changes. In each stage, new abilities, ways of thinking and responding appear; a complex pattern of related characteristics or responses occur together and may be conveniently grouped. Each stage is characterised by distinct ways of functioning, and no stage can be skipped. In this view, each child goes through the same stages in the same order; a child cannot achieve a later stage without going through the earlier ones. The stage theorist’s curve of development is more like a series of steps (Mussen, Conger & Kagan, 1980). According to Craig (1999), it seems more likely that, assuming the stages of development are meaningful, development is most often gradual from one stage to the next and that the possibility exists that the individual could go back and forth between stages.
e. Stability of Characteristics over Time

The question of whether stability or consistency of characteristics over time exists has no fixed answer. Rather, the answer varies with the particular characteristic and with the age and gender of the individual.

Even though a wide array of theories on emotional and cognitive development in children were utilized in this study, it is important to again highlight that no one theory emerged as the primary theory for emotional and cognitive development, but rather that all theories mentioned had aspects which were relevant to the current study. In this way, it could be said that the researcher made use of living theory which can be described as an explanation produced by an individual for their educational influence in their own learning, in the learning of others and in the learning of the social formation in which they live and work (Cohen, Manion & Morrison, 2007).

The following section aims to provide and clarify the areas or domains of development in children and to further provide a measuring stick by which the development of the children in residential care can be compared to predictable patterns of development.

3.5 Developmental Domains

Early and middle school years are times of tremendous developmental changes. Some of these changes, such as the development of literacy, are a direct result of formal education. Schools also provide the opportunity for significant changes in children’s social lives and experiences. At the same time during this period there are surges in physical, cognitive, social; and emotional maturation. Children’s lives outside the home usually become increasingly important, they have friends, join clubs, are involved in sports and so on.
During this period it can become painfully obvious if a child’s potential is not being supported. It can also become clear if one child’s potential is different from another’s because of the number of changes to which the child is subject, adversity or abuse can have further dramatic effects on the child’s life. In the present study, the focus falls primarily on the emotional development of children in residential care, and how decrements in emotional development may affect the overall development of this population group. It is therefore necessary to have a holistic understanding of child development. This is discussed in more detail below:

### 3.5.1 The Physical Domain

In this section, physical changes of children between the ages of 5 and 8 years will be discussed, followed by both gross and fine motor development of the normal child\(^1\), and then a comment on the physical development of children in residential care facilities will be made.

#### 3.5.1.1 Early Childhood (ages 2 to 6 years)

Craig and Baucum (2003) state that the bodies of children between the ages of 2 and 6 years change in size, body proportions, and shape. At the same time, rapid brain development leads to more sophisticated and complex learning abilities and refinement of both gross and fine motor skills.

During early childhood, the child’s body form becomes more mature. As the upper parts of the body begin to approach adult dimensions, their growth slows down, giving the lower

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\(^1\) In this context the concept of ‘normal child’ refers to a child who had received optimum support while developing across all domains.
extremities a chance to catch up. Thus, during early childhood, head growth is slow, trunk growth is intermediate, and limb growth is rapid. By the age of 6 years the child has lost the relatively large, round, and protruding stomach characteristic of the younger child (Mussen, Conger & Kagan, 1980).

Craig and Baucum (2003) state that the centre of gravity in young children is higher than in adults since children carry a greater proportion of their weight in their upper body. Being top-heavy makes it more difficult to control the body. In early childhood, children lose their balance more easily and have difficulty coming to a quick stop without tipping forward. It is also hard for them to catch a large ball without falling backward. The centre of gravity gradually descends to the pelvic area as body proportions change. Along with these changes in body proportions, the child’s skeletal, muscular, and nervous systems are also becoming more mature (Daniel, Wassell & Gilligan, 1999).

Rapid changes in body size and proportions are obvious signs of growth, but unseen changes are also taking place in the brain. By the age of 5 years a child’s brain is nearly the size of an adult’s. Craig and Baucum (2003) state that brain development makes possible increasingly complex learning, problem solving, and language use; in turn, sensory perceptual and motor activity create and strengthen neural connections.

The hemispheres of the brain develop at different rates. Language is said to develop rapidly from age 3 to 6 years, and the left hemisphere of most children shows accelerated growth during that period. In contrast, their right hemisphere matures more slowly during early childhood (Daniel, Wassell & Gilligan, 1999). Brain lateralization is fully established during the preschool years as the child indicates hand and foot preferences (Craig & Baucum, 2003).
Children’s motor skills improve markedly during early childhood. The most dramatic changes are in gross motor skills such as running, hopping, and throwing. In contrast, fine motor skills such as writing and handling eating utensils develop more slowly (Daniel, Wassell & Gilligan, 1999). By the age of five years, children are able to skip smoothly, walk along a balance beam confidently, stand on one foot for several seconds, and imitate dance steps. Many 5-year-olds can throw a ball overhead and catch a large ball thrown to them (Craig & Baucum, 2003).

Fine motor skills require the coordinated and dexterous use of hand, fingers, and thumb. These skills are often not mastered by the preschool child since further maturation of the appropriate neuromuscular mechanisms is required. Craig and Baucum (2003) state that despite their increasing competence, young children have difficulty with precise fine motor movements. This is linked to the immaturity of the child’s central nervous system as well as to the child’s limited patience and relatively short attention span.

3.5.1.2 Middle Childhood (ages 6 to 12 years)

Middle childhood is an exciting time for learning and refining skills from reading and writing, arithmetic to playing ball and dancing. Given appropriate opportunities or training, children can learn to ride a bicycle, jump rope, swim, dance, write, or play a musical instrument (Daniel, Wassell & Gilligan, 1999). Children focus on testing themselves, on meeting their own challenges as well as those imposed on their world. The child who is successful will become capable and self-assured; the child who is unsuccessful may develop feelings of inferiority or a weak sense of self (Craig & Baucum, 2003).
Growth is slower and steadier during middle childhood. Gradual, regular growth continues until about age 9 years for girls and age 11 years for boys. Between ages 6 and 8 years the forebrain undergoes a temporary growth spurt, and by age 8 years the brain is 90% of its adult size. Brain development during this period produces more efficient functioning.

According to Craig and Baucum (2003) numerous studies have demonstrated how motor development progresses during middle childhood. At age 7 years, a boy can typically throw a ball about 10 meters. Accuracy improves as well. Girls are said to make similar progress in throwing and catching, although at each age their throwing distance is, on average, shorter than that of boys.

Fine motor skills also develop rapidly during middle childhood, growing out of skills taught in nursery schools and day-care centers. Craig and Baucum (2003) report that most of the fine motor skills required for writing develop between the ages of 6 and 7 years, although some quite normal children cannot draw a diamond or master many letter shapes until the age of 8 years. Ideally, children develop mastery over their bodies and at the same time and gain feelings of competence and self-worth that are essential to good mental health. Controlling their bodies also helps them win the acceptance of peers (Daniel, Wassell & Gilligan, 1999).

Kellmer Pringle (1986) states that on average, proportionately at the age of 7 years, more children in residential care facilities are shorter in height and lighter in weight for their age. In comparison with their classmates they appear to their teachers to have poor control over their hands when writing, drawing or buttoning up their coats; they are fidgety; they tend to have poor physical coordination when running about, jumping, or throwing balls; they are clumsy; and hardly ever sit still.
3.5.2 The Cognitive Domain

Craig and Baucum (2003) state that it is difficult to disentangle the contributions of increasing physical competence from those of cognitive development, when considering all the developmental changes that occur during early childhood.

For the purpose of this study, the following aspects of cognitive development in the normal child in early childhood as well as middle childhood will be discussed: cognitive processes, including the preoperational and concrete operational stages of development, and language development. For all the above mentioned aspects of cognitive development reference is made to children in residential care facilities in South Africa.

3.5.2.1 Cognitive Processes

3.5.2.1.1 Preoperational And Concrete Operational Cognitive Processes

Piaget was able to provide a clear description of the cognitive process of normal preschool children in the Preoperational stage of cognitive development. This period, that spans from age 2 to 7 years, and is characterised by children’s ability to form concepts and use symbols such as language to help them communicate. Craig and Baucum (2003) state that such concepts are limited to their personal, immediate experience. They add further that children in this stage of cognitive development possess very limited, sometimes magical notions of cause and effect and have difficulty classifying objects or events. They do not hold broad, general theories, but use their daily experiences to build specific knowledge. Preoperational children neither make generalizations about classes of objects, nor can they think through the consequences of a particular chain of events (Craig & Baucum, 2003).
In Piaget’s theory, the period from age 5 to age 7 years marks the transition from preoperational to concrete operational thought. Craig and Baucum (2003) state that thought becomes less intuitive and egocentric and more logical. Toward the end of the preoperational stage, the rigid, static, irreversible qualities of children’s thought begin to change. Children’s thinking becomes reversible, flexible, and considerably more complex. Children now notice more than one aspect of an object and can use logic to reconcile differences. They can evaluate cause-and-effect relationships if they have the concrete object or situation in front of them and can see the changes occur (Oates & Grayson, 2004).

The concrete operational stage of cognitive development spans from age 7 to 12 years and embodies the stage whereby children begin to think logically (McShane, 1991). They begin to classify using more than one dimension at a time, and understand mathematical concepts, provided that they can apply these operations to concrete or at least concretely imaginable objects or events. The concrete operational children begin to use logic in their thinking, but they may experience difficulty in understanding that a particular animal can be both a dog and a terrier (Oates & Grayson, 2004).

**3.5.3 Language Development**

Barrett (1999, p.1) defines spoken language as a code in which spoken sound is used in order to encode meaning. In the acquisition of language, there are four main areas of competence that the child must acquire. These are the rules of sound (phonology), meaning (semantics), grammar (syntax) and knowledge of social context (pragmatics). There seems to be similarities in all human societies in the sequence of language development, as children progressively master the rules of sounds, of meaning and of grammar, and learn to combine
words in ways which are acceptable and understandable within the linguistic community (Smith, Cowie & Blades, 2003).

Throughout early childhood children rapidly expand their vocabularies, their use of grammatical forms, and their understanding of language in socio-cultural activity. Craig and Baucum (2003) assert that every culture transmits language to its children. It was found that the child’s language develops most from everyday communication with adults who seek to communicate, that is, to understand and to be understood. When parents speak to their children, they communicate far more than words, sentences, and syntax. They demonstrate how thoughts are expressed and ideas are exchanged (Oates & Grayson, 2004). They teach the child about categories and symbols, about how to translate the complexities of the world into ideas and words. Conceptual tools provide a scaffold for the child to use in understanding the world and expressing her or his place in it. Craig and Baucum (2003) also state that language is one of the ways in which children learn who they are and how they should relate to other people.

The language of the child in early childhood gradually becomes more complex than the telegraphic forms used earlier. Now the child begins to use adverbs and an occasional article and puts proper endings on some nouns and verbs. However, progress is gradual. Children may use the proper inflection half the time and not use it at other times (Mussen, Conger & Kagan, 1980).

Oral and written language skills become more refined during middle childhood. As the child’s vocabulary continues to expand, children master increasingly complex grammatical structures and more sophisticated language usage (Craig & Baucum, 2003). Although oral language development is often dramatic, it frequently takes a back seat to the development of literacy. Younger children focus on learning to produce and understand spoken language;
older children learn to read and write. Reading includes learning phonetics and how to decode the alphabet, and writing includes refining the fine motor skills needed to form letters. Reading requires the ability to elicit meaning from print and writing requires the ability to convey meaning in print. Both reading and writing are symbolic forms of communication that require attention, perception, memory, and other cognitive processes. Symbolic communication affords children the ability to relate to the external world through their inner thoughts and feelings. The development of reading and writing skills during middle childhood is a complex, multidimensional process that also emerges out of a sociocultural context (Oates & Grayson, 2004).

Kellmer Pringle (1986) found that lower levels of language, intellectual and educational performance were found among children of school age in long term residential care in the United Kingdom, when compared to their peers. This has also been demonstrated in a series of linked studies of seven-, eleven- and fifteen-year-olds. At all three age levels, both intellectual and reading skills were found to be below average but the most serious backwardness was in language development. Admission to care at an early age (i.e., preschool) and subsequent lack of contact with adults outside the residential home seemed to have particularly detrimental effect on both achievement and adjustment. Kellmer Pringle (1986) goes on to say that in general knowledge, ability to express themselves in conversation, reading and arithmetic, the proportion performing was twice or three times as high among children in residential care than their peers.

3.5.4 Development In The Social Domain

Early childhood is a time when the pace of children’s learning about their social and cultural world accelerates just as the overall cognitive development does (Daniel, Wassell &
Gilligan, 1999). Ideally, children learn what constitutes good and bad behaviour; how to handle their feelings, wants and needs in socially appropriate ways; and what their family, community, and society at large expect of them. They begin to acquire the norms, rules, and mores of their culture. At the same time, they develop a keen and perhaps lasting concept of self (Craig & Baucum, 2003). For this reason, the focus of the study falls primarily on the social development of children between the ages of 5 and 8 years through paying special attention to their emotional development, which contributes significantly to their social development. This section will also elaborate on the social and emotional development of children in residential care facilities. The discussion is first contextualised within Erikson’s psychosocial stage theory and then, emotional development.

3.5.4.1 Psychosocial Development

Werner (1990) argues that the life stories of resilient individuals have taught us that competence, confidence and caring can flourish, even under adverse circumstances, if young children encounter persons who provide them with a secure basis for the development of trust, autonomy, and initiative. It is with this view in mind, that we now explore Erikson’s stages of psychosocial development as they apply to the current study.

Erikson’s (1964) eight stage model is based on the premise that each age is characterised by an emotional struggle between two polar internal states, one negative and one positive. In this regard Erikson states that the key struggle in early childhood is initiative versus guilt. This stage embraces the third to the sixth year and is characterised by the development crisis initiative versus guilt. This stage embodies the child’s increasing independence of movement and the eroticisation of the genitals. What emerges are the psychosocial modalities of intrusion and inclusion (Meyer, Moore & Viljoen, 2003). Children at this stage can act on
their own initiative, and can therefore feel guilty about their behaviour. In this context, initiative refers to the purposefulness of young children as they ambitiously explore their surroundings. They eagerly learn new skills, interact with peers, and seek guidance of parents in their social interactions. Children experience conflict between their abilities to intrude into other people’s lives and their new-found realisation of moral rules, which are encouraged by their identification with the parent of the same sex.

Erikson (1964) believes that at this stage the children psychologically become rudimentary parents, in their readiness to adopt and apply rules and their eagerness to care for younger children. This stage is therefore exceptionally important in the development of the conscience. The danger of this stage is that the conscience will develop too strictly or in a moralistic way. Excessive guilt can dampen the child’s initiative. If the child’s self-confidence and initiative-taking breaks down, it could result in timidity and fearfulness that can remain a part of the child’s personality for life. The ideal resolution of the crisis lies in finding a balance between the childlike enthusiasm for doing and making things and the tendency to be too strict in self-judgement.

The industry versus inferiority stage covers the ages of six to twelve years. Children now learn to gain recognition by producing things. They develop a sense of industry, learn to handle the tools of their culture and become keen collaborators in any productive process. Society meets these tendencies of children by creating opportunities for learning and cooperation. In society this is the prolonged and complex process of formal schooling directed at the acquisition of basic skills such as reading, writing and arithmetic. The danger in this stage is that children may fail to acquire the skills and tools of their culture, which causes feelings of inferiority to develop. This sense of inferiority can affect personality throughout life if it isn’t compensated for later or by ongoing success in other activities that are valued.
A healthy balance is reached through the ego strength of competence, which is one of the conditions for participating successfully in the cultural processes of productivity and, later, to be able to maintain a family (Meyer, Moore & Viljoen, 2003).

Emotions, however also impact on both the development and behaviour of children. This will now be further explored in the section below.

3.5.4.2 Emotional Development

Emotions have been the subject of much interest throughout history. Like many of life’s most important features, emotion is easier to experience than to define. Greenspan and Greenspan (1985) define emotions as “complex, subjective experiences that have many components, including physical, expressive, cognitive, and organizing, as well as highly personalized, subjective meanings” (p.7). Developmental psychologist and researcher in the field of emotion Izard (1991) elaborates on this definition by further stating that an emotion is experienced as a feeling that motivates, organizes, and guides.

Emotions provide children as well as others with information that can shape their behaviours after or during the experience of emotion. Emotions also affect the behaviours of others, because their expression can help in the effort to describe and predict the child’s behaviour. Emotions are thus important both interpersonally and intrapersonally (Denham, 1998). Denham further states that the experience and expression of emotion signal that goal-directed behaviour of the child or other people needs to be modified or continued.

Saarni (1987) states that “emotion’s meaningfulness is grounded in human relationships…transactions among people [are] the primary focus for feelings to be experienced, observed or inferred, talked about, and elaborated into expectancies for guiding
one through future interpersonal interactions” (p.536). Therefore very young children learn the ‘feeling rules’ of their community from their own experiences and the socialization of adults (Hochschild, 1979). Most contemporary emotion researchers believe that the ‘emotion system’ seems to guide or organize human thought and action (Bower, 1981; Campos, Barrett, Lamb, Goldsmith & Stenberg, 1983; Emde, 1980; Izard, 1977; 1991).

3.6 Conclusion

As stated previously in this chapter, human development is viewed in terms of accomplishments of crucial socialisation tasks. These tasks will be learned and skills acquired if the socialising agents (such as parents) create an atmosphere and opportunities for the child to learn to the best of his or her ability. This chapter provided information on the study of child development, theories of child development, issues in child development and the child domains in development. However, since emotional abuse and neglect affect the speed and quality of development, especially during the early years of a child’s life, the concept of emotional development requires further investigation. This will be investigated in depth in the next chapter.
CHAPTER FOUR
THE EMOTIONAL WORLD OF CHILDREN

4.1 Introduction

As stated in Chapter 2, the children who participated in this study had all been removed from their homes and parents due to abuse and neglect. In the context of this study abuse or neglect is referred to as maltreatment. This section aims to provide an overview of the experiences of the children in the sample of this study.

Maltreatment manifests itself in many different ways and in varying degrees, from lack of care and provision of basic physical needs, to lack of attention to stimulation and encouragement of optimal growth and development of children. It also manifests itself by failure to provide love, affection, and emotional availability to the child. At its worst, the child might be rejected and badly affected by parental hostility and dismissiveness (Iwaniec, 1995). Table 1 depicts the factors of maltreatment.

Table 1
Factors Of Maltreatment

While physical neglect and abuse are more obvious and easier to recognise, emotional abuse and neglect can go unnoticed for a long time. The child might appear well dressed, clean, and well provided for, but seldom played with, spoken to, looked at, comforted, attended to when in difficulties, or cuddled. Verbal and physical contact is limited, and emotional input is insignificant in cases of neglect. When children live in such a hostile, anxiety-arousing, or indifferent atmosphere, their physical, cognitive, intellectual, and emotional development will quite likely be arrested. In infancy curtailed development will tend to manifest in insecure attachment and delayed psycho-motor development; in preschool children it will manifest in disturbance of social and emotional behaviour; and in school-age children it will show itself in serious learning deficits and behavioural problems (Iwaniec, 1995).

This chapter aims to provide a holistic understanding of emotional development as well as the emotional worlds of children housed in residential care.

4.2 Theories Of Emotion

The first modern theory of emotion was proposed by William James in the 1880s. At the same time, a Danish psychologist, Carl Lange, reached the same conclusions. According to the James-Lange theory, stimuli in the environment cause physiological changes in the human body that are interpreted as emotions. If these physiological changes alone cause specific emotions, it is possible to pinpoint different bodily changes for each emotion. Some evidence indicates that the physiological changes associated with fear and anxiety are somewhat different from those that accompany anger and aggression. Similarly, fear and anger appear to be distinguishable from happiness by subtle changes in heart rate acceleration. Moreover, to some extent, different emotions are associated with different brain areas. Positive emotions are accompanied by an increase in the electrical activity on the left
side of the brain, whereas negative emotions result in more activity on the right side (Morris & Maisto, 2002).

The James-Lange theory does pose some problems. Sensory information about bodily changes flows to the brain through the spinal cord. If bodily changes are the source of emotions, then people with severe spinal cord injuries should experience fewer and less intense emotions. Research, however, has demonstrated that this is not the case. Moreover, most emotions are accompanied by quite similar physiological changes. Thus bodily changes do not cause specific emotions and may not even be necessary for emotional experience (Morris & Maisto, 2002, p. 375).

The Cannon-Bard theory dates back nearly 70 years and states that the experience of emotions occurs simultaneously with biological changes. This theory was expanded on by cognitive psychologists who argue that emotional experience depends on one’s perception or judgment of the situation one is in. According to the cognitive theory of emotion, the situation gives us clues of how we should interpret our state of arousal (Morris & Maisto, 2002).

Although a cognitive theory of emotion makes a great deal of sense, some critics reject the idea that feelings always stem from cognitions. Another direct challenge to the cognitive theory claims that emotions can be experienced without the intervention of cognition (Morris & Maisto, 2002). According to this view, a situation such as separation or pain provokes a unique pattern of unlearned facial movements and body postures that may be completely independent of conscious thought. When information about our facial expressions and posture reaches the brain, we automatically experience the corresponding emotion.
Izard (1993) proposes four highly interactive activators of emotion that are arranged in a loose hierarchical manner: neural, sensorimotor, motivational, and cognitive. According to Morris and Maisto (2002), many neuroscientists agree that activity in brain circuits involving emotion-related neurotransmitters, or direct stimulation of networks involving emotion-related brain structures, can lead to emotion.

The effects of sensorimotor feedback from facial and postural movement as a cause of emotion have also been well documented. Tomkins (1962) speculated that certain facial expressions initiate neural programs that produce emotional experiences. Specific facial movements may create a change in blood flow to the brain resulting in changes in cerebral brain temperature, and presumably, neurochemical processes that mediate feeling states. Morris and Maisto (2002) go on to say that emotional states also arise from motivational processes, especially those related to variations in drives (i.e., hunger and sex) or potential or actual tissue damage (pain). Finally, Izard (1993) proposes that cognitive processes – appraisals, attributions, beliefs, and desires – affect the activation of emotions. Although individuals often refer to cognitive processes as though they operated independently, these events work in conjunction with neural, sensorimotor, and motivational processes to produce emotions.

4.3 Emotional Development

Emotional development occurs as a function of cognitive development and the acquisition of new knowledge according to Kagan (1978). With the development of new cognitive functions (e.g., the ability to evaluate self and to recognize when social standards have been violated), the types of incentives that contribute to emotion states change, systematically, from external to internal. These new acquisitions permit the individual to experience
emotions that would not be possible without them, and the resulting emotions are seen to be qualitatively distinct from previous ones. In this view, emotions function to keep the mind focused on the desires and events of the moment, to direct the person to find ways to maintain the pleasant feelings and eliminate the unpleasant ones, and to support the enculturation of values.

Greenspan (1985) has built upon a neo-Freudian view of emotions to construct a description of six overlapping stages in the first 4 years of children’s development. His approach can be characterised as a developmental-structuralist theory of ego development that includes consideration both of general developmental trends and of inborn, constitutional differences in children’s affective, sensory, and behavioural responsiveness (Hyson, 1990). Greenspan (1985) developed a model of early emotional development based on Erikson’s theory describing psycho-social development that can be summarized as follows:

a. **Basic trust versus mistrust forms** the stage from birth to six months. During this stage, a favourable outcome is negotiated when the child is able to develop hope and trust in the environment. If this outcome is not negotiated, the child will develop suspicion and fear.

b. **Autonomy versus shame and doubt** forms the second stage in emotional development and includes the age range of 1 to 2 years. Should this stage be negotiated successfully, the child will develop the ability to exercise choice and self-restraint as well as a sense of self-esteem and pride. An inability to negotiate this stage successfully will result in a propensity for shame and doubt about his or her ability to control his or her actions.
c. The third stage of emotional development is called \textit{initiative versus guilt} and it spans children between the ages of three and four years old. Successful negotiation of this stage allows the child to be able to initiate actions and enjoy accomplishments. However, should the child fail during this stage, he or she will end up fearing punishment. Hyson (1990) states that as infants grow into toddlers and preschoolers, children move toward wider, more complex emotional relationships. They have more varied complex, and flexible ways of expressing emotions and better coordination and control of emotions and emotion-related skills. They also develop an ability to reflect on their own feelings and those of others. Children of this age are able to represent emotions through language, play, and fantasy. This is important in emotional development since it allows the linking of individual emotions to culturally valued skills and standards and results in an integrated, positive, autonomous but emotionally connected sense of self.

d. The last stage of emotional development is \textit{industry versus inferiority} and includes children between the ages of 6 and 8. An ability to successfully negotiate this stage, enables the child to feel competent and allows him or her the ability to use his or her skills to make things well. Should the child not negotiate this stage successfully, he or she will harbour feelings of inadequacy and inferiority.

At every emotional developmental stage, children are active constructors of their own emotional development. Even in infancy, children actively attempt to regulate their own emotions and to cope with feelings of anger, fear, and loss. Greenspan (1985) points out that, by the end of the first year of life, early attachment relationships lead to purposeful
communication and to toddlers’ creations of a coherent, positive sense of self. These accomplishments then make it possible for the toddler and preschooler to use language, pretend play, and other tools to create ‘emotional ideas’ and to engage in increasingly complex and differentiated ‘emotional thinking.’ Not all children negotiate these stages with ease. Greenspan (1985) emphasized that individual differences may create problems for some children.

Understanding that children show differing patterns of emotional competence across ages and individuals is important as well as realizing that these differences have a very real impact on how children work and play together, and on their feelings of mastery. It is therefore important to be cognizant of what to look for in terms of young children’s emotional development, why such development is crucial, and what aspects need fostering (Greenspan, 1985).

4.4 Key Factors In Emotional Development

In emotional development as in other areas, it would be difficult to find anyone today who believes that development is caused entirely either by heredity or by environment. Every aspect of children’s development is shaped by a dynamic interaction of biological, environmental, individual, personal, and sociocultural factors.

Five factors have been found to play a key role in the emotional development of children in early childhood. By themselves and in dynamic interplay with one another, these factors account for the typical progression of emotional development.

The factors for consideration are children’s:

a. Biological and physical characteristics, including physiological processes.
b. Individual differences in temperament.

c. Skills and limitations in other developmental areas, including the cognitive, language, and social domains; and

d. Family environment and relationships.

a. Biological and Physical Characteristics

Children’s biological or physical characteristics may influence their emotional development in many complicated ways. These influences may occur as a result of: (1) the basic features of children’s brains and nervous systems; (2) individual differences in children’s physiological responses; (3) gender differences; and (4) atypical developmental patterns, such as autism, Down’s syndrome, and visual impairment (Hyson, 1990).

Feelings, emotional expressions, and emotional behaviour originate in the brain and nervous system. Some writers go as far as to believe that each basic emotion is associated with a specific set of circuits in the nervous system. There is good evidence that emotions such as anger, fear, and interest are associated with changes in children’s heart rate, respiration, and brain activity. Researchers have also found actual variations in brain wave patterns, depending on whether children appear to be experiencing positive or negative emotions (Hyson, 1990). The maturation of the brain and the central nervous system helps children to develop better control over when and how they express emotions. In most normally developing children, this process occurs automatically and on a predictable schedule. Especially important is the maturation of the cerebral cortex, which plays an important role in inhibiting behaviour. This allows children to stop themselves from expressing strong emotions and helps them to delay action instead of acting impulsively.
It should however be noted that children of the same age also differ from one another in their physiological patterns of emotional response. These normal, innate differences, which may be detected in newborns, can predict later differences in children’s emotional responses, including their level of interest when interacting with a parent, their expressiveness, and their anxiety in new situations (Hyson, 1990).

