RESILIENCE IN HIV/AIDS’ ADOLESCENT HEADED FAMILIES

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To all the orphaned and vulnerable children;

Salutations to you for “bouncing forward”

To Sonal;

Your strength & courage instilled

appreciation and humility within me

To my family;

Our lives are testament

to our own resilience
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Abstract

HIV/AIDS has presented humanity with various challenges, one of which is the manner in which it has affected family structure and patterns. Parental illness and eventual death due to the HIV/AIDS pandemic is escalating. One of the major challenges of HIV/AIDS in southern Africa is the increase in the number of orphaned and vulnerable children. As a result new family forms are emerging such as the "skip-generation" family in which children or adolescent siblings head the family. It is anticipated that HIV/AIDS in South Africa will progressively increase the number of such families. During this time of profound family change, the family as an institution has remained remarkably resilient.

The present study utilised the Family Resilience Framework and the Resiliency Model of Family Stress, Adjustment and Adaptation to explore and describe the resilience of HIV/AIDS’ adolescent headed families. A qualitative, exploratory-descriptive research design, which was assessed against Guba’s (1985) model of trustworthiness, was employed and the participants were sampled using non-probability purposive sampling.

The Masizakhe Community Project volunteers (an AIDS Community Project in Kwazakhele, Port Elizabeth receiving support from the iThemba AIDS Foundation) assisted in identifying participants according to the predetermined inclusion criteria. The sample consisted of four female, adolescent heads of HIV/AIDS’ affected households, who volunteered at the Masizakhe Community Project and resided in Kwazakhele.

The data that was collected via audio-recorded semi structured interviews were transcribed verbatim and subjected to Interpretive Phenomenological Analysis. Family resilience factors that emerged included intrafamilial strengths (family cohesion, organisation, hardiness, and adaptability); social support resources (especially from the community project, friends, and
community members); family appraisal processes; and problem solving and coping strategies.

Extended family support was partial and largely financial.

The findings from this study provided insights into the resilience of adolescent-headed families; provided guidance for the development of intervention programmes to assist these families; and affirmed the existing strengths of the families. Furthermore, it has contributed to the research and literature on family resilience and formed the foundation for future research projects.

Keywords: Adolescent Headed Families, HIV/AIDS, Family Resilience, Resiliency Model of Family Stress, Adjustment and Adaptation, Family Resilience Framework.
CHAPTER ONE

Introduction: Background and Motivation

1.1 Introduction

This introductory chapter provides the contextual and conceptual framework of the study. A brief theoretical overview is outlined, followed by the motivation for the research. The primary objective of the study is highlighted and the chapter concludes with the delineation of the research.

1.2 Context of Research

A review of the literature on HIV/AIDS indicates that South Africa has the fastest growth of HIV/AIDS in the world (Brookes, Shishana & Richter, 2004; Rehle & Shishana, 2003; UNAIDS, 2006; Whiteside & Sunter, 2000). An important consequence of the high HIV/AIDS prevalence is the increasing number of prime age adult deaths (Makame, Ani & Grantham-McGregor, 2002). Consequently, the number of orphaned and vulnerable children resulting from HIV/AIDS is increasing. According to Shetty and Powell (2003), the orphan crisis caused by the HIV/AIDS pandemic is a serious issue globally and has immediate and long term social consequences. Sub-Saharan Africa is the most severely affected, accounting for more than 80% of those orphaned by HIV/AIDS worldwide (Shetty & Powell, 2003).

Orphaned and vulnerable children lack adequate food, shelter, clothing and schooling (Badcock-Walters, 2002; Giese, 2002; Ntozi, 1997; Ntozi & Mukiza-Gapere, 1995). Their circumstances predispose them to psychological problems that emerge from caring for terminally ill parents and experiencing the deaths of their parents (Foster, Makufa, Drew, Mashumba & Kambeu, 1997; Hunter, 1990). Some of them may have to seek employment to earn an extra
income to support their families whilst others have an increased load of household chores (Foster, 2000; Foster et al., 1997).

The placement of children following the death of the parent/caregiver remains a critical issue (Freeman & Nkomo, 2006). Various models for placing children have been proposed including extended families, foster parents, community carers, kibbutz type situations and institutional care (Freeman & Nkomo, 2006; Nyambedha, Wandibba & Aagaard-Hansen, 2003). Extended families usually assume responsibility for orphaned and vulnerable children (Ansel & Young, 2004; Foster, 2000; Malinga, 2002; Ntozi & Mukiza-Gapere, 1995), although the rapidly increasing numbers of orphans is now overwhelming this care system (Foster, 2000; Freeman & Nkomo, 2006).

It has been highlighted that some threshold for the extended families’ capacities is inevitable (UNICEF, 2003). There are indications that the integrity, cohesion, capacity and efficacy of the extended family as a social support network is being undermined for reasons such as social upheavals, rapid urbanisation, poverty and strained resources (Foster, 2000; Freeman & Nkomo, 2006). When these suggested options for orphan care fail, the care of orphaned and vulnerable children falls on those who have the least capacity to provide parenting, support and care. This leads to the emergence of child/adolescent/sibling headed households (Foster & Williamson, 2000; Guest, 2001; Singhal & Howard, 2003; World Health Organisation, 2005). Whilst there is considerable research on the consequences of HIV/AIDS for children (Foster, 2000; Gow, Desmond & Ewing, 2002; Loewenson & Whiteside, 1998; Whiteside & Sunter, 2000), little or no attention has been given to reconceptualising these deficits from a strength based perspective (Donald & Clacherty, 2005; Eloff, Ebersöhn & Viljoen, 2007). The resilience of the adolescent headed family is the focus of interest in the present study and these concepts are clarified in the following section.
**1.3 Conceptual Clarification**

In this section the South African legal definition and various psychological definitions of adolescence are expounded in order to clarify the concept of adolescence for this study. The concepts of resilience and resiliency are also defined.

**1.3.1. Defining the Child and Adolescent Headed Family**

The child headed family is defined as a family that is led by a child who is below the age of 18 years and who has assumed parental responsibilities. A parent may be present in the home but unable to assume any responsibilities due to illness, disability, and so on (International HIV/AIDS Alliance-Family Health International, 2005). Adolescent headed families are those families that are headed by a person aged 18 to 24 years and who is not the biological parent of any of the children. In many cases child headed families become adolescent headed when the primary care giver reaches 18 years of age (International HIV/AIDS Alliance-Family Health International, 2005).

Authors differ on the chronological age for adolescence, for example, Sadock and Sadock (2003) indicated that this stage spans from about 13 years to 21 years and Nicholson and Ayers (2004) defined it as beginning at approximately 10 years to 13 years of age and ending between 18 years and 22 years of age. Some developmental psychologists approximate adolescence to be from 12 years to 20 years of age (Shaffer, 1993). Craig (1996) and Salkind (1981) demarcated this stage from 12 years to 18 years of age. A review of adolescent definitions found that the earliest age for onset of adolescence was eight years and the latest age for the end of adolescence was 25 years (Manaster, 1989; Meyer, Moore & Viljoen, 1997; Sadock & Sadock, 2003).

It is easier to indicate the beginning of adolescence as physical changes can be used as an indicator. These physical indicators cannot be used to mark the end of adolescence as there is no physical change that distinguishes adolescence from young adulthood (Manaster, 1989).
Therefore, some theorists use the legal demarcation of adulthood to signify the end of adolescence (Manaster, 1989). In South Africa, sections of the Child Care Act No. 38 (2005) came into effect on the 1st of July 2007. This Act clarifies the grey area that existed in relation to the age of adulthood. A child is defined as “a person below the age of 18 years” (Child Care Act No. 38 p. 20) and a child becomes a major on reaching the age of 18 years. However, it is argued that although legislation has lowered the age of maturity, it does not mean that the time taken for individuals to negotiate through all the developmental tasks of adolescence, is effectively decreased (Manaster, 1989).

From a cultural contextual perspective, adolescence is seen as a developmental stage in some, but not all cultures (Gardiner, 2001). The definition of adolescence depends on whether or not young people reach biological maturity before they have acquired the knowledge and skills needed to ensure cultural reproduction. According to Gardiner (2001), adolescents in non-industrialised societies assume adult responsibilities at a much earlier age than in industrialised cultures because they are unable to afford the luxury of being non-productive and spending time in self discovery. It is highlighted that age does not have the same meaning in all eras and all cultures and that the course of human development in one historical or cultural context is likely to differ from that observed in other cultural settings (Shaffer, 1993).

The Masizakhe Community Project, within which this study was conducted, did not differentiate between child headed and adolescent headed households. This project refers to child headed households as those households where either one or both parents have died or is too ill to assume parental responsibilities and as a result of these circumstances, the household is headed by the eldest child. The ages of these heads of households ranged from 18 years to 27 years.

Having considered the aforementioned literature on adolescence and the Masizakhe Community Project’s definition of child headed households, it was decided that for the purpose
of this study, reference would be made to adolescent headed families. Adolescence was defined as being composed of a series of phases rather than as a homogenous stage (Steinberg, 1993). These phases are early adolescence which covers 11 years to 14 years, middle adolescence from about 15 years to 17 years and late adolescence spanning from 18 years to 21 years (Sadock & Sadock, 2003; Steinberg, 1993). The phase of late adolescence which spans from 18 years to 21 years was the focus of the present study.

For the purpose of this study, an adolescent headed family was defined as a family that is headed by a person who is 18 years to 21 years of age and who is not the biological parent of any of the children. The adolescent assumed parental responsibilities irrespective of whether one or both parents have died or whether one or both parents are present but ill and unable to assume parental responsibility.

1.3.2. Defining Resilience

Resiliency refers to the personality trait of being resilient in the face of adversity (Luthar, Cicchetti & Becker, 2000) whilst resilience refers to the process of competence despite adversity (Luthar, Cicchetti & Becker, 2000). Family resiliency describes the capacity of the family system to successfully manage their life circumstances (Patterson, 2002) and family resilience describes the processes by which families are able to adapt and function competently following exposure to significant adversity (Patterson, 2002).

1.4 Theoretical Overview

Several research studies to date have focused on the disease model or model of pathogenesis. It is argued presently that the disease model does not move us closer to the prevention of serious problems (Ganong & Coleman, 2002). Rather, more insight into prevention resulted from a perspective focused on systematically building competency, not on correcting weaknesses (Keyes
& Haidt, 2003). Pittman (2003) outlined that professionals and community members are realising that the eradication of problems by itself does not result in “holistically healthy individuals” (p. 8). The focus is shifting towards creating optimal societal conditions rather than attempting to contain the pathology (Carruthers, 2005). This noticeable paradigm shift reflects a movement from pathogenesis to salutogenesis and intends to emphasise strengths rather than illness (Antonovsky, 1987). The salutogenic paradigm emphasises positive characteristics and strengths which contribute towards growth and development.

Emerging from salutogenesis is the expanding field of Positive Psychology. Positive psychologists have discovered that human strengths act as buffers against mental illness (Keyes & Haidt, 2003). The aim of positive psychology is to study, identify and amplify the strengths and capacities that individuals, families and societies need to thrive (Seligman & Csikszentmihalyi, 2000).

A key concept arising from positive psychology is that of resilience. Positive human functioning is most significant when evident in contexts of significant life challenge and adversity. It is then when individuals are being challenged that much learning about human strengths takes place (Keyes & Haidt, 2003). The growing literature on human resilience addresses this juxtaposition of being well in the face of difficulty. Walsh (2003b) defined resilience as “the ability to withstand and rebound from disruptive life challenges” (p. 1).

The field of family therapy has also been refocusing its attention from family deficits to family strengths (Nichols & Schwartz, 2000). This shift intends to counter the historic overemphasis on family pathology and attempts to enhance family functioning and well being (Walsh, 2002a). In keeping with the trends offered by positive psychology, family theorists and researchers have changed focus from family stress theory to family resilience (Hawley & De Haan, 1996; Walsh, 2002b).
Family resilience theory emphasises the role that family characteristics, behaviour patterns and capabilities play in buffering the impact of stressful situations and in assisting the family in recovering from significant adversity (McCubbin & McCubbin, 2001). Risk and protective factors have been described as key components that influence resilience (McCubbin & McCubbin, 1988; Walsh, 1998). Walsh (1998) described three protective factors or resources that could serve as buffers. These included economic resources, parental resources and community resources (Walsh, 1998).

Valuable applications of the family resilience framework are evident in changing family forms (such as divorce and stepfamily reorganisation); in job loss and workplace transitions; in serious mental and physical illness; in end of life challenges and loss and war related trauma (Walsh, 2002a, 2003b). The adolescent headed families identified in this study had faced the unprecedented challenge of having cared for their infected caregivers as well as having witnessed their eventual deaths. Coming to terms with death and loss is an emotional challenge with ripple effects (Walsh & McGoldrick, 1991). Adaptational pathways in response to loss and death have been identified. These included sharing the experience of death, dying and loss; reorganising the family system and reinvesting in other relationships and life pursuits (Walsh, 2002b). It is highlighted that individual, family, cultural and religious diversity exists in the various approaches to death and bereavement and these must not be ignored even though the common adaptive processes have been outlined (Walsh, 2002a).

Family resilience offers several advantages. It focuses on strengths under stress, on overcoming adversity and it assumes that no single model fits all families or situations (Walsh, 1996, 2003a). Functioning is assessed in context and is viewed as varying over time and evolving across the life cycle (Walsh, 1996, 2003a). A family resilience framework also affirms the reparative potential in all families and offers valuable guidance for clinical practice and
intervention strategies (Walsh, 1996, 2002b). The present research was undertaken in light of the shift from pathogenesis to salutogenesis; the intentions of positive psychology and the contributions of a resilience framework in family studies.

1.5 Problem Statement

1.5.1. HIV/AIDS

Studies pertaining to HIV/AIDS and children have focused mainly on the impact of this epidemic on children. Monasch and Boerma (2004) investigated the impact of AIDS on the prevalence of orphanhood and care patterns in forty countries in sub-Saharan Africa. Findings from this study indicated that nine percent of children under 15 years have lost at least one parent and on average one in six households with children were caring for orphans. This study also reflected that orphans are vulnerable as they live in households with less favourable demographic characteristics and have lower school attendance (Monasch & Boerma, 2004).

Bicego, Rutstein and Johnson (2003) examined levels, trends and differentials in orphan prevalence in sub-Saharan Africa. Findings from this study revealed a strong correlation between orphanhood prevalence and adult HIV/AIDS prevalence estimates. Freeman and Nkomo (2006) reported on practical placement strategies for the increased number of orphaned or vulnerable children resulting from adult AIDS deaths. The views of adult caregivers (and prospective caregivers) regarding the placement of children were assessed. Twelve percent of adults could not identify a caregiver or predicted a bleak future for their children. It was also highlighted that the willingness of relatives and extended family members to take care of orphaned children may not necessarily be translated into reality as these potential caregivers identified significant additional stressors and expressed a strong need for assistance (Freeman & Nkomo, 2006).
South African studies focusing on HIV/AIDS and children included the investigation of the care of children infected and affected by HIV/AIDS at a children’s home in KwaZulu-Natal (Okello, 2005), a study investigating the fundamental needs of children orphaned by HIV/AIDS (Reyneke-Bernard, 2006) and Maqoko’s (2006) study of HIV/AIDS’ orphans and its challenge to pastoral care. Okello (2005) reported that the care of the children at the children’s home was not effective. Several reasons were advanced for this phenomenon such as the inability to protect children from exploitation, abuse and neglect; the inability to foster close and secure relationships with caregivers and other family members and the inability to help the children understand their parents’ deaths (Okello, 2005).

Findings from Reyneke-Bernard’s (2006) study of HIV/AIDS orphaned children also highlighted that children were not provided with the opportunity or the skills to manage grief and that the protection of these children against abuse and crime remains questionable. This study concluded that the fundamental needs of the children affected by HIV/AIDS are not being satisfied (Reyneke-Bernard, 2006). Maqoko (2006) reflected on the difficulties and setbacks experienced by HIV/AIDS orphans who became heads of households. Findings from this study indicated that these children are not only physically impoverished but are also psychologically, spiritually and socially deprived (Maqoko, 2006).

Smyth (2004) explored the lived experiences of social support of Black South African women living with HIV/AIDS and this study assisted in the development of a cultural and contextual understanding of social support. Leatham (2006) explored the lived experiences of adolescent learners from child headed families in the Northern Free State. Findings suggested that these learners are governed by values and principles that inform responsible and respectful interactions with their environments. Their personal attributes together with their social support networks are protective structures that strengthen their resilience (Leatham, 2006).
Mogotsi (in progress) investigated the challenges presented by child headed families to families and service providers, Netshiswinzhe (in progress) studied the effect of child headed households on schools from an education management perspective and Ratsaka-Mothokoa (2001) reported on the impact of HIV/AIDS on children and their families. Andrews, Skinner and Zuma (2006) emphasised that a key problem in the literature is that the focus of research studies is on assertions and predictions of the negative impact of AIDS orphans.

1.5.2. Family Resilience

Ganong and Coleman (2002) highlighted that even though there have been studies on families, these studies have not been framed from within a family resilience perspective. This sub section identifies studies of family resilience with the intention of highlighting the lack thereof. Therefore the findings from these studies are not reported on extensively. Studies that have focused on family resilience include the study by Rand and Kathi Conger which entailed a longitudinal study of Midwestern farm families and investigated how these families adapted to economic hardship (Coleman & Ganong, 2002). A similar study on the resilience and strengths of low-income families was also conducted (Orthner, Jones-Sanpei & Williamson, 2004). Oswald investigated the elements that contribute to resilience in gay and lesbian families whilst Seecombe (2002) examined the issue of resilience in families in poverty (Coleman & Ganong, 2002). Studies of families’ durability and resilience in the face of normative and non-normative strains were also conducted by other researchers (Hill, 1949; McCubbin, Dahl & Hunter, 1982; McCubbin & McCubbin, 1987, 1988; McCubbin & Patterson, 1983).

Family resilience studies in South Africa included Redinger (2005) and Robertson’s (2005) studies of family resilience in response to extra-familial child sexual abuse and Van Breda’s (1997) study of the development of the deployment resilience seminar. Studies that focused on the family structure as an important variable in family resilience included Greeff and Human’s
(2004) study of resilience in families in which a parent has died, Der Kinderen and Greeff’s (2003) study of resilience in families in which a parent has accepted a voluntary teacher’s retrenchment package, Solomon’s (2001) study of family resilience in poor single parent families and Greeff and van der Merwe’s (2004) study that investigated resilience in divorced families. The study of resilience has only recently emerged in the family field and much of the work done has been at a theoretical level (De Haan, Hawley & Deal, 2002; Hawley, 2000). This section highlights the need for further studies on family resilience.

1.5.3. HIV/AIDS, Family Resilience, and Child/Adolescent Headed Families

Studies conducted within South Africa and focusing on family resilience, HIV/AIDS and child headed households include Nokomo’s (2007) study of the experiences of children carrying responsibility for child headed households as a result of parental death due to HIV/AIDS and Reedley’s (in progress) doctoral study of the resilience in HIV and AIDS orphaned adolescent caretakers. Whilst Nokomo’s (2007) study addresses the challenges, psychological experiences and perceptions of children in child headed households, it was the intention of the present study to address the experiences of adolescent headed families from a family resilience perspective. Reedley’s (in progress) study focuses on the resilience of adolescent caretakers and as it is still in progress one can only assume from the title, that it addresses individual resilience. Thus, the present study will build on the concept of resilience but from a family perspective.

Andrews, Skinner and Zuma (2006) identified a gap in the literature as recently as 2006 and highlighted the importance of focusing on the health and well being of vulnerable children. Furthermore, considerable efforts have been expended on examining the maladaptive behaviours that may result from exposure to high risk situations. However, it may be valuable to examine the mechanisms by which children and families come through risk situations exhibiting adaptive coping behaviours (Andrews, Skinner & Zuma, 2006). In view of the importance of the topic and
the paucity of studies on the subject, this study was undertaken to investigate resilience in adolescent headed families.

1.6 Primary Objective of the Research

The present exploratory-descriptive study investigated the resilience of HIV/AIDS’ adolescent headed families. The aim of the study was to explore and describe the resilience of adolescent headed families affiliated with the Masizakhe Community Project in Kwazakhele, Port Elizabeth. The methodology was embedded in the interpretative phenomenological paradigm.

1.7 Delineation of the Research

Chapter one introduces the present study. The contextual background, the conceptual clarification and the theoretical overview of the study is provided. This is followed by the problem statement and the primary objective of the study. The chapter is concluded with the chapter overview.

Chapter two clarifies the context of this research. It provides a discussion of the HIV/AIDS epidemic, highlighting the enormity of the epidemic and its impact on orphaned and vulnerable children. Care options for these children are presented and the phenomenon of child headed households is outlined.

Chapter three provides the theoretical underpinning of the study by introducing the positive psychology paradigm. Family resilience is emphasised and conceptualised from the Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework. This chapter facilitates an understanding of the theoretical components of the afore-mentioned theories.
Chapter four describes the research design and methodology. The research procedure and the research setting are outlined, followed by a description of the sampling strategy and the sample. The procedure of data collection and data analyses are discussed. Finally, the ethical considerations are explored.

Chapter five presents the emergent findings and these results are discussed in light of the contextual and theoretical frameworks that have been presented in chapters two and three. Chapter six provides an evaluation of the study and includes conclusions based on the results of the research. The contributions and limitations of the study are presented and the chapter concludes with recommendations for future research.

1.8 Conclusion

This chapter has introduced the study from a contextual and theoretical framework. Concepts as utilised in this study have been clarified. The problem statement and primary objective of the study have been highlighted followed by the delineation of the chapters. The following chapter expands on the context of the research.
CHAPTER TWO
The HIV/AIDS Epidemic

2.1 Introduction

The context of the research is clarified in this chapter. A brief overview of the bio-medical perspective of HIV/AIDS is outlined, followed by the global estimates of the epidemic. The Sub-Saharan epidemic is highlighted as this region is reported to have the highest HIV/AIDS prevalence rates in the world and emphasis is placed on South Africa. The consequences of HIV/AIDS on orphaned and vulnerable children are focused on specifically, and the care options for these children are expounded, highlighting the efforts of extended family and the community in caring for them. Finally, an alternative strategy for orphan care such as child headed households is explored.

2.2 HIV/AIDS: The Bio-Medical Perspective

AIDS is the acronym for ‘acquired immuno-deficiency syndrome’ and it is the end stage disease manifestation of an infection with the retrovirus called HIV (human immuno-deficiency virus) (Schoub, 1999; Whiteside & Sunter, 2000). HIV attacks mainly T-Lymphocyes (CD4 cells) of the body’s immune system (Loewenson & Whiteside, 1998). Initially, the antibodies produced in response to the virus may not be identifiable (window period) (Whiteside & Sunter, 2000). This period is followed by the silent or latent phase which may last from eight to 15 years after which the virus actively multiplies and produces disease manifestations and opportunistic infections (Loewenson & Whiteside, 1998; Schoub, 1999; Whiteside & Sunter, 2000).

Symptoms include chronic fatigue or weakness, diarrhoea, minor skin infections, respiratory problems, sustained weight loss, persistent swelling of the lymph nodes and deterioration of the
central nervous system (Loewenson & Whiteside, 1998; Schoub, 1999). Later, more severe diseases such as cryptococcal meningitis, tuberculosis, pneumocystic pneumonia and cancers such as Karposi’s sarcoma manifest themselves (Loewenson & Whiteside, 1998; Schoub, 1999). This severe phase may continue for up to two years before death occurs, with progressively longer periods of illness that may be interspersed with periods of remission (Loewenson & Whiteside, 1998; Schoub, 1999). The clinical picture presented by HIV/AIDS imposes various strains/stressors upon the family unit. The resiliency model of family stress, adjustment and adaptation, which is outlined in chapter three, refers to these stressors as the pile-up of family demands (McCubbin & McCubbin, 1993, 2001).

Highly active antiretroviral therapy (HAART) can alleviate many of the symptoms of HIV and may reduce the patient’s susceptibility to opportunistic infections, dementia and malignancy (Madzikanga, Kangwende, Pfumojena, Slobod, & Hurwitz, 2005). These drugs may lower HIV transmission and death rates, reducing the orphan numbers while improving the quality of life of HIV infected individuals and workforce productivity (Madzikanga et al., 2005). However, due to limited infrastructure and strained resources, most people are unable to utilise this therapy (Madzikanga et al., 2005). Limited infrastructure and strained resources are examples of associated stressors or circumstantial difficulties as described by the resiliency model of family stress, adjustment and adaptation (McCubbin & McCubbin, 2001). In the absence of treatment the typical period from AIDS onset to death is about 12 to 24 months (Schoub, 1999; Whiteside & Sunter, 2000). The proceeding section presents the global extent of the HIV/AIDS epidemic.

2.3 HIV/AIDS: The Global Epidemic

Nearly 15 years after HIV was identified as the virus that causes AIDS, the HIV/AIDS epidemic had spread to virtually all corners of the developing world (Fransen, 1998). The United
Nations’ 2006 estimates revealed that 39.5 million people were living with HIV/AIDS, 37.2 million of these being adults and 2.3 million being children (UNAIDS, 2006). It was also reported that 4.3 million newly acquired HIV infections occurred during 2006 and the number of people living with HIV had increased from eight million in 1990 to 39.5 million by the end of 2006 (Avert.org, 2007; UNAIDS, 2006). Table 1 provides the Global Estimates for 2006.

Table 1: **GLOBAL HIV/AIDS ESTIMATES, 2006**

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimate</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV/AIDS in 2006</td>
<td>39.5 million</td>
<td>34.1-47.1 million</td>
</tr>
<tr>
<td>Adults living with HIV/AIDS in 2006</td>
<td>37.2 million</td>
<td>32.1-44.5 million</td>
</tr>
<tr>
<td>Women living with HIV/AIDS in 2006</td>
<td>17.7 million</td>
<td>15.1-20.9 million</td>
</tr>
<tr>
<td>Children living with HIV/AIDS in 2006</td>
<td>2.3 million</td>
<td>15.1-20.9 million</td>
</tr>
<tr>
<td>People newly infected with HIV in 2006</td>
<td>4.3 million</td>
<td>3.6-6.6 million</td>
</tr>
<tr>
<td>Adults newly infected with HIV in 2006</td>
<td>3.8 million</td>
<td>3.2-5.7 million</td>
</tr>
<tr>
<td>Children newly infected with HIV in 2006</td>
<td>0.53 million</td>
<td>0.41-0.66 million</td>
</tr>
<tr>
<td>AIDS deaths in 2006</td>
<td>2.9 million</td>
<td>2.5-3.5 million</td>
</tr>
<tr>
<td>Adult AIDS deaths in 2006</td>
<td>2.6 million</td>
<td>2.2-3.0 million</td>
</tr>
<tr>
<td>Child AIDS deaths in 2006</td>
<td>0.38 million</td>
<td>0.29-0.50 million</td>
</tr>
</tbody>
</table>

Avert.org, 2007

It has been estimated that out of the 40 million people infected with HIV in the world, 26.6 million of these cases are located in Africa (Heymann, Earle, Rajaram, Miller & Bogen, 2007). Although the African countries reported some of the highest HIV prevalence rates, western countries are not spared (Madzikanga et al., 2005; U.S. Department of Health and Human
Services, 2002). The following two sections reflect the magnitude of the Sub-Saharan African and the South African epidemic respectively.

2.4 HIV/AIDS: The Sub-Saharan African Epidemic

Since 1986 HIV has spread rapidly and within a decade and a half southern Africa was faced with prevalence rates that were in excess of 20% (Lewis, 2004). By the end of 2002 it was estimated that 70% of all persons living with HIV/AIDS were located in Sub-Saharan Africa, a region with ten percent of the global population (Lewis, 2004; Whiteside & Sunter, 2000).

Sub-Saharan Africa accounted for 24.7 million of the 39.5 million people living with HIV/AIDS at the end of 2006 (UNAIDS, 2006). This translated into a prevalence of 5.9%, which is the highest prevalence rate in the world. The only other region, outside of Sub-Saharan terrain to have a prevalence rate greater than one percent is the Caribbean, which had a prevalence of 1.2% by the end of 2006 (Avert.org, 2007).

2.5 HIV/AIDS: The South African Epidemic

The South African epidemic is magnified by drawing on relevant statistics and highlighting the South African Government’s response to the epidemic. South Africa has experienced one of the fastest growing HIV/AIDS epidemics in the world (Brookes, Shishana, & Richter, 2004; Rehle & Shishana, 2003; Whiteside & Sunter, 2000), has one of the highest levels of HIV prevalence, and is estimated by UNAIDS to have more HIV positive citizens than any other country (Avert.org, 2007; UNAIDS, 2000, 2004). The ASSA (Actuarial Society of South Africa) 2003 model predicted that 5.4 million South Africans were infected with HIV by mid 2006 with a prevalence of 11.2% (Dorrington, Johnson, Bradshaw & Daniel, 2006).
Although in the past there have been a wide range of estimates, these estimates all point to the enormity of the epidemic (Dorrington et al., 2006). More recently the range has been narrowing and is bracketed by the estimate of 4.5 million assumed by Statistics SA (2005) in producing the 2005 mid year population estimates, and 5.54 million estimated by the Department of Health (2006) derived using the Spectrum Model of the UNAIDS (Dorrington et al., 2006).

Despite the South African epidemic having had a late start relative to the epidemic in other African countries, the epidemic has already reached high proportions in many parts of the country. Since the onset of the HIV/AIDS epidemic, it has been estimated that more than one million South Africans have died of AIDS related causes. By 2010 the number of AIDS related deaths in South Africa is projected to be more than six million (Lewis, 2004). The South African provinces have prevalence rates ranging from as low as 5.4% in the Western Cape to as high as 15.7% in KwaZulu-Natal (Dorrington et al., 2006).

Table 2: HIV/AIDS Estimates South Africa 2006

<table>
<thead>
<tr>
<th>Province</th>
<th>People living with HIV/AIDS</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>666 822</td>
<td>10.0%</td>
</tr>
<tr>
<td>Free State</td>
<td>387 770</td>
<td>13.9%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>1 407 486</td>
<td>14.5%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>1 540 183</td>
<td>15.7%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>396 873</td>
<td>6.9%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>446 010</td>
<td>13.4%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>61 415</td>
<td>6.9%</td>
</tr>
<tr>
<td>North West</td>
<td>480 387</td>
<td>12.7%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>267 289</td>
<td>5.4%</td>
</tr>
<tr>
<td>Total South Africa</td>
<td>5 372 476</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

Dorrington et al., 2006
Initiatives by the South African government included the creation of a dedicated AIDS Unit within the Department of National Health and the establishment of specialised AIDS Training and Information Centres throughout the country (Phillips, 2004; Whiteside & Sunter, 2000). However, these initiatives appeared to be inadequate and communities throughout South Africa mobilised around non governmental organisations (Ogden, Elsim & Grown, 2004; World Bank, 1993). The Masizakhe Community Project within which this study was conducted, is an example of a community initiative.

In the early 1990’s, South Africa underwent a political transition and the new government identified AIDS awareness as a special Presidential Lead Project (Phillips, 2004; Van der Vliet, 2001). The budget for combating HIV/AIDS was doubled and the chief beneficiaries of this increased budget were sex education programmes in schools, public information campaigns via the mass media, free condom distribution and the expansion of Sexually Transmitted Diseases (STD) clinics (Phillips, 2004; Walker, Reid & Cornell, 2004). The new government attempted to provide support to HIV/AIDS affected households by providing formal safety nets. These formal safety nets included attempts to alleviate poverty through employment creation, free basic education and health care, community development programmes, feeding schemes and grants (Foster, 2007).

These attempts by the government to offer formal safety nets to HIV/AIDS affected families are described as community and social support by family theorists (McCubbin & McCubbin, 1993, 2001; McCubbin & Patterson, 1983; Walsh, 2002a, 2002b). Social support as an adaptive resource has been highlighted in other studies (Garvin, Kalter & Hansell, 1993; Lavee, McCubbin & Olson, 1985). Social and institutional policies such as employment creation, affordable health services and feeding schemes and grants may encourage the ability to thrive (Walsh, 1996, 2003b).
The positive intention of these safety nets is acknowledged but the success of these services in reaching the people has been ineffective (Madhavan, 2004). In South Africa, only 16% of eligible households affected by HIV/AIDS received a government support grant by the end of 2000 (Steinburg, 2002). The combined efforts of government, Non Governmental Organisations (NGOs), the private sector, churches and communities have not retarded the rate of infection or mitigated the problems created by HIV/AIDS (Phillips, 2004). The impact of HIV/AIDS is extensive, complex and far reaching.

2.6 The Impact of HIV/AIDS on Children

Problems experienced by orphaned and vulnerable children are examined in this section. These include additional household responsibilities, food insecurity, compromised health care, educational difficulties and emotional and psychological stressors. This sub-section highlights the stressors or pile-up of family demands experienced by HIV/AIDS affected families.

2.6.1. The Orphan Crisis

HIV/AIDS has impacted and continues to impact on the population growth and structure by altering mortality, morbidity, life expectancy and dependency ratios (Crampin et al., 2003; Department of Health, 2007; Dorrington et al., 2006; Fransen, 1998; Loewenson & Whiteside, 1998; Zaba et al., 2005). This demographic impact affects children indirectly by reducing the life expectancy by 25 to 30 years. The peak ages for AIDS deaths in Africa are between the ages of 25 years to 35 years for females and 35 years to 45 years for males (Dorrington, Bourne, Bradshaw, Laubscher & Timaeus, 2001; Fransen, 1998; Kelly, 2003). Since HIV/AIDS is claiming the lives of a high proportion of young mothers and fathers while their children are still young (Kelly, 2003; Walker et al., 2004), the number of orphaned children is increasing (Loening-Voysey, 2002; Watts, Lopman, Nyamukapa & Gregson, 2005).
Orphan statistics vary, partly because definitions of an orphan differ and partly because records of parental deaths are inadequately kept. Utilising the definition that an orphan is a person under the age of 18 years whose mother has died (whether or not the father has died), it was estimated that in 2001, 14 million children worldwide were orphaned due to AIDS related causes (Patterson, 2003; Shetty & Powell, 2003). Between 1994 and 1997 there was a 400% increase in the number of children orphaned by HIV/AIDS. It is projected that by 2010, orphans will comprise nine to 12% of the population, which is 36 to 48 million children worldwide (Smart, 2000; UNAIDS, 2000; Whiteside & Sunter, 2000).