Gender is the most obvious biological characteristic that distinguishes children from one another. The influence of gender on emotional development is not simple and straightforward. Many studies have found differences in boys’ and girls’ ways of expressing emotions.

b. Individual Differences in Temperament

Differences in temperament play an integral role in describing how children express emotions and how easily emotions can be activated. Recent research in developmental psychology supports the practitioner’s awareness of individual differences in temperament or ‘behavioural style’ (Bates, 1987). Some researchers have pointed out that temperament characteristics are closely related to children’s styles of emotion expression and emotion-related behaviour (Bornstein, Gaughran & Homel, 1986; Goldsmith & Campos, 1990; Thompson & Lamb, 1983). Temperament studies and the experiences of early childhood demonstrate that children have strong individual differences on a number of emotion-related dimensions.

From an early age, children differ in how fussy they are, how easy they are to soothe, how irritable they become, how sociable they are, how fearful and inhibited in new situations. Children also differ in how intensely they express emotions, how quickly they become
emotionally aroused, how well they can regulate their emotions and be comforted by others, and how they respond emotionally in stressful situations. In observing the same children over a number of years, researchers have found that differences in children’s temperament and related emotional expression styles tend to persist over time. Individual children’s characteristic facial expressions of emotion tend to stay the same as they get older (Hyson, 1990).

As seen with older biologically based differences, ‘innate’ temperament patterns exert a complicated influence on development. Although children may seem to be born shy or irritable, as they get older these temperament/emotion characteristics may motivate them to seek out or avoid certain experiences. Then, those experiences as well as the temperament pattern itself may further shape children’s social and emotional development (Hyson, 1990).

c. Development in other domains

Hyson (1990) asserts that the course of early emotional development is also influenced by children’s advances or limitations in other developmental stages. Cognitive skills also exert a clear influence on emotional development. When children are able to symbolize or mentally represent experiences, they can use pretend play to act out emotional issues or conflicts. When children begin to understand general cause-effect relationships, their awareness of the causes of emotion is enhanced. Children’s limited understanding of certain concepts and processes sometimes results in fear, sadness, or distress.

Children’s emotional development is also influenced by their developing language skills. Toddlers’ new ability to use language allows them to label their own feelings and those of
others. Within the family, they use language to express affection, to comfort others, and even to tease or joke about emotional states.

The domains of social and emotional development are closely related; thus, it is not surprising that children’s emerging social skills help them with their emotional development. The peer group often becomes the place where children unambiguously find out what happens when they inappropriately express or regulate their emotions.

d. **Family Environment and Relationships**

Children’s experiences at home are linked to their understanding and expression of emotion (Denham, 1998). Children influence their parents as least as much as parents influence their children. Parents’ own temperament characteristics and styles of emotion expression may affect children through parents’ interactions with them; but these same parental characteristics may also be transmitted to children through genetic inheritance. For all these reasons, children’s family environments have a strong impact on the course of their emotional development.

Parents’ expressions of emotion influence children’s immediate behaviour as well as their long-term development. Both beneficial and harmful effects of adult emotion have been identified. On the beneficial side, parents’ positive emotions capture and hold babies’ interest in toys, books, and interesting sights. These episodes of affectively positive ‘shared focus’ are essential for early cognitive development (Trevarthen, 1984, pp.129-157). And children whose parents warmly encourage them to express their sadness and distress – but who also help them to cope effectively with negative emotions – are likely to develop more sympathetic, adaptive, competent patterns of social behaviour (Eisenberg, Fabes, Carlo &
Karbon, 1992; Roberts & Strayer, 1987). Parents’ patterns of emotion may also produce less beneficial influences. Even very young infants show marked negative reactions to mothers who are unresponsive and detached when the infants try to engage them in play. In the face of this adult detachment, children who began by displaying persistence and distress often lapse into passivity or avoidance of their parents (Stoller & Field, 1982). Children whose mothers express a great deal of negative emotion are often sadder and less mature in their peer relationships.

4.5 Emotional Development In Childhood

Denham (1998) states that the age period from 2 to 5 years is a time for change in both caregivers and children since progress in all areas of children’s development take place. According to Denham children from 2 to 5 years of age are more emotionally sophisticated.

Goleman (1995) states that a lack of emotional competency could have dire consequences. He argues that emotional literacy is as vital as any type of learning. These abilities continue to develop throughout the lifespan, but at preschool age children are surprisingly adept at several components of emotional competence, some of which are highlighted in the next paragraph.

Children at preschool age are able to better express their emotions in that they are able to make use of gestures to express nonverbal emotional messages about a social situation or relationship (e.g., giving a hug) as well as demonstrating empathic involvement in others’ emotions (e.g., kissing a baby sister when she falls down and bangs her knee). These children are able to display complex social and self-conscious emotions, such as guilt, pride, shame, and contempt, in appropriate contexts. Children are also able to realize that one may
feel a certain way ‘on the inside’, but show a different demeanour ‘on the outside’ – in particular, that overt expression of socially disapproved feelings may be controlled, while more socially appropriate emotions should be expressed. Children of this age group also display a form of emotional understanding. The preschool child has learnt how to discern his or her emotional states as well as other’s emotional states and are better equip to use the vocabulary of emotion (Denham, 1998). In terms of emotion regulation, the preschool child is better able to cope with aversive or distressing emotions or the situations that elicit them. They are also able to cope with pleasurable emotions or the situations that elicit them and to strategically ‘up-regulate’ the experience and expression of emotions at appropriate times (Denham, 1998).

These component skills of emotional competence work together in an integrated way when functioning optimally. Denham (1998) states that they are intricately interdependent. This integration of emotional expressiveness and understanding within the social milieu of young children is inescapable. First, the development of emotion regulation is necessary because of preschoolers’ increasingly complex emotionality and the demands of their social world. Their emotional experience becomes more and more complicated as they begin to feel blends of emotions and finely nuanced emotions (e.g., guilt and shame). With so much going on emotionally, some organized emotional gatekeeper – emotion regulation – must be cultivated. Preschoolers’ become concerned about success with friends, as well, and this developmental focus demands emotion regulation. A cry-baby does not fare well on the playground. Second, emotion regulation is possible because of young children’s increased comprehension of emotionality.

The development of emotion happens in stages much like development in the other domains. For a child to have emotional security and be able to express emotions in socially
appropriate ways, he or she has to be able to negotiate certain stages of emotional
development in order to progress. Table 2 taken from Iwaniec (1995) provides a summary of
the emotional developmental tasks from birth to 15 years of age and hazards in the
achievements thereof. Table 2 is presented on the following page.

Table 2

Developmental Tasks

<table>
<thead>
<tr>
<th>APPROXIMATE AGE PERIOD</th>
<th>CHARACTERISTIC TO BE ACHIEVED</th>
<th>MAJOR HAZARD TO ACHIEVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 2 years</td>
<td>Sense of trust or security</td>
<td>Neglect, abuse, or deprivation of consistent and appropriate love in infancy; harsh or early weaning</td>
</tr>
<tr>
<td>2 to 4 years</td>
<td>Sense of autonomy—child viewing self as an individual in his/her own right, apart from parents although dependent on them</td>
<td>Conditions which interfere with the child’s achieving a feeling of adequacy or the learning of skills such as talking</td>
</tr>
<tr>
<td>4 to 6 years</td>
<td>Sense of initiative—period of vigorous reality testing, imagination, and imitation of adult behaviour</td>
<td>Overly strict discipline, internalisation of rigid ethical attitudes which interfere with the child’s spontaneity and reality testing</td>
</tr>
<tr>
<td>6 to 11 years</td>
<td>Sense of duty and accomplishment—laying aside of fantasy and play; undertaking real tasks, developing academic and social competencies</td>
<td>Excessive competition, personal limitations, or other conditions which lead to experiences of failure, resulting in feeling of inferiority and poor work habits</td>
</tr>
<tr>
<td>12 to 15 years</td>
<td>Sense of identity—clarification in adolescence of who one is, and what one’s role is</td>
<td>Failure of society to provide clearly defined roles and standards; formation of cliques which provide clear but not always desirable roles and standards</td>
</tr>
</tbody>
</table>

Source: Iwaniec (1995, p. 50)

The initial stages of emotional development presented in Table 2 are essential to providing
the child with a solid emotional foundation upon which they can build as they mature. From
the Table presented above, it can be seen that the primary caregivers of the child play a
crucial part in setting a firm emotional foundation and since it would appear that the children in this study did not have such emotional care, they may present with a plethora of emotional difficulties due to neglect, removal from home and consequent placement in residential care. The impact of residential care on these children will be explored in the next section.

4.6 The Impact Of Residential Care Facilities On Children’s Emotional Development

When considering the impact of residential care facilities on the emotional development of children it is important to be cognizant of the fact that there is a complex interweaving between these aspects, the value and limitations of residential care. This will be explored further in the section below.

4.6.1 Insecure Attachment

Apart from the duration of the stay in the facility, it is reasonable to assume that the child’s personality traits will also influence his adaptability. Attachment style is an individual difference variable that is rooted in the child’s early upbringing and provides the context for later relationships with the environment. The child’s attachment style is found to be related to the degree of his adjustment to institutional placement. Bowlby’s (1988) original theory of attachment assumed that the child’s mother or mothering figure is the primary attachment figure. While it is true that at the start of their lives all infants form an attachment to their mothers, the child’s ability to develop a secure attachment to his caregiver depends upon the degree to which the care is consistent and effective.

Children who have experienced faulty care may form an insecure attachment pattern, which will very likely manifest itself in the avoidance of contact or in an attachment pattern with high levels of anxiety and ambivalence (Bowlby, 1988). Bowlby held that poor
attachment with parents was both a source and an outcome of trauma. Children develop maladaptive internal working models of relationships when caregivers are consistently unreliable, absent, or unresponsive. These disruptions in the attachment process produce intense anger, anxiety, fear, and grief and impede the child’s ability to develop a trusting and secure attachment to the caregiver. As a result, insecure attachment may lead to the development of maladaptive affective regulation patterns (e.g., withdrawal, avoidance, intimidation, aggression).

Bowlby (1969) asserts that studies investigating physically abused and neglected children in the context of the attachment theory found that those children tended towards insecure attachment to their mothers. Ainsworth (1989) claimed that attachment patterns between mother and child can be extrapolated to individual differences arising later in life, since individual attachment styles leave a distinctive mark on all emotional relationships that have an attachment component.

Ainsworth (1989) stated that the term ‘working models’ in the theory of attachment refers to cognitive patterns which integrate all that the person knows about close relationships, based on how he experienced his early childhood relationships. The assumption is that this knowledge continues to impel him throughout his life and shapes the nature of the relationships that he will form later.

These working models not only affect cognition, memory, and attention, but also affect behaviour and the appraisal of experiences. Similarly, it has been found that these working models are related not only to coping in one’s close relationships, but also to additional aspects of one’s emotional life, among them emotional regulation and mechanisms for coping with stress. Research conducted to examine these assumptions has shown that children and adolescents with a secure attachment pattern show fewer behavioral disturbances and lower
levels of aggression than those with insecure attachment patterns (Ainsworth, 1989). Children with attachment security will also have less fear in new situations, develop better problem-solving abilities and show more cooperation and empathy in interpersonal relationships and more ego resiliency, as well as better cognitive intellectual performance (Bowlby, 1973). Children characterized by an anxious or ambivalent style, which is assumed to reflect a history of inconsistent maternal responsiveness, will in subsequent social situations be withdrawn and vulnerable to threats of separation. Avoidant attachment may lead to later emotional insulation, lack of empathy, and antisocial and aggressive behavior.

Being placed in residential care, particularly at an early age, would lessen the damaging effects of insecure attachment since these children would then be exposed to primary caregivers that play active roles in their lives and the satisfaction of basic needs. It would then, in turn, reduce the behavioural and developmental fallout that one would observe in children that have been exposed to inconsistent parenting for extended periods of time. If developmental and behavioural fallout persists, the residential care facility also has the resources to rectify these negative patterns by either offering remedial intervention or psychotherapeutic services.

4.6.2 Personal Identity And Relationships

It is important to be cognizant of the fact that however adverse the home, the child lives in familiar surroundings and is looked after, however inadequately, by familiar people. Being taken from it means the collapse of the world the child has accepted and trusted as the only one he or she knows. The younger the child, the greater the distress at being removed to an unfamiliar environment. The more limited the child’s understanding of verbal explanations,
the greater his or her bewilderment and the more difficult the task of restoring his or her sense of security (Kellmer Pringle, 1986).

The most damaging effect, however, is probably on the growth of self-awareness and the development of a sense of identity (Kellmer Pringle, 1986). The child has no single person who shares his own most basic and important memories, no one to confirm whether these memories are in fact correct or figments of his imagination, no one to polish up a fading memory before it is too late. Such a deprivation seems so damaging, that it is unsure as to whether it could ever be reversed. Not only does the child in long-term care have no reliable past; equally devastating, he has no predictable future except that he will come out of care at the age of eighteen.

There is some evidence of the importance of the child of having at least one dependable and lasting relationship with an adult while in long-term institutional care. In a study conducted, two groups of children were compared, one notably stable, the other severely maladjusted (Bowlby, 1973). All of them had been separated from their mothers before the age of 5 years and had spent the major part of their lives away from their own home; their ages ranged from 5 to 15 years old. The aim was to investigate possible reasons for the difference in their adjustment.

The most marked and consistent difference between them was in the amount of contact maintained with parents or parent substitutes: the stable children enjoyed a dependable, lasting relationship in contrast to the maladjusted group, where only one child had done so. Hence the maladjusted group had neither established nor maintained stable relationships and their outstanding characteristic was an inability to make relationships with adults or children (Kellmer Pringle, 1986).
According to Kellmer Pringle (1986) three hypotheses could account for these findings. First, the maladjusted group might have been constitutionally inferior and hence more susceptible to emotional instability. Secondly, their very early and virtually permanent separation might have done irreparable harm to their basic personality structure. This view of emotional development has been criticised as being too sweeping, narrow and deterministic. At the same time, knowledge is lacking on whether there is in fact a point of no return if the child remains permanently deprived of a close personal relationship with an adult (Kellmer Pringle, 1986).

The third hypothesis holds that, although prolonged and early separation and residential life are disturbing and potentially damaging experiences, this is not inevitably so. The opportunity to maintain continuous, frequent and regular contact with an adult outside the institution appeared to enable many a child to cope with them (Kellmer Pringle, 1986).

It seems as though a child needs to feel that he or she matters as an individual; that he or she is valued for his or her own sake and not only by someone who is paid for the job of caring for him or her. If lasting and unconditional love and loyalty from an adult are never experienced, then the child may fail to develop these qualities; also the later he or she learns to establish such relationships, the more difficult and longer it will be before he or she learns to trust adults and eventually reciprocate affection. Thus a vicious cycle is likely to develop; not having known a secure relationship, the child fails to learn in early infancy the responses appropriate and expected in such a relationship (Kellmer Pringle, 1986).
4.6.3 Long-Term Effects Of Emotional Neglect Or Abuse

The most commonly identified developmental deficits among 5 to 10 year-old emotionally abused and neglected children are in the areas of academic achievements at school and their ability to relate to the peer group (Iwaniec, 1995). Maltreated children were commonly found to be 2 years behind their peers with regard to verbal performance and maths abilities. It was also found that maltreated children were seriously failing in one or more subjects and had to receive remedial intervention. Iwaniec (1995) found that emotionally abused children and neglected children had parents who displayed a lack of interest in their children’s achievements and performance and further demonstrated a serious deficit in stimulating and providing opportunities for these children to learn and acquire new knowledge. Teachers found that these children were unable to concentrate and pay attention to the given task. Their problem-solving abilities were poor as was their ability to read and write. Social behaviour in the class was found to be marked by aimless overactivity and disrupting their own and other peers’ learning (Iwaniec, 1995).

Iwaniec (1995) stated that teachers find these children attention-seeking on the one hand and detached and uninvolved on the other. They desperately try to be noticed and accepted by their peers and teachers, but the way they do this is usually aggressive and disruptive. Therefore they are often excluded from the peers’ play in the playground and outside school activities. They are seldom invited to the birthday parties of other children and are seen as not worthwhile to have around or with whom to make friends. In order to compensate for their rejection by peers some of them will try to become particularly close to the teachers or to other adults in the school, and tend to follow them around just in case they have the chance to be helpful, appreciated, and wanted. They tend to volunteer to do various tasks at school, or to compete in sport or other competitions, even though they have no abilities to do so.
Emotionally abused children, in many cases, show longing and desire to belong and to be wanted, but lack social skills to get themselves into a circle of peers. Disruptive and aggressive behaviour as well as an inability to observe the ‘rules of play’ eliminate them from the peer group. Those children who are not performing well academically and who are criticised by the teachers are not easily accepted by their peers.

These children tend to suffer from very low self-esteem and low self-worth, and their attempts to be accepted, wanted, appreciated, and loved have been unsuccessful at home and often at school. Low self-esteem demonstrates itself in uncertainty, constant doubting, a sense of guilt, a belief that everything which is unfortunate or problematic is their fault, and apologising for everything verbally or by writing little notes (Iwaniec, 1995).

4.6.4 The Long-Term Effects Of Institutional Life

When entering into care, establishing a bond of affection could help the child to regain self-confidence, but this requires time and continuity in daily handling. It is important to be cognizant of the fact that not all residential care facilities are unable to provide the time and continuity which is required to foster self-confidence. In many instances, residential care facilities are able to completely eradicate the negative consequences of an unstable living environment or to, at least, minimise it. The focus of this section, however, falls on the residential care facilities that are unable to provide either. Young children who remain in residential care facilities tend to crave affection, to cling to visitors and to later on make indiscriminate friendships and to have difficulty in forming lasting relationships (Iwaniec, 1995).
When in later life the child is offered affection, he does not know how to reciprocate. His reactions will be immature, like those of a very young infant who naturally takes love for granted and demands unceasing devotion. In a normal family, the child learns as he grows older that he is expected to reciprocate: by delaying his demands for immediate or exclusive attention; by controlling his anger and selfishness; by considering the feelings of others; and by conforming to social expectations (Iwaniec, 1995).

Not having learned all this at the usual time, the emotionally deprived child will later alienate and often lose any affection and goodwill offered. This deprives him of the opportunity to learn the very skills needed in making close human relationships; instead he learns to mistrust affection when offered. Because of this mistrust, coupled with his emotional immaturity, he is likely to grow increasingly unable to respond to further opportunities for building up close, emotional ties. The more his ability to respond becomes stunted, the more his chances to build a reciprocal relationship recede. Eventually the vicious circle is closed: unloved and friendless, he is in turn unloving and hostile towards others (Kellmer Pringle, 1986).

Susceptibility to maladjustment and resilience in the face of rejection appear to depend on the quality of relationships available to the child while in care. By themselves, neither physical separation from the family nor living for long periods in institutions necessarily leads to emotional or learning difficulties.

4.7 Conclusion

It would appear that emotional abuse and neglect and consequent placement in residential care may have an overriding role in poor developmental attainment and may contribute
significantly to the development of emotional and behavioural problems in children in residential care. Neglect and rejection in infancy are associated with insecure and anxious attachment, which may impair a child’s intellectual, cognitive, social, and emotional development. At the toddler stage, it may delay language development and distort personality formation, peer-relations, and social adjustments. In middle childhood, the maltreatment will contribute to poor school performance, learning difficulties, lack of motivation, and behaviour problems. It would therefore be expected that we would see distortions in development in children placed in residential care. The theories and literature presented in this chapter will be compared to the results obtained in this study in Chapter 6. The next chapter aims to provide an overview of the methodological approach utilised in the study.
CHAPTER FIVE

METHODOLOGY

5.1 Introduction

The previous chapters emphasized how children in residential care may have significantly different emotional and general development patterns in comparison to children reared by their biological family unit.

The present chapter formulates the problem explored in the study and provides the aim and the specifics of the methodology employed to achieve this aim, the sampling method, a description of data gathering methods and how the research was conducted, as well as the data analysis procedures that were adopted.

5.2 Problem Formulation

The family structure of modern times, both in the more developed and in developing countries, can vary considerably. Relationships rather than structure have a greater impact on the ability of children to grow spiritually, emotionally and socially. Every aspect of children’s development is shaped by a dynamic interaction of biological, environmental, individual, personal, and sociocultural factors (Hyson, 1990). Since the world is made up of imperfect individuals, parenting is often inadequate. Yet children are often resilient and, for all its failings, the parent or primary caregiver relationship can sustain and nurture the child and help him or her to grow. Not all children, however, are resilient enough to cope with damaging family behaviour in its extreme form. Some can become psychologically and even physically traumatised as a result which may result in them being removed from their family environment (Hyson, 1990).
Historically and geographically, even in extremely difficult circumstances, most orphaned children are absorbed into their extended families, however tenuous the relationship, and also into other families in their communities without the involvement of any outside agent. But as traditional religious and cultural values break down – and this is particularly true in urban settings- people may be more reluctant to adopt children. With the increased incidence of HIV/AIDS, some communities are feeling unable to cope with and absorb the large numbers of children who are orphaned. Furthermore, many different types of children are still being abandoned (e.g., mentally and physically disabled children as well as HIV positive children). There has thus been a rise in the number of children housed by residential care facilities in South Africa.

Pringle (1986) states that three major advances in our understanding of the implications of substitute care for children has been made. These findings are well supported by research although none has been translated into action on the required scale (Pringle, 1986). The first is that adequate physical care is not sufficient to ensure the satisfactory emotional, social and intellectual growth in children. Secondly, prolonged institutional life in a residential care facility may have very damaging effects on a child’s all-round development; and thirdly that many, if not a majority, of children could remain in their own homes if effective and sufficient supportive services within the community were available. Pringle (1986) goes on to say that each year about half of all children who come into care do so because of their mother’s confinement or short term illness. Also, chronic mental or physical illness, and desertion or death of one parent account for a further ten percent of children. Research is needed to clarify how many children could be kept in their own homes, and how successfully, both in the short – and long-term; and how best to plan for those who are in care.

It is imperative to research the emotional development of children in residential care to determine whether decrements in emotional development would hamper the general
development of these children. Once this has been established, a treatment plan to overcome developmental lags could be established and implemented to give these children the opportunity to maximise their innate potential.

Quantitative and qualitative exploratory-descriptive research with regard to the general and emotional development of children in residential care facilities may contribute towards better understanding of the overall development of this sample group of children. It may also contribute to the formulation of more effective treatment programmes to assist with the skills for formal learning in either mainstream or specialized education.

5.3 Primary And Specific Aims Of The Study

The primary aim of the present study was to explore and describe the general and emotional development of a sample of children between the age of five and eight years in residential care. More specifically, the study aimed to explore and describe the general level of development of a sample of children in residential care; to explore and describe the development of a sample of children in residential care in six areas of development; and to describe the emotional wellbeing of children in residential care.

The Griffiths Mental Development Scales - Extended Revised (GMDS-ER) as well as the Human Figure Drawing (HFD) were utilised to assess the children in the sample on a one-on-one basis. The test data as well as scholastic reports and information obtained from the multidisciplinary team was then utilised to develop a developmental profile for each child. The developmental profiles were then studied to identify certain trends among the entire sample and these trends were discussed within the context of the domains of child development as well as existing literature on developmental trends identified in children housed in residential care.
5.4 Research Method

The primary focus of this research study was exploratory and descriptive in nature. The exploratory-descriptive approach was used to observe, record, and describe behaviours of interest. This is the primary and necessary goal for the development of scientific knowledge (Cozby, 1993). The multiple case study method was employed to explore and describe the development and emotional well-being of a sample of children in residential care, using both qualitative and quantitative data. Each aspect of the research methods employed is elaborated on in this section of the chapter.

The current study was exploratory in that the area of the general as well as the emotional development of children in residential care facilities is a relatively new area of research. Struwig and Stead (2001) state that exploratory research is a probe into an area of research which is relatively unexplored with the purpose of developing more explicit questions in order to generate further research. Makowem (2005) states that gathering information and describing aspects of development creates a wider knowledge base and better enables researchers to formulate pertinent questions with regard to the development of children with emotional developmental and/or general developmental lags. This study sought to explore the development of children in this sample group, rather than to explain their development. The sample group was small, which is typical of the exploratory method according to Struwig and Stead (2001).

The study is descriptive in nature due to the fact that the aim is to accurately describe specific areas of development. Aiken (2000) states that descriptive studies are structured to focus on relatively few dimensions of well-defined entities and to measure these dimensions systematically and precisely. Due to the fact that the aim of the study was descriptive, no prior research hypotheses were stated. The descriptive process in research can be conducted
using various methods, with the case study being one of these. The case study method, according to Struwig and Stead (2001), aims to isolate the features common to all cases, those that refer to only some of the cases, and those that are case-specific.

In the current study, the descriptive nature of the study was achieved by making use of multiple case studies to explore and describe the different areas of the development of children in a residential care facility. The appropriateness of this method lies in the fact that it allows the researcher to explore the status of the children’s development without any intervention on the part of the researcher. A unique strength of the case study design is its capacity to deal with a full range of evidence (Yin, 1994). Further advantages of making use of the case study method include the fact that the case study method can be used successfully to probe beneath the surface of a situation and to provide a rich context for understanding the phenomena under study. Due to the fact that case studies are intended to take the reader of the research into the world of the subject(s), case studies can provide a much richer and more vivid picture of the phenomena under study than other, more analytical methods (Marshall & Rossman, 1999). The single case study is best suited to rare and critical cases (Yin, 1994). In contrast, the multiple case study has a broader focus and is better suited to identifying common themes. Case studies cannot be generalized to populations or universes, but can be generalized to theoretical propositions (Yin, 1994).

However, cognizance must be taken of the possible disadvantages of conducting this form of research. These include the fact that case studies have been criticized because of their lack of rigor of the research methods employed and the degree to which personal bias, either of participants or of the researcher, could influence the findings and conclusions. Also, where participant observation is used, there is potential for bias, both in data collection and analysis. In any study that relies on observed behaviour, there is always the possibility that the very act of studying the behaviour will alter it.
Multiple case studies were utilised in this study to explore and describe general and emotional development of children in residential care facilities in South Africa, between the ages of 5 and 8 years. Contextual influences were considered; specific categories of information, such as family background, previous assessments by professionals, progress reports and general information from the residential care facility were examined in an attempt to more fully explore and understand each child’s development.

Yin (1994) states that quantitative and qualitative evidence usually form the basis of a case study. In the present study, the quantative test scores obtained from the two measures were used in conjunction with the information obtained from the Biographical Questionnaire and the staff at the residential care facility. Struwig and Stead (2001) state that when comparing quantitative and qualitative research, the most pertinent difference evident is that they differ in conceptualization of reality. Schurink (1996) reports that the quantitative paradigm is based on positivism which considers scientific explanation to be nomothetic, that is, based on universal laws. Reality is considered to be a single existence, the researcher is considered to be separate to that which is being researched, and therefore he/she is not influenced by the research (Struwig & Stead, 2001). This paradigm thus embodies the objective measurement of the social world in order to test hypotheses and ultimately predict and control human behaviour. The qualitative paradigm, in contrast, is antipositivistic and does not view reality as separate from the researcher. As a result, the researcher is part of that reality and research cannot be objective (Struwig & Stead, 2001). This form of research aims to understand social life and the meaning people attach to everyday living. A combination of both qualitative and quantitative approaches were used in this study: the quantitative data provided a measurement of each participant’s performance on a standardized developmental test, but this data was enriched with qualitative information.
provided by the primary caregivers of the children, namely the director of the residential care facility as well as the house mothers.

The quantitative data in this study consisted of scores obtained from the Griffiths Mental Development Scales-Extended Revised (GMDS-ER) while the Human Figure Drawings (HFD), information obtain during the interview with the staff (including biographical questionnaires) school progress reports and clinical observations made during the administration of the assessment measures were utilized to obtain qualitative data with regard to the participant’s emotional world.