Sub-Saharan Africa is reported to be the most severely affected, accounting for more than 80% of those orphaned by HIV/AIDS (Shetty & Powell, 2003). This region had approximately six million orphans due to AIDS by the end of 2003 (UNAIDS, 2004) and the projection for 2010 is approximately 15.7 million (Avert.org, 2007). Studies collated from various parts of the sub-Saharan region point to the escalating orphan crisis (Loewenson & Whiteside, 1998; O’Grady, 2004; Patterson, 2003; Shetty & Powell, 2003).

It is estimated that by 2015, 12% of South African children will be orphaned due to HIV/AIDS (Bradshaw, Johnson, & Schneider, 2002; Walker et al., 2004) and the number of AIDS orphans will escalate to 2.3 million by 2020 (Actuarial Society of South Africa, 2005). Even when the HIV prevalence stabilises or decreases, it is anticipated that the orphan numbers will continue to grow, reflecting the time lag between HIV infection and death (UNICEF, 2003). It was estimated that there were over 1.5 million orphans in South Africa by mid 2006. Of the overall total, two thirds were orphaned because of AIDS related causes (Dorrington et al., 2006). Table 3 presents the orphan estimates (mid 2006) for each South African Province. Attention is drawn to the Eastern Cape estimates as this region is the focus of the present study.
Table 3: **South Africa’s Orphans, mid 2006**

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>225 618</td>
<td>124 055</td>
<td>40 321</td>
<td>30 835</td>
</tr>
<tr>
<td>Free State</td>
<td>102 737</td>
<td>69 265</td>
<td>19 632</td>
<td>16 458</td>
</tr>
<tr>
<td>Gauteng</td>
<td>277 109</td>
<td>203 287</td>
<td>59 361</td>
<td>51 015</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>480 004</td>
<td>360 026</td>
<td>90 701</td>
<td>79 227</td>
</tr>
<tr>
<td>Limpopo</td>
<td>136 752</td>
<td>78 569</td>
<td>25 781</td>
<td>19 792</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>143 919</td>
<td>106 895</td>
<td>26 914</td>
<td>23 285</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>17 160</td>
<td>7 884</td>
<td>3 124</td>
<td>2 090</td>
</tr>
<tr>
<td>North West</td>
<td>114 628</td>
<td>78 262</td>
<td>22 580</td>
<td>18 923</td>
</tr>
<tr>
<td>Western Cape</td>
<td>77 739</td>
<td>29 830</td>
<td>13 847</td>
<td>295 588</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1 542 201</strong></td>
<td><strong>1 018 548</strong></td>
<td><strong>295 588</strong></td>
<td><strong>241 867</strong></td>
</tr>
</tbody>
</table>

Dorrington et al., 2006

2.6.2. Economic Consequences

The orphan crisis has led to severe economic hardships for these children. In this sub section poverty, labour and the financial implications of an adult’s death on children are outlined. These economic hardships are followed by a review of economic coping strategies.
2.6.2.1. Poverty

Prior to the emergence of HIV/AIDS large numbers of children already lived in poverty. The HIV/AIDS epidemic is responsible for intensifying this poverty (Cross, 2001; Giese, 2002). Based on an absolute poverty line of R400 per capita per month, roughly 75% of children in South Africa live in circumstances of poverty (Wilson, Giese, Meintjies, Croke & Chamberlain, 2002). Households in which one and often both parents are HIV positive are more prone to increasing poverty conditions than households that have no infected members (Steinberg, Kinghorn, Soderlund, Schierhout & Conway, 2000; Whiteside & Sunter, 2000). With a loss in income and the subsequent increase in medical spending it is expected that the expenditure patterns of the household will change in the direction of reduced budgets for education, health care and food for other family members, especially children (Ainsworth, Fransen & Over, 1997; Badcock-Walters, 2002; Cross, 2001; Dorrington et al., 2001; Gow, Desmond & Ewing, 2002; Lewis, 2004).

Prevailing poverty coupled with the difficulties of HIV/AIDS leads to food insecurity, malnutrition, poor hygiene, poor health care, loss of opportunities and poor school attendance (Giese, 2002; Gow, Desmond & Ewing, 2002). An attempt to alleviate their poverty is observed when children are compelled to join the work force. An examination of children’s contribution to labour follows.

2.6.2.2. Labour

As a result of increased adult deaths, the labour force has been reduced as has the mean age of the labour force (Loewenson & Whiteside, 1998). In South Africa 90% of HIV/AIDS infected individuals are in the age group 20 years to 64 years and this age group comprises a significant portion of the labour force (Dorrington et al., 2006). This implies that a large portion of children and adolescents are expected to contribute to the economy and the labour force (Giese, Meintjies,
Croke & Chamberlain, 2003). Due to the unemployment or employment inactivity of the infected adult, many households attempt to survive on the adult disability grant or pension which is terminated once the adult recipient dies (Badcock-Walters, 2002; Giese, 2002). The financial impact of an AIDS related death on the average family is greater than the financial impact of any other cause of death (Lewis, 2004; Steinberg et al., 2000) and has immediate implications for the children of that household. The financial impact of an adult death is explored in the next sub-section.

2.6.2.3. Financial Impact of Adult Death

When death occurs the surviving children must contend not only with the emotional loss but also with medical and funeral expenses and the additional loss of income and services that a prime age adult typically provides (Gow & Desmond, 2002). In most African countries a large funeral is an important tradition. The transportation and feeding of guests and the cost of the burial can lead families into debt and financial difficulties (Ainsworth, Fransen & Over, 1997; Foster, 1996; Lewis, 2004).

The impact of an AIDS related death on children differs, depending on which family member is infected. In most African communities the death of a father from AIDS often leads to conflict over family income and inheritance and a father’s death usually translates into the loss of financial security (Nemapare & Tang, 2003). One possible resolution to this financial insecurity is for property to revert back to the husband’s family and for the mother and her children to return to her own family for economic and social support (Patterson, 2003). Kin and social networks offer practical and social support to vulnerable families. This support strengthens family resilience (Ledward & Mann, 2000; Masten & Coatsworth, 1998; Reed & Sherkat, 1992).

Households experiencing an adult death draw on assets to mitigate the economic shock of such an event. It follows that houses with lower levels of assets will have more difficulty in
coping economically with an adult death (Gow & Desmond, 2002; Lundberg & Over, 2000). The various coping strategies are examined in the following sub section.

2.6.2.4. Economic Coping Strategies

Research on the various household coping strategies employed in response to the loss of an adult breadwinner has been conducted mainly in Sub-Saharan Africa (Ainsworth, Fransen & Over, 1997). Four main coping strategies were observed: doing nothing; withdrawing savings or selling assets; receiving assistance from other households and altering household composition (Ainsworth, Fransen & Over, 1997; Gow & Desmond, 2002). Financial management and economic decision-making skills have been identified as factors that facilitate family resilience (Beavers & Hampson, 1990; McCubbin & McCubbin, 1988).

Families who have experienced an AIDS related death have severe resource constraints and the capacity to respond in any meaningful way to overcome the difficulties can sometimes be beyond their capabilities (Ainsworth, Fransen & Over, 1997). In these circumstances the most rational response is to change nothing about their living arrangements and while sufficient resources are still accessible, the immediate pressure to respond is absent (Gow & Desmond, 2002).

The second coping mechanism is referred to as dis-saving and the sale of assets. These households may respond to the breadwinner’s death by withdrawing savings or liquidating assets. Although the sale of assets is a means of coping with the increased costs and reduced income, it has a series of negative implications for the future economic potential and security of the household (Gow & Desmond, 2002; Rugalema, 2000). Sometimes the capacity to cope economically may be enhanced by borrowing funds from microfinance organisations (Ainsworth, Fransen & Over, 1997; Lundberg & Over, 2000). South African households in the midst of a
financial crisis were more likely to borrow money from relatives and less likely to borrow from banks (Oni, Okorie, Thabede & Jordan, 2002).

The third coping strategy is that of receiving help from neighbours and relatives. The poor and bereaved households turn to each other rather than outsiders when faced with stressors (Wilkinson-Maposa, Fowler, Oliver-Evans & Mulenga, 2005). These bereaved households are likely to receive monetary assistance and other support from neighbours and relatives (Ainsworth, Fransen & Over, 1997; Gow & Desmond, 2002; Oni, Okorie, Thabede & Jordan, 2002; Wilkinson-Maposa et al., 2005). It has been evidenced that in developing countries extended family safety nets have been the first option for HIV/AIDS affected households (Foster, 2007). Walsh (2003b) also highlighted financial security offered by family members, the extended family and community groups as an adaptive resource.

Households experiencing economic difficulties and receiving inadequate support from relatives will then utilise the services offered by community safety nets (Ayieko, 1997; Foster, 2007; Walker, 2002) but studies to evaluate the efficacy of these nets are lacking (Barnett & Whiteside, 2002; Haddad & Zeller, 1996; Madhavan, 2004). The impact of the epidemic has been felt on social institutions that have to deal with an increasing number of unemployed, ill, prime age adults who are in need of social assistance in the form of an adult disability grant (Giese, 2002; Walker et al., 2004; Whiteside & Sunter, 2000).

The cycle of increased demands being placed on social institutions continues when the death of the prime age adult occurs and many children are left to be responsible for themselves (Grodney, 1994; Loening-Voysey, 2002; Townsend & Dawes, 2004). As a result there has been an increase in the number of applications for child support and foster care grants being made to the department of social services, which is not coping with the numerous applications
(Department of Health, 2007) and many children are left with no financial assistance as they wait for long periods of time before their applications are assessed.

The final coping strategy is that of altering the household composition and referring to the household and the family interchangeably (Agarwal, 1990; Letuka, Mamashela, Matashane, Mbatha & Mohale, 1994). A typical example of this is the creation of child/sibling/adolescent and grandparent headed households (Ansell & Van Blerk, 2004; UNICEF, 1999). Households that are affected by HIV/AIDS may be headed by employed adult siblings, by school going older siblings, by children caring for each other with adult support from another household, or by children caring for a dying parent with no adult support (Datta, 1998; Dodson, 1998; Ewing, 2002; Izzard, 1985; Murray, 1981).

An altered family composition and reorganisation of the family unit in response to the impact of HIV/AIDS, is an indication of the family’s adaptability (McCubbin & McCubbin, 2001) or flexibility (Walsh 2002a, 2002b). Family adaptability refers to the family’s ability to shift course (McCubbin & McCubbin, 1993, 2001). Flexibility or adaptability is a core process of resilience and encompasses the family’s ability to construct a new sense of normality and reorganise patterns of interaction to meet new demands (Walsh, 2002a, 2002b, 2003b). Apart from the economic hardships and coping strategies, orphaned and vulnerable children often assume adult responsibilities from a young age (Grodne, 1994; Loening-Voysey, 2002; Robson, 2000; Robson & Ansell, 2000; Townsend & Dawes, 2004). These responsibilities are now outlined.

2.6.3. Additional Household Responsibilities

It is projected that by 2011 56% of the population will live in households where at least one person is HIV positive or has died of AIDS (Haarman, 2001). The impact of HIV/AIDS on children is exacerbated because HIV is a disease that typically strikes more than one member of
an infected household and this usually includes the primary caregiver and/or breadwinner (Dorrington et al., 2001; Steinberg et al., 2000).

As the cycle of illness develops the infected breadwinner or parent may be unable to work, may require specialised nursing and direct physical and emotional support on a more or less constant basis (Foster, 1996; Loewenson, 1998). As a consequence the school going child may be forced to leave school in order to find employment (income earner) and may be cast in the role of caregiver and nurse for the ill parent (Ansell & Van Blerk, 2004; Badcock-Walters, 2002; Robson, 2000; Robson & Ansell, 2000; Von Donk, 2003). This altered household composition and reversal of roles is commonly observed when the prime age adult dies (Badcock-Walters, 2002; Von Donk, 2003). This initiative (altered household composition and reversal of roles) by family members to dispel the crisis (death) leads into the adaptation phase of the resiliency model of family stress, adjustment and adaptation (McCubbin & McCubbin, 1988). The resiliency model distinguishes the adjustment phase (which focuses on minor changes) from the adaptation phase (which focuses on major transitions such as death and divorce).

2.6.4. Food Insecurity

Food security in HIV infected households is affected by reduced household income and increased expenditure on healthcare, which leaves less money available to purchase appropriate food. The preparation of food is also affected by decreased energy levels and poor physical health of caregivers (Giese, 2002). In many cases the child may also be unable and unwilling to eat due to a range of physical, emotional and psycho-social factors which play a role in appetite suppression (Giese, 2002; Gow & Desmond, 2002). A study conducted in South Africa in 2002 found that the major health impact on orphans and vulnerable children as expressed by these children was malnutrition (Giese, Meintjies, Croke & Chamberlain, 2003).
2.6.5. Compromised Health Care

As the total household income decreases, the total expenses increase simultaneously. One reason for the increase in the expenditure is that health facilities are often located at some distance from home and frequent journeys to these facilities can be costly (Gow & Desmond, 2002). The medication required for the treatment is costly and requires re-balancing of the family budget (Bechu, 1998).

Although the total household expenditure on health care has increased, the non infected members (especially children) utilise less than average of this amount for health care because of the disproportionate amount being used to care for the ill adult (Bechu, 1998; Foster, 1996). The increase in health care expenditure and the fall in income are compensated for by a decrease in expenditure on basic needs (Gow & Desmond, 2002). This compensation has implications for the children’s health care, growth, development and education.

2.6.6. Educational Difficulties

Increasing numbers of children are leaving school due to HIV/AIDS related poverty, despite free education since 1994 (Ansell & Van Blerk, 2004; Kelly, 2000; Van Donk, 2003). Although caregivers can insist on the right to free education, pressure from principals of impoverished schools on equally impoverished parents to pay school fees is considerable (Gow, Desmond & Ewing, 2002; Kelly, 2000). The inability to pay school fees may prohibit the entry of the child to school as school principals are faced with issues of institutional viability and routinely turn away learners who are unable to pay fees (Badcock-Walters, 2002). With competing priorities for resources, children in affected households are often unable to afford school uniforms, school fees and school books which are a prerequisite for school attendance (Badcock-Walters, 2002; Cross, 2001; Giese, 2002).
Some children who have been unable to pay school fees reported being expelled from school, held back a grade, having report cards withheld, being threatened by teachers, excluded from the school feeding scheme and being embarrassed and teased (Giese, Proudlock & Meintjies, 2002). Even though the levels of HIV/AIDS awareness are high and awareness is continuously increasing, there still remains a reasonably high level of suspicion and fear (Foster, Makufa, Drew, Mashamba & Kambeu, 1997). Thus a child coming from a home in which infection is perceived to be HIV/AIDS linked, may be stigmatised or even physically deterred from entry to school by his or her peers or traumatised by the peers’ responses that they themselves opt to stay away (Badcock-Walters, 2002; Cross, 2001).

Studies from Botswana, Lesotho and Zambia reported that female children were more frequently taken out of school to care for one or both HIV positive parents (United Nations, 2004). These studies highlighted that their educational deprivation commenced before they were orphaned (O’Grady, 2004). Even though it has been extensively documented in the literature that female children were more likely to become family caregivers once an adult caregiver falls ill, it has ironically been discovered that in Lesotho, Namibia and South Africa, secondary school enrolment amongst female learners was higher than for male learners (O’ Grady, 2004). Qualitative and quantitative data from a number of African countries confirmed significantly lower school enrolment rates for orphans compared to non orphans (Desmond & Gow, 2002; Foster & Williamson, 2000) and evidence from South Africa pointed to a similar but not as pronounced trend in areas of high HIV prevalence (Marcus, 1999).

2.6.7. Emotional and Psychological Stressors

The psychological and emotional stressors experienced by children in HIV positive homes are extreme. Before the death of a family member HIV/AIDS places extreme pressure on the family and the community. Many children may experience their parents’ deteriorating physical and
mental health for long periods of time creating periods of uncertainty and crisis (Ewing, 2002; O’Grady, 2004; Patterson, 2003). The conditions associated with HIV/AIDS infection are chronic and arduous because the death of a parent is preceded by a gradual physical decline and the increasing inability to perform parenting roles. These children are forced to become independent at a premature stage while simultaneously experiencing their parents’ suffering (Loening-Voysey, 2002; Townsend & Dawes, 2004).

Furthermore, given the large number of people who are (and will be) dying from AIDS related causes, children who endure the death of their parent/parents will more than likely also experience the death of other family members and members of their immediate communities (Townsend & Dawes, 2004). The stress of parental death is compounded by the experience of witnessing multiple deaths (Townsend & Dawes, 2004). Children who experience a maternal death from AIDS face the psychological trauma of losing their primary caregiver (Patterson, 2003). For many children this is exacerbated by the fear and insecurity of not knowing who will care for and support them after their parents’ deaths (Giese, 2002). AIDS orphans often also face the additional burden of not being able to grieve openly for a deceased loved one because of the stigma associated with an AIDS related death (Giese, 2002).

In situations where the deceased person was a single parent, many orphans suffer a double loss because they are often unable to remain in the care of a family member (Patterson, 2003; Walker et al, 2004). These orphans require emotional and psychological support that is not available in poorer communities as mental health services are unavailable, overcrowded or unaffordable (Walker et al., 2004). The psychological well being of children orphaned by HIV/AIDS is under researched and much less is known about the factors in these children’s lives which can affect their mental status (Cluver & Gardner, 2007).
The impact of the epidemic on individuals and households has a ripple effect on the communities in which these families reside. HIV/AIDS and its social and economic implications may cause individuals to change how they view themselves within the community. Those left behind after relatives die of AIDS may withdraw from the community, perceive themselves as worthless, be viewed by others as worthless or feel ashamed because they are excluded from communal activities (Walker et al., 2004). As HIV/AIDS shapes the relationships people have with their communities, individuals then change their view of their rights and responsibilities as citizens within the political realm (Patterson, 2003). The following section explores the care options for orphaned and vulnerable children.

2.7 Orphan Care

Upon the death of the parents, efforts may be made to entrust the orphaned children to the care of other relatives (Kelly, 2003). In many developing countries, orphans were traditionally cared for by the extended family or the community (Ankrah, 1993). Loening-Voysey and Wilson (2001) outlined six orphan care approaches that have been utilised in placing orphaned children. These included 1) informal fostering (with little support from the community or government); 2) community based support structures/family foster care with community support; 3) home based care and support; 4) unregistered residential care; 5) statutory foster care; and 6) statutory residential care (Loening-Voysey & Wilson, 2001).

As a result of the HIV/AIDS epidemic, increased numbers of children are being orphaned and traditional support structures like statutory foster care and statutory residential care are largely saturated (Giese, 2002; Loening-Voysey & Wilson, 2001). The statutory foster care and statutory residential care options are heavily entrenched in First World models of alternative family care and are therefore under utilised by South African families (Brink, 1998; Harber, 1999a). Since
community based support structures is the preferred strategy for orphan care (Ankrah, 1993; Loening-Voysey & Wilson, 2001) this is explored further and thereafter the barriers to this approach are identified.

2.7.1. Community Based Support Structures

The South African government has decided to shift from residential care to extended family and other members in the communities to care for orphans (Giese, 2002; Loening-Voysey & Wilson, 2001). The decision to scale up on family and community support mechanisms is reported to be supported by international research findings (Freeman & Nkomo, 2006; Giese, 2002). It has been evidenced that the extended family and kinship networks are able to provide better quality services to orphans than residential based models of care (Foster, 2007; Loening-Voysey & Wilson, 2001) and that these types of care can be delivered at a lower cost (Desmond & Gow, 2001; Foster, 2007).

Furthermore these options centre on the fact that child care within the black African culture has historically been viewed as a social task to be performed by the entire extended family rather than an individual household (Brink, 1998; Pakati, 1984; Thomas & Mabusela, 1991). It has therefore been suggested that the caregiving efforts of extended families and kinship networks should be supported (Desmond & Gow, 2001; Jacques, 1999). Even though this approach is encouraged by government and supported internationally, it is increasingly becoming a strained resource as the number of orphaned and vulnerable children is growing. The barriers to community based support structures are outlined.

2.7.2. Barriers to Community Based Support Structures

The community based support structures have been the method of choice as it has been effective. However, this option is presently a strained and saturated resource due to the enormity of the HIV/AIDS epidemic. The problem of orphan care is extenuated by the collapse of these
traditional models (Walker et al., 2004). The stigma associated with HIV/AIDS is such that children orphaned by HIV/AIDS are at risk of being turned away by extended families who are fearful of the consequences of caring for them (Freeman & Nkomo, 2006; Giese, 2002; Harber, 1998; Kelly, 2003; McKerrow & Verbreek, 1995). A person with a stigma is perceived as one who is reduced from a whole and usual person to a tainted, discounted one (Ostrom, Serovich & Mason, 2006). HIV bears the pre-existing stigma associated with sexual behaviours and illegal drug activity, fatality and viewing individuals as transmitters of the virus (Herek & Glunt, 1988; Pryor, Reeder & Landau, 1999).

Another challenge arises when one household may have reached its absorptive capacity and groups of siblings are subsequently split between different households (Foster, 2007; Giese, 2002). There may be no surviving close relatives who can absorb the orphans into their households or the household of surviving relatives may have reached their absorptive capacity (Foster, 2007; Harber, 1999b; Kelly, 2003; Walker et al., 2004). Integral to the approach of community based support structures are the grandparents of those children who are made vulnerable by HIV/AIDS.

It must be realised that these grandparents or great grandparents are often living in impoverished conditions themselves and are elderly, physically weak and lacking energy. Their child rearing capabilities are compromised and some also reported an inability to discipline the children in their care (Giese, 2002; Townsend & Dawes, 2004). These grandparents may die while the child is still young and the cycle of being orphaned once again and having to allocate another care giver for the child repeats itself. Many children therefore experience a string of caregivers before they finally reach the age of independence (Giese, 2002). It has also been highlighted that the next generation of grandparents is being severely depleted by the HIV/AIDS
epidemic and this source of alternative care will be less available in the longer term (Harber, 1999a).

The HIV/AIDS epidemic has stretched the resources of extended families to the limit (Harber, 1999a) and other authors also agree that the extended family is becoming overwhelmed (Halkett, 1999; Harber, 1998; Smart, 2000) and possibly reaching saturation point (Foster, 2007; Freeman & Nkomo, 2006; Halkett, 1999; Harber, 1998; McKerrow, 1996; McKerrow & Verbreek, 1995). It appears that as the financial resources of the extended family become overstretched, the traditional and cultural norms are also challenged (Freeman & Nkomo, 2006; UNICEF, 2003).

While some community workers in different parts of South Africa identified some remaining capacity of caring for orphans, many other communities reported that the support structures upon which extended family and community fostering depended, are already under strain (Ewing, 2002). It is apparent that the much supported and favoured approach of utilising community and extended family in orphan care is not entirely problem free.

Although studies of orphans in Sub-Saharan Africa reflect that a remaining parent, aunts and uncles, and grandparents are the main caregivers for orphans (AIDS/STD Unit, 1998; Jacques, 1999; Monasch & Boerma, 2004; UNAIDS, 2002; UNICEF, 2001), there is evidence of the emergence of child headed households (AIDS/STD Unit, 1998; Foster & Williamson, 2000). When suitable caregivers are not available, some children are forced to become responsible for the care of their younger siblings and a child headed household is created. The phenomenon of child headed households is expounded in the following section.
2.8 Child Headed Households

This section examines the creation of child headed households followed by a description of these households in Africa. The South African context of child headed households is detailed and the section is concluded with an exploration of the implications of this phenomenon.

2.8.1. The Emergence of Child Headed Households

The HIV/AIDS pandemic is directly responsible for the emergence of a relatively new sociological phenomenon, the household in which there is no adult member and where by unspoken consent the oldest child assumes economic and “quasi parenting” (p. 61) responsibility for the siblings (Kelly, 2003). In Africa where the epidemic is at its worst, a generation of children is growing up without their parents. The middle generation succumbs to HIV/AIDS, leaving the first and third generations to fend for themselves (Guest, 2001; Singhal & Howard, 2003). As a result of the loss of one or more parents, some children without any experience, education or resources are now heading and managing households, raising their younger siblings and attempting to be economically viable (Shetty & Powell, 2003). Thus the impact of HIV/AIDS does not end with the death of the sufferer but continues through the lives of the children who are orphaned (Guest, 2001). These orphaned children then attempt to restore balance and harmony within the four domains of family life as conceptualised by the resiliency model of family stress, adjustment and adaptation.

Evidence from various parts of southern Africa suggested that decisions to leave children living in child headed households were often made by relatives who were reluctant to foster older children, when there was a lack of contact between children and their relatives and when there was a death or illness of a potential relative caregiver (Foster, Makufa, Drew & Kravolec, 1997; Foster & Williamson, 2000). Also the decision to leave these children in child headed households was made when adolescent siblings or older children had experience in child care, when siblings...
wished to stay together and/or when it was the dying mother’s wish for her family to remain intact (Foster et al., 1997; Foster & Williamson, 2000).

2.8.2. Child Headed Households in Africa

In the late 1980’s child headed households were observed in the Rakai district of Uganda (Alden, Salole & Williamson, 1991) and the Kagera region of Tanzania (Mukoyogo & Williams, 1991). In 1991 such households were observed in Lusaka, Zambia (Ham, 1992), Manicaland, Zimbabwe (Foster, Makufa & Drew, 1995) and for the first time in the Masaka district of Uganda, where previously no such households had been noted (Naerland, 1993). It has been highlighted that the challenges of child headed households are poorly understood and data on the number of children currently living in child headed households is scarce (Statistics South Africa, 2001).

2.8.3. Child Headed Households in South Africa

In the 2002 survey commissioned by the Nelson Mandela Foundation it was found that 1.5% of South African children were heading households. This figure had almost doubled to 2.6% in 2005 or 180 433 child headed households (Shishana et al., 2005). It was estimated that there were 104 423 children living in child headed households in South Africa by the end of 2004 and this figure increased to 118 564 (0.7%) by the end of 2005 (Children’s Institute, University of Cape Town, 2006). Table 4 presents the number of South African child headed households.
Table 4: **Number of children living in child headed households (CHHs), South Africa 2005**

<table>
<thead>
<tr>
<th>Province</th>
<th>Number of children living in CHHs</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>27,280</td>
<td>0.9%</td>
</tr>
<tr>
<td>Free State</td>
<td>7,877</td>
<td>0.7%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>5,306</td>
<td>0.2%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>15,152</td>
<td>0.4%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>45,795</td>
<td>1.8%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>5,945</td>
<td>0.4%</td>
</tr>
<tr>
<td>North West</td>
<td>9,156</td>
<td>0.6%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>474</td>
<td>0.1%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1,580</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total South Africa</td>
<td>118,564</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Children’s Institute, University of Cape Town, 2006

A total number of 4960 child headed households were identified in the Eastern Cape in 2001 and were receiving a number of services from community based projects. This estimate reflected only those households that were registered with a community based organisation and does not account for those households that have not been registered. Of these, 361 child headed households were surveyed in the Nelson Mandela Metropolitan Municipal area, which is the geographic area of interest in this study (Province of the Eastern Cape, Department of Social Development, 2003).
2.8.4. The Implications of Child Headed Households

There is a considerable overlap in the difficulties experienced by orphaned children and by child headed households. The following sub section highlights the literature pertaining to child headed households specifically, even though these children also experience the afore-mentioned consequences of HIV/AIDS (section 2.6 The Impact of HIV/AIDS on Children).

2.8.4.1. Loss of a Typical Family Unit

The most far reaching impact of an AIDS death within a family is the destruction of the family and the household as a whole unit. The worst outcome for children is where no able bodied adult is available to provide resources, maintain the household and hold the family together. This leads to the destruction of the family unit as a household and displacement of the children may occur (Gow & Desmond, 2002). It is reported that in many parts of the world it is not divorce that creates single-parent, step and sibling headed families, but parental illness, parental death and orphanhood due to the HIV/AIDS pandemic (Olson, 2006). By altering family structure and functions due to parental death, HIV/AIDS increases the vulnerability of families (Olson, 2006). In some fortuitous circumstances, sufficient resources are available for the children to maintain the household structure despite the absence of adults although these child headed households face many difficulties in keeping their family together (Ansell & Van Blerk, 2004; Gow & Desmond, 2002; UNICEF, 1999).

2.8.4.2. Educational Difficulties

While there have been significant increases in the number of children living in households without parental supervision, home based caregivers reported that older siblings (over the age of 18 years) are fulfilling the role of caregiver, having left school early to provide for the needs of younger siblings (Giese, 2002; Guest, 2001; Kelly, 2000). The burden of responsibility for caring for the siblings often rests with the eldest female child (Walker et al., 2004) and almost certainly
increased household responsibilities will mean that the oldest sibling no longer attends school (Kelly, 2003). The attendance of the other children at school will depend on the resourcefulness of the one heading the household and on the presence of the outlook of a better future that schooling may provide (Kelly, 2003). However, the first priority is survival and many child headed households prioritise obtaining food and generating an income (Kelly, 2003).

2.8.4.3. Developmental Barriers

Children living in child headed households typically live in conditions of poverty without adequate adult supervision and suffer from stunted development which includes poor physical (Kamali et al., 1996) and mental health (Foster & Williamson, 2000) and pervasive hunger or malnutrition (UNICEF, 2003). These children have reduced opportunities for education (UNICEF, 2000), limited access to health and welfare services and no access to social security (Giese, 2002; Whiteside & Sunter, 2000). In the midst of these various challenges these children have to manage the family resources and assume adult responsibilities at a young age (Robson, 2000; Robson & Ansell, 2000; Walker et al., 2004). There appears to be a significant gap in the literature with regards to the developmental implications of children living in child headed households and further research is indicated.

2.8.4.4. Social and Emotional Difficulties

As a result of their plight, children in child headed households may be exploited and forced into child labour (UNICEF, 2003; UNICEF, 2004), prostitution or early marriage (Giese, 2002; Von Donk, 2003). Some leave home to supplement the household income through begging in city centres, thereby increasing the number of street children (Giese, 2002; Townsend & Dawes, 2004; Von Donk, 2003). These children frequently engage in prostitution, turn to crime and abuse drugs and alcohol (Mazikanga et al., 2005; Patterson, 2003).
Many child headed households face eviction from their homes, either through property grabbing by relatives or because they are unable to sustain the mortgage agreements and are too young to access a housing subsidy (Giese, 2002; Townsend & Dawes, 2004). Most of the children living in child headed households may also experience stigma and social exclusion (Gilborn, 2002; Simpson & Raniga, 2004; UNICEF, 2004). The following section provides a summary of the impact of HIV/AIDS on children and their families.

2.9 Summary

Figure 1 provides a flow chart of the impact of HIV/AIDS on children and families.
Figure 1: Impact of HIV/AIDS on children and families (Foster & Williamson, 2000).
2.10 Conclusion

This chapter provided evidence of the escalating HIV/AIDS epidemic globally and has highlighted the enormity of the disease in Sub-Saharan Africa and more specifically South Africa. Emphasis was placed on the impact of HIV/AIDS on orphaned and vulnerable children and the care options for these children were expounded. As the traditional models of care are being exhausted, alternative strategies for orphan care, such as child headed households are being mobilised. The phenomenon of child headed households was discussed by providing relevant statistics and demonstrating some of the difficulties that these households experience.

Bray (2003) cautioned against apocalyptic predictions for orphaned children and their suggested role in the future break down of society. The same author has also warned against interventions for these children that are ill informed, largely based on fear, and that may unintentionally undermine children’s effective strategies for coping in these conditions (Bray, 2003). In spite of all the difficulties that orphans may be experiencing, some show a high degree of hope (Nemapare & Tang, 2003). In light of this, the following chapter provides a theoretical framework within which to understand the processes utilised by child headed families. Chapter three encapsulates the Family Resilience Framework and the Resiliency Model of Family Stress, Adjustment and Adaptation.
CHAPTER THREE

Family Resilience Theory

3.1 Introduction

This chapter introduces the positive psychology paradigm, followed by the conceptualisation of resilience and family resilience. Since theory triangulation is employed to interpret the data, two models of family resilience are theorised. The Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework are outlined and a comparison of the two models is provided in order to facilitate the subsequent integration of the findings.

3.2 Positive Psychology

Historically, health and social sciences have focused on the causes of disease, deficits and behavioural problems. The focus was oriented towards a pathogenic paradigm (Carruthers, 2005; Strümpfer, 2005). There has been a shift towards health and strengths (salutogenesis) as opposed to cause and disease (pathogenesis). Professionals and other community members are gradually realising that the eradication of problems alone does not necessarily result in healthy individuals (Pittman, 2003). Focus is now shifting towards creating optimal societal conditions for individuals rather than attempting to contain or eradicate the pathology (Carruthers, 2005; Hawley & De Haan, 1996), leading to the development of Positive Psychology. The aim of Positive Psychology is to study, identify and amplify the strengths and capacities that individuals, families and societies require in order to thrive (Seligman & Csikszentmihalyi, 2000).

A key concept arising from this paradigm is that of resilience. Resilience is positive human functioning in the context of significant life challenges and adversity. Much learning about human strengths takes place when individuals are being challenged. The growing literature on
human resilience addresses this juxtaposition of being well in the face of difficulty (Ryff & Singer, 2003). Studies undertaken in the family field have been dominated by deficit based theories that emphasised family failures and disruptions (McCubbin & McCubbin, 2001). The lens has since been shifting toward strength based approaches that magnify the potential of families to recover in the face of adversity. The evolution of the concept of resilience follows.