5.5 Participants

5.5.1 Inclusion Criteria And Description Of Participants

The participants in this study were comprised of eleven South African children who were currently housed in a residential care facility. According to Yin (1994) there are no hard-and-fast rules about how many cases are required. Yin (1994) further suggests six to ten cases, if the results turn out as predicted, are sufficient to “provide compelling support for the initial set of propositions” (p.46). Since the multiple-case study approach does not rely on the type of representative sample logic used in survey research, the typical criteria regarding sample size are irrelevant. Instead, sample size is determined by the number of cases required to reach saturation.

The number of children selected for the study was influenced by the number of children available between the ages of 5 years and 8 years of age at the residential care facility. The sample consisted of both boys and girls and did not dependent on the length of their stay in the residential care facility at the time.
5.5.2 Sampling Procedure

Non-probability, purposive sampling was incorporated since it refers to procedures directed towards obtaining a certain type of participant (Dane, 1990). This form of sampling was utilized in this study since it allowed the researcher to purposefully select the sample group on the basis of certain characteristics (Shaughnessy, Zechmeister & Zechmeister, 2000). The children selected to participate in this study were all housed at the same residential care facility. Due to the fact that this study’s objective was not to generalize findings, but to rather find general trends, purposive sampling was deemed appropriate. The advantage of non-probability sampling is that the researcher uses his/her own judgement and chooses those participants who will best meet the purposes of the study. The disadvantage lies in the fact that since the probability that a person will be chosen is not known, the investigator cannot claim that his/her sample is representative of the larger population (Bailey, 1987). A further disadvantage is that the sampling error cannot be estimated (Dane, 1990). The study utilized purposive sampling due to the fact that the researcher approached a single residential care facility to assess the children that met the inclusion criteria. It should however be noted that the use of a purposive sampling method limits the generalizability of the findings, although generalization of the findings was not a key consideration in this study.

The sample participants were selected explicitly to encompass instances in which the phenomena under study were likely to be found. This approach to sample design is consistent with the strategy of homogeneous sampling, in which the desired outcome is the description of some particular subgroup in depth (Patton, 1990).
5.5.3 Description Of Participants

The number of children selected for this study was influenced by the limited number of children between the age ranges of 5 years to 8 years residing at the residential care facility. The total sample in the present study was comprised of 11 children between the ages of 5 years and 8 years old who currently resided at the residential care facility. Four participants were boys and seven were girls. The variables of gender, cultural group and duration of stay at the residential care facility were not used as inclusion or exclusion variables for the present sample.

Table 1 provides a summary of the pertinent characteristics of each participant in the sample.

Table 1

Summary Of The Characteristics Of The Sample

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age in Months</th>
<th>Gender</th>
<th>Language</th>
<th>Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>63.7</td>
<td>Female</td>
<td>Afrikaans</td>
<td>Coloured</td>
</tr>
<tr>
<td>B</td>
<td>76</td>
<td>Male</td>
<td>Afrikaans</td>
<td>White</td>
</tr>
<tr>
<td>C</td>
<td>77.9</td>
<td>Male</td>
<td>Afrikaans</td>
<td>White</td>
</tr>
<tr>
<td>D</td>
<td>76.2</td>
<td>Female</td>
<td>Afrikaans</td>
<td>White</td>
</tr>
<tr>
<td>E</td>
<td>93</td>
<td>Female</td>
<td>Afrikaans</td>
<td>White</td>
</tr>
<tr>
<td>F</td>
<td>88</td>
<td>Male</td>
<td>Afrikaans</td>
<td>White</td>
</tr>
<tr>
<td>G</td>
<td>84.9</td>
<td>Female</td>
<td>Afrikaans</td>
<td>Coloured</td>
</tr>
<tr>
<td>H</td>
<td>102.6</td>
<td>Female</td>
<td>Afrikaans</td>
<td>Coloured</td>
</tr>
<tr>
<td>I</td>
<td>101.2</td>
<td>Male</td>
<td>Afrikaans</td>
<td>Coloured</td>
</tr>
<tr>
<td>J</td>
<td>95.9</td>
<td>Female</td>
<td>Afrikaans</td>
<td>Coloured</td>
</tr>
<tr>
<td>K</td>
<td>105.8</td>
<td>Female</td>
<td>Afrikaans</td>
<td>Coloured</td>
</tr>
</tbody>
</table>
All children for the sample were selected from the same residential care facility as they had all been exposed to the same living circumstances in the residential care facility. It is also important to be cognizant of the fact that although all the children in the sample happened to be Afrikaans speaking and that no English speaking children were eliminated due to a language variable.

As all the participants, with the exception of Participant K, were in remedial classes, and as the scholastic progress reports obtained from the residential care facility indicated that the entire sample of children were performing below average scholastically, the careful selection of an appropriate assessment measure became essential. The GMDS-ER was therefore selected and incorporated to provide a fair representation of the children’s’ abilities as it was felt that a more challenging assessment measure would not have been appropriate. If these children were found to have obtained high scores on the GMDS-ER, the choice and incorporation of the needed assessment measures would have been revisited.

5.6 Data Gathering Methods

Yin (1994) stated that the strength of the multiple case study method lies in the fact that it incorporates a variety of types of data in order to thoroughly address the research question. The following methods of data gathering will be adopted in this study: The Griffiths Mental Development Scales - Extended Revised (GMDS-ER) and Human Figure Drawings (HFD), clinical observations, the Biographical Questionnaire, school progress reports obtained from the residential care facility and verbal information obtained from the social worker, director and house mother of the children in question at the residential care facility. These methods will be briefly discussed below.
a. The Griffiths Mental Development Scales-Extended Revised (GMDS-ER)

The Griffiths Mental Development Scales-Extended Revised (GMDS-ER) has been found to be a valuable and relatively culture-fair measure that can be used to assess the mental development of young children, an attribute which is obviously very significant within the South African context (Luiz et al., 2006). Ruth Griffiths, the inventor of the GMDS-ER, was keenly aware of the importance of interactions between the various learning avenues. She was aware of the importance of social and emotional development factors, and the interplay between these and mental development. The GMDS-ER is thus described as a developmental test rather than a cognitive or intelligence test. Assessing developmental abilities across infant and childhood years to the age of eight, it measures, individually and collectively, several different avenues of learning in six subscales, namely:

a. The Locomotor Subscale (A)

The items in this subscale assess the child’s regular physical strength, skill in speed and movement and rhythm according to what is expected at a specific chronological age. This scale indicates possible physical weakness or disability, neurological deficits or specific inadequacies of movement (Luiz et al., 2006).

b. The Personal-Social Scale (B)

Luiz et al. (2006) state that this subscale assesses the child’s level of independence and self-sufficiency as well as the degree of social interaction and co-operation in play with other children.
c. The Language Subscale (C)

This is the most intellectual subscale and challenges the child’s ability to use both receptive and expressive language. It involves the comprehension of language, but also the ability to use language in terms of vocabulary, the construction of sentences and paragraphs, the correct use of parts of speech, as well as the use of auditory memory (Luiz et al., 2006).

d. The Eye and Hand Co-ordination Subscale (D)

Luiz et al. (2006) state that the items in this subscale require manual dexterity, hand-eye co-ordination, manipulation of a pencil and persistence with a task.

e. The Performance Subscale (E)

This subscale assesses manual performance, including skills in manipulation, speed and precision. It supplements Subscale D in that hand-eye co-ordination is required, but the child needs to apply these skills in novel situations and needs to perform with speed (Luiz et al., 2006).

f. The Practical Reasoning Subscale (F)

The items of this subscale present practical problems to be solved, drawing on the basics of arithmetical comprehension. Some items require short-term auditory memory and some require the ability to differentiate between objects in terms of size, weight, length and height. This subscale provides an indication of the child’s ability to benefit from formal schooling as well as his or her understanding about moral and sequential issues (Luiz et al., 2006).

The GMDS-ER is considered by the critics to be the most thorough measure of mental development of young children (Luiz, 1994). The Griffiths Scales were originally developed
in the United Kingdom in 1954 to assess the development of children from birth to two years of age (Griffiths, 1954; 1970; 1986). The Scales were revised and extended in 1970 to encompass the assessment of children from birth to eight years and four months (Griffiths, 1970) and a sixth scale, the Practical reasoning Scale, was eventually added to assess emerging problem-solving and logical reasoning skills (Griffiths, 1970). According to Kotras (2003), research indicated a pressing need to revise the Scales, which were based on 1960 norms, as some items were deemed to be outdated, culturally biased or ambiguous. In 1994 a project was launched by the Association for Research in Infant and Child Development to revise and restandardize the Griffiths Extended Scales. The revision was completed (Luiz, Collier, Stewart, Barnard, & Kotras, 2002) and the GMDS-ER standardized in the British Isles, using a sample of over 1000 children. The restandardization of the Scales in South Africa will be next on the agenda, but until such a time it is important to bear in mind that studies utilizing the Revised GMDS, such as the present study, do so on the basis of the British standardisation sample norms.

Research on the GMDS-ER with regard to reliability and validity confirm that it is a sound psychological measuring instrument. In terms of reliability, during the standardization of the extended scales, a test-retest reliability of 0.77 was obtained (Griffiths, 1984). Griffiths was satisfied with this in view of the young ages of most of the children. In terms of validity, initially the General Quotient (GQ) of the 285 children in their 5th year were correlated with the developmental quotients of the different scales. The correlation ranged from 0.64 to 0.78. Griffiths (1984) regarded this as an indication of a common factor in the different scales. When the GQ was compared to IQ on the Terman-Merrick and Binet Simon scale, the correlation varied from 0.79 to 0.81 for the different year groups indicating a substantial common factor. Although the Griffiths’ psychometric properties have been discussed in numerous studies, Povey (2002) stressed that all the subscales need to be
investigated further with regard to construct validity. Therefore, caution must be taken when interpreting a child’s performance on the Griffiths Scales.

The reliability and validity of the Revised Griffiths Scales are currently being investigated. Initial studies of face and construct validity have been conducted and have revealed favourable results (Barnard, 2000; Kotras, 1998; Luiz, Oelofsen, Stewart & Mitchell, 1995).

The GMDS-ER has been used and researched worldwide and is considered to be applicable to diverse cultures (Luiz, 1994). Research regarding the clinical use of the GMDS-ER has confirmed that the measure is useful in the clinical assessment and diagnosis of children from normal as well as special population groups, such as children with attention deficit hyperactivity disorder (Baker, 2005), autistic children (Gowar, 2003), HIV positive/AIDS infants (Kotras, 2001; Sandison, 2005), children with cochlear implants (Makowem, 2005), and hearing impaired children (Schröder, 2004). Other studies have focused on comparing twins, 5 and 6 year old boys and girls, and normal South African and British children on the GMDS-ER (Davidson, 2008; Jakins, 2009; Van Heerden, 2007; Van Rooyen, 2005). In addition to the above, research has also been conducted on the Subscales of the GMDS-ER. Barnard (2000) revised the Practical Reasoning Subscale; and Knoesen (2003) completed a predictive validity study involving the assessment of urban preschool children to determine whether the GMDS-ER could be used to predict the scholastic performance of Grade 1 learners. Furthermore, doctoral theses have also been conducted on the Subscales of the GMDS-ER, such as Kotras’s (2003) exploration of the construct validity of the Revised Extended Griffiths Language Subscale; Knoesen’s (2005) exploration of the reliability and construct-validity of the revised Locomotor Subscale; Moosajee’s (2007) exploration of the validity of the revised Personal-Social Subscale and Povey’s (2008) exploration of the validity of the revised Eye and Hand Co-ordination Subscale. At present
there is an ongoing GMDS-ER research project in place focussing on clinical and normal samples of children as well as on the psychometric properties of the GMDS-ER such as its reliability and validity.

In the present study the Griffiths Mental Development Scales – Extended Revised (GMDS-ER) was utilised to assess the sample group of children currently housed in residential care, as it is an updated and comprehensive measure of the categories of child development discussed previously. These categories of development are measured according to the following six subscales in the test battery: locomotor; personal-social; hearing and language; eye and hand co-ordination; performance and practical reasoning. The GMDS-ER also gives an indication of the child’s abilities according to chronological age. It was therefore able to give an indication for each scale of how the child performed in comparison to a child of his/her age which is not housed at the residential care facility.

b. The Human Figure Drawing (HFD)

The interest in children’s drawings has a long and well-documented history. Over the years, the emphasis in the literature has shifted from comparative investigations of graphic productions by children and primitive people to clinical analyses of paintings and drawings of disturbed children, to longitudinal studies of individual youngsters from their first scribbles to mature drawings, and to the assessment of mental maturity by means of human figure drawings (Craig & Baucum, 2002). Studies have varied from descriptive observations to carefully controlled research and the use of statistical analysis.

Human figure drawings (HFD) have become one of the most widely used techniques of psychologists working with children (Munsterberg Koppitz, 1968). It should be noted, however, that the purposes to which the drawings are put vary greatly. Two main approaches to the interpretation of the HFDs exist today. The first of these is employed mainly by
clinicians who regard HFDs as a projective technique and who analyze the drawings for signs of unconscious needs, conflicts, and personality traits. Representatives of the second school of thought approach HFDs as a developmental test of mental maturity. It can therefore be said that the HFD test is one of the most valuable techniques for evaluating children just because it can be used both as a developmental test and as a projective method.

Human Figure Drawings (HFD) reflect primarily a child’s level of development and his or her interpersonal relationships, that is, his or her attitudes toward him or herself and toward the significant others in his or her life. It is further maintained that the Human Figure Drawings (HFD) may reveal a child’s attitudes toward life’s stresses and strains and his way of meeting them; drawings may also reflect strong fears and anxieties which may concern the child, consciously or unconsciously, at that given moment. HFDs are not regarded as a portrait of a child’s basic and enduring personality traits or as an image of the child’s actual appearance. Instead, it is believed that HFDs reflect the child’s current stage of mental development and his attitudes and concerns of the given moment, all of which will change in time due to maturation and experience. The HFD’s particular value is seen in its very sensitivity to change within the child, and these changes may be both developmental and or emotional.

The HFD requires that the child draw a whole person at the request of the examiner in her presence. It represents a graphic form of communication between the child and the examiner and as such differs from spontaneous drawings children may make when they are alone with friends.

There are four projective uses for children’s human figure drawings (Klepsch et al, 1982):
1. As a measure of personality: By examining the drawing of a person, one can derive information about the uniqueness of the drawer and discover how the drawer sees himself.

2. As a measure of self in relation to others: When children draw themselves along with their family or friends, they project into their drawings their view of themselves in relation to the others in the group.

3. As a measure of group values: The drawing of a person also provides clues to group values, since children tend to draw the kind of individual they most admire or respect.

4. As a measure of attitudes: By having children draw specific people with whom they come in contact, one can learn what their attitudes are towards these people.

Drawings can frequently offer insights into a child’s interpersonal relationships and emotional world which other psychological techniques or methods often fail to provide.

The Human Figure Drawing (HFD) obtained from the children during the administration period was scored and interpreted according to the Koppitz system as outlined in Psychological Evaluation of Children’s Human Figure Drawings (Munsterberg Koppitz, 1968) which focussed on the 30 emotional indicators on HFDs of children.

c. The Biographical Questionnaire

A Biographical Questionnaire currently being used in all studies utilizing the GMDS-ER as a measuring instrument was incorporated to act as a screening measure to identify whether any of the participants have been diagnosed with either a mental or physical disorder which may influence their performance on the GMDS-ER and the HFD. Should such disorders be identified, the participant would not form part of the research sample since participation may skew results.
The Biographical Questionnaire (See Appendix B) aided the researcher by providing relevant biographical and developmental information about the participants. The Questionnaire took the form of a mailed questionnaire that touched on information regarding the child’s age, gender, culture, language preference, and normalcy of development some of these variables determined whether the participant was eligible for inclusion. The Biographical Questionnaire was completed by the director of the residential care facility in consultation with the children’s caregivers. This ensured that all information was accurate and dealt with in a confidential manner.

5.7 Ethical Considerations

The proposed study commenced after permission was obtained from the Ethics Committee (Human) at the Nelson Mandela Metropolitan University (NMMU). Ethical guidelines form an integral part of this proposed study since it ensured that the sample was not abused in any way whilst providing clear guidelines for the researcher in terms of responsibilities. The following ethical considerations were enforced in the proposed study.

a. Informed Consent

Written informed consent was obtained from the director of the residential care facility and caregiver, before data collection commenced (See Appendix C and D). The director of the residential care facility acts as the guardian of the participants while they are housed at the facility. A cover letter accompanied the informed consent form, which presented the necessary information regarding the study, potential risks associated with participation as well as its benefits (See Appendix A). This form also stipulated that participation was
voluntary and that the residential care facility could withdraw the children from the research project at any point. Prior to administration, informed consent was also obtained from the participants verbally. The administration of the GMDS-ER and HFD only proceeded once informed consent from residential care facility had been given in written form to the researcher.

b. Confidentiality and Privacy

Participant confidentiality was ensured at all times by means of a coding system which replaced the participant’s names and surnames when capturing the assessment data took place. The names of the participants were not mentioned in the research report.

c. Inclusion Criteria

The selection, inclusion and exclusion of the participants were based on the purpose of the study and it was ensured that the selection process was just and fair. Participants were not excluded from the study on the basis of race, disability, gender, or religious beliefs.

d. Investigator Competence

The researcher conducted all the assessments herself and was fully trained in the administration, scoring and interpretation of the GMDS-ER and HFD.
e. Feedback

Feedback took the form of a confidential report for each participant which was delivered to the residential care facility. Verbal feedback was provided when needed or requested. In addition, the residential care facility will be provided with a copy of the proposed study. In the proposed study, suggestions in terms of enhancing the emotional development of children in residential care facilities will be made.

5.8 Procedure

The following procedure was incorporated to achieve the aims of the study:

1. The research proposal was submitted to the Faculty of Health Sciences Research Technology and Innovation Committee (FRTI) and the Ethics Committee (Human) of the Nelson Mandela Metropolitan University (NMMU). Once the respective committees had viewed the proposal, the necessary alterations were be made in order to ensure that the research study was conducted in an ethical manner.

2. The potential participants for the research study were then identified. The researcher delivered the information letters, informed consent forms and Biographical Questionnaires to the director of the residential care facility, who has been granted guardianship over the children in the care of the residence as well as to the formally allocated caregivers of the children.

3. The signed and completed documentation were then screened to ensure that it was completed correctly, and to ensure that the participants were suitable to the study. An opportunity for discussion was provided to allow for the clarification of any questions arising from the completion of the given documentation and Biographical Questionnaire.
4. Testing sessions were scheduled with the residential care facility. The researcher conducted the assessment herself to ensure that the children were not exposed to many strangers.

5. An individual report was compiled for each research participant in which feedback regarding his or her performance was given. In instances where areas of concern arose as a result of the research study, the director of the facility was made aware and a referral was made to the appropriate professionals so that the identified participant could receive the necessary intervention.

6. Data were captured and analyzed. Each individual case was described to highlight key emerging themes in the data.

7. The research treatise was then compiled and a copy of the study will finally be provided to the residential care facility.

5.9 Data Analysis

The information obtained from the biographical questionnaire, the GMDS-ER and the HFD was recorded under appropriate headings and the general quotient and sub-quotients were listed for each participant per case study (Appendix E and F depicts the format in which the data was captured). To analyse the GMDS-ER data further the mental age was compared to the chronological age for each case study participant. In this way, it was hoped that a rich description would be provided for each child separately. Table 2, depicted below, was utilized to determine the categorization of results obtained from the GMDS-ER:
### Table 2

**Interpreting Griffiths Mental Developmental Scales – Extended Revised Scores:**

**Descriptive Categories**

<table>
<thead>
<tr>
<th>Intellectual/ Mental Range of Functioning</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>140 and higher</td>
<td>Very Superior</td>
</tr>
<tr>
<td>130 to 139</td>
<td>Superior</td>
</tr>
<tr>
<td>116 to 129</td>
<td>Above Average</td>
</tr>
<tr>
<td>85 to 115</td>
<td>Average</td>
</tr>
<tr>
<td>70 to 84</td>
<td>Below Average</td>
</tr>
<tr>
<td>55 to 69</td>
<td>Borderline Case</td>
</tr>
<tr>
<td>54 and lower</td>
<td>Cognitively Handicapped</td>
</tr>
</tbody>
</table>

In the next step of the data analysis, the researcher considered the data obtained across the case studies and subjected this to thematic analysis to identify common or over-arching themes related to describing the general and emotional development of the sample group of children. Thematic analysis is a method of studying and analysing data in a systematic, objective and quantitative manner to assess certain psychological variables. As the present study is rooted within the framework of developmental psychology, the well-documented domains of childhood development, namely physical, cognitive and social development, were utilised as themes, rather than adopting the method of content analysis where themes are elicited and coded with appropriate wording. The researcher employed Tesch’s suggestion, as documented in De Vos (1998), to first read through the data of the case as a whole to get an overview before separating the data into the specific themes. The data were analysed case
by case and then all the cases were considered as a whole in order to integrate them and explore the possibility of common or over-arching themes.

The data for each case were analysed by recording a summary of salient points in the individual’s history under the headings previously mentioned. Thereafter, information from the reports of the multidisciplinary team was collected according to developmental domains, which in this study form the themes of analysis. Finally, the information from the GMDS-ER and the HFDs were recorded under appropriate headings. The general quotient and sub-quotients of the GMDS-ER were then listed. In order to analyse the quantitative data, the mental age was compared to the chronological age.

The present study incorporated Guba’s (1981) model for assessing the trustworthiness of the qualitative analysis. Quantitative research is subjected to assessment of validity and reliability, but qualitative research, because it is different in nature, needs to be assessed for merit using different techniques (Krefting, 1991). Guba’s (1981) model is based on the identification of four aspects of trustworthiness that are relevant to both quantitative and qualitative studies: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality.

a. Truth Value

In qualitative research, truth value refers to the credibility of the study and involves the researcher establishing confidence in the truth of the findings, given the context of the study (Lincoln & Guba, 1985). Truth value is considered the most important principle for the assessment of qualitative research (Krefting, 1991). An important aspect of assessing credibility is to identify and document recurrent patterns, themes, values and behaviours (Leininger, 1985). The credibility of any qualitative research study speaks to the issue of whether the findings are plausible; this in turn rests on the steps taken during the whole
process of data collection and analysis. Key among the factors that ensure credibility are the completeness of the data collection, the use of multiple analytical perspectives, and member checks to confirm the accuracy of the conclusions drawn (Yin, 1994). It is advisable for a researcher to spend time with the participant in order to identify recurring patterns. In this study, the researcher was the sole administrator of the GMDS-ER and HFD. This process allowed the researcher to make clinical observations. Any concerns or queries were directed at the staff at the residential care facility in an attempt to confirm or explain the observations. Similarly, observations made by the multidisciplinary team who work with the sample children, were documented in their files and discussed with the researcher during a meeting. The compilation of observations by a team of professionals was used to identify patterns and in this way credibility has been established by using more than one source of information with regard to each participant.

An added strategy of assessing truth value is the triangulation of data method in which multiple perspectives contribute to the establishment of data credibility (Knafl & Breitmayer, 1989). In the present study this was achieved as data were collected using the GMDS-ER, a quantitative measure, as well as the HFD, a qualitative measure, along with a variety of archival records. Peer examination furthered the aim of establishing truth value as during the process of the research; findings were continually presented to supervisors experienced in qualitative research for their input on the working hypotheses, evolving design of the study and overarching themes.

Miles and Huberman (1984) have proposed that the researcher can be viewed as a measurement tool and should also fall under scrutiny of credibility assessment. The following four characteristics are deemed necessary to assess the trustworthiness of the human instrument: the degree of familiarity with the phenomenon and the setting under study; strong interest in theoretical knowledge and the ability to conceptualise large amounts
of qualitative data; the ability to take a multidisciplinary approach and good investigative skills. In the present study these characteristics have been addressed in the following ways:

The researcher spent time at the residential care facility and was familiarised with the objectives and modus operandi of the facility with regard to housing and, in some cases, educating the children. The researcher studied the effect of emotional development on general development in vulnerable children before attempting to interpret both the qualitative and quantitative findings. A multidisciplinary approach was also adopted as the progress reports and other relevant data were included in the data gathered. The researcher was trained to be perceptive to qualitative cues in the clinical setting and the researcher’s investigation was monitored by supervisors.

b. Applicability

Trustworthiness also concerns the applicability of the findings to other contexts and settings. It is not considered as relevant to qualitative research as it is quantitative research due to the fact that its purpose is to describe a particular phenomenon or experience rather than to generalize. Because the aim of the study was to describe, and not to explain or make generalizations, the criterion of applicability did not assume prime importance. Lincoln and Guba (1985) maintain that if the researcher provides adequate data to allow comparison, the problem of applicability has been addressed. In this study the archival data was written up according to developmental domains, which allowed for comparison to other case studies. Also, a set procedure was used for data recording and analysis in each case study.
c. Consistency

Consistency considers the feasibility of the findings being similar if the study were to be replicated. Unlike the relatively controlled experimental quantitative environment, the qualitative field setting may be complicated by extraneous and unexpected variables. According to Duffy (1985), the key to qualitative work is to learn from the informants rather than to control them. Moreover, instruments that are assessed for consistency in qualitative research are the researcher and the informants, both of whom vary greatly within a research project, with the result that variability is expected in qualitative research. Guba’s (1981) model defines consistency in terms of dependability. In relation to the present research the exact methods of data gathering, analysis, and interpretation of the qualitative research process were described. Such dense description of methods provides information as to how repeatable the study might be or how unique the situation is (Kielhofner, 1982).

d. Neutrality

Neutrality refers to the extent to which the findings have been influenced by outside influences, biases, perceptions and motivations. In quantitative research this would refer to research objectivity, but in assessment of qualitative data the audit strategy is a major technique for clarifying what Guba (1981) refers to as conformability. This strategy involves an external auditor following the progression of events in the study to confirm that there is a logical sequence and adequate reasoning for decisions made. To avoid the effects of investigator bias, steps were taken to collect data from a variety of sources and, where possible, by researchers with different perspectives. For the purpose of the present research study a team of experienced supervisors, rather than a single supervisor, monitored the process of the research and confirmed that the conclusions reached were feasible.
5.10 Conclusion

The current chapter aimed to formulate the problem explored in the study and provided the aim and the specifics of the methodology employed to achieve this aim, the sampling method, a description of data gathering methods and how the research was conducted, as well as the data analysis procedures that were adopted.

Chapter 6 will discuss the themes and sub-themes identified through data analysis and will discuss the results obtained from the test administration, clinical observations, scholastic progress reports and information obtained from the residential care facility according to the themes and sub-themes identified.
CHAPTER SIX

RESULTS

6.1 Introduction

According to Craig and Baucum (2002), children five years of age have a brain that is nearly the size of an adult’s. During this time, brain development makes complex learning; problem solving and language use increasingly more complex while sensory-perceptual and motor activity create and strengthen neural connections. These neural connections are formed throughout the lifespan and are the physical basis of learning, memory and general knowledge.

During infancy and toddlerhood a growth spurt occurs which continues well into early childhood. The brain growth spurt is a period of consistent plasticity or flexibility, during which children can more readily recover from brain injury than at later ages (Craig & Baucum, 2002). It is therefore not surprising that increased knowledge on early brain development has led many theorists to the conclusion that interventions aimed at children who are at risk for cognitive impairment and developmental delays, because of poverty and intellectually impoverished home environments should start as early as possible (Craig & Baucum, 2002).

It was established in Chapter 3 that development refers to the changes over time in body and in behaviour due to the interplay between biology and experience. Theorists like Piaget defined child development as gradual changes in cognitive organizations and structures that occur as the child encounters and adapts to new situations. All theorists acknowledge the impact of social factors on the general development of children. Even though the present study focuses primarily on the emotional development of children in residential care and how
decrements in emotional development may affect the overall development of this group of children, it is imperative to have a holistic understanding and investigation of child development according to the traditional child development domains in order to understand the implications of decrements in emotional development on general development.

6.2 The Context And Themes Identified

The results portrayed in this chapter are aligned with the general aim of the study, which was to explore and describe the general and emotional development of a sample of South African children between the ages of five and eight years in residential care. More specifically, the study aimed to explore and describe the general level of development of a sample of children in residential care; to explore and describe the development of a sample of children in residential care in six areas of development; and to describe the emotional wellbeing of children in residential care. As discussed in Chapter 5, the strength of the case study method, which was used in this study, is its capacity to deal with a full range of evidence (Yin, 1994) and to provide a context for the phenomenon being investigated.

The results are presented across the case studies in accordance with established themes derived in relation to the traditional domains of child development. These themes are depicted in Table 1. The results obtained, which were summated to generate the themes, are based on the participants’ scores on the GMDS-ER and HFD, information obtained from the residential care facility, and school progress reports as well as clinical observations noted during the assessment period. In this chapter, the thematic results will be described and interpreted in relation to the theories and research discussed in Chapters 2, 3 and 4.
### Table 1

**Themes And Sub-themes Identified**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General cognitive development</td>
<td></td>
</tr>
<tr>
<td>Attention, task-orientation and task</td>
<td></td>
</tr>
<tr>
<td>completion</td>
<td></td>
</tr>
<tr>
<td>Language and auditory-perceptual</td>
<td>General language development</td>
</tr>
<tr>
<td>development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Auditory-perceptual</td>
</tr>
<tr>
<td></td>
<td>development</td>
</tr>
<tr>
<td></td>
<td>Literacy</td>
</tr>
<tr>
<td>Motor and non-verbal development</td>
<td>Gross motor development</td>
</tr>
<tr>
<td></td>
<td>Fine motor development</td>
</tr>
<tr>
<td></td>
<td>Visual-perceptual development</td>
</tr>
<tr>
<td></td>
<td>Body awareness</td>
</tr>
<tr>
<td>Planning and reasoning development</td>
<td></td>
</tr>
<tr>
<td>Social development</td>
<td></td>
</tr>
<tr>
<td>Emotional development</td>
<td></td>
</tr>
<tr>
<td>Scholastic performance</td>
<td>General scholastic performance</td>
</tr>
<tr>
<td></td>
<td>Numeracy</td>
</tr>
</tbody>
</table>

Please note: Not all the themes have sub-themes
A brief discussion on each of the themes identified will now be presented in order to provide the reader with an understanding of what the theme covered and which information was utilized to derive the theme.

Information was obtained from the GMDS-ER on each child’s overall development relative to their chronological age and developmental stage. A theme labelled “general cognitive development” was thus identified. General cognitive development can be defined as the way in which a child perceives, thinks, and gains understanding of his or her world through the interaction of genetic and learned factors (Bjorklund, 2004).

Attention can be defined as the ability to concentrate on an idea or activity as well as the completion of the activity (Bjorklund, 2004). The ability to concentrate plays a pivotal role in the development of children. Qualitative information obtained from school progress reports, case reports from the multidisciplinary team at the residential care facility as well as clinical observations recorded during the assessment highlighted the children’s ability to sustain their attention at any given time, the way in which they went about initiating a task as well as completing it. A theme labelled “attention, task-orientation and task completion” was therefore identified.

Language is the means by which individuals communicate thoughts, feelings, needs and wants with one another. It is the most human characteristic, essential to all human relationships (Bjorklund, 2004). It is a process starting early in human life, when a child begins to acquire language by learning it as it is spoken and by mimicry. Children’s language development moves from simple to complex. Since the development of language plays such a vital role in the formation of relationships, it was identified as a theme labelled “language development”. General language development was measured by the Language subscale on the GMDS-ER. This subscale allowed the examiner to assess the child’s use of language,
that is, their expressive language and also their receptive language or their understanding of
glanguage. The sub-theme titled “auditory-perceptual development” was included since
this area of development refers to the child’s ability to identify, interpret, and attach meaning
to sound. Information obtained from the scholastic progress reports were utilised to report on
this particular area of development as it was not formally measured during the assessment
period. Since the GMDS-ER does not provide a complete assessment of the child’s speech
and language development, the researcher incorporated information from the scholastic
progress reports specifically pertaining to literacy, to complement the information obtained
during the assessment period. “Literacy” was therefore identified as a sub-theme under the
theme “language and auditory-perceptual development”. The aspects of literacy obtained
from the school reports covered listening, speaking (speech, sentence construction and
vocabulary), expression and writing. It is important for the reader to be cognizant of the fact
that the researcher is including information on literacy from the scholastic progress report
even though it was not formally assessed during the assessment period.

As stated earlier in the chapter, sensory-perceptual and motor activity creates and
strengthens neural connections which, in turn, forms the basis of learning, memory and
general knowledge. Information was obtained from the GMDS-ER which measures specific
areas of motor development. In addition, information was also obtained from the school
progress reports regarding aspects of motor development. As a result, the theme “motor and
non-verbal development” was established with sub-themes on gross-motor development,
fine-motor development, and visual perceptual development. These sub-themes will be
elaborated on below.

**Gross-motor development** refers to movements that involve large muscle groups and are
generally more broad and energetic than fine motor movements. These may include walking,
kicking, jumping, and climbing stairs. Gross motor skills development is governed by two principles that also control physical growth. Head to toe development refers to the way the upper parts of the body develop, beginning with the head, before the lower ones. The second principle of development is trunk to extremities. Head control is gained first, followed by the shoulders, upper arms, and hands. Upper body control is developed next, followed by the hips, pelvis, and legs (Liddle & Yorke, 2003). Information gathered from the Locomotor subscale of the GMDS-ER, school progress reports and clinical observations during the assessment period were utilized to gather information on gross motor development.

Fine motor skills are the collective skills and activities that involve using the hands and fingers (Henderson & Pehoski, 2006). That is, fine motor skills are those skills that require the small muscles of the hand to work together to perform precise and refined movements. Eye-hand co-ordination, where a person uses their vision to control the movements and actions of their small muscles, is also an important component of fine-motor development. Information utilised to describe the fine-motor development of the children consisted of results obtained on the Eye and Hand Co-ordination subscale and the Performance subscale of the GMDS-ER, scholastic progress reports and clinical observations where applicable.

Perceptual development provides the foundation for interpreting the events of the world around us. Stimuli from the environment that evoke sensory experiences of hearing, seeing, and touching promote brain growth and development. Perceptual development occurs as infants explore and identify invariant features in the environment, discovering properties of and relationships between features (Hickey & Peduzzi, 1987). The sub-theme titled “visual perceptual development” was included since vision facilitates infants’ or toddlers’ exploration in the world, informing spatial awareness and orientation. Information for this sub-theme was largely gathered from the scholastic progress reports but some information
was also gathered from tasks performed on the Performance and Eye-hand Coordination Subscales of the GMDS-ER. Information obtained from the scholastic progress reports highlighted the need for a sub-theme titled “body awareness and laterality”. Body awareness or proprioception is the internal sense that tells you where your body parts are without your having to look at them (Cheatum & Hammond, 2000). Should a child present with poor proprioception in the fingers, it makes it difficult for that child to manage fine motor manipulations needed to write well, button clothing, and make a peanut butter and jelly sandwich without shredding the bread. Lateral preference (laterality) is a term used when a child favours the use of one eye, hand, or foot over the other. Children who do not establish lateral preference have difficulty using the non-preferred hand to assist the other.

Decision-making is the process of choosing what to do by considering the possible consequences of different choices (Jacobs & Klaczynski, 2005). Reasoning skills are utilized in the decision-making process and refer to specific cognitive abilities, some of which include assessing probability and thinking systematically or abstractly (Jacobs & Klaczynski, 2005). “Planning”, in this context refers to the capacity to do something that will achieve a goal. Much human behaviour is goal-directed. The ability to plan allows an individual to organize his or her behavioural and cognitive resources in ways that enable him or her to achieve goals that are not the immediate consequence of one simple action (Oates & Grayson, 2004). It was therefore imperative to the study to create a theme titled “planning and reasoning development”. The results obtained for this theme consisted primarily of the participants’ performance on the Practical Reasoning subscale of the GMDS-ER, some tasks on the Language and Performance subscales, school progress reports and clinical observations where applicable.
To successfully interact with others and cope with the complexities, stress and expectations of modern life, it is vital that all children acquire social skills. Social skills include the ability to recognize, interpret, and respond appropriately in social situations. Young children need a minimum level of social and emotional competence to function in a group and benefit from the learning environment of the school setting. School success is not predicted by a child's storehouse of facts or a precocious ability to read so much as by emotional and social measures. As stated previously, Piaget reinforced the fact that social factors impact on general development since it involves the growth of a child’s ability to relate to others appropriately, become independent, within a social framework, and included the growth of the child’s relationships with others, socialisation (the process by which children learn the culture of the society into which they are born) and the development of social skills (Craig & Baucum, 2003). Information that was obtained from the Personal-social subscale of the GMDS-ER, case reports from the residential care facility, school progress reports and clinical observations highlighted the need to include a theme labelled “social development”. The information utilised described the children’s’ ability to act independently and their behaviour within a group setting (such as school) and individually (during the assessment period).

In children, emotional development refers to the attainment of emotional capabilities and their expansion as the child grows. These capabilities enable children to have feelings about what they do and also about others. As stated by Greenspan (1985) in chapter 4, understanding that children show differing patterns of emotional competence in their emotional development across ages and individuals is important as well as realizing that these differences have a very real impact on how children work and play together and on their feelings of mastery. It is therefore important to be cognizant of what to look for in terms of
young children’s emotional development, why such development is crucial and what aspects need fostering (Greenspan, 1985). Since the focus of the study is on the emotional development of a sample of South African children between the ages of 5 and 8 years in residential care, it would only be fitting to have a theme labelled “emotional development. As stated in Chapter 3, emotions provide children as well as others with information that can shape their behaviours after or during the experience of emotion. Emotions also affect the behaviours of others, because their expression can help in the effort to describe and predict the child’s behaviour. Information for this theme was largely gathered from the HFD as well as case reports from the multidisciplinary team at the residential care facility where applicable.

During the data gathering, it became apparent that there was some information regarding the participants’ scholastic performance that did not fit under the themes already established. As a result, an additional theme labelled “scholastic performance” was created in order to accommodate this information. The information for this theme was gathered from the scholastic reports in terms of the general scholastic performance of the children as well as their numeracy proficiency.

The results will be presented per theme, after which a summative comment will be made. However, an in-depth discussion of the results and the implications thereof will be reserved for Chapter 7.

6.3 General Cognitive Development

The results utilised to assess this domain of development consisted of the participants’ general quotient scores on the GMDS-ER as depicted in Table 2. Yellow colouring in the
chronological age (CA) column indicates a performance above the participant’s CA whereas green indicates a performance below the participant’s CA. Additionally, the sub-quotient column has been colour-coded to highlight the intelligence category in which the performance fell.

**Table 2**

**General Quotient (GQ) On The GMDS-ER**

<table>
<thead>
<tr>
<th>Participant</th>
<th>GQ Score</th>
<th>Category</th>
<th>CA</th>
<th>MA</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>119</td>
<td>Above Average</td>
<td>63.7</td>
<td>73.7</td>
<td>Very Superior</td>
</tr>
<tr>
<td>B</td>
<td>104</td>
<td>Average</td>
<td>75.9</td>
<td>79.1</td>
<td>Superior</td>
</tr>
<tr>
<td>C</td>
<td>86</td>
<td>Average</td>
<td>77.9</td>
<td>67.3</td>
<td>Above Average</td>
</tr>
<tr>
<td>D</td>
<td>104</td>
<td>Average</td>
<td>76.2</td>
<td>79.3</td>
<td>Average</td>
</tr>
<tr>
<td>E</td>
<td>92</td>
<td>Average</td>
<td>93</td>
<td>85.6</td>
<td>Below Average</td>
</tr>
<tr>
<td>F</td>
<td>98</td>
<td>Average</td>
<td>88</td>
<td>86.3</td>
<td>Borderline</td>
</tr>
<tr>
<td>G</td>
<td>87</td>
<td>Average</td>
<td>84.9</td>
<td>74.3</td>
<td>Cognitively Handicapped</td>
</tr>
<tr>
<td>H</td>
<td>84</td>
<td>Below Average</td>
<td>102.6</td>
<td>86.4</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>87</td>
<td>Average</td>
<td>101.2</td>
<td>87.9</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>85</td>
<td>Average</td>
<td>95.9</td>
<td>81.4</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>88</td>
<td>Average</td>
<td>105.8</td>
<td>92.6</td>
<td></td>
</tr>
</tbody>
</table>

Please note: CA refers to chronological age whereas MA refers to mental age.

Based on the results illustrated above, Participant A was the only participant to obtain an above average score. Nine of the participants (Participants B, C, D, E, F, G, I, J and K) obtained average scores and 1 participant (Participant H) obtained a below average score.

When comparing the mental ages for the GQ with the chronological ages of the children, 3 Participants (Participants A, B and D) obtained a mental age that was higher than their chronological age while the mental ages of Participants G and K was relatively similar to their chronological age albeit lower. For 5 participants (C, E, F, H, I, and J) their mental age was found to be below their chronological age on all 6 subscales of the GMDS-ER.
Participant H was identified as having a possible developmental lag based on her performance on the HFD. Participants C, J and I were identified by the HFD as possibly presenting with cognitive immaturity or neurological impairment whereas Participant F was identified as a child in need of specialised education. Participant E’s performance on the HFD did not indicate any cognitive deficits.

In Chapter 3 it was pointed out that Piaget (1896-1980) considers children between the ages of 5 and 7 years as being in the transition period from preoperational to concrete operational thought. This transition marks a new-found ability to think morecomplexly, to evaluate cause-and-effect relationships and to use logic in problem solving. Earlier in the chapter it was stated that general cognitive development includes the way in which a child perceives, thinks and gains understanding of his or her world through the interaction of genetic and learned factors. Based on the results illustrated in Table 2, it is probable that Participant A had already successfully negotiated this transition, discussed above since she obtained an above average score. The remaining participants are likely to still be stuck in the more rigid, limited notions of cause and effect as well as classifying objects or events. In conclusion it can be said that the children’s general development was largely average. This will be discussed more thoroughly in the section pertaining to cognitive development in Chapter 7.

6.4 Attention, Task-Orientation And Task Completion

Table 3 depicts the results obtained from the school progress reports and case reports from the multidisciplinary team (social worker, director and respective house mothers) at the residential care facility, and clinical observations during the assessment. A cross (x)
indicates that the individual experienced difficulty in that particular area according to the participants’ scholastic progress report, an “o” indicates difficulty in a particular area identified by the multidisciplinary team, and a “*” indicates difficulty in an area observed by the clinical assessments.

Table 3

Attention, Task-orientation And Task Completion

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of Attention Deficit Disorder</td>
<td>A B C D E F G H I J K</td>
</tr>
<tr>
<td>Restless</td>
<td>o</td>
</tr>
<tr>
<td>Needs motivation to participate/ complete tasks</td>
<td>o x* x* x x * * o</td>
</tr>
<tr>
<td>Task-orientation and completion</td>
<td>x x x x</td>
</tr>
<tr>
<td>Tires quickly</td>
<td>x x</td>
</tr>
<tr>
<td>Lack of maintaining sustained attention</td>
<td>x* x* x x * x *</td>
</tr>
<tr>
<td>Physically overactive</td>
<td>x x</td>
</tr>
<tr>
<td>Physically underactive</td>
<td>x x</td>
</tr>
<tr>
<td>Gave up on tasks prematurely</td>
<td>o</td>
</tr>
<tr>
<td>Concentration difficulties</td>
<td>x</td>
</tr>
</tbody>
</table>

Observations reflected in Table 3 will now be discussed briefly. A more in-depth discussion will follow in Chapter 7. Participants B, J and K did not manifest any attention difficulties during the assessment period and will therefore not be included in the brief discussion.

Participant A had a short attention span during the course of the assessment and had to be reminded or prompted to complete certain tasks (especially tasks which required writing or drawing). She often did not listen adequately to instructions which resulted in failure at the task. She had difficulty extending herself during difficult tasks and tended to blurt out the first thing that came to mind. This was not noted by the residential care facility or the school.
Participants C, D and H were observed to display a lack of sustained attention and needed to be motivated to complete tasks. In particular, Participant H was frequently found to be daydreaming. This observation is confirmed by the residential care facility and the speech therapist of the child. The information displayed in the table above also indicates that these participants have difficulty sustaining their attention.

Participant G did not concentrate on activities where cards were used and often gave up prematurely. This was not highlighted as being a problem at the residential care facility or in the classroom.

Participant J had difficulties sustaining her concentration and was described as being overactive by the residential care facility. She was restless and did not want to complete tasks on her own. She frequently sought validation and would become angry when she could not complete an exercise.

It is evident that inconsistencies arise when one compares the information obtained from the various sources in that an overlap in difficulties is not observed across the various sources of information (i.e., the scholastic progress reports, information provided by the multidisciplinary team and clinical observations from the assessment period).

Based on the results presented above it appears as though the common trends in this area of development were a lack of sustained attention, difficulty completing tasks and requiring motivation to complete tasks. A more in depth discussion on the implications of these findings will follow in Chapter 7.
6.5 Language Development

6.5.1 General Language Development

Table 4 depicts the performances of the 11 participants on the Language Subscale of the GMDS-ER. The performances highlighted in green in the MA column fell below the participant’s chronological age. The performances highlighted in yellow in the MA column were above the participant’s chronological age. Additionally, the sub-quotient column has been colour coded according to the category in which the participants’ performance fell.

Table 4

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sub-quotient</th>
<th>Category</th>
<th>CA</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>107</td>
<td>Average</td>
<td>63.7</td>
<td>68</td>
</tr>
<tr>
<td>B</td>
<td>100</td>
<td>Average</td>
<td>75.9</td>
<td>76</td>
</tr>
<tr>
<td>C</td>
<td>98</td>
<td>Average</td>
<td>77.9</td>
<td>76</td>
</tr>
<tr>
<td>D</td>
<td>105</td>
<td>Average</td>
<td>76.2</td>
<td>80</td>
</tr>
<tr>
<td>E</td>
<td>95</td>
<td>Average</td>
<td>93</td>
<td>88</td>
</tr>
<tr>
<td>F</td>
<td>98</td>
<td>Average</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>G</td>
<td>68</td>
<td>Borderline</td>
<td>84.9</td>
<td>58</td>
</tr>
<tr>
<td>H</td>
<td>76</td>
<td>Below Average</td>
<td>102.6</td>
<td>87</td>
</tr>
<tr>
<td>I</td>
<td>85</td>
<td>Average</td>
<td>101.2</td>
<td>86</td>
</tr>
<tr>
<td>J</td>
<td>77</td>
<td>Below Average</td>
<td>95.9</td>
<td>74</td>
</tr>
<tr>
<td>K</td>
<td>79</td>
<td>Below Average</td>
<td>105.8</td>
<td>84</td>
</tr>
</tbody>
</table>

Please note: CA refers to chronological age whereas MA refers to mental age.

Based on the results obtained from the GMDS-ER Language Subscale, 7 of the 11 participants obtained average scores on this subscale while 1 participant obtained a borderline score and the remaining 3 participants obtained below average scores on this subscale.
Participants A, B and D were the only participants whose mental ages were found to be higher than their chronological ages on this subscale.

Certain aspects of language skills assessed by the Language subscale are highlighted to illustrate which of the four aspects within language development (i.e., phonology, semantics, syntax and pragmatics all of which were discussed in Chapter 2 and will be discussed in greater detail in Chapter 7) the participants exhibited difficulty with. Participants A and G were the only participants who could name the capital letters (semantics). Participants C, D, F, and J could not complete the similarities exercise whereas participants C, F, G, H, I, J and K could not complete the differences exercise (semantics). Participants F, G, H, and I could not perform the picture completion exercise (syntax), Participants G, H and J could not talk in sentences of more than 10 syllables (syntax). Participant F was the only participant who could not complete the opposites exercise (semantics).

6.5.2 Auditory-perceptual Development

This area of development refers to the child’s ability to identify, interpret, and attach meaning to sound.

Information obtained from the scholastic progress reports were utilised to report on this particular area of development. Table 5 depicts individual performances in this area of development, however only the participants’ who have been identified with markers (x) in various blocks presented with difficulties in this area.
Table 5

Auditory-perceptual Abilities As Obtained From School Progress Reports

<table>
<thead>
<tr>
<th>Participants</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auditory Discrimination</strong></td>
<td>Identify everyday sounds and phonics</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Sure of differences in phonics</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>Auditory Sequencing and Memory Recall</strong></td>
<td>Complete a sequence of instructions</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Memorize songs and poems</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>Auditory Analysis and Synthesis</strong></td>
<td>Ability to phonetically break words into units and put them back together again</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Results obtained from the scholastic progress reports indicate that this area of development requires attention in the future. All the participants had difficulty with auditory discrimination when it comes to discriminating between different sounds in phonics. In addition, Participants C and F had difficulties both with identifying everyday sounds as well as discriminating between sounds in phonics. The participants performed better in the area of auditory sequencing and memory recall. Participants A, C and J could not complete a series of 3 or more instructions and Participant C was the only participant who could not memorize songs and poems. Participants A, B, C, D, G and J were unable to phonetically break words into units and put them back together again in auditory analysis and synthesis.

According to the residential care facility Participants C, F and I appear not to hear a person at times even though the participants’ hearing has not been assessed on an annual basis. Participants A, B, G and K could not repeat a 16 syllable sentence which may be indicative of difficulty in auditory sequential memory.

The auditory perceptual problems identified might indicate difficulties with regard to auditory processing. This will be discussed in greater depth in Chapter 7.
6.5.3 Literacy

A multitude of information was gathered from the scholastic reports regarding the participants’ language development. The language section on the scholastic reports obtained information regarding the participants’ literacy. The literacy section consisted of listening, speaking, expression and writing with “speaking” being sub-divided into speech, sentence construction, and vocabulary.

Table 6 depicts the participants’ performance in these areas. The “x” indicates that the participant had difficulty in that particular area.

Table 6

Performance In Literacy According To Scholastic Reports

<table>
<thead>
<tr>
<th>Participants</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Speaking</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Sentence Construction</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Vocabulary</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Expression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participants C, D, E and I were the only participants who experienced difficulty with the listening aspect of literacy. Participants E and I had difficulty with listening in general whereas Participants C and D had difficulty in that they could not listen for specific information when stories were read to them. All the participants had difficulty pronouncing phonics correctly whereas participants A, B, C, D, G and J pronounced words incorrectly as well. Participants’ A, B, C, D, G and J could not construct sentences completely and also had the tendency to swap words around. These participants were also identified as having a
limited vocabulary. Participants A and F were identified by their teacher as swapping letters around frequently while both Participant A and Participant C were identified as having a tendency to leave letters out.

Participants E, F, H and I’s scholastic reports had a different format for relaying information in this area and specific information was not supplied. What was reported was that Participants F and H proved to have the most difficulty with literacy. Additionally, Participants E, F, H and I were identified as having difficulty with prepared reading and Participants E, H and I had difficulty with creative writing.

If one compares the GMDS-ER and scholastic progress reports results, one would expect to find that Participants A, B, G and K would have been identified as having difficulty listening for specific information since they were unable to repeat the 16 syllable sentences. One would also expect to have observed more participants being unable to talk in 10 or more syllables due to the fact that all but 2 participants possess a limited vocabulary and Participants’ A, B, C, D, G and J could not construct sentences correctly. Similarities between the information include the fact that Participants E, H and I had difficulty with creative writing and Participants H and I also had difficulty completing the picture description. Trends identified from the results provided were an inability to repeat a 16 syllable sentence or talk in 10 syllable sentences; an inability to name capital letters; an inability to identify similarities, differences and opposites; and an inability to identify objects in a picture. Participants also presented with a poor vocabulary; difficulty listening for specific information and listening in general; difficulty pronouncing phonics and pronouncing words correctly; swapping words around and leaving letters out. Further areas of concern were creative writing and prepared reading. Auditory-perceptual developmental difficulties were also identified, Participants displayed difficulty with auditory discrimination and
auditory analysis and synthesis. However they seemed to have fared well in auditory sequencing and memory recall in that only 3 participants could not complete a sequence of instructions. A more comprehensive discussion on the fallouts in this domain of development and the implications thereof will be discussed in Chapter 7.

In conclusion, it could be said that the participants mainly obtained average scores in this domain of development and that their performances were reasonably on par for their ages (only 5 participants scored significantly below their chronological ages). In general these children experience difficulty with listening and speaking-related tasks at school.

6.6 Motor And Non-Verbal Development

Motor skills are actions that involve the movement of muscles in the body. They are divided into two groups: gross motor skills, which are the larger movements of arms, legs, feet, or the entire body (crawling, running, and jumping); and fine motor skills, which are smaller actions, such as grasping an object between the thumb and a finger or using the lips and tongue to taste objects. Motor skills usually develop together since many activities depend on the coordination of gross and fine motor skills. Gross motor skills develop over a relatively short period of time. Most development occurs during childhood (Liddle & Yorke, 2003). The other area of development that influences motor development is perceptual development. Perceptual development provides the foundation for interpreting the events of the world around us. Stimuli from the environment that evoke sensory experiences of hearing, seeing, and touching promote brain growth and development. It is therefore imperative that visual-perceptual development and auditory-perceptual development (which forms perceptual development) is discussed.
This theme consists of four sub-themes: Gross-motor development, Fine-motor development, Visual-perceptual development and Auditory-perceptual development. These four sub-themes will be discussed individually. Information obtained from the school progress reports will be included where applicable.

6.6.1 Gross-motor Development

Results related to gross-motor development were obtained from the Locomotor subscale of the GMDS-ER as well as information from the school progress reports and clinical observations. Table 8 depicts the participants’ scores on the Locomotor subscale of the GMDS-ER. Yellow colouring in the MA column indicates a performance above the participant’s CA whereas green indicates a performance below the participant’s CA. Additionally, the sub-quotient column has been colour-coded to highlight the category in which the performance fell.
Table 7

Performance On The Locomotor Subscale

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sub-quotient</th>
<th>Category</th>
<th>CA</th>
<th>MA</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>130</td>
<td>Average</td>
<td>63.7</td>
<td>82</td>
<td>Very Superior</td>
</tr>
<tr>
<td>B</td>
<td>113</td>
<td>Average</td>
<td>75.9</td>
<td>86</td>
<td>Superior</td>
</tr>
<tr>
<td>C</td>
<td>105</td>
<td>Average</td>
<td>77.9</td>
<td>82</td>
<td>Above Average</td>
</tr>
<tr>
<td>D</td>
<td>116</td>
<td>Average</td>
<td>76.2</td>
<td>88</td>
<td>Average</td>
</tr>
<tr>
<td>E</td>
<td>103</td>
<td>Average</td>
<td>93</td>
<td>96</td>
<td>Below Average</td>
</tr>
<tr>
<td>F</td>
<td>109</td>
<td>Average</td>
<td>88</td>
<td>96</td>
<td>Borderline</td>
</tr>
<tr>
<td>G</td>
<td>101</td>
<td>Average</td>
<td>84.9</td>
<td>86</td>
<td>Cognitively Handicapped</td>
</tr>
<tr>
<td>H</td>
<td>96</td>
<td>Average</td>
<td>102.6</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>91</td>
<td>Average</td>
<td>101.2</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>104</td>
<td>Average</td>
<td>95.9</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>95</td>
<td>Average</td>
<td>105.8</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Please note: CA refers to chronological age whereas MA refers to mental age.