3.3 Resilience

The definition and conceptualisation of resilience has evolved over a number of years. Hawley and De Haan (1996) indicated that even though there are many definitions of resilience, these definitions encompass similar themes. Resilience emerges in the face of challenge; it carries the property of buoyancy (the individual has the ability to bounce back) and is described in terms of wellness rather than pathology (Hawley, 2000; Hawley & De Haan, 1996). The foundation of resilience is embedded in the studies of children who functioned competently despite exposure to risk (Block, 1971, 1980; Garmezy, 1991; Garmezy, Masten & Tellegen, 1984; Patterson, 2002; Walsh, 2003a).

Whilst some researchers still assess resilience as a personality trait of an individual, many researchers define resilience from a process-oriented perspective (Coleman & Ganong, 2002; Walsh, 2003a). Resilience was conceptualised as an inborn trait or as acquired on one’s own (Wolin & Wolin, 1993) but as research extended, the understanding of resilience evolved to include the interplay of risk and protective processes over time, which involves individuals, family and socio-cultural influences (Anthony & Cohler, 1987; Rutter, 1985, 1987; Walsh, 1996, 2003a; Werner, 1993, 1995).

Luthar, Cicchetti and Becker (2000) defined resilience as “a dynamic process encompassing positive adaptation within the context of significant adversity” (p. 243). These authors
highlighted the presence of two conditions namely, the exposure to significant threat and the achievement of positive adaptation despite major challenges. Resilience is an important concept in child development (Block, 1971; Block & Block, 1980; Garmezy, 1991; Garmezy, Masten & Tellegen, 1984; Robins, John, Caspi, Moffitt & Stouthamer-Loeber, 1996) however this focus on individual resilience has neglected the resilience that can be found in families (Walsh, 1996). Family resilience differs from individual resilience in that the unit of analysis is the family as a whole rather than the individual. It is a dynamic, emergent, multidimensional process that unfolds over time (Patterson, 2002; Walsh, 2003b). Crises are seen as opportunities for families to struggle well (Walsh, 2003b). As resilience has evolved to include not only individuals but also family and socio-cultural influences, it is appropriate to examine the role of the family unit.

3.4 The Family Unit

Recent research revealed that well functioning families can be found in a variety of family structures and that it is not family structures that matter but the processes that families engage in when they are faced with adversity (Walsh, 2002a, 2003b). The concept of family resilience extends beyond viewing individual family members as potential resources for resilience, to focusing on risk and resilience in the family as a functional unit (Walsh, 1996). Family units serve four important functions, namely, nurturance and socialisation, family formation and membership, economic support and protection of vulnerable members (Ooms, 1996; Patterson, 2002).

Family research has been based on some fundamental assumptions. For example the family experiences transitions and it subsequently changes. This is a natural, anticipated part of family life and continues to take place over the family life cycle (McCubbin & McCubbin, 2001). Another assumption is that, in the face of these transitions the family develops competencies to
facilitate the growth, development and protection of all the family members as well as the family unit as a whole (McCubbin & McCubbin, 2001). These competencies are designed to foster the family’s recovery following a crisis or major transition. It is also assumed that families extract from, and contribute to the community and social networks of which they are a part, especially during crises (McCubbin & McCubbin, 2001). Finally, the goal of the family unit is to restore harmony and balance during a transition by adapting the family functioning, community and the environment (McCubbin & McCubbin, 2001). The processes that a family engages in, in order to restore balance and harmony are examined.

3.5 The Resiliency Model of Family Stress, Adjustment and Adaptation

This section describes the development of the Resiliency Model of Family Stress, Adjustment and Adaptation and explains the theoretical components of the model. The adjustment and adaptation phases are detailed below in order to facilitate an understanding of family resilience.

3.5.1. Evolution of the Resiliency Model of Family Stress, Adjustment and Adaptation

McCubbin and McCubbin (1988) defined family resilience as “characteristics, dimensions and properties of families which help them to be resistant to disruption in the face of change and adaptive in the face of crisis situations” (p. 247). McCubbin and McCubbin (2001) suggested that a family’s resilience is indicated by the family’s ability to change its appraisal of a crisis in order to make the situation manageable and less formidable. The Resiliency Model of Family Stress, Adjustment and Adaptation developed by McCubbin and McCubbin (1993, 2001) is an expansion of Hill’s (1949) ABCX Model, McCubbin and Patterson’s (1983) Double ABCX Model, McCubbin and Patterson’s Family Adjustment and Adaptation Response (FAAR) Model and McCubbin and McCubbin’s Typology Model of Family Adjustment and Adaptation
(McCubbin & McCubbin, 1993, 2001). These models have their roots in family stress theory (McCubbin & Patterson, 1983; Patterson, 2002).

Hill’s (1949) ABCX Model emphasised the pre-crisis factors such as the stressor (A), resources (B) and the definition of the stressor (C) which mediate and protect the family in a crisis situation (X) (McCubbin & McCubbin, 1993, 2001). The Double ABCX Model (McCubbin & Patterson, 1983) focused on both pre-crisis and post-crisis factors as well as on coping and social support factors which facilitate family adjustment and the ability to recover from adversities (McCubbin & McCubbin, 2001). Whilst the Family Adjustment and Adaptation Response Model (McCubbin & Patterson, 1983; Patterson, 2002) was an extension of the Double ABCX Model, it also highlighted the processes involved in the family’s efforts to balance demands and resources (McCubbin & McCubbin, 2001).

Thereafter the Typology Model of Family Adjustment and Adaptation was developed to emphasise the family’s established patterns of functioning (typologies) and the family’s level of appraisal in facilitating adjustment and adaptation (McCubbin & McCubbin, 2001). Family stress theorists and family resilience theorists have recently highlighted that it is important to consider the community and cultural contexts in which families reside in order to understand the families’ stress and how they cope with it (Boss, 2001; McCubbin & McCubbin, 2001).

The Resiliency Model of Family Stress, Adjustment and Adaptation is the most recent extension of the afore-mentioned models and it aims to understand and explain why some families recover and others remain at risk or even deteriorate under similar circumstances (McCubbin & McCubbin, 2001). This model highlights the relational processes of family adjustment and adaptation, the patterns of family functioning and the family’s problem solving and coping (McCubbin & McCubbin, 1993, 2001). Four important domains of family life, in which balance and harmony need to be restored and maintained, are identified in this contextual
framework. These include interpersonal relationships; structure and function; development, well-being and spirituality and community relationships and nature (McCubbin & McCubbin, 2001). Since the family is viewed as a system, each of these domains has an effect on each other and the family system is an integral part of the ecology, community and society (McCubbin & McCubbin, 2001).

This model distinguishes the adjustment phase from the adaptation phase. The adjustment phase explains a family’s adjustment to minor changes such as relocations, vacations and short term illness whilst the adaptation phase assesses a family’s strengths and capabilities to manage major transitions (for example death, divorce) which require family reorganisation (McCubbin & McCubbin, 1988). An example of a major transition that is relevant to this study is the death of an AIDS infected adult care giver. This requires reorganisation of the family unit as has been variously outlined in chapter two. The adaptation phase is the foundation for the present study but for the sake of clarity and completion, the adjustment phase is detailed followed by the adaptation phase.

3.5.2. The Adjustment Phase

During the first phase of adjustment several components interact with one another to shape the level of adjustment of the family (McCubbin & McCubbin, 1993). The stressor (A) and its severity interact with the family’s vulnerability (V) and this interacts with the family’s established patterns of functioning (T). These interact with the family’s resistance resources (B) which in turn interact with the family’s appraisal of the stressor (C). This appraisal then interacts with the family’s problem solving and coping strategies (PSC) (McCubbin & McCubbin, 1993, 2001).

The stressor (A) is a demand or strain that is imposed on the family and that produces or has the potential to produce changes in the family system or in any of the four domains of family
functioning (McCubbin & McCubbin, 1993). Stressors experienced by HIV affected families as outlined in chapter two, include economic problems, educational difficulties, psychosocial distress, malnutrition and so on. The severity of the stressor is the extent to which it threatens the family’s stability, disrupts the family functioning or places strain on the family’s resources and capabilities (McCubbin & McCubbin, 1993, 2001). The family vulnerability (V), which ranges from low to high, is determined by the accumulation of demands (pile-up) on the family unit and the normative transitions associated with the family’s life cycle stage (McCubbin & McCubbin, 2001; McCubbin & Patterson, 1983).

A family’s typology (T) is a set of attributes that the family typically employs and it is a discernable pattern of family functioning (McCubbin & McCubbin, 1993, 2001). These typologies are crucial in the development, restoration and maintenance of family harmony and balance (McCubbin & McCubbin, 2001). The family’s ability to manage the stressor and its demands and to maintain and restore harmony and balance is referred to as the family’s resistance resources (B). Family resources include social support, economic stability, cohesiveness, flexibility, hardiness, shared spiritual beliefs, open communication, traditions, celebrations, routines and organisation (McCubbin & McCubbin, 1993, 2001). As has been outlined in chapter two HIV affected families display various resistance resources such as seeking help from extended family and community members, employing several economic coping strategies, utilising the services offered by formal safety nets, keeping the family unit in tact upon parental death and reorganising the family unit.

The family’s appraisal of the stressor (C) which ranges from perceiving the stressor as uncontrollable to approachable is the family’s perception of the seriousness of the stressor and its consequences (McCubbin & McCubbin, 1993, 2001). Finally, problem solving and coping (PSC) refers to the family’s management of the stressor by utilising its skills such as organising the
stressors into manageable components, identifying alternative options, initiating resolution of the problems and employing effective problem solving communication patterns (McCubbin & McCubbin, 1993, 2001). Coping refers to the behaviours that family members adopt to manage the stressor (McCubbin & McCubbin, 1993).

Outcomes of the adjustment phase are on a continuum ranging from bonadjustment (positive outcome) to maladjustment (negative outcome) (McCubbin & McCubbin, 1993, 2001). Bonadjustment is the outcome in which the family negotiates the stressful stage with relative ease. There may have been minor adjustments to the family system and its patterns of functioning but balance and harmony are restored (McCubbin & McCubbin, 2001). Families typically engage in daily patterns of interacting as they attempt to balance their daily demands with their existing capabilities in order to achieve a level of family adjustment. If these demands significantly outweigh the family’s capabilities, the family will experience maladjustment (Patterson, 2002).

Maladjustment is when the family is unable to restore balance and harmony to its system despite numerous efforts. This kind of stressful situation demands more substantive changes in the family system, family roles, values, boundaries and overall patterns of functioning (McCubbin & McCubbin, 2001). Maladjustment challenges the family’s established patterns of functioning and accumulates into a family crisis (C). Family crisis (C) is a state of imbalance, disharmony and disorganisation. It demands changes in the family’s patterns of functioning in order to restore harmony and balance (McCubbin & McCubbin, 2001; McCubbin & Patterson, 1983). An initiative to dispel the family crisis leads into the adaptation phase of the Resiliency Model (McCubbin & McCubbin, 1993, 2001). The creation of child and adolescent headed families are examples of families’ initiatives to dispel the crisis caused by HIV/AIDS and lead the family into the adaptation phase.
3.5.3. The Adaptation Phase

The adaptation phase is initiated by a family crisis and the level of family adaptation is determined by the cyclical interactions of various components such as the family’s established patterns of functioning (T), other stressors that the family may be experiencing concurrently (AA) and the present crisis (C) (McCubbin & McCubbin, 1993). Figure 2 presents a flow diagram of the adaptation phase which facilitates understanding of the interacting components.

Figure 2: The Adaptation Phase of the Resiliency Model of Family Stress, Adjustment and Adaptation.
Whether a family will achieve a successful level of adaptation (XX) is dependent on whether they will engage in new patterns of functioning (TT), the maintenance of viable established patterns of functioning (T), the family’s own internal resources and capabilities (BB), the family’s network of social support (BBB) and the family’s situational appraisal (CC) by the appraisal processes: schema (CCCCC), coherence (CCCC) and paradigms (CCC) (McCubbin & McCubbin, 1993, 2001). These three levels of appraisals will impact on the family’s appraisal of the situation (CC) and the definition of the stressor (C). Families with a strong sense of coherence, a strong family schema and a general view of optimism are generally more resilient (Hawley & De Haan, 1996; McCubbin & McCubbin, 1993).

The new patterns of functioning and the family’s resources and appraisal will influence and be influenced by the family’s problem solving and coping abilities (PSC) (McCubbin & McCubbin, 1993, 2001). The outcome or family adaptation (XX) of this cyclical interaction can either be a level of successful adaptation called bonadaptation or unsuccessful adaptation referred to as maladaptation (McCubbin & McCubbin, 1993, 2001). In the event of a maladaptive outcome, the family recycles through the processes of adaptation. If the family adapts successfully (bonadaptation), the processes that the family engaged in are referred to as regenerative power (McCubbin & Patterson, 1983). Although all components of the adaptation phase interact with one another to produce the family’s adaptation, it is relevant to examine each component separately.

McCubbin and Patterson (1983) referred to a pile-up (AA) of family demands to describe an accumulation of sources of stress. The pile-up of demands includes the initial stressor and its related hardships which have developed over time; normative transitions involving individual family members and the family unit as a whole which occurred simultaneously to the initial stressor and previous family stressors that have accumulated over time (McCubbin & McCubbin,
1993, 2001; McCubbin & Patterson, 1983). Figure one in chapter two summarises the impact of HIV/AIDS on families and this translates to the pile-up of family demands that is indicated in the resiliency model.

Other stressors and strains that contribute to this pile-up of demands include the unforeseen situational demands and contextual difficulties; the family’s efforts to cope which added to the family’s burden and intrafamilial and social ambiguity (McCubbin & McCubbin, 1993, 2001; McCubbin & Patterson, 1983). The newly instituted patterns of functioning may be incongruent with the family’s schema and paradigms and may demand more changes in the family’s functioning. The old established patterns of functioning may be incompatible with the newly adopted patterns of functioning and this conflict may contribute further to the pile-up of demands (McCubbin & McCubbin, 2001).

The family’s resources (BB) include tangible (such as money) and intangible resources (such as family integrity, self esteem) (Hanson, McLanahan, & Thomson, 1998; McCubbin & McCubbin, 2001). These resources vary across families and are infinite in number. It includes personal resources such as knowledge, skills, personality traits and physical, spiritual and emotional health. Some of the personal resources that have been identified as facilitating family resilience, include financial management and economic decision-making skills and religious and spiritual beliefs (Beavers & Hampson, 1990; McCubbin & McCubbin, 1988; Olson et al., 1989). Financial management and economic decision-making skills have been demonstrated by HIV/AIDS affected families.

Other important family resources include family system resources such as family cohesion (bonds of unity within the family, support, integration and respect) and family adaptability (the family’s ability to shift course) (McCubbin & McCubbin, 1993, 2001). Family cohesion and adaptability have been identified as two of the most prominent family resilience resources.
(Hawley, 2000; McCubbin & McCubbin, 1993; Mederer, 1998). With regards to family cohesion, it has been documented that family members who feel supported by other family members showed greater competence in dealing with their problems (Barnard, 1994; Conger & Conger, 2002; Garvin, Kalter & Hansell, 1993; Hawley & De Haan, 1996; Johnson, 2000; Sigelman & Shaffer, 1995; Walsh, 1998). An indicator of family adaptability is the flexible balance between stability and change in order to maintain a stable family structure, while accommodating a change in response to life events (Beavers & Hampson, 1993; Walsh, 1998). Families affected by HIV/AIDS display adaptability in their attempts to reorganise the family unit by creating child/adolescent/sibling headed families and by sharing their roles and duties.

Family organisation and family hardiness are also considered as adaptive resources. Family organisation refers to the agreement, clarity, consistency, fluidity and communication patterns in the family roles and rules structure (McCubbin & McCubbin, 1993, 2001). Diverse authors point to the importance of communication in fostering well-being (Hawley & De Haan, 1996; McCubbin, McCubbin, Thompson, Hanson & Chad, 1997; Silliman, 1995). Communication facilitates the comprehensibility of a crisis and clear, open and direct communication influences the family’s resilience (Bloch, Hafner, Harari, & Szmukler, 1994; Walsh, 1998).

Family hardiness is the family’s sense of control over the outcome of life events, the views on change and growth and the family’s orientation to stressful situations (McCubbin & McCubbin, 1993, 2001). Family hardiness as an important resilience factor has also been identified in other studies (Anderson, 1998; Drapeau, Samson & Saint-Jacques, 1999; Linker, Stolberg & Green, 1999). Walsh (1998) highlighted the importance of a family finding meaning in a crisis. The importance of spirituality, belief, hope, initiative, perseverance and encouragement amongst family members are significant in the recovery from crises (Anderson, 1998; Angell, Dennis & Dumain, 1998; Beavers & Hampson, 1990; Parrot, 1990; Walsh, 1998, 1999). A family member
finding meaning that is not shared by the other members may possibly undermine the family’s resilience (Smith, 1999).