The above results indicate that Participant A scored within the superior range whilst the remaining 10 participants scored within the average range on this subscale. Of the 11 participants, only Participants H, I and K scored below their chronological age on this subscale. Nine of the eleven participants scored highest on the Locomotor Subscale, in relation to the other five subscales. South African children generally obtain their highest scores on this subscale of the GMDS-ER.

Participants A, B, C, D and I could not skip more than 3 skips whereas participants E, F and G could not complete 12 skips. Participants A, B, D and G could not complete the hopscotch activity correctly and Participant C could not hopskip in an open area.

Information obtained from the school progress reports indicated the following:
Participants A, B, D, G and J reported no delays in co-ordination in that the participants could complete basic movements (e.g., running) with ease, swiftly and in a co-ordinated way. These participants were also able to ride a bicycle or scooter and balance on one leg for longer than 10 seconds whereas Participant C was identified as being clumsy and “wobbly” when balancing on one leg for longer than 10 seconds. It should be noted here that Participants B and C could not balance on one leg for 20 seconds during the administration of the Locomotor subscale of the GMDS-ER.

Participants E, F, H, I and K’s school progress reports did not provide information on this particular area of development. The residential care facility did however report that Participant J displayed good co-ordination and that Participant K was particularly good at gymnastics. Clinical observations of Participant B revealed that behavioural problems hampered his performance on the Locomotor subscale of the GMDS-ER (he growled at the test administrator and would not complete activities that he had difficulty with). Information obtained from the HFD also indicated that Participants H, I and J may present with poor co-ordination even though this was not indicated in the scholastic progress reports.

According to the theory discussed in Chapter 3, most children are able to skip smoothly, walk along a balance beam, stand on one foot for several seconds, and imitate dance steps by the age of 5 years (Craig & Baucum, 2003). According to Craig and Baucum (2003) numerous studies have demonstrated how motor development progresses during middle childhood. Craig and Baucum (2003) stated in Chapter 3 that boys aged 7 years can typically throw a ball about 10 meters. Accuracy improves during this time as well. Girls are said to make similar progress in throwing and catching, although at each age their throwing distance is, on average, shorter than that of boys. This might explain why the older children in the sample did not display the same difficulties with balance and activities requiring accuracy.
The main trends identified in this domain of development include the fact that generally the gross motor development of the children was average, although there were some difficulties with skipping; doing hopskip; and with balancing. The implications of these findings will be discussed in greater depth in Chapter 7.

6.6.2 Fine-motor Development

Information utilised for the fine-motor abilities section consisted of results obtained on the Eye and Hand Co-ordination Subscale and the Performance Subscale of the GMDS-ER, scholastic progress reports and clinical observations were applicable. Table 8 reflects individual performances on the Eye and Hand Co-ordination Subscale of the GMDS-ER. Yellow colouring in the MA column indicates a performance above the participant’s CA whereas green indicates a performance below the participant’s CA. Additionally, the sub-quotient column has been colour-coded to highlight the category in which the performance fell.
Table 8

Performance On The Eye And Hand Co-ordination Subscale

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sub-quotient</th>
<th>Category</th>
<th>CA</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>95</td>
<td>Average</td>
<td>63.7</td>
<td>60</td>
</tr>
<tr>
<td>B</td>
<td>100</td>
<td>Average</td>
<td>75.9</td>
<td>76</td>
</tr>
<tr>
<td>C</td>
<td>87</td>
<td>Average</td>
<td>77.9</td>
<td>68</td>
</tr>
<tr>
<td>D</td>
<td>108</td>
<td>Average</td>
<td>76.2</td>
<td>82</td>
</tr>
<tr>
<td>E</td>
<td>101</td>
<td>Average</td>
<td>93</td>
<td>94</td>
</tr>
<tr>
<td>F</td>
<td>93</td>
<td>Average</td>
<td>88</td>
<td>94</td>
</tr>
<tr>
<td>G</td>
<td>106</td>
<td>Average</td>
<td>84.9</td>
<td>90</td>
</tr>
<tr>
<td>H</td>
<td>84</td>
<td>Below Average</td>
<td>102.6</td>
<td>86</td>
</tr>
<tr>
<td>I</td>
<td>87</td>
<td>Average</td>
<td>101.2</td>
<td>88</td>
</tr>
<tr>
<td>J</td>
<td>88</td>
<td>Average</td>
<td>95.9</td>
<td>84</td>
</tr>
<tr>
<td>K</td>
<td>83</td>
<td>Below Average</td>
<td>105.8</td>
<td>88</td>
</tr>
</tbody>
</table>

Please note: CA refers to chronological age whereas MA refers to mental age.

Compared to the scores on the Locomotor Subscale, scores on the Eye and hand Co-ordination Subscale are less elevated even thought the majority fell within the average range. This may be due to the fact that fine-motor development occurs at a slower rate than gross-motor development. Two participants’ scores fell within the below average category and the remaining 9 scored within the average range. Only one participant’s performance was the same for both subscales. Of the 11 participants, 5 (Participants B, D, E, F and G) scored within their chronological age.

Table 9 reflects individual performances on the Performance Subscale of the GMDS-ER. Yellow colouring in the MA column indicates a performance above the participant’s CA whereas green indicates a performance below the participant’s CA. Additionally, the sub-quotient column has been colour-coded to highlight the category in which the performance fell.
Based on the results illustrated above, 8 of the 11 participants’ scores fell in the average range. Three of the eleven participants’ performances on the Performance Subscale of the GMDS-ER fell within the below average range. Three of the eleven participants whose scores fell in the average range performed poorer on the Performance Subscale than on the Eye and Hand Co-ordination Subscale. This could be due to the fact that the Performance subscale requires more intricate manipulation of small objects as well as some reasoning ability. Participant A was the only participant whose performance was reflective of a MA that was higher than her chronological age on the Performance subscale of the GMDS-ER.

On the Eye and Hand Co-ordination subscale of the GMDS-ER (see Table 8), Participants A, B, C, G, H, I, J and K had difficulty copying some of the drawings. Participants C and G could not copy numbers. Participant H’s performance on the HFD indicated that there may be a problem with fine muscle control.
On the Performance subscale, Participants F, G and K could not complete some of the form board exercises whereas Participants G and H could not return the blocks to the box in time.

Reports from the residential care facilities, school progress reports as well as clinical observations revealed that Participant C displayed average handling of a crayon, brush and scissors as well as an average ability to cut with scissors. According to scholastic reports, Participant E has difficulty writing within the lines and writes backwards at times. The other participants were not reported to have difficulty in this area.

When comparing the performances of the participants’ across the two subscales it is interesting to note that 5 of the 11 participants had more than a 10 point difference between their performance on the Eye and Hand Co-ordination subscale (Table 8) and the Performance subscale (Table 9). The following participants obtained higher scores on the Eye and Hand Co-ordination subscale than the Performance subscale: Participant D scored 11 points higher on this subscale. Participant E scored 26 points higher but was identified as having difficulty writing within the lines and as having a tendency to write backwards, Participant G scored 26 points higher and was identified as having particular difficulty in copying some of the drawings. This could also be said for Participant J who scored 11 points higher on the Performance subscale. Participant A’s performance on the Performance subscale was 12 points higher than on the Eye and Hand Co-ordination subscale although this participant had difficulty in completing some of the drawing tasks.

The main trends that were identified in this area of development highlighted that the majority of the participants were found to be average, some had difficulty copying some of the drawings, letters and numbers as well as completing tasks where the manipulation of
objects was required (i.e., the formboard exercise and returning the blocks to the box). The implications of the trends in this domain of development will be discussed in Chapter 7.

6.6.3 Visual Perceptual Development

Information for this section was taken from the scholastic progress reports and was thus not formally assessed by the researcher during the assessment period. Table 10 reflects the participants’ individual performances in this area. The participants’ with x’s were identified as having problems in this area of development whereas the rest of the participants did not present with visual-perceptual difficulties.

Table 10

<table>
<thead>
<tr>
<th>Difficulties In Visual-perceptual Abilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visual Discrimination</strong></td>
</tr>
<tr>
<td>Identify primary and secondary colours as well as shades</td>
</tr>
<tr>
<td>Knows basic shapes</td>
</tr>
<tr>
<td>Sees some small differences between objects</td>
</tr>
<tr>
<td><strong>Visual Synthesis and Analysis</strong></td>
</tr>
<tr>
<td>Puzzle building ability</td>
</tr>
<tr>
<td><strong>Visual form Constancy</strong></td>
</tr>
<tr>
<td>Discriminate between shapes regardless of size or colour</td>
</tr>
<tr>
<td>Associates shapes with objects</td>
</tr>
<tr>
<td><strong>Spatial Orientation</strong></td>
</tr>
<tr>
<td>Knowledge of up/down: behind/in front and next to/beside</td>
</tr>
</tbody>
</table>

Based on the table above, it can be seen that 3 of the participants presented with visual-perceptual difficulties. The largest number of difficulties were found in the visual discrimination section and appeared to be associated with an inability to recognise basic shapes (Participants B, C and D) and identify differences between objects (Participants A, B, C and G). This might explain why some of the participants had difficulty completing activities like the formboard and copying certain shapes on the Performance and Eye-and-
Hand Co-ordination subscales individually. Only 1 participant, Participant C, had difficulty associating shapes with objects in the visual form constancy area.

It is interesting to note that even though the scholastic reports did not reflect difficulty with the participants’ puzzle building ability, the participants did have difficulty completing the formboard activity on the GMDS-ER. The only participants who could complete the entire formboard item were Participants E, H, I and J. Participants F and G could not complete the activity beyond that which would be expected for children above the age of 5 years even though they are both above the age of 7 years. Participants B, C and D could not complete the formboard items beyond which would be expected for children aged 6 years even though they are all 6 years old. Participants A and K could not complete the formboard items beyond that which would be expected for a child of 7 years. Participant A is aged 5 years old so this is not an unexpected finding for her and it represents a good performance, however, Participant K is already 8 years of age.

The main trends that were identified in this area of development was that of visual discrimination in that not all the participants could recognise basic shapes or identify the differences between objects. This will be discussed in greater depth in Chapter 7.

6.6.4 Body Awareness And Laterality

Participants A, B, D, G and J were reported to know all their body parts whereas Participant C was still unsure. Participants A, B and J have an inner awareness of left and right whereas Participants C, D and G are still unsure. As stated in Chapter 3, brain lateralization is fully established during the preschool years as the child indicates hand and foot preferences (Craig & Baucum, 2003). It could thus be speculated these individuals may
not have developed complete brain lateralization as of yet. This could be normal due to the fact that these participants range between 6 and 7 years of age. Participants A, B, D, G and J give preference to their right eye, hand and foot. Participant C gives preference to his left eye, right hand and right foot. Information obtained from the HFD indicated that Participant H might experience difficulty with lateralization. Participants A, B, G and J are able to demonstrate controlled and effective movement of their eyes when following a moving object. Participants C and D are reported to be progressing well with their eye movements. Participants E, F, H, I and K’s scholastic progress reports did not include information on body awareness. However, Participant H was observed to have the tendency to rotate images to her left.

When reflecting on this domain of development, one can conclude that the participants’ gross motor development was average although there were some difficulties with skipping; doing hop skip; and with balancing. The majority of the participants were found to be average in terms of their fine-motor development however, some had difficulty copying some of the drawings, letters and numbers as well as completing tasks where the manipulation of objects was required (i.e., the formboard exercise and returning the blocks to the box). The participants’ performance in terms of visual-perceptual development indicated that the main area of concern was that participants could not recognise basic shapes or identify the differences between objects. The area of body awareness and laterality appears to be an area in which the participants’ indicate minimal delays as only 1 participant could not name all the body parts and only 3 participants did not have an inner awareness of left and right. The implications of the results in this domain will be discussed in greater detail in Chapter 7.
6.7 Planning And Reasoning Development

The results obtained for this domain of development consists primarily of the participants performance on the Practical Reasoning subscale of the GMDS-ER, some tasks on the Language and Performance subscales, school progress reports and clinical observations (where applicable). Table 11 provides the results obtained on the Practical Reasoning subscale of the GMDS-ER. Yellow colouring in the MA column indicates a performance above the participant’s CA whereas green indicates a performance below the participant’s CA. Additionally, the sub-quotient column has been colour-coded to highlight the category in which the performance fell.

Table 11

Performance On The Practical Reasoning Subscale

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sub-quotient</th>
<th>Category</th>
<th>CA</th>
<th>MA</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>114</td>
<td>Average</td>
<td>63.7</td>
<td>72</td>
<td>Very Superior</td>
</tr>
<tr>
<td>B</td>
<td>103</td>
<td>Average</td>
<td>75.9</td>
<td>78</td>
<td>Superior</td>
</tr>
<tr>
<td>C</td>
<td>72</td>
<td>Below Average</td>
<td>77.9</td>
<td>56</td>
<td>Above Average</td>
</tr>
<tr>
<td>D</td>
<td>102</td>
<td>Average</td>
<td>76.2</td>
<td>78</td>
<td>Average</td>
</tr>
<tr>
<td>E</td>
<td>93</td>
<td>Average</td>
<td>93</td>
<td>86</td>
<td>Below Average</td>
</tr>
<tr>
<td>F</td>
<td>98</td>
<td>Average</td>
<td>88</td>
<td>86</td>
<td>Borderline</td>
</tr>
<tr>
<td>G</td>
<td>75</td>
<td>Below Average</td>
<td>84.9</td>
<td>64</td>
<td>Cognitively Handicapped</td>
</tr>
<tr>
<td>H</td>
<td>84</td>
<td>Below Average</td>
<td>102.6</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>89</td>
<td>Average</td>
<td>101.2</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>79</td>
<td>Below Average</td>
<td>95.9</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>85</td>
<td>Average</td>
<td>105.8</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

Please note: CA refers to chronological age whereas MA refers to mental age.

Based on the results obtained above, it can be seen that 7 of the 11 participants obtained an average score on this subscale. The remaining 4 participants obtained a below average
score. Of the 11 participants, the performance of only Participants A, B and D resulted in their mental age being higher than their chronological age.

Participant A had the best performance on this subscale. She was able to complete all the tasks in her age group except identifying which items cost more. She had difficulty completing the picture arrangements and repeating digits but was able to complete all the comparisons. Clinical observations indicated that she was unable to coherently verbalise the similarities and differences but she was the youngest child in the sample and her abstract reasoning ability is still developing.

Participant B is described by the residential care facility as being structured and responsible. Scholastically he does not have the ability to observe small differences and similarities in objects. When looking at his answers on the Language subscale of the GMDS-ER, particularly the section pertaining to the differences, he often said perseveration (“weet nie” and “nie rêrig nie”\(^1\)).

Participant C sees some differences and similarities and experiences difficulty in associating shapes with objects. On the GMDS-ER, he could not complete a number of the pattern-making activities, build a ten-brick memory stairs, complete the “which goes faster” exercise correctly or repeat 4 digits. The test administrator also observed that the participant had difficulty in understanding the gestalt of some activities. He was also unable to complete the similarities and difficulties sections of the language subscale.

Participant D could not verbalise which item cost more and could not complete the similarities exercise correctly. She also had difficulty completing the picture arrangement.

\(^1\) “Don’t know” and “not really”.
Participant E was identified by her school as needing significant input with regard to her thinking and reasoning ability. On the Practical Reasoning subscale, she could not build the superior bridge model, complete the pattern-making exercise or complete the picture arrangements exercise.

Participant F was identified by his teacher as having difficulty with equations, problem solving, speaking in a logical order, and thinking and reasoning. On the Performance subscale of the GMDS-ER he had difficulty completing all the pattern-making exercises and completing some of the form boards. On the Practical Reasoning subscale, he had difficulty completing the series. On the Language subscale, he could only see some similarities, differences and name some opposites.

Participant G was observed by the school to only see some small differences and similarities. On the Performance subscale she indicated difficulty with completing the pattern making tasks, building the superior bridge, some of the form boards and returning the bricks to the box in time. Clinical observations during the assessment period indicated that she did not look at the picture cards in the pattern making exercise. On the Practical Reasoning subscale of the GMDS-ER, she was unable to count the number of fingers on each hand, distinguish between “morning” and “afternoon”, indicate which goes faster, and complete the picture arrangements.

Participant H’s school report revealed that she requires attention with regard to her thinking and reasoning. On the Performance subscale of the GMDS-ER, she was unable to complete the 10-brick memory stairs (she rotated it), return the bricks to the box and complete some pattern making. Clinical observations on this subscale revealed that she tends to rotate images to her left. Her performance on the Practical Reasoning subscale indicated that she had difficulty completing some of the picture arrangement exercises. Her
Participant I’s school report stated that he requires input with regard to his thinking and reasoning abilities. His performance on the Performance subscale suggested that he could not complete some of the pattern-making exercises even though clinical observations reported that his drawings were structured. His performance on the Language subscale highlighted that he has difficulty with completing the differences.

Participant J was not identified by her school as having problems regarding her thinking and reasoning ability. On the Performance subscale of the GMDS-ER she had difficulty with the pattern-making exercises. Her performance on the Practical Reasoning subscale highlighted problems with regard to completing the picture arrangement exercise and completing the directional arrows. Her performance on the Language subscale indicated difficulty with completing the similarities exercise and completing the differences exercise.

Participant K’s performance on the Performance subscale of the GMDS-ER indicated that she had difficulty with completing some pattern-making exercises and completing some formboard exercises. Her performance on the Practical Reasoning subscale indicated difficulty distinguishing between “morning” and “afternoon”, completing picture arrangement.

As stated in Chapter 3, children between the ages of 5 and 7 years find themselves in the transition from preoperational to concrete operational thought. Concrete operational thought allows the child to engage in more logical thought processes such as cause-and-effect relationships, being able to notice more than one aspect of an object and they can reconcile differences. From this information pertaining to the participants’ results, it appears that the
children may be experiencing difficulty with this task due to either still being busy negotiating the preoperational stage of cognitive development or by finding themselves in the transition period. Seven of the 11 participants obtained average scores on this domain of development and 3 participants scored at or above their chronological age. Additional trends that were identified in this domain of development include the inability to complete a series; identifying similarities and differences; recognizing and naming shapes and colours; difficulty in associating shapes with objects; and difficulty with tasks which require working memory such as repeating digits, returning the blocks to the box and building the bridge on the GMDS-ER.

6.8 Social Development

The information utilised to obtain results for this domain consisted of the individual performances on the Personal-Social Subscale of the GMDS-ER, case reports obtained from the multi-disciplinary team at the residential care facility and clinical observations. Information from the school progress reports pertaining to this section will also be included where applicable.

Results for individual participants on the Personal-Social Subscale of the GMDS-ER are provided in Table 12. Yellow colouring in the MA column indicates a performance above the participant’s CA whereas green indicates a performance below the participant’s CA. Additionally, the sub-quotient column has been colour-coded to highlight the category in which the performance fell.
Table 12

Performance On The Personal-social Subscale

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sub-quotient</th>
<th>Category</th>
<th>CA</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>92</td>
<td>Average</td>
<td>63.7</td>
<td>58</td>
</tr>
<tr>
<td>B</td>
<td>111</td>
<td>Average</td>
<td>75.9</td>
<td>84</td>
</tr>
<tr>
<td>C</td>
<td>69</td>
<td>Borderline</td>
<td>77.9</td>
<td>54</td>
</tr>
<tr>
<td>D</td>
<td>97</td>
<td>Average</td>
<td>76.2</td>
<td>74</td>
</tr>
<tr>
<td>E</td>
<td>86</td>
<td>Average</td>
<td>93</td>
<td>80</td>
</tr>
<tr>
<td>F</td>
<td>89</td>
<td>Average</td>
<td>88</td>
<td>78</td>
</tr>
<tr>
<td>G</td>
<td>94</td>
<td>Average</td>
<td>84.9</td>
<td>80</td>
</tr>
<tr>
<td>H</td>
<td>78</td>
<td>Below Average</td>
<td>102.6</td>
<td>80</td>
</tr>
<tr>
<td>I</td>
<td>83</td>
<td>Below Average</td>
<td>101.2</td>
<td>84</td>
</tr>
<tr>
<td>J</td>
<td>83</td>
<td>Below Average</td>
<td>95.9</td>
<td>80</td>
</tr>
<tr>
<td>K</td>
<td>95</td>
<td>Average</td>
<td>105.8</td>
<td>100</td>
</tr>
</tbody>
</table>

Key

<table>
<thead>
<tr>
<th>Very Superior</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above Average</td>
<td>Average</td>
</tr>
<tr>
<td>Below Average</td>
<td>Borderline</td>
</tr>
<tr>
<td>Cognitively Handicapped</td>
<td></td>
</tr>
</tbody>
</table>

Please note: CA refers to chronological age whereas MA refers to mental age.

Based on the table above, 7 participants obtained average scores, 1 participant obtained a score in the borderline category and 3 participants obtained below average scores on this subscale. Participant B was the only participant that scored within his chronological age on the Personal Social Subscale which indicates that he is able to act independently. The other participants’ may not have had ample opportunity to engage in activities associated with independence which may explain their below CA performances.

Based on the clinical observations and information obtained from the residential care facility, the following can be said about the participants:

Participant A’s confidence improved significantly after she started to participate in modelling. In this activity she reportedly acts as a leader. It was also reported that she does not interact with the other children and that she is often found sitting alone. During the
assessment it was observed that she frequently sought validation and, at times, would not complete a task until she received validation.

Participant C was described by the residential care facility as a child who does not like to interact with others and often befriends children younger than himself. During the assessment process, Participant C often displayed socially inappropriate behaviour in that he growled at the test administrator in an aggressive way when he did not succeed at a task.

Participant D was described by the residential care facility as a child who frequently withdraws from others and does not trust easily. She acts as a leader amongst her peers and will not play a game unless she occupies that role. During the test administration she frequently questioned how her friends had performed on a certain task as a means of comparing herself to them.

Participants E and I did not display any noteworthy behaviour during the assessments and no significant information on their social development was provided by the school or residential care facility.

Participant F was identified by the residential care facility as often taking on the role of a follower amongst his peers and is seldom given the opportunity to make decisions with regards to games and roles played in games. It was noted, however, that he is able to act independently.

Participant G is described by the residential care facility as a child who actively seeks to be the centre of attention and who has the tendency to lose her temper quickly. She often rejects other children frequently and prefers to be alone. Both the residential care facility as well as her school, report bad behaviour in that she frequently displays temper tantrums.
Participant H was described by her speech therapist as “living in stories”. This tendency to daydream was also observed by the residential care facility as well as the school. She prefers to be alone rather than socialising with other children.

Participant J is described as a child that is very aggressive towards other children. He also has great difficulty acting independently.

Participant K is described by the residential care facility as a shy child who does not express her emotions. She becomes aggressive at times.

In Chapter 3, Werner (1990) stated that individuals have taught us that competence, confidence and caring can flourish, even under adverse circumstances, if young children encounter persons who provide them with a secure basis for the development of trust, autonomy, and initiative. If they receive this input, children learn what constitutes good and bad behaviour; how to handle their feelings, wants and needs in socially appropriate ways; and what their family, community, and society at large expect of them. They begin to acquire the norms, rules, and mores of their culture. At the same time, they develop a keen and perhaps lasting concept of self (Craig & Baucum, 2003). When one reviews the results obtained on this domain of development, it appears as though their development is generally on track (average) when observing some aspects of their social development as displayed in their test-taking behaviour as well as their individual results. A more comprehensive discussion will follow in Chapter 7.

6.9 Emotional Status

As stated in Chapter 3, emotions provide children as well as others with information that can shape their behaviours after or during the experience of emotion. Emotions also affect
the behaviours of others, because their expression can help in the effort to describe and predict the child’s behaviour. This domain was measured through the use of the HFD. This section will thus reflect individual results obtained on this measure as well as case reports that was obtained from the multidisciplinary team at the residential care facility were applicable to the results obtained.

Table 13 reflects the emotional indicators (indicated by a “x”) obtained by the participants on the HFD.
Table 13

Emotional Indicators On The Human Figure Drawing

<table>
<thead>
<tr>
<th>Special features</th>
<th>Participants</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor integration of parts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of the face</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of the body/limbs</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of the neck/hands</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross assymmetry of limbs</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Slanting figures</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Tiny figure</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Big figure</td>
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<tr>
<td>Transparencies</td>
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</table>

<table>
<thead>
<tr>
<th>Omissions</th>
<th>Participants</th>
<th>5</th>
<th>3</th>
<th>3</th>
<th>7</th>
<th>2</th>
<th>1</th>
<th>7</th>
<th>1</th>
<th>4</th>
<th>1</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>No eyes</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No nose</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No arms</td>
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</tr>
<tr>
<td>No legs</td>
<td>X</td>
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<td></td>
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</tr>
<tr>
<td>No feet</td>
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<tr>
<td>No neck</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>TOTAL EMOTIONAL INDICATORS</td>
<td></td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Case reports from the residential care facility and clinical observations will be discussed where it applies to this area of development.
Participant A has two older sisters who also live in the residential care facility. The sisters are not connected to one another in that they do not spend time together at the residential care facility. When Participant A entered residential care, she was still wearing nappies, didn’t speak and cried constantly. The residential care facility reports that she has made a lot of progress since then but still presents as a shy and insecure child who speaks softly. Clinical observations during the assessment period revealed that she constantly sought validation and had the tendency to display regressive behaviour (i.e., gurgling sounds and speaking in an immature fashion) when she failed at a task or did not succeed at gaining affirmation. Participant A’s performance on the Human Figure Drawing suggests that she might be prone to anxiety and insecurity. When faced with situations that provoke anger or aggression she might tend to withdraw, be stubborn and refuse to interact with others. She might also present with psychosomatic complaints and perfectionistic behaviour patterns.

Participant B was removed from his parents’ care because the home environment was unstable. His parents have since separated. Case reports from the residential care facility state that the parents had the tendency to play the children up against one another. At the residential care facility, Participant B presents as an anxious child who is structured, responsible and likes to feel needed. Clinical observations during the assessment period revealed that Participant B frequently made aggressive growling sounds when he was asked to complete certain tasks which he anticipated he couldn’t do. The results Participant B obtained on the Human Figure Drawings indicated the possibility that there might be an underlying anxiety and aggression, although this was not observed during the test administration.

Participant C has an older brother and sister with whom he has a good relationship. He is currently in psychotherapy following a recent disclosure of sexual abuse. The residential care
facility reports that he has no attachments and tends to display role confusion. He does not play with other children (boys in particular) and tends to befriend children younger than him. During the assessment period he frequently erased, frequently sought validation and displayed regressive behaviour (i.e., sucking sounds, gurgling, and head churning). It was also quite apparent that Participant C was anxious during the assessments in that he displayed anxious laughter. Participant C’s results on the Human Figure Drawings suggests severe emotional and cognitive immaturity as well as emotional disturbance with acute body anxiety which is consistent with the recent disclosure of sexual abuse in individual psychotherapy.

Participant D’s mother and father are separated. She still has contact with the mother who fetches her and her brother for school holidays. Participant D’s mother blatantly favours Participant D over her older brother (Participant F). The siblings stay in the same cottage at the residential care facility and share a close relationship. The staff at the residential care facility state that participant D possesses a lot of anger which is directed inward and that she has the tendency to sulk when she does not get her way. She is described as a child that does not trust easily and withdraws from other children at times. Clinical observations revealed that the participant frequently displayed manipulative behaviour during test administration and that she often tried to provoke a negative response when she did not receive the input she wanted. Her drawing reflected a tendency towards impulsiveness, extreme insecurity, anxiety, hostility and rebellion.