Other family system resources include family time together and family routines and these are indicators of family integration and stability (McCubbin & McCubbin, 1993). Emotional support amongst family members, family members’ participation in household tasks, clear boundaries and rules and frequent contact with family members have been implicated in a family’s resilience (Gordon-Rouse, Longo, & Trickett, 2000; Hochschild, 1997; Imber-Black, Roberts & Whiting, 1988). The afore-mentioned family strengths are positively related with the adaptation of a family to a crisis (Barnard, 1994; Garvin, Kalter & Hansell, 1993; Hawley & De Haan, 1996; Saurez & Baker, 1997).

Social support (BBB) that is available to families include all community and social resources such as family members, extended family and friends, medical and health services, schools, churches, employers, and so on (McCubbin & McCubbin, 2001; Walsh, 1996). Social support as an adaptive factor has been highlighted in previous studies (Garvin et al. 1993; Hanson et al. 1998; Lavee, McCubbin & Olson, 1987; Reed & Sherkat, 1992; Solomon & Draine, 1995). Families who are able to mobilise and utilise social support in the form of practical or financial assistance are more resistant to major crises and better able to recover and restore stability (Raveis, Siegel & Karus, 1998; Walsh, 1996). Social support networks that have rendered its services to HIV/AIDS affected families include the governmental and non-governmental organisations and extended family members and community members.

Social support has been conceptualised as the information that is exchanged at the interpersonal level with the intention of providing emotional support (family members are cared for and loved), esteem support (family members are respected and valued) and network support (sense of belonging) (McCubbin & McCubbin, 1993, 2001; McCubbin & Patterson, 1983). This
conceptualisation has also been extended to include appraisal support (feedback allowing family members to assess their progress) and altruistic support (goodwill from others) (McCubbin & McCubbin, 1993). Social support in the form of recognition and affirmation has been identified as an important resilience factor (Gordon-Rouse et al. 2000; Hawley, 2000; Hawley & De Haan, 1996).

The family’s appraisal processes involve five levels: Schema (CCCCC), Coherence (CCCC), Paradigms (CCC), Situational Appraisal (CC) and Stressor Appraisal (C). Family schema is the structure of fundamental convictions, values, beliefs and expectations that the family creates and adopts over time. The schema creates the family’s unique character and is also the informational framework which the family utilises to evaluate and process experiences and behaviours (McCubbin & McCubbin, 2001). It includes family, cultural and ethnic beliefs and values such as respecting one’s ethnic heritage and honouring one’s elders. Family schema is central to the development of family meanings (understanding shared by family members) (McCubbin & McCubbin, 2001). Families that reveal a strong schema emphasised their investment in their family unit, their shared values and goals and the sense of ‘we’ rather than ‘I’ (McCubbin & McCubbin, 1993).

The motivation and appraisal to transform the family’s potential resources to actual resources, is explained by coherence (CCCC). The family’s coherence is its confidence that the world is comprehensible, manageable and meaningful (Antonovsky, 1987). Coherence assumes qualities such as acceptance, loyalty, pride, respect and shared values regarding the family problems (Marsh et al. 1996). In this model a relationship is assumed between a family’s sense of coherence and their adaptation to a crisis situation (Anderson, 1998; Antonovsky & Sourani, 1988; McCubbin & Patterson, 1983). Lavee, McCubbin and Olson (1987) concluded that a family’s sense of coherence plays a stress-buffering role. Families with a strong sense of
coherence adapted more easily after a period of crisis and attained a higher level of reorganisation after the crisis (Antonovsky & Sourani, 1988).

The family’s paradigms (CCC) are shared expectations and rules which are created and adopted by the family unit in order to inform its development within specific domains of functioning (such as work, childrearing, education) (McCubbin & McCubbin, 1993, 2001). The role of rituals in maintaining and perpetuating a family’s paradigms has been previously documented (Reiss, 1981).

The family’s ability to assess its capabilities and resources against the consequences and the impact of the stressor will influence the family’s appraisal of the situation (CC) (McCubbin & McCubbin, 1993, 2001). A positive situational appraisal will emerge when a family believes that it has the capability to overcome and manage the stressor. This will facilitate adaptation (McCubbin & McCubbin, 2001). The stressor appraisal (C) is the family’s definition of the stressor and its severity. A family’s appraisal of the stressor has been cited as a critical component in predicting the family’s adaptation (McCubbin & McCubbin, 2001; McCubbin & Patterson, 1983; McKenry & Price, 1994).

Family problem solving and coping (PSC) is intended to reduce or eliminate the stressors and their hardships and to acquire new resources. Coping strategies are employed to manage the family system’s tension. These strategies also shape the situational appraisal and the family schema (McCubbin & McCubbin, 1993, 2001).

Although each component has been detailed separately to facilitate a better understanding, it is highlighted that the afore-mentioned components interact cyclically to produce a level of adaptation. The adaptation phase remains the primary focus of the present study. This section detailed the Resiliency Model of Family Stress, Adjustment and Adaptation. The following section explains Walsh’s (2003a, 2003b) Family Resilience Framework.
3.6 Family Resilience Framework

Walsh’s Family Resilience Framework (2003a, 2003b) is outlined below and the developmental and ecological contributions to this framework are explored. Thereafter the key processes of family functioning are detailed.

The framework is informed by clinical and social science studies which sought to explain fundamental variables contributing to well-functioning families (Walsh, 1996, 2002a, 2003a). The basic assertion in this systemic view is that crises and persistent adversity have an impact on the entire family and that these stressors can disrupt the functioning of the family. Consequently, the family utilises key family processes to mediate the recovery of all family members and the family unit (Walsh, 2002a, 2002b, 2003a, 2003b).

This family resilience framework combines an ecological and developmental perspective to view family functioning in a broader context (Walsh, 1996, 2003b). From an ecological perspective it employs Falicov’s (1995) multidimensional framework and from a developmental perspective it accounts for adaptational pathways over time, the family’s life cycle and multi-generational systems (Walsh, 2002a, 2002b, 2003a, 2003b). This framework draws from McGoldrick and Carter’s (2003) family development theory. The ecological and developmental perspectives are explored, followed by the key processes of family resilience.

3.6.1. Ecological Perspective

The ecological perspective provides a biopsychosocial orientation in which risk and resilience are viewed in the context of multiple recursive influences involving individuals, families and larger social systems (Walsh, 1996, 2003a, 2003b). Problems emerge from an interaction of individual and family vulnerability with stressful life and social experiences (Walsh, 1996, 2003a). Symptoms may be biologically based or influenced by socio-cultural variables. The family, peer group, community resources, school or employment settings and other social settings
are viewed as contexts for nurturing and reinforcing resilience (Walsh, 2002a, 2003a). Each family’s crisis will have both common (typical) and unique features (Walsh, 2003a).

Falicov’s (1995) multidimensional framework for cultural diversity locates each family as occupying a complex ecological niche, sharing borders and common ground with other families, as well as differing positions related to gender, economic status and life stage. A family resilience framework seeks to identify common elements and effective family responses in a crisis situation while also taking into account each family’s unique perspectives, resources and challenges (Walsh, 1996, 2003a).

3.6.2. Developmental Perspective

Families comprise of members who have a shared history and a shared future. Relationships with parents, siblings and other family members also undergo transitions as they move along the life cycle. Boundaries shift, psychological distance among members change and roles within and between subsystems are constantly being redefined (McGoldrick & Carter, 2003). Spiritual and cultural factors also play a major role in how families traverse the life cycle (Walsh, 1999). As a result family functioning and symptoms of distress are assessed in the context of a multigenerational and culturally specific family system as it moves forward across the life cycle (McGoldrick & Carter, 2003).

At each developmental stage the balance shifts between stressful events that heighten vulnerability and protective processes that enhance resilience, as well as the relative influence of family, peers and other social forces (Walsh, 2002a, 2003a, 2003b). The Family Resilience Framework focuses on family adaptation around nodal events, including both predictable, normative transitions and unexpected events (Walsh, 2003a, 2003b).

The convergence of developmental and multigenerational strains increases the risks for complications (Carter & McGoldrick, 1999). Distress is heightened when current stressors
reactivate memories and emotions from the past (Walsh, 2003b). Many families function well until they reach a point in the life cycle which had been traumatic to the previous generation (Walsh, 2003b). Some families may handle a short term crisis well but buckle under the strains of persistent or recurrent challenges (Walsh, 2003a). A pile-up of internal and external stressors can overwhelm the family, heightening vulnerability and risk for subsequent problems (Boss, 2001; Patterson, 2002). This pile-up of internal and external stressors has been previously explored. The processes that families engage in, when faced with adversity are now outlined.

3.6.3. Key Processes of Family Resilience

Walsh (2002a, 2002b, 2003a, 2003b) collated findings from numerous studies, identifying and synthesising key processes within three domains of family functioning namely, family belief systems, organisation patterns and communication processes. These domains of family functioning and their associated sub domains are detailed and similarities between this framework and the adaptation phase of the Resiliency Model are highlighted.

3.6.3.1. Family Belief Systems

Family belief systems influence how the family views crises and helps members make meaning of crisis situations. This belief system also facilitates a positive outlook and offers transcendental learning (Walsh, 2003a; Wright, Watson & Bell, 1996). It is a shared construction of reality through family and social transactions and organises the family’s approach to crisis situations (Walsh, 2003a). Resilience is fostered by shared facilitative beliefs that increase options for problem solving, healing and growth (Walsh, 2003a, 2003b; Wright, Watson, & Bell, 1996). Whilst Walsh (2003a, 2003b) highlighted family belief systems, the adaptation phase of the Resiliency Model refers to the family’s hardiness and the family’s appraisal processes, which include schema, coherence, paradigms and situational and stressor appraisals.
3.6.3.1.1. Making Meaning of Adversity

It is suggested that high functioning families approach adversity as a shared challenge and hold a relational view of strength (Walsh, 2003a). In joining together, individuals strengthen their ability to overcome adversity. By normalising and contextualising distress, family members are able to understand overwhelming situations. The tendency towards shame and blame is reduced if the family is able to view a dilemma as ‘normal’ (Walsh, 2003a). Families gain a sense of coherence by recasting a crisis as a challenge that is comprehensible, manageable and meaningful to tackle. This involves efforts to clarify the nature and source of problems and to explore available options. The meaning of adversity and beliefs about what can be done vary with different cultural norms (Walsh, 2002a, 2003b).

The adaptation phase of the Resiliency model refers to family hardiness, family schema and family coherence which is similar to Walsh’s (2002a, 2003b) family belief system of making meaning of adversity. Family hardiness is the internal strengths and durability of the family unit and is characterised by the family’s sense of control over life events (McCubbin & McCubbin, 2001). The family’s schema is composed of the shared values, goals, rules and expectations that the family develops and shapes over time (McCubbin & McCubbin, 2001) and the family’s coherence is its motivation and confidence that the world is comprehensible (Antonovsky, 1987).

3.6.3.1.2. Positive Outlook

Considerable research documented the strong effects of a positive outlook in coping with stress, recovering from crises and overcoming barriers to success (Seligman & Csikszentmihalyi, 2000). High functioning families have been found to hold a more optimistic view of life. In order to be sustained, a positive outlook must be reinforced by successful experiences and a nurturing community context (Walsh, 2003a, 2003b). Affirming family strengths and potential helps families to counter a sense of helplessness, failure and blame as it reinforces pride, confidence
and a can-do-spirit (Walsh, 2003a, 2003b). A positive outlook involves evaluating the situation and its challenges and the resources and options that are available, and then deciding on the best option. This requires an acceptance of what is beyond their control and cannot be changed, and what is actually possible (Walsh, 2003a).

Parallel to the belief system of positive outlook, the Resiliency Model offers the component of the family’s situational and stressor appraisals. The family’s situational appraisal reveals the adequacy or inadequacy of the family unit to manage the situation (McCubbin & McCubbin, 2001). The process of situational appraisal involves the evaluation of the crisis, the assessment of the family’s capabilities and strengths and the evaluation of alternative courses of action and coping strategies (McCubbin & McCubbin, 1993, 2001).

### 3.6.3.1.3. Transcendence and Spirituality

Transcendent beliefs provide meaning and purpose beyond ourselves, our families and immediate troubles (Beavers & Hampson, 1990). Most families find strength, comfort and guidance in adversity through connections with cultural and religious traditions (Parrot, 1999; Walsh, 1999, 2003b). Spiritual resources that enhance resilience include rituals, ceremonies, prayer and religious/congregational affiliation (Angell, Dennis, & Dumain, 1998; Walsh, 2003a; Werner & Smith, 1992). Resilient families commonly emerge from crises with a heightened moral compass and sense of purpose in their lives and usually gain compassion for the plight of others (Walsh, 2003a, 2003b). The experience of adversity and suffering can inspire creative expression and social action (a life dedicated to helping others) (Walsh, 2003a, 2003b).

The concepts of transcendence and spirituality are addressed in the Resiliency Model under the components of social support, intangible personal family resources and problem-solving and coping strategies.
3.6.3.2. Organisational Patterns

The organisation patterns which contribute towards resilience are flexibility, connectedness (cohesion) and social and economic resources (Walsh, 2003a). These patterns are now discussed.

3.6.3.2.1. Flexibility

Flexibility is a core process in resilience. The ability to rebound is described as bouncing back to a preexisting shape or norm. However, after most major transitions, families cannot return to ‘normal’ life. Thus bouncing forward and changing to meet new challenges seems more appropriate (Walsh, 2002a, 2002b, 2003b). Families construct a new sense of normality and reorganise patterns of interaction to meet new demands. Firm yet flexible authoritative leadership is most effective and it is important for parents and other caretakers to provide nurturance, protection and guidance (Beavers & Hampson, 1993; Walsh, 2003a, 2003b).

A similar concept is that of adaptability as highlighted in the adaptation phase of the Resiliency Model. Family adaptability or flexibility is the degree to which the family is able to change roles, rules and boundaries (McCubbin & McCubbin, 2001). Family flexibility is also one of the dimensions of the Resilient Family Type (T) of the Resiliency Model (McCubbin & McCubbin, 2001). The reorganisation of the HIV/AIDS affected family unit as an example of flexibility has been highlighted and is therefore not repeated.

3.6.3.2.2. Connectedness

Resilience is strengthened by connectedness which is manifested in mutual support, collaboration and a commitment to face challenges together (Walsh, 2003b). Individual family members need to respect each other’s differences and boundaries. It is important to sustain connections within the family through photos, letters and visits with the extended family (Walsh, 2003a). Links to the shared cultural and religious heritage also promote connectedness (Walsh,
Daily routines can provide family members with regular contact and order (Hochschild, 1997) and rituals bind the family together (Imber-Black, Roberts & Whiting, 1988). The Resiliency Model addresses family connectedness in its component of family cohesion. Family cohesion refers to the bonds of unity that are evident in a family system and is composed of aspects of trust, appreciation, support, integration and respect for individuality (McCubbin & McCubbin, 2001).

3.6.3.2.3. Social and Economic Resources

Kin and social networks offer practical and emotional support to the family during difficult times. Role models and mentors, participation in community groups and religious congregations, all strengthen resilience (Ledward & Mann, 2000; Masten & Coatsworth, 1998; Reed & Sherkat, 1992; Walsh, 1996, 2003b). Family resilience can be enhanced by social and institutional policies and practices that encourage the ability to thrive. These include flexible work schedules, quality, affordable health services and child and elder care services (Walsh, 1996, 2003b). Economic resources that foster family resilience include, amongst others, financial security that is offered by family members, the extended family, community groups and social services (Walsh, 2003b). Similar economic and social services have been offered to HIV/AIDS affected families as has been evidenced by the literature review in chapter two.

Social and economic resources are included in the Resiliency Model under the broad component of social support and include all community and institutional resources that the family may use to cope with a crisis (McCubbin & McCubbin, 1993, 2001). These include the support offered by friends, schools, churches and employers.

3.6.3.3. Communication Processes

Communication processes facilitate resilience by bringing clarity to crisis situations and by encouraging open emotional expression and collaborative problem solving (Bloch et al., 1994;
Walsh, 2003b). It should be noted that cultural norms vary considerably in the sharing of sensitive information and expression of feelings (Walsh, 2002a, 2002b, 2003a).

Whilst Walsh (2003a, 2003b) highlighted communication processes, the Resiliency Model refers to family organisation and problem solving and coping skills, which covers the communication processes that are highlighted in Walsh’s (2003a, 2003b) framework. Family organisation includes agreement, clarity, consistency and fluidity in the family role and rule structure. Communication skill is a critical component of family organisation (McCubbin & McCubbin, 2003).

3.6.3.3.1. Clarity

Effective family functioning is facilitated by clear and congruent messages. Clarifying and sharing information facilitates meaning making, authentic relating and informed decision making whilst ambiguity and secrecy may block understanding and mastery (Imber-Black, 1995; Raveis et al., 1998; Walsh, 2003a, 2003b). Shared acknowledgement of reality and its circumstances fosters healing whereas denial can hinder recovery (Walsh, 2003a). The Resiliency Model also refers to the importance of clear and direct messages, instrumental and affective communication and verbal-nonverbal consistency (McCubbin & McCubbin, 1993, 2001).

3.6.3.3.2. Open Emotional Expression

Open communication and mutual trust, empathy and tolerance for differences enable family members to share a wide range of feelings (Walsh, 2003a). A breadwinner may suppress strong emotional reactions in order to protect other family members while children may stifle their own feelings and needs in an attempt to help the family. However when emotions are intense, conflict is likely to emerge (Walsh, 2003a, 2003b). Family resilience is fostered by family members who are able to share their feelings openly, comfort one another and find moments of pleasure and humour (Gilbert & Smart, 1992; Walsh, 2003a).
3.6.3.3. Collaborative Problem Solving

Shared decision making and conflict resolution involves negotiation of differences with fairness and reciprocity over time, so that family members accommodate one another. Resilient families set clear goals and priorities and take concrete steps toward achieving them. Families become more resourceful when they are able to shift from a crisis-reactive mode to a proactive stance (Walsh, 2003a).

The problem solving and coping (PSC) component of the resiliency Model draws parallels to the collaborative problem solving referred to by Walsh (2003a, 2003b). Problem solving and coping (PSC) is directed at the reduction of stress and hardships, the acquisition of additional resources and the management of the family’s tension (McCubbin & McCubbin, 1993, 2001).

3.7 Comparison of the Two Models

While the similarities between the two models were highlighted in the previous section, this section tables some of the differences.
Table 5: Differences between the Two Models

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<thead>
<tr>
<th>Resiliency Model of Family Stress, Adjustment and Adaptation (Adaptation Phase)</th>
<th>Family Resilience Framework</th>
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<td>Family system resource</td>
<td>Walsh’s Framework does not refer to family roles and functions.</td>
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<td>Outcomes</td>
<td>Walsh’s Framework identifies key processes but does not offer dimensions of functioning.</td>
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<td>-bonadaptation vs. maladaptation</td>
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<td>-new patterns of functioning (TT)</td>
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</table>

3.8 Conclusion

Chapter three has provided an overview of the positive psychology paradigm and highlighted the concept of resilience within this paradigm. Two theoretical frameworks of family resilience, namely, The Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework were examined. The results of the study will be presented within the context of these two models in Chapter five. Chapter four which follows describes the research design and methodology as utilised in this study.
CHAPTER FOUR
Research Design and Methodology

4.1 Introduction

A description of the research design and methodology that was utilised for this study is provided. The research procedure, research setting and the sampling strategy is outlined, followed by a description of the data collection tools and the data analysis. The ethical concerns that were raised during the study are considered.

4.2 Research Design

The qualitative, exploratory descriptive design is described in this section. Qualitative studies occur in natural settings and provide detailed descriptions and analyses of the quality of human experience (Creswell, 2003; Marvasti, 2004). This involves collecting data in the form of verbal reports and interpreting the meaning of the text. The interpretation is conveyed via detailed narrative reports of the participants’ perceptions, understandings or accounts of the phenomenon under investigation (Silverman, 2006; Smith, 2003). Qualitative approaches aim to understand a small number of participants’ personal frames of reference and its findings are emergent, whereas quantitative approaches attempt to test a pre-conceived hypothesis on a large sample and the findings are tightly prefigured (Creswell, 2003; Marvasti, 2004; Smith, 2003).

Qualitative studies in psychology generally aim to explore, describe and interpret the personal and social experiences of the participants (Henning, Van Rensburg & Smit, 2004; Neuman, 2000). They enable the researcher to gain new insights, develop theoretical perspectives and discover the problems that exist within the phenomenon (Creswell, 2003; De Vos, 2005). The
validity of certain assumptions and theories can be tested (verification) and the effectiveness of particular policies and practices can be judged (evaluation) (De Vos, 2005; Silverman, 2006).

Exploratory studies are conducted when there is a lack of basic information in an area of interest, when a need to formulate a problem or develop a hypothesis is expressed and to gain insight into a situation, phenomenon, community or individual (Fouché & De Vos, 2005; Neuman, 2000). Descriptive studies present specific details and intensive examinations of the phenomena by providing thick and rich descriptions (Fouché & De Vos, 2005; Neuman, 2000). These studies can have a basic or applied research goal and are either qualitative or quantitative in nature (Fouché & De Vos, 2005). This section demarcated the research design and is followed by the methodology.

4.3 Research Methodology

This section provides an overview of interpretive approaches and phenomenology is introduced. Emphasis is placed on Interpretative Phenomenological Analysis (IPA).

4.3.1. Interpretive Approaches

The methodology is embedded within interpretive phenomenology which involves a detailed examination and exploration of the participants’ worlds, personal experiences and perceptions (Creswell, 2003; Osborn & Smith, 1998). The ontology and epistemology of this approach is that the participants’ subjective experiences are real and that their experiences can be understood by interacting with them and listening to them (Fouché, 2005; Henning, Van Rensburg & Smit, 2004). Qualitative research designs are best suited to this task of understanding the complex world of lived experiences from the perspective of those who live it and in order to understand this world of meaning, one must interpret it (Creswell, 2003; Willig, 2001).
Interpretive researchers are interested in what is meaningful or relevant to the participants and how these participants experience daily life (Neuman, 2000). These researchers maintain that social life is a socially constructed meaning system that is based on social interactions and people’s definitions of reality. It follows that multiple interpretations of human experience or realities are possible (Neuman, 1997, 2000).

4.3.2. Phenomenology

A phenomenological study attempts to understand people’s perceptions, perspectives and understandings of a particular situation (phenomenon) (Creswell, 2003; Fouché, 2005; Smith & Osborn, 2003). This method involves three distinct phases of contemplation: epoche, phenomenological reduction and imaginative variation (Leedy & Ormrod, 2005).

Epoche is the suspension of presuppositions, assumptions, judgements and interpretations with the intention of being fully aware of what is being presented (Willig, 2001). Phenomenological reduction is the description of the phenomenon itself which includes describing the physical features (such as shape, colour and texture) and the experiential features (such as thoughts and feelings) (Leedy & Ormrod, 2005; Willig, 2001). Imaginative variation involves accessing the structural components (such as time, space and social relationships) of the phenomenon (Leedy & Ormrod, 2005; Willig, 2001).

4.3.3. Interpretative Phenomenological Analysis (IPA)

Interpretive phenomenology is advocated when the intention is to answer in-depth questions about the nature of individuals’ experiences, when an active contribution from the researcher is required and when an understanding of both the idiosyncratic and cultural aspects of a person’s world is sought (Shaw, 2001). Even though IPA aims to explore the participant’s experience from his or her perspective, it recognises that such exploration must necessarily implicate the researcher’s own view of the world and the interaction between researcher and participant (Smith
& Osborn, 2003; Willig, 2001). The emerging analysis is phenomenological because it aims to represent the participant’s view of the world (Smith & Osborn, 2003) and since it is dependant upon the researcher’s own conceptions and standpoint, it is referred to as being interpretive (Marvasti, 2004; Willig, 2001).

The benefits of using IPA include its ability to reveal unforeseen phenomena, to expose previously underdeveloped constructs and its characteristic of being data driven rather than theory driven. This makes it possible to investigate phenomena from a new perspective rather than from theories (Shaw, 2001; Willig, 2001).

Some of the practical limitations of IPA involve its reliance on language and on participants’ accounts (Smith & Osborn, 2003; Willig, 2001). This limitation was evident in the present study as the data collected relied upon the participants’ language preference and their accounts of family resilience. It is assumed that language provides participants with the necessary tools to capture their experiences but it has also been argued that language constructs reality rather than describes reality (Henning, Van Rensburg & Smit, 2004; Willig, 2001). Therefore, interviews inform the researcher about how an individual talks about an experience rather than about the experience itself (Willig, 2001). IPA is dependent on the participants’ accounts and these accounts may not provide suitable material for phenomenological analysis. The suitability of these accounts is influenced by the participants’ ability to use language to capture and convey rich narrations of their experiences (Willig, 2001).

The researcher acknowledges that there is some discrepancy between the theoretical framework (family resilience) and the methodology. Family resilience theories depart from a systemic paradigm and the focus is on the family as a holistic unit. The phenomenological approach advocated in this study, however, is focused on the experience of an individual. Individuals were interviewed for the purpose of this study but it is emphasised that the
participants were asked to describe the functioning of their families as a whole. Although individuals were interviewed, the focus remained on the families’ functioning as a holistic unit and the interview guide was derived from the relevant family resilience literature. Hence, the aforementioned subtle discrepancy between the theoretical framework and the methodology has been addressed. It is proposed that future research of this nature may account for these theoretical problems by interviewing two or more family members and interviewing an individual who is independent of the family under observation. Although IPA presents with some practical limitations, its benefits are highlighted especially in its ability to address the exploratory-descriptive nature of the present study and its aim.

4.4 Research Procedure

In this section the implementation of the research process is outlined. This includes contact that was made with the HIV/AIDS Unit, the iThemba AIDS Foundation and the Masizakhe Community Project. A description of the field work concludes this section.

4.4.1. The HIV/AIDS Unit and iThemba AIDS Foundation

The iThemba AIDS Foundation had been funding and supporting various HIV/AIDS support groups in the Eastern Cape. They approached the HIV/AIDS Unit at the Nelson Mandela Metropolitan University (NMMU) to assist with research projects within these support groups. These groups were identified as the outreach programme in Veeplaas (St. Paul’s), the Masizakhe Community Project in Kwazakhele and the Ikwezi Support Group in Alexandria (Appendix A). The groups were informed by the iThemba representative about the possibility of a research study being conducted within their structures and arrangements were made for a preliminary needs analysis. One of the most successful ways of gaining entry into a setting is to make use of
indigenous people who are part of the setting (Strydom, 2005c). The iThemba representative was a key figure in gaining access to the research site.

4.4.2. The Needs Analysis

The needs analysis identified areas of research within each support group, assessed their level of motivation and commitment to participate in a research project and fostered an understanding of how the research process was envisaged. The analysis involved visiting each support group at their respective premises; discussing their structure, organisation and services rendered and collaboratively identifying research areas. They were informed that this was a preliminary needs assessment and that it did not imply a commitment to a research undertaking.

4.4.3. The Masizakhe Community Project

The Masizakhe Community Project in Kwazakhele, Port Elizabeth was identified for this study. The project has ten volunteers rendering services such as home based care, supportive counselling, skills development, soup kitchens, food parcels for orphans and child headed families, a pre school and an after school care programme for orphaned and vulnerable children (OVC). It was agreed that the focus of the study should be the adolescent headed families that were affiliated with the Masizakhe Community Project. The research proposal was accepted by the Psychology Department and it was submitted to and approved by the Faculty Research, Technology and Innovations Committee and the Ethics Committee (Human) of the NMMU.

Upon approval, contact was made with the Masizakhe Community Project volunteers. Rapport was established between the collaborators, roles were clarified and the nature and process of the study were outlined. The inclusion criteria for the selection of participants were discussed and the provision of a summary report on the findings and recommendations was decided upon. A formal contract was signed between the Masizakhe Community Project and the researcher. The volunteers recognised the benefits of planning intervention programmes in the community,
assisting the specified group and affirming their efforts. The afore-mentioned process is testament that the probability of obtaining permission to undertake research is increased when the researcher is able to explain the purpose and methods of the research in a way that gate keepers and participants are able to understand its benefits (Strydom, 2005c).

4.4.4. The Field Work

Once the participants were identified, the researcher and a volunteer from the project approached each participant. The volunteer introduced the researcher to the participants and verified the researcher’s credentials. The participants were informed about the purpose and nature of the study, important research information was highlighted (refer to 4.9 Ethical Considerations) and the participants were invited to participate. All of the above was communicated in the language of preference of the participants and a Xhosa speaking interpreter was utilised when requested. Each participant received the English and Xhosa versions of the introductory letter (Appendix B). The participants were given opportunity to ask any questions and a willingness to participate was confirmed by the participants signing a pre-designed consent form (Appendix C). Thereafter, arrangements were made for interviewing to begin.

The interviews were audio recorded and this ensured that important information was not omitted during the interview and allowed the interviewer to concentrate on the conversation rather than attempting to document the dialogue (Osborn & Smith, 1998; Willig, 2001). Note taking distracts both the interviewer and the interviewee, interferes with eye contact and other non verbal communication and hinders the development of rapport between the interviewee and the interviewer (Willig, 2001).

A total of four interviews ranging from one and a half hours to two hours were conducted with the four participants. The interviews took place during the mornings over consecutive days in order to minimise disruption of the daily routine of the Masizakhe Community Project. Process
notes were compiled immediately after each interview and transcription commenced thereafter. Each participant was given an opportunity to verify the findings in an individual feedback session which took place three weeks after the initial interviews. A total of four feedback sessions of forty-five minutes each were held. Upon final completion of this study the audio recordings will be discarded to ensure confidentiality.

4.5 The Research Setting

A description of the sampling strategy and the sample characteristics are presented. This is followed by the context of the interviews.

4.5.1. Participants and Sampling

Non-probability, purposive sampling was utilised to select the participants. Non-probability sampling is used by qualitative researchers who focus less on a sample’s representativeness and more on the sample’s relevance to the research topic (Neuman, 1997, 2000; Silverman, 2006). Purposive sampling is used in exploratory research to select participants from a difficult-to-reach, specialised population, to select unique cases that are especially informative and to select particular cases for in-depth investigations (Neuman, 1997, 2000; Strydom, 2005b). The participants in this study were especially selected based on their experiences of belonging to HIV/AIDS’ adolescent headed families.

Qualitative studies are conducted on small sample sizes since the aim is to gain information in detail about the perceptions of this particular group rather than to make more general claims (Greig & Taylor, 1999; Smith & Osborn, 2003). Smith (2003) suggested a sample size of five or six participants as this provides enough cases to examine similarities and differences between cases. This sample size guide was employed and four participants were selected from the five adolescent headed families that were registered with the Masizakhe Community Project.
The participants were selected based on the following inclusion criteria: participants must have been heading an adolescent headed family that was created due to HIV/AIDS; participants must have been between 18 years and 21 years old as per the conceptual definition utilised for this study; they must have been heading the household for six months or longer, either one or both parents may have died due to AIDS related causes or either one or both parents may have been present yet too ill to assume responsibility and participants could be either male or female and English and/or Xhosa speaking. These inclusion criteria were stipulated in order to increase the homogeneity of the sample.

Concerns of sample bias were raised as all the participants were receiving services as well as volunteering at the Masizakhe Community Project. The influence of this symbiotic relationship would need to be acknowledged in relation to the participants’ responses. Furthermore, only female heads of households were approached and the volunteer (who was responsible for introducing the researcher to the participants) seemed uncertain as to whether any male household heads had been approached by the project leader and whether any male household heads were affiliated with Masizakhe. This uncertainty prevailed, even upon pursuing clarity from the project head. The first participant’s age (24 years) was discovered during the first interview after she had agreed to participate. Therefore, a decision to continue with the interview was made. The following table provides the sample characteristics of all the participants.
### Table 6: Sample Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Participant A</th>
<th>Participant B</th>
<th>Participant C</th>
<th>Participant D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>24yrs</td>
<td>20yrs</td>
<td>20yrs</td>
<td>20yrs</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>Xhosa</td>
<td>Xhosa</td>
<td>Xhosa</td>
<td>Xhosa</td>
</tr>
<tr>
<td><strong>Number of yrs as head</strong></td>
<td>4yrs</td>
<td>8yrs shared responsibility. 10 months sole responsibility.</td>
<td>1yr</td>
<td>5yrs</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td>Volunteer</td>
<td>Volunteer</td>
<td>Volunteer</td>
<td>Volunteer</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td>Kwazakhele</td>
<td>Kwazakhele</td>
<td>Kwazakhele</td>
<td>Kwazakhele</td>
</tr>
<tr>
<td><strong>Family Composition</strong></td>
<td>Sister 20yrs Brother 18yrs Cousin 16yrs (female)</td>
<td>Brother 17yrs Brother 14yrs Nephew 7yrs (sister’s child)</td>
<td>Cousin 13yrs Cousin 6yrs 7 months (participant’s baby)</td>
<td>Sister 11yrs Sister 7yrs</td>
</tr>
</tbody>
</table>
4.5.2. The Context for Interviewing

The Masizakhe Community Project is located in Kwazakhele Township, Port Elizabeth. Interviews took place in the mornings in one of the community project’s containers (a cargo container) which is usually used in the afternoons for after school care for OVC (orphaned and vulnerable children). The container provided a private and confidential interviewing environment and the participants appeared comfortable here. This had become the usual venue for all of the interviews due to its proximity to the Masizakhe offices and the participants’ homes and having electricity for the audio recorder.

4.6 Data Collection

The methods selected for this study were considered in light of the qualitative design, the exploratory-descriptive nature of the research question and most importantly to suit the potential participants. The reduction of bias was an important aspect of the qualitative methodology and one way of achieving this was by using triangulation of methods (Creswell, 2003; Neuman, 2000). Method triangulation involves using two or more methods of data collection within a project which provides a means of verifying the findings obtained (Willig, 2001). In the present study, semi-structured interviews and simple observations were utilised.