Participant E is the second youngest of 4 children. One of her older brothers and her younger brother, Participant C, are also housed at the residential care facility. She has a good relationship with her older brother and nurtures her younger brother (Participant C) a lot. They were removed due to an unstable home environment. According to the residential care facility she adapted well to residential care and is always grateful to come back to the
residential care facility. Staff describe her as a child who always tries to help where she can and goes the extra mile. She finds solace in maintaining her routine and requires a lot of validation. Participant E was the only participant who had no emotional indicators on the HFD even though she presents with cognitive and perceptual problems.

Participant F is the older brother of Participant D. The residential care facility staff members report that Participant F tends to be a follower when with his peers. He is polite and friendly but is also stubborn. He appears to have a low self-esteem and actscorrectively towards his sister, Participant D. At school he often fights when placed in group settings and often refuses to complete his work. Clinical observations revealed that he was very eager to impress the test administrator and appeared extremely shy. He also appeared to be holding his emotions back in that he did not want to indicate to the test administrator that he was excited to participate in an activity. Participant F’s performance on the Human Figure Drawings indicated extreme insecurity, withdrawal and possible depression. It was also reflective of a child who could be described as timid who has feelings of inadequacy and a concern over dealing with the environment.

Participant G has an older sister with whom she plays. She is often fetched by her family for the weekend. The residential care facility staff described her as having a low frustration tolerance, always wanting to be the centre of attention and as having the tendency to lose her temper quickly (i.e., she has temper tantrums frequently). She always wants physical contact but often rejects others. She also does not care about getting others’ approval. It was observed that Participant G was very upset by her housemother verbalising that she is a trouble maker and that I should not bring her back after the assessment. This impacted on the participant’s mood during the assessment period (i.e., she was tearful and withdrawn). Participant G’s performance on the Human Figure Drawings reflects aggression, poor co-
ordination, impulsiveness, rebellion and a poor self-concept. Her results further indicated that she may suffer from anxiety and poor social interest.

Participant H was described by her speech therapist as “living in stories”. During the assessment period she displayed a tendency to be perfectionistic. Participant H’s performance on the HFD indicated possible difficulties in the domain of motor and non-verbal development, which was discussed under the relevant theme elsewhere.

Participant I’s biological mother and father are not in a relationship. The staff at the residential care facility report that he easily feels rejected even though he has the ability to control his emotions. They also stated that he displays temper tantrums frequently. His performance on the HFD indicated that he might suffer from anxiety, psychosomatic complaints and a tendency to withdraw socially.

Participant J is described by the staff at the residential care facility as being very aggressive towards other children and needing a lot of monitoring. Clinical observations during the assessment period revealed that she was restless and became very angry when she could not complete tasks. She frequently sought validation and acted perfectionistic. Participant J’s performance on the Human Figure Drawings is indicative of a child who displays poor social interest and often feels helpless in social situations.

Participant K has an older brother and maintains contact with her aunt who frequently houses her over weekends. The staff at the residential care facility describe her as an insecure child who has a tendency to become aggressive at times. She is shy, does not express her emotions and bites her nails. Participant K’s performance on the Human Figure Drawings suggests extreme insecurity, withdrawal and poor impulse control.
As can be seen from the results obtained on the HFD as well as the case information obtained from the residential care facility, the children involved present with numerous emotional difficulties. This could be due to the fact that they may not have successfully negotiated Erikson’s initiative versus guilt stage of psychosocial development, wherein resulting in fearful and insecure individuals who do not take initiative in their lives. This concept and how it applies to the sample of children will be discussed in greater depth in Chapter 7.

6.10 Scholastic Performance

This section contains any relevant scholastic information that was not covered in the foregoing sections. It is based solely on the scholastic progress reports and was therefore not formally assessed by the test administrator. Numeracy as well as some of the results pertaining to the HFD will be discussed in this section. Aspects pertaining to literacy (including phonics, reading and writing) were presented in section 6.5.3.

6.10.1 General Scholastic Performance

Ten of the participants are currently receiving remedial schooling and are currently experiencing difficulties in all areas of learning. This contrasts with the fact that 7 of the 11 participants obtained an average GQ.

Results obtained from the HFD indicated that all participants except Participant E (who is currently receiving remedial education) may be in need of remedial education. This is a
noteworthy result since only one participant (Participant K) is currently receiving mainstream schooling even though she is not performing well at school.

6.10.2 Numeracy

When reviewing the numeracy development of the participants’ not too many areas of concern were noted. Based on the results obtained from the scholastic reports, Participants F and K displayed difficulty with numerical concepts while participants C and H had an average capacity for numerical concepts. Participants B, C, and D displayed an average concept of time.

6.11 Conclusion

The results portrayed in this chapter were presented according to the general aim of the study, which was to explore and describe the general and emotional development of a sample of South African children between the ages of five and eight years in residential care. Results were reported according to themes that were identified following data collection (i.e., information from the GMDS-ER, HFD, clinical observations, scholastic progress reports and case information from the multidisciplinary team at the residential care facility). This chapter aimed to describe the participants’ functioning, including both strengths and weaknesses, in the identified areas. An in-depth discussion on the implications of the results will now follow in Chapter 7.
CHAPTER SEVEN

DISCUSSION AND CONCLUDING REMARKS

7.1 Introduction

This chapter aims to shed light on the implications of the results presented in Chapter 6. The discussion will focus on developmental themes identified in Chapter 6 rather than discussing the results in a case by case fashion. The discussion will be outlined according to the developmental themes with the main theories utilized to contextualise these findings being that of Piaget and Erikson. Piaget’s theory will be utilised in all the developmental themes whereas the psychosocial theory of Erikson will be utilised to contextualise the two themes related to the social and emotional development of the sample. All of the developmental themes identified in the study impact on general cognitive development. The theme of general development will therefore be covered last so as to better contextualise the findings in relation to the other themes discussed.

7.2 The Context

In Chapter 3 both Piaget and Erikson’s theories were discussed in terms of how they apply to cognitive development and psychosocial development respectively. The researcher would, however, like to recap some of this theory before the implications of the results are discussed.
7.2.1 The Cognitive-developmental Theory Of Piaget

Piaget viewed intelligence as having three primary components: content, function, and structure. *Content* is defined as what children know about. It refers to observable behaviours and reflects intellectual activity. By its nature the content of intelligence varies considerably from age to age and from child to child. *Function* refers to those characteristics of intellectual activity (assimilation and accommodation) that are stable and continual throughout cognitive development (Wadsworth, 1971). *Structure* refers to the inferred organizational properties (schemata) that explain the occurrence of particular behaviours.

Piaget (1970) asserted that cognitive and intellectual changes are the result of a developmental process. He believed that cognitive development is a coherent process of successive qualitative changes of cognitive structures (schemata), each structure and its concomitant change deriving logically and inevitably from the preceding one. New schemata do not replace prior ones; they incorporate them, resulting in a qualitative change. He conceptualized development as a continuous process along a continuum (Wadsworth, 1971). Changes in intellectual development are gradual and never abrupt. Schemata are constructed and reconstructed gradually.

Piaget divided intellectual development in four distinct stages. For the purpose of this study, the stage of preoperational thought (2 to 7 years of age) and the stage of concrete operations (ages 7 to 11 years) will be the focus as this age range is representative of the sample. It is important to note that the chronological ages during which children can be expected to develop behaviour representative of a particular stage are not fixed. The age spans suggested by Piaget are normative and denote the times during which a typical or average child can be expected to display the intellectual behaviours that are characteristic of the particular stage (Wadsworth, 1971). It is also important to be cognizant of the fact that
Piaget’s theory is fixed. According to him, every child must pass through the stages of cognitive development in the same order. A child cannot move intellectually from the preoperational stage to the stage of formal operations without passing through the stage of concrete operations.

In the preoperational stage (toddlerhood and early childhood) intelligence is demonstrated through the use of symbols, language use matures, memory and imagination are developed, but thinking is done in a non-logical, non-reversible manner. Egocentric thinking predominates.

The concrete operational stage (middle childhood and early adolescence) is characterized by intelligence being demonstrated through logical and systematic manipulation of symbols related to concrete objects. Operational thinking develops (mental actions that are reversible) whilst egocentric thought diminishes.

These stages of cognitive development will be discussed in more depth in the sections to follow.

7.2.2 The Psychosocial Theory Of Erikson

According to Erikson’s (1964) theory, individual development is the result of two simultaneous and complex influences, namely genetic and social factors (Schultz, 1990). Genetic factors determine development through the manifestation of characteristics that develop according to a genetically determined ground plan (Meyer, Moore & Viljoen, 2002, p.193). Social influences are present at this time and places demands on the individual while at the same time providing the individual with opportunities for growth. These demands and
opportunities are in accordance with, and complementary to, the developmental potential and needs of the individual at each stage of development.

Erikson believed that development occurs as individuals move through different psychosocial stages, each with its own developmental crisis. Successful resolution of the developmental crisis would result in optimal development. Erikson promoted eight psychosocial stages of development. The stages that were the focus of this study were the Initiative versus Guilt stage and the Industry versus Inferiority stage, since this span from ages three to six years, ages six to twelve years respectively and the sample of this study falls within these two stages.

The Initiative versus Guilt stage of psychosocial development is described by Erikson as the process of Initiative adding to the quality of undertaking, planning and attacking a task for the sake of being active and on the move. The child is learning to master the world around him, learning basic skills and principles of physics. He learns how to zip and tie, count and speak with ease. At this stage, the child wants to begin and complete his own actions for a purpose. Guilt is a confusing new emotion. He may feel guilty over things that logically should not cause guilt. He may feel guilt when his initiative does not produce desired results. The development of courage and independence are what set preschoolers, ages three to six years of age, apart from other age groups. Young children in this category face the challenge of initiative versus guilt. As described in Bee and Boyd (2004), the child during this stage faces the complexities of planning and developing a sense of judgment. During this stage, the child learns to take initiative and prepare for leadership and goal achievement roles. Activities sought out by a child in this stage may include risk-taking behaviors, such as crossing a street alone or riding a bike without a helmet; both these examples involve self-limits. Within instances requiring initiative, the child may also develop negative behaviors.
These behaviors are a result of the child developing a sense of frustration for not being able to achieve a goal as planned and may engage in behaviors that seem aggressive, ruthless, and overly assertive to parents. Aggressive behaviors, such as throwing objects, hitting or yelling are examples of observable behaviors during this stage. At the same time, preschoolers are increasingly able to accomplish tasks on their own and with this growing independence comes many choices about activities to be pursued. Sometimes children take on projects they can readily accomplish, but at other times they undertake projects that are beyond their capabilities or that interfere with other people's plans and activities. If parents and preschool teachers encourage and support children's efforts, while also helping them make realistic and appropriate choices, children develop initiative— independence in planning and undertaking activities. But if, instead, adults discourage the pursuit of independent activities or dismiss them as silly and bothersome, children develop guilt about their needs and desires.

The Industry versus Inferiority stage of psychosocial development is concerned with aiming to bring a productive situation to completion gradually supersedes the whims and wishes of play. The fundamentals of technology are developed. To lose the hope of such "industrious" association may pull the child back to the more isolated, less conscious familial rivalry of the oedipal time. "Children at this age are becoming more aware of themselves as individuals." They work hard at "being responsible, being good and doing it right." They are now more reasonable to share and cooperate. Allen and Marotz (2003) also list some perceptual cognitive developmental traits specific for this age group: Children understand the concepts of space and time, in more logical, practical ways, beginning to grasp, gain better understanding of cause and effect and understand calendar time. At this stage, children are eager to learn and accomplish more complex skills: reading, writing, telling time. They also get to form moral values, recognize cultural and individual differences and are able to
manage most of their personal needs and grooming with minimal assistance (Allen & Marotz, 2003). At this stage, children might express their independence by being disobedient, using back talk and being rebellious. Erikson viewed the preschool years as critical for the development of self-confidence. Ideally, preschool provides many opportunities for children to achieve the recognition of teachers, parents and peers by producing things, drawing pictures, solving addition problems, writing sentences and so on. If children are encouraged to make and do things and are then praised for their accomplishments, they begin to demonstrate industry by being diligent, persevering at tasks until completed and putting work before pleasure. If children are instead ridiculed or punished for their efforts or if they find they are incapable of meeting their teachers' and parents' expectations, they develop feelings of inferiority about their capabilities.

A discussion of the participants’ results will now be discussed within the theoretical frameworks of Piaget and Erikson.

7.3 Attention, Task-orientation And Task Completion

As stated in Chapter 6, the definition of attention is the ability to concentrate on an idea or activity as well as the completion of the activity. The ability to concentrate plays a pivotal role in the development of children.

Based on the results presented in Chapter 6, the common trends in this area of development were a lack of sustained attention, difficulty completing tasks and the need to be motivated to complete tasks.

Literature reviewed in Chapter 3 indicated that generally children within this age group have difficulty sustaining their attention for a long period of time and have the tendency to be
impatient. Piaget stated that tasks of the preoperational child include developing an increased attention span (Wadsworth, 1971). Children should become more efficient at processing inputs, increasing their attention span and their ability to focus and concentrate their attention should become more pronounced and reliable. What was observed in the sample however was that a reasonable number of the children sampled were unable to sustain their attention towards a topic for longer periods of time, which is not consistent with what is expected of children within this age group. Additionally, children’s ability to inhibit or ignore the automatic tendency of their attention wandering as a result of distractions should also improve. This was not the case for some of the children in the study and consequently, these children have not become efficient learners who are able to benefit maximally from classroom instruction. Research findings presented in Chapters 2 and 4 suggested that emotionally abused and neglected children were identified by their teachers as having significant difficulty concentrating and paying attention to certain tasks and they appeared detached and uninvolved in the classroom (Wadsworth, 1971). Consequently, the trends related to concentration and attention difficulties identified for some children in this study are consistent with those found in previous studies of abused children. Given that the children in this study struggled to concentrate and sustain their attention in the increasingly demanding school, family and social environments they find themselves in, it could be speculated that this may have contributed to their substantial academic and social problems.

7.4 Language Development

It was established in Chapter 4 that the acquisition of language skills are important in the development of children since it allows them to label their feelings and those of others. The conceptual tools that children learn from the primary caregiver during the acquisition of
language, enables them to understand the world and their place in it. It is with this in mind that the language development of the children will now be discussed.

A general trend identified from the results provided in Chapter 6 were that the language development of most of the children fell in the low average to below average range, which suggests that they may experience difficulties with certain aspects of language. For example, it was identified that difficulties were experienced by the children in terms of repeating a 16 syllable sentence or talking in 10 syllable sentences; naming capital letters; identifying similarities, differences and opposites; and identifying objects in a picture. Participants also presented with a poor vocabulary; difficulty listening for specific information and listening in general; difficulty pronouncing phonics and pronouncing words correctly; reversing the order of words and leaving letters out. Additionally, results from Chapter 6 indicated difficulties in identifying everyday sounds and phonics, being aware of differences in phonics, completing a series of 3 or more instructions, listening and concentrating in individual or group settings, and to phonetically break words into units and put them back together again. Further areas of concern were creative writing and prepared reading.

Piaget stated that the single most evident development during the preoperational stage is the development of spoken language. By the age of 4 years, the typical child has largely mastered the use of spoken language. The child can speak and use most grammatical rules, and can understand what is heard if it contains familiar vocabulary. The rapid development of this form of symbolic representation (spoken language) is instrumental in facilitating the rapid conceptual development that takes place during this stage. Piaget (1970) stated that from age 2 to age 4 or 5 years, a child’s speech is in part lacking in communicative intent. The child speaks in the presence of others, but without any apparent intention that others should hear his words. Piaget called these non-conversations collective monologues and
stated that such speech is clearly egocentric. By age 6 or 7 years, language has become intercommunicative. Children’s conversations clearly involve an exchange of ideas. The development of language during the preoperational stage is seen by Piaget as a gradual transition from egocentric speech to socialized intercommunicative speech. Piaget goes on to say that spoken language is learned and that the motivation for learning spoken language is the adaptation value of doing so.

Difficulties in identifying everyday sounds and phonics, being aware of differences in phonics, completing a series of 3 or more instructions, listening and concentrating in individual or group settings, to phonetically break words into units and put them back together again may indicate difficulties with regard to auditory processing. Auditory processing is a term used to describe what happens when an individual’s brain recognizes and interprets the sounds around him or her. Humans hear when energy that they recognize as sound travels through the ear and is changed into electrical information that can be interpreted by the brain. The “disorder” part of auditory processing disorder means that something is adversely affecting the processing or interpretation of the information. Some of the children in the sample may present with Auditory Processing Disorder (APD) in that they have difficulty recognizing subtle differences between sounds in words, even though the sounds themselves are loud and clear. They also experience difficulty in paying attention and remembering information presented orally, difficulty carrying out multistep directions, poor listening skills, low academic performance, behaviour problems, language difficulty (e.g., confuse syllable sequence and have difficulty developing vocabulary and understanding language), they also have difficulty with reading, comprehension, spelling and vocabulary as stated in the preceding sections, all of which are symptoms of this disorder. Although this
diagnosis cannot be made based on the information obtained, it should be explored in future work with these children.

Chapter 2 highlighted four main areas of competence in the acquisition of language, namely: phonology, semantics, syntax and pragmatics. Each component was described as having its own appropriate developmental period. Based on the trends identified in Chapter 6, it becomes apparent that all four these areas are of concern in the acquisition of language for some of the children in the sample. Difficulties with auditory discrimination and the inability to pronounce or repeat words correctly and to reverse the order of letters indicate that these children may have difficulty with phonology. These children thus have difficulty distinguishing between similar sounds and with the rules about the structure and sequence of speech sounds.

The trends identified in the present sample such as having a limited vocabulary and having difficulty with similarities, differences and opposites may indicate a problem with semantics since it is primarily concerned with vocabulary and how concepts are expressed through words. Piaget (1970) reported that children between the ages of 6 and 10 years should be able to understand the meanings of words based on their definitions, appreciate the multiple meanings of words and use words precisely through metaphors and puns. It could be speculated that the inability to listen in class and listen for particular information is linked to the limited vocabulary that the particular children in this study possess. Furthermore, a limited vocabulary could hamper conceptual development.

As was discussed in Chapter 3, oral and written language skills should become more refined during middle childhood. This is dependent on the child’s vocabulary expanding which would then allow the child to master increasingly complex grammatical structures and more sophisticated language usage. When the vocabulary does not expand at a sufficient
rate, the child experiences difficulty with writing tasks, as was found in the present study. In Chapter 4 it was observed that emotionally abused children and neglected children were identified by their teachers as having a poor ability to read and write, which is consistent with the findings of the present study.

The inability to talk in sentences of 10 syllables or to discuss what is seen in a picture may be indicative of a problem in the development of syntax. This area of development allows the child to produce more complex grammatical structures by the age of 5 years. Typically a 6 to 10 year old child would be able to refine complex grammatical structures such as passive voice.

Many behavioural concerns were identified during the assessment period. Some of these included the elicitation of praise or affirmation, aggressive noises or regressive behaviour such as head churning and baby noises. It may be possible that the children who displayed these patterns of behaviour were trying to elicit a certain response from the test administrator. It might also be that these children had difficulty with pragmatics in that they have not yet learned the rules for appropriate and effective communication. By the age of 6 to 10 years, individuals should be able to communicate effectively in structured settings.

The children’s inability to pronounce phonics correctly and to decode the alphabet may indicate a delay in reading ability. This delay in language ability was anticipated in that Kellmer Pringle (1986) found lower levels of language, intellectual and educational performance among children of school age in long-term residential care when compared to their peers. In Chapter 4 it was further stated that maltreated children were commonly found to be 2 years behind their peers with regard to verbal performance and maths abilities.
Many children in the sample are still having difficulty making the transition from egocentric speech to socialized intercommunicative speech. This was observed in that the children had difficulty exchanging ideas. The possibility also exists that these children had not yet developed the ability to internally represent experience and therefore cannot construct spoken language. The development of language is based on the prior development of sensory-motor operations. When language develops, there is a parallel development of conceptual abilities that language helps to facilitate, probably because language and representation permit conceptual activity to proceed more rapidly than sensory-motor operations do. The development is seen as a facilitator of cognitive development but not as a prerequisite for it or a necessity for it.

7.5 Motor And Non-verbal Development

It was stated in Chapter 3 that motor development is important in facilitating the child’s feelings of competence and self-worth which are essential to good mental health. Being able to exert control over their bodies helps them to win the acceptance of peers, therein facilitating healthy relationships. A critical aspect in this area of development is that the child has to be given appropriate opportunities for training, which are not always available in residential care facilities. This should be kept in mind when the trends identified related to motor and non-verbal development are considered below.

This theme covered four areas of motor and non-verbal development, namely: Gross-motor development, Fine-motor development, Visual-perceptual development, body awareness and laterality. Each sub-theme will be discussed individually.
7.5.1 Gross-motor Development

The participants in this study obtained their best result in this area of development in that all the participants’ performances fell within the average range for this subscale. The majority of the participants scored the highest on the Locomotor subscale of the GMDS-ER and only 3 participants scored below their chronological age. The main difficulties identified in this domain of development include difficulties to skip, to hopskip, and some difficulty with balancing.

Information from Chapter 3 stated that the rapid development of the brain between the ages of 2 and 6 years allows for more sophisticated and complex learning abilities as well as the refinement of both gross and fine motor skills. Children who currently find themselves in early childhood (ages 2 to 4 years) have difficulty maintaining their balance or coming to a quick stop without tipping forward due to the fact that they carry the majority of their weight in their upper body. This makes the control of the body more difficult. However, by the age of 5 years the body’s size and proportions even out and development in sensory perceptual and motor activity strengthens neural connections. Generally speaking, children 5 years of age should be able to skip smoothly, walk along a beam confidently and stand on one foot for several seconds. The fact that the children in the sample were unable to perform these activities with confidence may indicate a delay in this area of development. This may be due to missed opportunities at learning these particular skills. Since middle childhood is a time where children are refining their skills, these children often focus on themselves and meeting their own challenges as well as those imposed on them by the world. Therefore the delay in developing these skills might have resulted in the participants developing feelings of inadequacy as well as a weak sense of self. This in turn would affect both their mental health and peer relationships in a negative way.
Kellmer Pringle (1986) stated in Chapter 3 that children in residential care tend to be shorter in height and lighter in weight for their age group compared to the general population. This was not observed in the children who formed part of the study. In terms of their development, there are indications that they might not yet have mastered sufficient control over their hands when writing, drawing, or buttoning up their jackets and have the tendency to have poor physical coordination in tasks which require running, jumping or throwing balls. They also appear to be clumsy.

7.5.2 Fine-motor Development

Compared to the scores on the Locomotor Subscale, scores on the Eye and Hand Coordination Subscale of the GMDS-ER were less elevated. This may be due to the fact that fine-motor development occurs at a slower rate than gross-motor development since it requires further maturation of the appropriate neuromuscular mechanisms of the brain as stated in Chapter 3. It is still important to be cognizant of the fact that 9 of the 11 participants obtained average scores on this subscale while only 2 obtained below average scores. Three of the eleven participants whose scores fell in the average range performed poorer on the Performance Subscale than on the Eye and Hand Coordination Subscale of the GMDS-ER. This could be due to the fact that the Performance subscale requires more intricate manipulation of small objects as well as some reasoning ability.

The main difficulties that were identified in this area of development included difficulty copying some of the drawings, letters and numbers as well as completing tasks where the manipulation of objects was required (i.e., the formboard exercise and returning the blocks to the box). As indicated in Chapter 3, Craig and Baucum (2003) assert that the majority of the
fine motor skills required for writing develop between the ages of 6 and 7 years, although some children cannot draw a diamond or master many letter shapes until the age of 8 years. It can therefore be argued that these children might still be in the process of mastering this skill and that it might thus be premature to conclude that they are experiencing a delay in this area of development.

In general, play that involves gross and fine motor skills plays an important role in development during middle childhood. According to Piaget, play in this phase of life is related to cognitive development because children are beginning to use logic and reasoning in order to achieve their goals (Wadsworth, 1971). Thus activities such as team sports, challenge a child's gross motor skills, but also appropriately allow the child to test out new skills related to logic in order to win the game. Individual tasks involving fine motor skills such as learning to knit or play an instrument focus on dexterity along with memory and pragmatics. The problem with delays or difficulties experienced in this area lies in the fact that the child will be less likely to engage in activities that would require him or her to make use of these skills due to the fact that he or she feels incompetent and fears alienation or rejection from peers or teachers. As mentioned in Chapter 4, Iwaniec (1995) asserted that emotionally abused and neglected children have a desperate need to be noticed, accepted by their peers and teachers. They tend to seek this attention in negative ways by being disruptive and aggressive. It could thus be speculated that if the children in the present study were able to perform age appropriate gross and fine motor skills, this could enhance their cognitive abilities, social skills and therefore result in a decrease of poor behavioural responses.
7.5.3 Visual Perceptual Development

Visual discrimination involves the ability to perceive words accurately by noting likenesses and differences in words (Stock Kranowitz, 2005). There are several ways in which readers, especially beginner readers, experience difficulty with the visual discrimination of words. They often do not note likenesses and differences of vowels and consonants in words, and or display reversals, omissions and additions in their reading. For example, a student who does not note the difference between words like went and want, ride and rode, horse and house, confused and confessed may be one who experiences difficulty with vowel discrimination (Stock Kranowitz, 2005). A student who experiences difficulty with consonant discrimination may confuse words such as “then” and “when”, “would” and “could”, “ever” and “even”, and “presents” and “prevents”. Reversals are displayed, for example, by confusion of “was” and “saw”, “big” and “dig”, “spot” and “stop”, “conserve” and “conversed”. Additions and omissions are evident in discriminating between “our” versus “your”, “ever” versus “every”, “though” versus “through”, and “conversion” versus “conversation”.

When a student shows signs of letter reversal when reading words, there is often a concern that the student may be learning disabled or dyslexic. While reversals in reading may be one indicator that a student has a visual discrimination skill deficiency, a diagnosis of learning disabilities is based on multiple indicators. Visual perceptual problems can impact many areas of academic performance in children. In reading, children may experience difficulty in recognizing letters that are similar or words that they have seen before (Stock Kranowitz, 2005). Spelling can be impacted with visual perceptual problems, as children often reverse letters and numbers. Interpreting math symbols, charts, maps, graphs and diagrams can also
be difficult. Lastly, handwriting and left or right discrimination for fine motor and gross motor activities can also be affected by visual perceptual problems.

The main difficulty that was identified in this area of development was that of visual discrimination in that the participants could not recognise basic shapes or identify the differences between objects.

Wadsworth (1971) stated that Piaget identified three levels of relationship between the actions of a child and his or her thought. The first is the sensori-motor level of direct action upon the environment. Between birth and 2 years of age all schemata are sensori-motor and dependent on the actions of the child. The second stage (2 to 7 years) includes the egocentric thoughts of children and the third, after age 7 or 8, is the level of operations, or logical thought. The child becomes able to reason in a way that is not dependent on immediate perceptual and motor actions. Between the ages of 2 and 7 years is the preoperational stage which is an advance over sensori-motor intelligence but is not as advanced as the logical operations of later stages. Cognitive behaviour is still influenced by perceptual activities. Actions are internalized via representational functions, but thought is still tied to perception. When considering Piaget’s theory it could be speculated that the children in the present sample could have experienced difficulty with centration. In essence, when they are presented with a visual stimulus, they tend to centre or fix their attention on a limited perceptual aspect of the stimulus. This could leave them unable to explore all the aspects of the stimulus, or de-center the visual inspection. As a result the children, when centering, could tend to assimilate only limited aspects of an event.

In order to develop good visual discrimination skills students need consistent and developmentally presented vision training to help them learn how to establish consistent left-
right eye movement and how to focus on the differences in similar words (Stock Kranowitz, 2005).

7.5.4 Body Awareness And Laterality

Lateral preference (laterality) is a term used when a child favours the use of one eye, hand, or foot over the other. It is an expected result of a child progressing through a normal developmental sequence and should occur naturally (Cheatum & Hammond, 2000). A child who has developed lateral preference will have a different feeling in the side of the body that he favours. This innate feeling enables him to automatically know which hand, arm, foot or leg to use for a particular academic or motor task. This awareness or feeling developed in the preferred side of the body forms the foundation that children need in order to determine which objects are up, down, right or left of their bodies or other objects. Children who do not establish lateral preference have difficulty using the non-preferred hand to assist the other. This assistance is necessary in activities such as throwing the ball, cutting food, or holding the bottle steady while unscrewing the lid (Cheatum & Hammond, 2000).

Body awareness or proprioception is the internal sense that tells you where your body parts are without you having to look at them. This internal body awareness relies on receptors in your joints, muscles, ligaments, and connective tissue. They pick up information as muscles bend and stretch as well as when your body is stationary.

Information about body position travels through the spinal cord and into parts of the brain that are not conscious. Because of this, a person is seldom aware of where his body parts are unless he actively thinks about them. Life for a child with impaired proprioception is not easy. He's a "space cadet" because he doesn't know where his body is in space; there's no
internal body map to ground him. He's not quite sure where any body part is at any given
time unless he looks (Cheatum & Hammond, 2000). Both moving and staying still take some
conscious effort. Such children may be physically clumsy or move slowly to compensate.
Without proper proprioceptive input from his or her trunk and legs, the child might slide off a
classroom chair, stumble on stairs, or fall when he runs.

Poor proprioception in the fingers makes it difficult to manage fine motor manipulations
needed to write well, button clothing, and make a peanut butter and jelly sandwich without
shredding the bread. Without being able to gauge the weight of things, the child drops
pencils or uses so much force to pick up things that he hits himself in the face. Since
proprioceptors detect the stretch and pull on muscles and joints, telling the brain just how
much tension the muscles need, impaired proprioception robs the body of key information
needed to maintain good muscle tone.

The main difficulty that was identified in this area in the study was uncertainty with
regards to lateral preferences and awareness of left and right. Craig and Baucum (2003) state
however that foot preference is usually established between the ages of 3 to 5 years and
further refined during middle childhood. Failure to develop foot preference may be an
indicator of developmental delays associated with establishing preference (Craig & Baucum,
2003).

One of the normal patterns of developmental change consists in the establishment of hand
preferences for skilled manual activities. In addition, the development of such consistent
preferences in the majority of individuals bears a systematic relation to the establishment of
preponderant usage in other bilaterally represented functions such as vision and lower limb
utilization (Cheatum & Hammond, 2000). Knowledge of the details of the development of
such preferences in normal children is of special importance because of the emphasis which has been placed upon the significance of this feature of development for normal educational functioning, language, reading functions and personality patterns.

It is interesting to reflect back on the participants’ performances in the areas pertaining to gross and fine-motor development. The main trends that were identified in the section were the difficulty with skipping, hopskipping and some difficulty with balancing. Difficulties to complete these tasks may be additionally influenced by impaired proprioception, which would present itself as clumsiness. Additionally, difficulties that were identified in fine-motor development included difficulty copying some of the drawings, letters and numbers as well as completing tasks where the manipulation of objects was required (i.e., the formboard exercise and returning the blocks to the box). As stated above, poor proprioception in the fingers may have contributed to the difficulties identified since it makes it difficult to manage fine motor manipulations needed for writing and certain tasks of daily living (e.g., buttoning clothing).

7.6 Planning And Reasoning Development

As stated in Chapter 6, the development of planning and reasoning abilities are vital since it allows the individual to weigh up the consequences of choices, therein having a direct impact on behaviour and the ability to learn from one’s mistakes.

Of the 11 participants, 7 obtained average scores on the Practical Reasoning subscale of the GMDS-ER, whilst the remaining 4 obtained below average scores. The main difficulties that were identified in this domain of development were: difficulty to complete a series,
identifying similarities and differences, recognizing and naming shapes and colours, and
difficulty in associating shapes with objects.

In Chapter 3, Piaget’s preoperational and concrete operational cognitive processes were
discussed to shed light on the thinking styles of children between the ages of 2 to 12 years.
Children who find themselves in the preoperational stage of cognitive development have a
tendency to focus their attention on one aspect of an object and ignoring others. The
concepts that are formed tend to be crude and irreversible. It was very apparent in the trends
identified in the sample that the participants experienced difficulty in classifying objects or
events. This was observed in their difficulty to associate shapes with objects as well as
identifying and naming objects. The difficulty to make generalizations about classes of
objects which is characteristic of this stage of development was noted in the participants’
difficulty to complete tasks where they had to identify similarities and differences.

The preoperational stage of cognitive development marks the development of **symbolic**
**thinking** where children begin to give labels to objects they see in everyday life. They also
develop what are known as **schemes** for recognizing new objects. For example, in the early
part of this stage, language skills are developing very rapidly, a child may learn that the four-
legged creature running around the house is symbolized by the word "dog." Upon seeing a
cat, which is similar to a dog because it walks on all fours and is a household pet, the child
may label it as a dog. This is because the cat falls into the same scheme as the dog (i.e. walks
on all fours and is kept as a pet). Of course, as a child grows older, he or she will realize the
differences between cats and dogs. As children progress through this stage and they acquire
labels or symbols, their vocabularies will expand very quickly (Oates & Grayson, 2004).
These labels and symbols enable a child to think about an object, such as the pet dog, even
when the dog is not physically present. This is an advancement from the sensorimotor stage
in which children are incapable of thinking about objects that are not physically present. Not only do these labels help the child to think about things that are not present, but they also allow children to interact socially with their parents, teachers and peers through verbal communication. Children use verbal communication to express their thoughts and receive new information. Children in this stage may also engage in symbolic play which is when a child assimilates a concrete object with a scheme which already exists for a familiar object (Oates & Grayson, 2004). For example, as a child, he or she may pretend to be a rock star and use a household broom as a guitar. Both the guitar and the broom have similar features (long and skinny at one end and short and wide at the other). Children not only form verbal and mental symbols for objects, but also concrete symbols which they use many times in play.

Children in this stage also display illogical thinking (Oates & Grayson, 2004). Examples of this are lack of conservation (the inability to realize that when objects change in form they do not necessarily change in amount), irreversibility (the inability to realize that certain processes can be undone or reversed), single classification (inability to understand that one object can be classified in more than one way) and transductive reasoning (seeing similarities between two or more concrete objects or events when there is actually no relationship). All of which were observed in the present sample.

The behaviors and characteristics of this stage are most commonly observed in preschool and the first few years of primary school. Towards the end of this stage children begin to display somewhat logical thinking and the realization that perspectives besides their own do exist.
During the concrete operational stage of cognitive development, children begin to display somewhat logical thinking. Piaget (1970) suggests that in the concrete operational stage, a child's thought processes become organized and integrated with one another. These larger thought processes were given the term operations. Operations allow children to think logically. This brings about many differences between these two stages (Oates & Grayson, 2004). In this stage, children can grasp many concepts that were difficult for them to grasp during the preoperational stage (Oates & Grayson, 2004). They understand the concept of conservation. They are able to understand that changes in the form of an object do not cause changes in amount because they are able to see that the process of changing the form can usually be easily reversed and the object can be restored to its original form (reversibility). Children in this stage can also classify one object in more than one way (multiple classification) and they demonstrate deductive reasoning (the ability to draw conclusions from given facts and information, an advancement from transductive reasoning described in the preoperational stage). As children grow and develop in this stage, their logical thinking skills increase and they are able to handle more complex problems, but they still have some difficulty with abstract thinking (Oates & Grayson, 2004). A child in this stage has trouble thinking about objects and events that do not have concrete evidence (such as hypothetical situations).

Ideally, a child in the preoperational stage of cognitive development would start making the transition to concrete operational thought between the age ranges of 5 to 7 years. However, when reflecting on the areas of concern highlighted in this domain of development, it seems as though the participants are struggling to negotiate the preoperational stage of cognitive development and thus had not yet started to make the transition to concrete operational thought.
7.7 Social Development

As indicated in Chapter 2, Schechory and Sommerfeld (2007) assert that the removal from the home and the transition to an institution poses enormous challenges for a child’s coping resources. This needs to be kept in mind when reflecting on the fact that social and emotional development impact on one another as stated in Chapter 4. It is therefore important to be cognizant of the fact that there might be some overlap in the discussion of these two areas of development.

The following trends were noted with respect to the social domain of development:

(a) the majority of the participants’ scores on the Personal-social subscale of the GMDS-ER fell below their chronological age (CA);

(b) the tendency for the children to seek validation before or during completion of a task and often failing to complete the task without encouragement;

(c) the preference to be alone;

(d) exhibiting anxious behaviour;

(e) the inability to trust others;

(f) the tendency to lose their tempers and act aggressively towards adults and peers; and

(g) the display of temper tantrums.

In Chapter 4 it was noted that several variables play a role in the child’s social development. These variables will now be discussed as it relates to the results obtained from the participants. Craig and Baucum (2003) asserted in Chapter 3 that early childhood marks the period in which children acquire the knowledge of what constitutes good and bad
behaviour, how to handle their feelings, wants and needs in socially appropriate ways. The participants in this study, however, were removed from their parental home due to neglect or abuse and therefore lacked a warm parental figure that could encourage them to display their emotions constructively and in a socially appropriate way. If we consider Erikson’s stages of psychosocial development, the children in the sample fall either in the initiative versus guilt stage or industry versus inferiority stage of psychosocial development based on their age range. However, based on the trends identified, it is clear that the participants have not yet mastered the preceding stage of autonomy versus shame and doubt successfully. This stage of psychosocial development spans from age 2 to 3 years and is focussed on the child gaining control over eliminative functions and motor abilities whilst also beginning to explore their surroundings. The parents play a vital role in that they should provide a strong base of security that would allow the child to foster autonomy. The result should be self-sufficient behaviour and a sense of being able to handle many problems on their own. However, what was observed in the current sample is the development of shame and doubt as well as reluctance to attempt new challenges. Since these children have not yet managed to negotiate this stage successfully, they are unable to move on to the successive stages of psychosocial development.

According to the information reported in Chapter 4, children in residential care often develop a tendency to appear sadder and less mature in their peer relationships. This was observed in that the majority of the participants’ results for the Personal-Social subscale of the GMDS-ER fell below their chronological ages, therein indicating an immaturity in this domain of development. These children may further have developed insecure attachment patterns which was observed in the trend to avoid contact coupled with high levels of anxiety and ambivalence during test administration. The withdrawal and aggression observed in
these children may be due to the development of maladaptive internal working models of relationships since they did not have reliable, consistent and present caregivers. These disruptions in the attachment process produced anger, anxiety, fear, which hampered the children’s’ ability to develop trusting and secure attachment with both their caregivers and peers. This insecure attachment further lead to the development in maladaptive affective regulation patterns as observed in the participants’ tendencies towards emotional isolation and aggressive behaviour.

In Chapter 4 it was reported that Iwaniec (1995) asserted that the teachers of children in residential care often found the children to be attention-seeking on the one hand and detached and uninvolved on the other. The children in the sample were identified as having a tendency to seek acceptance in aggressive and disruptive ways through tantrums and this then resulted in rejection from their teachers. This was also observed during the test administration in that the participants were desperate to elicit affirmation from the test administrator.

The detachment observed in these children by the residential care facility could also be explained by Piaget’s theory of cognitive development. Piaget stated that the first social feelings arise during the preoperational stage. Representation and particularly spoken language are instrumental in the development of social feelings. Representation allows for the creation of images of experiences, including affective experiences. Thus, for the first time, feelings can be represented and recalled. In this way, the affective experiences come to last longer than the experiences themselves. As discussed in the section pertaining to language development, the participants have not yet successfully negotiated the preoperational stage of cognitive development and some delay in the development of spoken language was observed. As a result, the children find it difficult to represent and recall feelings. When children are still negotiating the transition from sensori-motor development
to preoperational development, past events and experiences cannot be reconstructed because they are not yet represented by the child. Once this ability is negotiated, behaviour can assume an element of consistency that was not possible before representation. When the reconstructed past forms an element in the child’s current behaviour, affect is less tied to immediate experience and perception than it previously was. Behaviour can become a bit more stable and predictable. Feelings have the potential of becoming more consistent as development in the stage proceeds.

This unconstructive cycle of seeking attention in negative ways and being rejected for behaving badly results in the participants having very low self-esteem and low self-worth as was observed in the participants’ uncertainty and constant doubting during the assessment period. Piaget contends that the basis for social interchange is reciprocity of attitudes and values between the young child and others. This form of exchange can lead to mutual respect. Moral reasoning was also seen by Piaget to be an aspect of social development. Piaget also contended that the norms or characteristics of moral reasoning are not fully in place until the concrete operational stage. During the preoperational stage moral reasoning is viewed as prenormative. But moral reasoning during this stage is a clear advance over the capabilities of the sensori-motor child. Piaget found that there were four broad stages in the development of children’s knowledge of rules, namely the motor stage, the egocentric stage, the stage of cooperation and the stage of codification of rules. These stages parallel his four stages of cognitive development. The stages that apply to the sample will be discussed briefly. In Piaget’s first stage of comprehension of rules, the motor stage, a child is not aware of any rules. During the first few years of life and frequently extending into the preoperational stage of cognitive development, games are played according to habit. The activity is non-social and there is no evidence of any awareness of a game in the social sense.
Children between the ages of 2 and 5 years fall into the egocentric stage which is when they become aware of the existence of rules and want to play a game with other children. Even though young children tend to imitate older children, the child is still mainly playing with himself without trying to win. In the same way children’s preoperational use of spoken language is characterized by asocial collective monologues and their play in groups is characterized by a lack of any social interaction or true cooperation. It could be speculated that as the children in the present sample probably still find themselves in the preoperational stage of cognitive development and therefore in the egocentric stage of the development of rules, this could explain why the children in this sample appeared to be socially isolated and detached. It is usually not until the age of 7 or 8 years that children begin to cooperate socially in playing games.

7.8 Emotional Status

The aim of this study was to explore the general and emotional development of children in residential care in order to determine whether decrements in emotional development would lead to decrements in general development. The implications of the results up to this point have indicated minor delays in some of the areas of development and therefore it is not surprising that the performances of the participants indicated that they may experience some difficulties in emotional development as well.

The main difficulties identified in this domain of development include:

(a) the tendency to be shy and insecure;

(b) regressive behaviour;
(c) a tendency towards anxiety and aggression;

(d) perfectionistic behaviour patterns;

(e) a tendency towards attention seeking behaviour;

(f) temper tantrums; and

(g) impulsivity.

As indicated in Chapter 4, Kagan (1978) asserted that emotional development occurs *inter alia* as a function of cognitive development and the acquisition of new knowledge. Hyson (1990) contended that the maturation of the brain and central nervous system helps children to develop better control over when and how they express their emotions. Therefore, age-appropriate development of the brain allows children, in general, to stop themselves from overly expressing strong emotions and helps them to delay action instead of acting impulsively. These abilities are further enhanced by the child’s understanding of cause-effect relationships. Based on the performance of the participants in the assessments, it was observed that the children in this sample displayed difficulty in completing tasks which require skills in both cognitive and language development. They may also be unable to display complex social and self-conscious emotions such as guilt, pride, shame and contempt in appropriate contexts. These children have not yet learnt how to discern their emotional states as well as that of others and are unable to use the vocabulary of emotion. This may have rendered them unable to cope with aversive or distressing emotions and increased the likelihood that they would express their emotions impulsively and in socially inappropriate ways as observed in temper tantrums. Bandura (1977) proposes that efficacy or positive expectations flow from a series of interrelated actions. First, when a task is performed well, efficacy expectations increase and the threat of failure subsides. This is likely to facilitate
sustained effort on later tasks. Psychological arousal is more manageable if tasks are seen as attainable, and if so anxiety declines. Moderate anxiety then facilitates positive feedback, which adds to later efficacy expectations. But information the person receives enhances self efficacy only if seen as reflective of a person’s abilities. When individuals consider external factors responsible for success, self efficacy declines. Not surprisingly, longitudinal data indicate that self efficacy is linked to field independence and to academic and vocational success.

The attention-seeking and detached behaviour noted previously may stem from the children wanting to attain approval and acceptance from both their peers and teachers as stated in previous chapters. However, in the current sample, attention is sought through disruptive and aggressive behaviour in the classroom as well as in the cottages which leads to rejection of the child and ultimately a low self-esteem and sense of self-worth. As a result the participants have difficulty trusting others. Since the children in the sample find themselves in the preoperational stage of cognitive development, they are still displaying egocentric thinking patterns and do not engage with other children in order to be social. This coupled with their consistent experiences of rejection also hinders them from progressing in Erikson’s psychosocial stages of development. As stated previously, the children in the sample should either be in the initiative versus guilt stage of development or the industry versus inferiority stage of psychosocial development. However, due to insecure attachment as young children, the children still find themselves in the autonomy versus shame and doubt stage where they are still trying to venture and explore their surroundings. Not having a patient and encouraging parent, the children are left with a sense of doubt and reluctance to attempt new challenges. This was observed in the children’s uncertainty about completing tasks and attempts to elicit affirmations during the assessment period. Some of the children also
displayed regressive behaviour that would be associated with a child of average
development’s behaviour when in the autonomy versus shame and doubt stage which
includes children between the ages of 2 to 3 years. As a result of the rejection from peers and
teachers, these feelings of doubt and shame leads these children to believe that they are
incapable of solving their problems and thus they do not act independently.

7.9 Scholastic Performance

As stated in Chapter 6, this theme was included to cover information regarding the
participants’ scholastic performance that did not fit under the themes already established. As
a result, an additional theme labelled “scholastic performance” was created in order to
accommodate the information. The information for this theme was gathered from the
scholastic reports in terms of the general scholastic performance of the children as well as
their numeracy proficiency.

Of the 11 participants, only 1 is currently attending mainstream schooling, the remaining
10 participants are receiving remedial education. Of the 10 participants currently receiving
remedial education, 1 will repeat his grade and 1 will be placed in mainstream schooling. The
remaining 8 children will continue with remedial education next year.

Iwaniec (1995) stated in Chapter 4 that academic achievements at school and the
children’s ability to relate to their peer group were the most commonly identified deficits
among 5 to 10 year old emotionally abused and neglected children. He also stated that
maltreated children were commonly found to fail one or more school subjects and often had
to receive remedial intervention, as was found in the current sample.
In terms of numeracy, very few difficulties were noted in that only 2 of the 11 participants displayed difficulty with numeric concepts. This finding does not concur with that of Iwaniec’s (1995) who asserted that maltreated children’s maths abilities are often found to be 2 years behind that of their peers. Iwaniec (1995) further stated that emotionally abused and neglected children *inter alia* often displayed developmental deficits in areas of academic achievements in school, which concurs with the findings of the study. It was also noted in Chapter 3 that Kellmer Pringle (1986) asserted that children in residential care also displayed delays in arithmetic. It is, however important to be cognizant of the fact that the GMDS-ER does have a limitation as far as the measurement of early mathematical abilities are concerned. This result should therefore be interpreted with caution.

### 7.10 General Cognitive Development

Numerous developmental changes occur during middle childhood in all domains of development. Usually there is an increase in physical competence as well as language development, both of which impact the continual development of cognition. In the current sample, many of the participants encountered difficulty in these areas even though many of their performances fell within the average range.

Results in this domain of development indicated that the majority of the participants performed below their chronological age even though their performance was largely within the low average range. However, the discrepancy between their CA and MA was not observed to be very significant.
7.11 Implications For Psychological Intervention In Residential Care Facilities

The results of the multiple case study emphasized that children housed in residential care have a unique developmental profile which is strongly influenced by their environment and interpersonal interactions. It is important to be cognizant of the fact that a variety of variables impacted on and resulted in the performances of these participants on the GMDS-ER and HFD.

The following recommendations regarding intervention are suggested based on the results obtained from the study:

1. The process of removing a child from home is very traumatic for the child.
   Irrespective of whether the social worker has a court order or not, the child has to go to court which, in itself, is very traumatic. The children in the present study ranged from 5 years old to 8 years old. At that age, they do not have the emotional coping skills to be able to make sense of what is happening around them, why it is happening and where that leaves them. It therefore becomes imperative that these children be provided with the opportunity to undergo debriefing and, if need be, enter psychotherapy, to deal with the insecurity and trauma surrounding their removal from their primary care givers.

2. The primary caregivers, in this case the house mothers in the cottages, act as the parental figure to the children placed in residential care. It becomes their task to see that the children are fed, bathed, complete their homework, etc. In many cases the number of children housed in these cottages can range from 6 to 10. As stated previously, children in residential care present with unique needs. Since these children have missed experiences vital to both their emotional and general
development, the housemothers become the individuals tasked with providing earlier missed experiences. It therefore becomes vital that these individual staff members acting as primary caregivers in the cottages, undergo counselling skills training to be better equipped to deal with the unique emotional needs these children present with.

3. As stated earlier, early intervention, whether remedial or psychological, provides the best results for the children in need. Therefore it is suggested that the children entering residential care facilities are assessed on a developmental scale such as the GMDS-ER, to determine the general cognitive ability, to determine whether there is a global delay or specific areas of development which may require attention. This would allow for the residential care facility to provide remedial or psychological intervention at the earliest possible stage, thereby creating a better developmental prognosis for each child.

4. The children placed in residential care should be assessed annually on a developmental scale, such as the GMDS-ER, to monitor development so that the appropriate interventions can be made over time.

7.12 Limitations And Suggestions For Future Research

7.12.1 Limitations

The following limitations were identified in the present study and need to be acknowledged:
7.12.1.1 Limitations Of The Research Method

The multiple case study method allowed the researcher to collect a wealth of information. However, there was an element of inaccuracy as a result of “selective deposit” (i.e., bias could exist due to what was decided to be included or omitted in the study) and “selective survival”, in terms of documents that are missing. The information obtained from the residential care facility was obtained by way of a meeting with the staff, thus allowing the staff the opportunity to either selectively offer or omit information. As a result, additional information that could have been relevant to the study might have been omitted. More specifically it was found that the information obtained from the residential care facility was at times inconsistent with the scholastic progress reports and clinical observations obtained during the assessment period. For example, the residential care facility reported that some participants did not have a developmental delay, when their results from the assessment battery and scholastic reports indicated otherwise. It was also reported that the participants could perform tasks, when it was found on the assessment used that they could not.

Limitations with regard to selective survival included scholastic reports having sections that were omitted. The researcher had also previously worked at this specific facility (in 2007) and had known some of the participants before the commencement of the study. The researcher found that many of the characteristics and mannerisms of the children had stayed the same over a two year period. The residential care facility, in contrast however, reported that these specific children had improved over the period.
7.12.1.2 Limitations Regarding The Sampling Procedure

A non-probability, purposive sampling method was applied to select participants for the sample as all the participants were drawn from one residential care facility. The disadvantages intrinsic in this procedure are the ensuing limit imposed on the size of the sample and the fact that the researcher cannot claim that the sample is reflective of the larger population.

Since the sample was heterogeneous, there were certain variables which were not controlled. These included the duration of the child’s stay at the residential care facility, the circumstances around the child’s removal from the nuclear family, whether the child has been exposed to trauma and the extent thereof. Whether the child has had or is having psychotherapeutic input, and whether the child is exposed to foster care or has relatives actively participating in the child’s life. These variables need to be acknowledged as limitations as they could not be controlled in the present study.

7.12.1.3 Limitations Regarding The Assessment Measures

7.12.1.3.1 Lack Of South African Norms For The Griffiths Mental Development Scales – Extended Revised

As mentioned in Chapter 3, norms for South African children are not currently available for the GMDS-ER and therefore the results should be interpreted with caution. Luiz (1994) states that the clinical merit of the Griffiths Scales have been established worldwide and generated a substantial body of research. As the GMDS-ER has likewise generated many research projects that have utilised this measure on both normal and clinical populations (e.g., Baker, 2005; Barnard, 2000; Gowar, 2003; Jakins, 2009; Kotras, 2001; Makowem, 2005;
Moosajee, 2007; Povey, 2002 & 2008; Sandison, 2005; Van Rooyen, 2005), the results can confidently be used for diagnostic purposes. Additional measures could be considered to endorse the results on the revised GMDS-ER until such time that South Africa norms are established.

7.12.1.3.2 Reliance On Verbal Skills For Assessment On The Verbal Scales

The sample used for the present study consisted of Afrikaans speaking individuals. As stated in Chapter 2, lower levels of language, intellectual and educational performance were found among children of school age in long term residential care, when compared to their peers. The verbal subscales of the GMDS-ER, namely the Language Subscale and the Practical Reasoning Subscale, rely on the understanding of language and giving verbal responses. Poor verbal skills could have impacted negatively on their performance on these scales.

7.12.1.3.3 Assessment Of Independent And Emotional Functioning

The sample used for the study consisted of individuals who have been removed from their parents and families due to insufficient care. The Personal-Social Subscale of the GMDS-ER measures confidence and competence when performing tasks of daily living (i.e., self-care). Many of the participants arrived at the residential care facility being unable to perform tasks usually mastered at that age. Due to the nature of their removal, it is postulated that many of these children had not yet been exposed to tasks of daily living and independent care. They may also have regressive behaviour, anxiety and low self-esteem due to exposure to trauma
that make exploration of such independence minimal. As such, these participants are at a disadvantage when compared to their peers.

When considering the emotional development of these children, the Personal-Social Subscale of the GMDS-ER and HFD were used. It was interesting to note that there was only 1 borderline performance and 3 below average performances on the Personal-Social Subscale. The remaining 7 participants obtained Average scores which would indicate that they were on par with regard to their emotional development. Ten of the 11 participants scored below their chronological age. When drawing on the results of the HFD, only one participant had no emotional indicators. The emotional indicators obtained from the performances of the remaining 10 participants were indicative of emotional delays and, in some cases, developmental delays. This highlights the need for a more comprehensive measure of emotional development and functioning for the GMDS-ER that extends itself beyond the primary care giver’s input to more extensive activities for the children.

A recent proposal for the restandardisation of the GMDS-ER suggests that the following areas will be investigated in the near future:

1. Age-specific pilot studies will determine factors that influence a child’s performance on the GMDS-ER in the context of present and potential future psychomotor theory.

2. Information on the testing of children from other cultures and special needs groups will be integrated into the new standardization.

3. The possible incorporation of new items that capture children’s newer learning methods and early emerging executive function will be explored.

4. Some developmental sequences need to be strengthened.
The investigation and possible restandardisation of these areas may have a profound impact on the assessment results and future interventions implemented to maximise these children’s potential.

7.12.1.4 Limitation To The Study

It was mentioned earlier in the study that the research sample consisted of Afrikaans speaking children. The reality is that the majority of children housed in residential care facilities are often not spoken to or educated in their first language during the time in which they are removed from their homes. As a result, some isiXhosa children and coloured or white English-speaking children end up being educated in a second language. This additional language barrier placed on these children when not schooled in their mother tongue adds to the verbal learning difficulties some children experience in residential care facilities.

7.12.2 Recommendations For Future Studies

As stated previously, there is limited research on the emotional development of children in residential care in South Africa. The present study has been descriptive in nature and as a result has highlighted areas where further research would be of value. The following recommendations for further research are thus suggested:

1. That more systematic research is conducted to control the variables that were not controlled for in this study, such as the duration of stay in residential care; whether the child has been exposed to trauma and the extent thereof, whether the child has had or
is having psychotherapeutic input, and whether the child is exposed to foster care or has relatives actively participating in the child’s life.

2. To conduct a longitudinal study using the GMDS-ER and HFD on children placed in residential care annually to assess the role the GMDS-ER and HFD can play in monitoring these children’s development (general and emotional) in relation to their peers and to assist in planning appropriate intervention.

3. An in-depth study is conducted on the children housed in residential care in South Africa to explore what percentages of them develop appropriately globally and emotionally. The purpose of this would be to identify the factors which preclude them from doing so and thereby contribute to the development of appropriate interventions for assisting these children.

4. Additionally, other assessment measures could also be employed to measure general cognitive development, attention, reality testing and emotions. This would allow for a more in-depth understanding of the unique needs this sample group presents with which could then be utilized to structure the appropriate interventions to maximise their potential.
7.13 Conclusion

The brain is a highly integrated organ and its multiple functions operate in a richly coordinated fashion. Emotional well-being and social competence provide a strong foundation for emerging cognitive abilities, together they are the bricks and mortar that comprise the foundation of human development. Thus, oral language acquisition depends not only on adequate hearing, the ability to differentiate sounds, the capacity to link meaning to specific words, but also on the ability to concentrate, pay attention and engage in meaningful social interaction. Furthermore, the emotional health, social skills and cognitive-linguistic capacities that emerge in the early years are all important prerequisites for success in school and later in the workplace and community. Brain architecture and the immune system also interact as they mature, which influences all domains of development and health.

The aim of the study was to explore both the general and emotional development of a sample of children in residential care. What was observed from the results was that these children present with difficulties in some of the areas of development although most of the results obtained fell either within the average category or in the below average category with very small discrepancies between CA and MA. The delay in language development plays a big part in the acquisition of language, social and emotional skills and can therefore be seen as an area that requires immediate attention.

The main contribution of the current study was identifying areas of development in which children in residential care experience difficulties in. Having been able to get an understanding of the areas, the residential care facility in conjunction with the schools involved, can now focus their activities to help these children to overcome these difficulties and to function at a higher level to enable them to achieve their potential.
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Unpublished Master’s treatise, Nelson Mandela Metropolitan University.


Dear Director,

Re: Participation in a Research Study conducted at the Department of Psychology, Nelson Mandela Metropolitan University

As per our face-to-face discussion, my name is Nicolene Wills and I am currently completing my internship as part of the Masters Degree in Counselling Psychology at the Nelson Mandela Metropolitan University.

A large component of the degree comprises of a research study. The purpose of this study is to generate information regarding the emotional development of both boys and girls in residential care facilities. The study aims to explore and describe the effect(s) that emotional development has on the general development of children between the ages of 5 and 8 on the Griffiths Mental Development Scales-Extended revised (GMDS-ER) and a Human Figure
Drawing. The six areas of general development that are measured on the subscales of the GMDS-ER include: Locomotor, Personal-Social, Language, Eye-Hand Co-ordination, Performance and Practical Reasoning.

The original Griffiths Scales were developed in Britain in the 1960s and are used internationally for the developmental assessment of young children aged between 2 and 8 years old. A research team based at the psychology Department of the Nelson Mandela Metropolitan University have recently revised the Scales, making them more culture fair. The Scales provide the researcher with the general Quotient (GQ) and an age equivalent, which provides an indication of the child’s overall development.

Participants will be asked to complete tasks that are age appropriate and based on the concept of play, resulting in much enjoyment by the participant. Please remain assured that the children will be free to refuse or withdraw at any stage of the assessment and will be informed of this.

The administrators of the assessment will consist of the researcher and two Intern Psychologists who have undergone training in the administration of these measures. The assessment procedure will consist of a one-on-one test session (approximately two hours long) in which the child will be assessed on the GMSD-ER after which the child will be asked to draw a human figure. The administrator will then spend some time with the child to process the drawing.

The administration of the test as well as the consultation will take place at your residential care facility. A brief feedback session, in addition to an individual report, will be provided.
Upon receiving the results, should further assessment be required, it will be arranged through the University Psychology Clinic (UCLIN).

Prior to the commencement of the research, I hereby request your permission to allow the children at your facility to participate in the study. It is kindly requested that you complete the attached Biographical Questionnaire and Information and Informed Consent Form. Upon completion, enclose the forms in the attached pre-addressed envelope and return to me as soon as possible. The information and assessment results will be treated as strictly confidential.

Should you require any further information regarding the research project, please do not hesitate to contact me telephonically or by e-mail. My details are as follows:

Telephonically: 041 504 2330 or

E-mail: nikiwills@webmail.co.za

I thank you in advance for your interest.

Yours Sincerely,

Ms. Nicolene Wills
Intern Counselling Psychologist
Prof. Louise Stroud
Supervisor

Prof. Cheryl Foxcroft
Co-Supervisor
Biographical Questionnaire To Be Completed By Primary Care Giver(S)

SECTION A
PERSONAL DETAILS

Child’s name and surname: ____________________________

Date of Birth: ____________________________

Gender: Tick appropriate box

☐ M  ☐ F

Cultural Group: Tick appropriate box

☐ Black  ☐ Coloured  ☐ Indian  ☐ White

Current Preschool/School:

_____________________________________________________

Preschool/School Telephone Number:

_____________________________________________________

Home Language:

_____________________________________________________

Has the child been diagnosed with a mental and/or physical disorder? If yes, please specify.

_____________________________________________________

_____________________________________________________
## SECTION B
### GENERAL DEVELOPMENT

Tick the appropriate answer (Y= Yes, N= No):

<table>
<thead>
<tr>
<th>Motor development</th>
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<tbody>
<tr>
<td>1 Is the child extremely passive?</td>
<td>Y/N</td>
<td></td>
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<tr>
<td>2 Is the child noticeably physically overactive?</td>
<td>Y/N</td>
<td></td>
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<tr>
<td>3 Is the child clumsy?</td>
<td>Y/N</td>
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<table>
<thead>
<tr>
<th>Language Development</th>
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<tbody>
<tr>
<td>4 Does the child use single words?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>5 Does the child speak in sentences?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>6 Does the child ask repetitive questions?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>7 Does the child talk to him/herself excessively?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>8 Does the child echo words or phrases constantly?</td>
<td>Y/N</td>
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<tr>
<th>Emotional Development</th>
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<th></th>
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<tbody>
<tr>
<td>9 Does the child cry or laugh for no reason?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>10 Does the child prefer to be alone?</td>
<td>Y/N</td>
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<tr>
<td>11 Does the child enjoy cuddling and respond to affection?</td>
<td>Y/N</td>
<td></td>
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<tr>
<td>12 Does the child display temper tantrums regularly?</td>
<td>Y/N</td>
<td></td>
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<tr>
<td>13 Does the child display extreme distress for no apparent reason?</td>
<td>Y/N</td>
<td></td>
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<tr>
<th>Social Development</th>
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</thead>
<tbody>
<tr>
<td>14 Does the child have difficulty in mixing with other children?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>15 Does the child make little or no eye contact?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>16 Does the child display inappropriate attachment to certain objects?</td>
<td>Y/N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory/ Hearing Development</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Does the child appear as if he/she does not hear you?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>18 Does the child cover his/her ears?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>19 Is the child upset by noises?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Y/N</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>20</td>
<td>Is the child on any kind of medication? If yes, for what?</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Does the child stutter?</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Does the child faint frequently?</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Does the child bite his/her nails frequently?</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Has the child had any childhood diseases?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(If yes, please list all diseases and the ages at which they occurred)</td>
<td></td>
</tr>
</tbody>
</table>
SECTION C

The following questions are applicable to children of a broad age range; therefore, we do not necessarily expect the child to be capable of the tasks below. We would appreciate a completely honest evaluation of the child’s ability. Please do not be concerned if the child is not yet able to complete each of the activities.

<table>
<thead>
<tr>
<th>General</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Does the child help with small household tasks?</td>
<td>Y/N</td>
</tr>
<tr>
<td>2 Does the child help with routine tasks when requested?</td>
<td>Y/N</td>
</tr>
<tr>
<td>3 Does the child help tidy a room?</td>
<td>Y/N</td>
</tr>
<tr>
<td>4 Does the child bath/shower with minimal assistance?</td>
<td>Y/N</td>
</tr>
<tr>
<td>5 Does the child clean his/her own teeth?</td>
<td>Y/N</td>
</tr>
<tr>
<td>6 Does the child wash his/her own hands and face but needs assistance with drying?</td>
<td>Y/N</td>
</tr>
<tr>
<td>7 Does the child was and dry his/her own hands and face but needs checking?</td>
<td>Y/N</td>
</tr>
<tr>
<td>8 Does the child was and dry his/her own hands and face without assistance?</td>
<td>Y/N</td>
</tr>
<tr>
<td>9 Does the child need some assistance to bath or shower?</td>
<td>Y/N</td>
</tr>
<tr>
<td>10 Does the child bath/shower without assistance?</td>
<td>Y/N</td>
</tr>
<tr>
<td>11 Does the child bath or shower, and dry him/herself without assistance?</td>
<td>Y/N</td>
</tr>
<tr>
<td>12 Does the child need assistance to put his/her own shoes and socks? E.g. Putting shoes on correct feet?</td>
<td>Y/N</td>
</tr>
<tr>
<td>13 Does the child put on his/her own shoes and socks without assistance?</td>
<td>Y/N</td>
</tr>
<tr>
<td>14 Does the child choose his/her own clothing?</td>
<td>Y/N</td>
</tr>
<tr>
<td>15 Does the child deliver a simple message?</td>
<td>Y/N</td>
</tr>
<tr>
<td>16 Does the child go on instruction to get a specific item in a public area, e.g. go and get bread from the counter and bring it to the care taker?</td>
<td>Y/N</td>
</tr>
<tr>
<td>17 Does the child go alone on errands to nearby shops, etc.?</td>
<td>Y/N</td>
</tr>
<tr>
<td>18 Does the child make a small purchase in a shop with some assistance, e.g. Checking the change?</td>
<td>Y/N</td>
</tr>
<tr>
<td>19 Does the child make a small errand in a shop without assistance?</td>
<td>Y/N</td>
</tr>
<tr>
<td>20 Does the child demonstrate an understanding that it is unsafe to accept rides, foods or money from a stranger?</td>
<td>Y/N</td>
</tr>
<tr>
<td>21 Does the child need to be reminded to follow the rules in a simple game?</td>
<td>Y/N</td>
</tr>
<tr>
<td>22 Does the child follow a rule in a simple game, without being reminded?</td>
<td>Y/N</td>
</tr>
<tr>
<td>23 Does the child neaten (brush/comb) own hair in the morning?</td>
<td>Y/N</td>
</tr>
<tr>
<td>24 Does the child ask to use the toilet?</td>
<td>Y/N</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>25</td>
<td>Does the child have bladder control during the day, with a few accidents?</td>
</tr>
<tr>
<td>26</td>
<td>Does the child have complete bladder control during the day and night?</td>
</tr>
<tr>
<td>27</td>
<td>Does the child drink water from the tap without assistance?</td>
</tr>
<tr>
<td>28</td>
<td>Does the child get water from the tap with some assistance?</td>
</tr>
<tr>
<td>29</td>
<td>Does the child eat without assistance?</td>
</tr>
</tbody>
</table>

Thank you for your co-operation in filling in this Questionnaire. All the information that you have supplied us with will be treated as strictly confidential.
APPENDIX C

THE GENERAL AND EMOTIONAL DEVELOPMENT OF A SAMPLE OF SOUTH AFRICAN CHILDREN IN RESIDENTIAL CARE

Residential Care Facility Consent Form

I give consent for you to approach the children aged 5 to 8 to participate in the research study entitled

“The General and Emotional Development of a Sample of South African Children in Residential Care”

I have read the Project Information Statement explaining the purpose of the research project and understand that:

- The role of the residential care facility is voluntary
- I may decide to withdraw the facility’s participation at any time without penalty
- Children between the ages of 5 and 8 will be invited to participate and that permission will be sought from them and also from their primary care givers.
- Only learners who consent and whose primary care givers consent will participate in the project
- All information obtained will be treated in strictest confidence.
- The learners’ names will not be used and individual learners will not be identifiable in any written reports about the study.
- The residential care facility will not be identifiable in any written reports about the study.
Participants may withdraw from the study at any time without penalty.

A report of the findings will be made available to the residential care facility.

I may seek further information on the project from Nicolene Wills on 041 504 4550.

__________________________   ___________________________
               Director                        Signature

__________________________
               Date
APPENDIX D

Informed Consent For A Psychological Research Study

I, (Name & Surname of Parent/Guardian) ______________________________
voluntarily grant my consent to allow (Name & Surname of Participant)
to participate in an exploratory study to be conducted by Nicolene Wills who is currently completing her treatise at the Nelson Mandela Metropolitan University Department of Psychology as a requirement for her Masters in Psychology. I have read the letter explaining the purpose of the research study and I understand what my son/daughter’s participation involves.

I understand that (Name and Surname of Participant) ______________________________
is free to decline to participate and may withdraw from the study at any time without prejudice.

I understand that all of the information obtained will be treated in the strictest confidence and that no names will be used in any reports about the study.
I understand that I may contact Nicolene Wills on 041 504 4550 for more information about the study.

__________________________  _______________________
Print Name                  Signature

__________________________
Date
Appendix E

Case Information On Participant C

GENERAL DATA

Gender: Male
Race: White
Language: Afrikaans

Age at time of GMSD-ER and HFD assessment: 77.9 months

FAMILY BACKGROUND

- Not a lot of information is available on his parents.
- Placed in the residential care facility in the beginning of 2009.
- Participant C has an older brother and sister.
- He has a relationship with both of them and plays a lot with his brother.

INTEGRATED OVERVIEW OF DEVELOPMENT DOMAINS

Based on GMSD-ER and HFD assessments as well as assessments of professional team as per archival records.

1. PHYSICAL

Team discussion: (house mothers, class teachers, social workers, students currently working with her)
Medical information:

- Recently diagnosed with Attention Deficit Disorder (ADD).
- Currently in psychotherapy – recent disclosure of sexual abuse.

Information highlighted by staff:

- Has no attachments and tends to display role confusion.
- Does not play with other children (boys in particular).
- Best friend is younger than him.
- Active child, restless.
- Recently displaying more interest since there has been some stimulation.
- Missed several developmental milestones.
- Not ready for school, repeating Gr. R in 2010.

1.1 GROSS MOTOR DEVELOPMENT

School Report:

DECEMBER 2009:

1.1.1 Co-ordination:

- Basic motor movement (running, jumping, crawling) with ease, swift & co-ordinated.
- Fearless when climbing.

1.1.2 Balance

- Can ride a bicycle or scooter.
- Can balance on one leg for 10 or more seconds although still wobbly.
The residential care facility reports that Participant C is not extremely passive, physically overactive but he tends to be clumsy.

1.2 FINE MOTOR DEVELOPMENT

School Report:

DECEMBER 2009:

1.2.1 Hand-eye Co-ordination:

- Average handling of a crayon, brush and scissors.
- Average ability to cut with scissors.

1.2.2 Eye-foot Co-ordination:

- Kicks, stops and dribbles a ball with ease.

1.3 BODY AWARENESS

School Report:

DECEMBER 2009:

1.3.1 Body Image:

- Knows some body parts.

1.3.2 Laterality:

- Unsure with regard to his consciences of left and right.

1.3.3 Dominance:

- Gives preference to his left eye, right hand and right foot.
1.3.4 Eye Movement:

- Movement of the eye when following a moving object is progressing well.

1.4 VISUAL PERCEPTION

1.4.1 Visual Discrimination:

- Colour recognition for primary colours and secondary colours.

- Recognition and naming of shapes is not good as he confuses some shapes.

- Only sees some differences and similarities.

1.4.2 Visual Syntheses and Analysis:

- Good puzzle building skills (49 piece puzzle).

1.4.3 Visual Form Constancy:

- Discriminates between different shapes regardless of size of colour with ease.

- Experiences difficulties in associating shapes with objects.

1.4.4 Spatial Orientation:

- Good knowledge of concepts such as up/down, behind/in front, next to/besides.

1.5 AUDITORY PERCEPTION

1.5.1 Auditory Discrimination:

- Identifies only some every day sounds and phonics.
- Recognition of small differences in phonics is still unsure.

1.5.2 Auditory Sequencing and Memory Recall:

- Doubts when asked to complete a sequence of instructions (3/more).
- Doubts in memorizing songs and poems.

1.5.3 Auditory Foreground-Background Discrimination:

- Attention is easily distracted with regard to his ability to listen and concentrate in a group situation.

1.5.4 Auditory Analysis and Synthesis:

- Unsure in his ability to phonetically break words up into units and put them back together again.

According to the residential care facility, Participant C often appears as though he does not hear you, he often covers his ears but he is not upset by noises.

1.6 LITERACY

1.6.1 Listening:

- Likes to listen to stories.
- Does not listen for specific information.

1.6.2 Speaking:

1.6.2.1 Speech:

- Pronounces some phonics incorrectly.
• Pronounces some words incorrectly.

1.6.2.2 Sentence Construction:

• Incomplete sentence structionning.

• Swaps words around.

1.6.2.3 Vocabulary:

• Limited.

1.6.3 Expression:

• Needs motivation to participate in class discussions.

• Spontaneous conversations with friends and teacher.

1.6.4 Writing:

• Leaves letters out.

• Does not attempt to write his name.

According to the residential care facility Participant C does not use single words as he speaks in full sentences. He does not ask repetitive questions or talk to himself excessively. Participant C echoes words or phrases constantly.

1.7 NUMERACY

1.7.1 Numeric Concepts:

• Counts physical objects correctly.

• Counts correctly to 10 or more.
• Average concept of number concepts.

1.7.2 Concept of Time:

• Average concept of passing of the day.

1.8 CONCENTRATION AND ATTENTION SPAN

1.8.1 Task orientation and completion:

• Needs constant motivation.

• Tires quickly.

• Takes time to complete tasks.

1.8.2 Attention in group situation and individually:

• Attention fluctuates.

• Restless.

• Attempts tasks on his own.

• Needs to be motivated to complete tasks.

• Attention easily distracted.

1.9 ACTIVITIES

1.9.1 Creative Activities:

• Enthusiastic.
• Needs motivation.

1.9.2 Creative Abilities:

• Only draws the known.

• Pictures contain little detail.

• Needs to be motivated to complete tasks.

1.10 EMOTIONAL DEVELOPMENT

Input from Residential care facility:

*Participant C does not cry or laugh for no reason. He prefers to not be alone and enjoys displaying and receiving affection. He displays no temper tantrums or extreme distress.*

1.11 SOCIAL DEVELOPMENT

• Does not have difficulty mixing with other children.

• Makes eye contact.

• Does not display inappropriate attachment to certain objects.

1.12 GMDS-ER and HFD ASSESSMENTS

The GMDS-ER:

A comparison in months to chronological age was used.

The number of months above or below chronological age for each scale are given on the GMDS-ER.

Above chronological age – highlighted in yellow

Below chronological age – highlighted in green
<table>
<thead>
<tr>
<th>Age (months)</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>GQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>77.9</td>
<td>82</td>
<td>54</td>
<td>76</td>
<td>68</td>
<td>68</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>

Sub-quotient: 105 69 98 87 87 72 86

RESREACHER’S ASSESSMENT AND CLINICAL OBSERVATIONS

1.12.1 PHYSICAL

Gross motor skills:

- Average performance on the Locomotor subscale.
- Could not:
  - Hopscotch.
  - Could not keep his balance (static balance II).
  - Could not hopskip some distance in an open area.
  - Could not skip with a rope 3+ single skips.

Fine motor skills:

- Average performance on the Eye-hand co-ordination subscale.
- Could not:
  - Copy letters.
  - Could not complete stage II drawings or some stage I drawings (diamond).
- Average performance on the Performance subscale.
- Could not:
  - Complete a number of the pattern-making activities.
  - Could not build a ten-brick memory stairs.

Clinical observations: Erased frequently, often looked for affirmation whilst drawing, regressive behaviour (i.e., sucking sounds, gurgling, and head churning while drawing).
1.12.2 COGNITIVE

- General quotient falls within the average range.

- Performance on the Practical Reasoning subscale fell within the below average range.

- Could not:
  - Count backwards from 10.
  - Complete “which goes faster” exercise correctly.
  - Count up to 30.
  - Repeat 4 digits.

Clinical observations: Test administrator observed a lack of attention while completing tasks, difficulty in understanding the gestalt of some activities, a constant need for reassurance, baby-like noises and anxious laughter.

Language development:

- Performance on the Language subscale fell within the average range.

- Could not:
  - Do similarities.
  - Could not do differences.
  - Could not name the capital letters.

1.12.3 SOCIAL

- Performance on the Personal-Social subscale fell within the Borderline category.

- Performance indicates that Participant C does not act independently.
Reported by residential care facility:

Participant C does not have difficulty mixing with other children, makes full eye contact and does not display inappropriate attachment to certain objects.

1.12.4 EMOTIONAL

- Borderline performance on the personal Social subscale.

Clinical observations: Participant C was very anxious while participating in the assessments. He indicated regressive behaviours and body postures at times.

The Human Figure Drawing (HFD):

Participant C’s performance on the HFD indicated the following 7 emotional indicators:

1. Poor integration of parts:
   - Only significant for boys at the age of 7 years.

2. Shading of face:
   - Indicates that the child might be overly aggressive.
   - The child might have stolen objects in the past.
   - Specific anxieties about the parts shaded or anxieties about its functions.

3. Shading of body and/or limbs:
   - Not valid.
4. Hands cut off:
   - Indicative of brain injured children or special class children.
   - Indicative of shyness.
   - Indicates a child who might have stolen.
   - Psychosomatic complaints.
   - Feelings of inadequacy.
   - Guilt over failure to act correctly or the inability to act at all.

5. No body:
   - Indicative of poor/special class pupils as well as children who stole.
   - Indicates a slower rate of maturation/neurological impairment.
   - In school age children it might indicate psychopathology i.e., mental retardation, cortical malfunctioning, severe immaturity due to a developmental lag, emotional disturbance with acute body anxiety and castration fear.

6. No feet:
   - Not significant.

7. No neck:
   - Not significant.

**Report to the Residential Care Facility:**

Participant C’s results on the Human Figure Drawings is consistent with that which one would find with special class students and suggests severe emotional and cognitive
immaturity due to a developmental lag as well as emotional disturbance with acute body anxiety which is consistent with the recent results from his individual psychotherapy.
Appendix F

Case Information On Participant F

GENERAL DATA

Gender: Male
Race: White
Language: Afrikaans

Age at time of GMSD-ER and HFD assessment: 88 months

FAMILY BACKGROUND

- Mother and father are separated.
- Mother is Hari Krishna faith.
- Still has contact with the mother who fetches him and his sister for school holidays.
- Mother blatantly favours Participant D over participant F.
- Stays in the same cottage as his sister in the residential care facility.
- Housed in residential care since 2007.

INTEGRATED OVERVIEW OF DEVELOPMENT DOMAINS

Based on GMSD-ER and HFD assessments as well as assessments of professional team as per archival records

2. PHYSICAL

Team discussion: (house mothers, class teachers, social workers, students currently working with her)
Staff reports:

- Tendency to be a follower in a group.
- Acts independently.
- Appears to be a normal child.
- Friends make all the decisions with regards to games and roles played in the games.
- Polite and friendly.
- Stubborn at times.
- Child with a lot of potential.
- He does not put a lot of effort into activities and listens selectively.
- Acts correctively towards his sister.

1.1 CHILD DEVELOPMENT

School Report:

1. Numeracy:

Demonstrated knowledge, ability and values in the following:

- Counting.
- Understanding of numbers.
- Measuring (length).
- Mass.
- Volume.
- Time.

Demonstrated knowledge, skills and values but still requires attention in:

- Equations.
• Problem solving.

2. First additional language:

Demonstrated knowledge, ability and values in the following:

• Listening.

Demonstrated knowledge, skills and values but still requires attention in:

• Speaking.
• Reading.
• Phonics.

3. Literacy:

Demonstrated knowledge, ability and values in the following:

• Listening.
• Creative writing: colours well.

Demonstrated knowledge, skills and values but still requires attention in:

• Speaking – logical order.
• Reading: unprepared: only recognises single words.
• Reading: prepared: recognises several sounds.
• Sounds: only recognises o- and –e sounds.
• Hand writing: reverses letter, especially 4’s and –s.
• Thinking and reasoning.

4. Life orientation:

Demonstrated knowledge, ability and values in the following:
- Behaviour: refuses to work.

Demonstrated knowledge, skills and values but still requires attention in:

- Participation in groups: Fights often.
- Concentration: can’t maintain consistent attention span.
- Completion of work: only completes a small portion of his work.

The residential care facility reports that Participant F is not extremely passive, physically overactive or clumsy.

According to the residential care facility, Participant F appears as though he does not hear you, he never covers his ears. He is never upset by noise.

According to the residential care facility Participant F does not use single words as he speaks in full sentences. He does not ask repetitive questions or talk to himself excessively.

Participant F does not echo words or phrases constantly.

1.2 EMOTIONAL DEVELOPMENT

Input from Residential care facility:

Participant F does not cry or laugh for no reason. He prefers not to be alone although he enjoys displaying and receiving affection. He displays no temper tantrums or extreme distress.

1.3 GMDS-ER and HFD ASSESSMENTS

The GMSD-ER:

A comparison in months to chronological age was used.

The number of months above or below chronological age for each scale are given on the GMSD-ER.

Above chronological age – highlighted in yellow
Below chronological age – highlighted in green

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<th>GQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>96</td>
<td>78</td>
<td>86</td>
<td>94</td>
<td>76</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>Sub-quotient</td>
<td>109</td>
<td>89</td>
<td>98</td>
<td>93</td>
<td>86</td>
<td>98</td>
<td>98</td>
</tr>
</tbody>
</table>

RESREACHER’S ASSESSMENT AND CLINICAL OBSERVATIONS

PHYSICAL

Gross motor skills:
- Performance on the Locomotor subscale fell within the average range.
- Could not:
  - Complete 12+ skips with rope.

Fine motor skills:
- Performance on the Eye-hand subscale fell within the average range.
- Could not:
  - Write his full name.
  - Draw a person stage III.
- Performance on the Performance subscale fell within the average range.
- Could not:
  - Complete all the pattern-making exercises.
  - Complete some of the form boards.

COGNITIVE
- General quotient fell in the average range.
• Performance on the Practical Reasoning subscale fell within the average range.

• Could not:
  o Name the days of the week.
  o Complete the series.
  o Count backwards from 20.
  o Repeat the digits.

Language development:

• Performance on the Language subscale fell within the average range.

• Could not:
  o Name the capital letters.
  o See some similarities.
  o See some differences.
  o See some opposites.

*Clinical observations: Participant F was very eager to impress the test administrator. He appeared extremely shy and was very quiet and polite.*

**SOCIAL**

• Performance on the Personal social subscale fell within the average range.

• It appears as though he is not able to act independently on a daily basis.

**EMOTIONAL**

• Average performance on the Personal-social subscale.
Clinical observations: Participant F appears to have a very low self esteem. He is very shy and holds back on his emotions a lot (does not want to indicate that he is excited to participate in an activity).

The Human Figure Drawing (HFD)

Participant F obtained 2 emotional indicators on the HFD:

1. Tiny figure:
   - Indicative of:
     - Special class/poor students.
     - Shyness.
     - Extreme insecurity.
     - Withdrawal.
     - Depression.
     - Timid child.
     - Withdrawn.

2. No feet:
   - Only significant after the age of 9 years for boys.
Report to the Residential Care Facility:

Participant F’s performance on the Human Figure Drawings was consistent with that of a special class pupil and indicated extreme insecurity, withdrawal and possible depression. It was also reflective of a child who could be described as timid who has feelings of inadequacy and a concern over dealing with the environment.