4.6.1. The Semi-Structured Interview

Face-to-face interviews in the form of semi-structured interviews with an interview schedule were employed to collect the data. The interview schedule (Appendix D) which had been developed from the relevant literature was translated from English to Xhosa and then back-translated from Xhosa to English by the two nominated linguists from the Language Department (NMMU). The translations were completed in advance of the actual interviewing sessions and the linguists were briefed about the nature and purpose of the study, issues of confidentiality and
anonymity and the basic principles of interviewing. The English speaking researcher conducted the interviews utilising the English version of the interview schedule whilst the linguist used the Xhosa version of the interview schedule. The linguist assisted with translating the questions asked by the researcher from English to Xhosa and assisted with translating the participants’ responses from Xhosa to English.

An interview schedule is a guideline for the interviewer and contains questions and themes that are important to the research (Henning, Van Rensburg & Smit, 2004; Smith, 2003). An example of a question for this study is, “Given all the changes you have mentioned, tell me how your family has worked through these changes”. The questions did not have to be asked in a particular order but ensured that all the relevant topics were covered (Smith, 2003). Biographical information about each participant and her family was extracted from the first open-ended question and the questions thereafter aimed to generate data on the family’s resilience.

4.6.1.1. Advantages of Semi-Structured Interviews

The semi-structured interview is widely utilised due to its flexibility and easy integration into the qualitative research context (Greeff, 2005; Silverman, 2006; Smith 2003; Willig, 2001). Researchers utilise the interview method to inform them about social life (Greeff, 2005; Silverman, 2006), to understand the participants’ life worlds and to generate rich, in-depth data (Greeff, 2005; Willig, 2001). Participants can elaborate on their answers, draw connections between responses and have the freedom to ask for clarification (Marvasti, 2004). The semi-structured interview allows for flexibility, unlike the structured interview where questions are structured and therefore little is gained about the interviewees’ world and responses are limited to the questions that are being asked (Greef, 2005; Marvasti, 2004). Whilst semi-structured interviews provide for the relatively systematic collection of data within a reasonable time frame and at the same time ensure that important data is not omitted, the in-depth interview is a time
consuming method that generates vast amounts of data that are difficult to manage and organise (Greeff, 2005; Silverman, 2006; Smith, 2003).

Semi-structured interviews are helpful in exploratory studies as they assist in clarifying concepts and problems and allow for the establishment of a list of possible answers and solutions which in turn facilitates the construction of more structured interviews (Bles, Higson-Smith & Kagee, 2006). They also facilitate the reformulation of ambiguous questions and the elimination of superfluous ones and allow for the discovery of new aspects of the problem by exploring in detail the explanations supplied by participants (Bles, Higson-Smith & Kagee, 2006; Silverman, 2006).

4.6.1.2. Disadvantages of Semi-Structured Interviews

The main disadvantage is that the interviewer’s personal characteristics may influence the participants’ answers (Bles, Higson-Smith & Kagee, 2006; Terreblanche & Durrheim, 1999). The interviewer may also instill bias by recording the information inaccurately, either by translating the ideas of the participant into the interviewer’s own words and interpreting the answers according to his/her own views or by recording only a summarised version of the answer (Bles, Higson-Smith & Kagee, 2006). Another disadvantage is the high cost associated with training and paying interviewers and covering travel expenses (Terreblanche & Durrheim, 1999).

4.6.1.3. The Process of Semi-Structured Interviews

The process of semi-structured interviewing was divided into five phases. Phase one entailed preparing for the interview which involved a literature review and construction of an interview guide (Marvasti, 2004; Smith, 2003). Emotional preparation for the interview took place in phase two (Greeff, 2005). Phase three described the initial ambivalent relationship between the interviewer and interviewee (Willig, 2001) and set the context for phase four which involved establishing a contractual relationship. The interviewer and the interviewee had common
objectives which developed into a relationship of mutual trust (Greeff, 2005; Henning, Van Rensburg & Smit, 2004). During the fifth phase termination occurred when the conditions of the research agreement had been met, the proposed objectives had been achieved and when saturation point had been reached. Interviews were terminated and participants were offered the opportunity to have a debriefing and feedback session.

The basic principles that were incorporated in all the interviews included respect and courtesy, acceptance and understanding, confidentiality, integrity and individualisation. Skills required by the interviewer included observing and attending, communication, coping with conflict, probing and analysis and interpretation (Henning, Van Rensburg & Smit, 2004; Smith, 2003).

4.6.2. Simple Observation

Simple observations throughout the field work process were recorded and included in the reflexive notes. These included describing the research context and the participants, noting participants’ non verbal behaviour during the interviews, interpreting the situation and including a reflexive analysis (researcher’s experiences and feelings). These simple observations were not subjected to the stages of IPA but were used for its value in describing the research sample, setting and for reflexivity. (Refer to Appendix G).

Unlike participant observation, this simple observation is not time consuming or labour intensive and does not create an enormous amount of data (Strydom, 2005c). Simple observations do not pose the problem of poor acceptance by the participants despite the necessary permission being obtained from authority figures (Strydom, 2005c; Willig, 2001).

4.6.3. Reflexivity

Reflexivity urges the researcher “to explore the ways in which the researcher’s involvement with a particular study influences, acts upon and informs such research” (Nightingale & Cromby, 1999, p. 228). It aims to prevent or reduce researcher bias by careful self monitoring and by
limiting the researcher’s interpretations to what the participants are saying (Shaw, 2001). There are two types of reflexivity namely, epistemological reflexivity and personal reflexivity.

4.6.3.1. Epistemological Reflexivity

Epistemological reflexivity addresses design and methodology issues (Willig, 2001). The formulation of a research question will influence its examination and interpretation (Nightingale & Cromby, 1999; Willig, 2001). One questions whether a reformulation of the problem statement from a deficit based lens would still generate themes of family resilience. The qualitative, exploratory descriptive design was appropriate, as research studies and literature highlighted the paucity of information on HIV/AIDS adolescent headed families and resilience.

The semi-structured interview allowed for flexibility, probing, clarifying and asking of questions in a sequence that was suitable for the interview pace and atmosphere. It addressed the research question, the sensitivity of issues being raised, the sample characteristics and the participants’ language preferences. The emotional impact of the participants’ accounts on the translator and interviewer was acknowledged and this highlighted the lack of debriefing sessions for the translator and interviewer, in the design.

A pilot interview would have given the interviewer a first opportunity to role play the interview questions, ease into the interview method and work with the translator. The inclusion of a pilot interview was not considered in the initial stages of the study as these practical limitations were not anticipated. The sampling strategy limited the sample to participants that were affiliated to Masizakhe and this had implications for the findings, such as participants’ bias toward the community project.

4.6.3.2. Personal Reflexivity

Personal reflexivity involves reflecting on one’s personal values, experiences, interests, beliefs, political commitments, goals in life and social identities and how all of these have shaped
the research. It includes reflecting on the influences the research may have had on the researcher personally and as a researcher (Willig, 2001). Researcher attributes that may have influenced this study included increased empathy towards disadvantaged groups and an affinity to empower these individuals. A positive view of human nature and a belief in individuals’ unique abilities and capacities to develop may have implications for a topic of resilience. The researcher’s work orientation is one of structure and organisation. This had to be kept in mind especially when having to work with collaborators who had different working styles. Also, when developing the interview guide, it had to be ensured that the guide was not too rigid and structured.

Researcher motivation was maintained on this project as the researcher enjoyed working from a qualitative perspective and had a special interest in the field of HIV/AIDS. The contemporary nature of this topic also made the work more interesting.

The researcher’s home situation stood in contrast to the families that have participated. That is, the researcher shared a typical family unit comprising of a parental sub unit and a sibling sub unit. The family contexts of the participants have heightened the researcher’s appreciation of her own family unit and the opportunities that have been afforded thus far.

4.6.4. Transcription

Transcription of the interviews commenced immediately after the process notes for each interview had been compiled. Each interview was transcribed verbatim. The English excerpts of the audio recorded data were transcribed verbatim by the researcher and the Xhosa translations were transcribed and verified by a linguist independent of the interview process. This ensured that the translations made during the interview process were verified.

4.6.5. The Role of the Researcher

The researcher was responsible for focusing on naturally occurring phenomena; studying these phenomena in all its complexity and presenting the findings in a multifaceted form (Leedy &
An ability to interpret what was being presented was critical for understanding the families’ resilience (Neuman, 2000). During the interview the researcher and the participant worked closely toward an objective. The researcher listened attentively to the participant and was alert to subtle yet meaningful expressions and questions (Greeff, 2005). IPA required an active contribution from the researcher, which included becoming familiar with and making sense of the data (Shaw, 2001). The researcher’s influence on the study was addressed by using reflexivity as has been previously outlined (Shaw, 2001).

Other responsibilities included conducting a needs analysis, establishing rapport with the relevant gatekeepers and negotiating working relationships with the collaborators. An important responsibility was that of honouring and maintaining the ethical commitment made to each participant at the onset of this process. Data collection has been described in this section, and is followed by a description of the data analysis.

### 4.7 Data Analysis

The two reasoning modes that can be utilised in analysis and interpretation of the data are the deductive model of reasoning and the inductive model of reasoning. Quantitative researchers utilise the deductive model of reasoning whilst qualitative researchers use the inductive model (Delport & De Vos, 2005). For this study an inductive model of reasoning (IPA) was employed and it is highlighted that the conclusions drawn from inductive reasoning are tentative. The five stages of IPA are outlined.

#### 4.7.1. Stage One and Stage Two

This stage involved reading the transcripts several times and producing notes that reflected initial thoughts and observations in the left margin (Smith & Osborn, 2003; Willig, 2001). In stage two, themes that characterised each section of the text were identified and labelled in the
right margin. The initial notes from stage one were transformed into concise phrases and psychological terminology (Smith & Osborn, 2003).

4.7.2. Stage Three

Stage three introduced structure into the analysis by clustering the themes. The themes identified in stage two were clustered according to shared meanings or clustered according to hierarchical relationships (Smith & Osborn, 2003; Willig, 2001). These themes were continually checked against the primary source and a directory of participants’ phrases that supported the related themes was compiled (Smith & Osborn, 2003). The clusters of themes emerging in this stage were given labels that captured their essence and represented the superordinate theme (Smith & Osborn, 2003; Willig, 2001).

4.7.3. Stage Four

This stage involved the compilation of a summary table. The summary table included the superordinate (cluster) themes, the subordinate themes that fitted into each cluster and identifiers (quotations and references to relevant extracts) (Smith & Osborn, 2003; Willig, 2001).

4.7.4. Stage Five

In stage five the summary table for each participant was integrated into an inclusive list of master themes that reflected the experiences of the participants as a whole (Willig, 2001). The list of master themes included labels of superordinate themes and their constituent themes together with identifiers that indicated which of the participants invoked them. Analysis continued until all the themes had been integrated.

The emergent analysis was then conceptualised from two frameworks of family resilience. Triangulation of theories entails using two or more theoretical perspectives either early in the planning stages of the research or later to interpret the data (Neuman, 2000). The trustworthiness of the study was assessed according to Guba’s (1985) model which is now outlined.
4.8 Assessment of the Qualitative Research

Guba’s model (1985) of trustworthiness presents criteria for assessing qualitative research. These criteria include credibility, transferability, dependability and confirmability.

4.8.1. Credibility

Credibility is whether the researcher has established confidence in the truth of the findings. A qualitative study can be considered credible when it presents such accurate descriptions of human experience that people who are familiar with that experience would instantly recognise the description (Willig, 2001). Credibility was achieved by utilising peer debriefing and member checks. Peer debriefing involves exposing the analysis and conclusions to peers and colleagues on a continuous basis (Creswell, 2003).

This research study was under constant scrutiny and consideration by the iThemba representative and the Supervisor and Co-Supervisor of this study, from the initial formulation of the research problem until the completion of the final report. The research proposal was subjected to review by the Psychology Department’s Proposal Meeting, comprising of psychology staff members, intern psychologists and psychology masters students. Thereafter, the proposal was submitted to and approved by the Faculty Research, Technology and Innovations Committee and the Ethics (Human) Committee of the NMMU. Constant supervision and feedback was provided by the Supervisor and Co-Supervisor and continuous peer evaluation was received from a colleague (a student in Masters in Clinical Psychology) who was also conducting research within the HIV/AIDS field. Member checking refers to taking the findings back to the participants in order to assess the accuracy of the qualitative findings (Creswell, 2003). The findings were further verified by employing theory triangulation.

Credibility was enhanced by providing thick, rich descriptions to convey the findings as these may transport the readers to the setting and provide the discussion an element of shared
experience (Creswell, 2003). Clarifying the researcher’s bias, presenting negative cases and spending a prolonged time in the field, enhanced the credibility of the research (Creswell, 2003; Smith, 2003).

4.8.2. Transferability

Transferability refers to the degree to which the findings can be generalised to other contexts. Research meets this criterion when the findings from a study fit into contexts outside of the study situation. The contexts are deemed similar by goodness-of-fit. It is argued that as long as the innovative researcher presents sufficient descriptive data to allow comparison, the problems of transferability are addressed (Creswell, 2003; De Vos, 2005). Transferability was achieved by providing detailed descriptions of the research methodology and design and by providing a full specification of the theoretical framework on which the study was based. An explication of the different methods that were considered was also provided.

4.8.3. Dependability

Dependability addresses the issue of whether the findings would be consistent if the study were replicated. One argues that qualitative designs are aimed at multiple realities thus the notion of reliability is no longer as relevant (De Vos, 2005). Triangulation of methods and triangulation of theories have been used to assess dependability.

4.8.4. Confirmability

Confirmability refers to freedom from bias in the research procedures and results and corresponds to the concept of objectivity (Creswell, 2003; De Vos, 2005). In qualitative designs the neutrality of the data is considered rather than the neutrality of the researcher. This was achieved by reflexivity, triangulation of theories, peer debriefing and member checking and a literature control.
4.9 Ethical Considerations

A study of this nature required ethical sensitivity. Ethical concerns that were addressed during the study are outlined in this section.

4.9.1. Emotional Distress

The nature of this study called for an increased sensitivity towards various ethical issues in working with the participants. The participants may have been subjected to emotional distress arising from the sensitivity of the topic of HIV/AIDS. Emotional distress to participants is difficult to determine and to predict (Creswell, 2003; Willig, 2001). Each participant was informed beforehand about the potential emotional impact of this study and was assured that should such emotional distress arise and continue it would be contained by providing an environment of empathy and sensitivity and by providing an appropriate referral. They were also provided with an opportunity for an optional debriefing session upon completion of the field work.

Two participants became emotional during the interviews and were contained immediately and provision was made for them to either continue or discontinue with the interview. Both participants opted to continue with the interview and declined further referrals, asserting that they would receive counselling from the Masizakhe Community Project.

4.9.2. Informed Consent

Strydom (2005a) emphasised that accurate, complete, relevant and adequate information about the aim, the procedures, the advantages, disadvantages, possible dangers and the credibility of the researcher should be presented to possible participants. Participants must be made aware of the liberty to withdraw from the study at any time. This will leave the participant in a position to make a voluntary and informed decision about participating in the research (Creswell, 2003; Neuman, 2000). Informed consent was addressed as each participant was verbally informed in
English and Xhosa about the study and was also presented with this information in the form of an English and Xhosa introductory letter (Appendix B) before being invited to participate. They were given opportunity to ask various questions and to clarify any confusion. The decision to participate was confirmed by signing a pre designed consent form (Appendix C).

4.9.3. Voluntary Participation

Due to participants receiving services from the Masizakhe Community Project they may have felt pressured into participating for fear of losing this support. Participants were reassured that participation was voluntary and that they would not be prejudiced for not wishing to participate (Greig & Taylor, 1999; Lewis & Lindsay, 2000).

4.9.4. Anonymity and Confidentiality

Anonymity and confidentiality were ensured by not publishing the participants’ identifying information on the audio tapes, on the transcripts or anywhere in the final treatise or summary report. Participants were reassured that information generated from the interviews would remain confidential and would not be used for any other purposes outside of the research study. Access to the audio tapes was limited to the researcher and the linguist who were responsible for transcribing the interview. The linguist did not have access to the identifying information of the participants, hence further addressing the issue of anonymity. However, anonymity was limited due to the face-to-face interview method (Creswell, 2003; Henning, Van Rensburg & Smit, 2004).

4.9.5. Collaboration

The study involved the collaboration of the researcher with the iThemba AIDS Foundation and the community support group, Masizakhe. The collaborators may act prescriptively towards one another (Creswell, 2003; Neuman, 2000; Strydom, 2005a). Therefore, a formal contract
between the researcher and the Masizakhe Community Project was drawn up and a Memorandum of Understanding between iThemba and the researcher was collaboratively finalised.

4.9.6 Respect for the Research Site

Since data collection involved working with the Masizakhe Community Project, it was important to outline the extent of time, the potential impact and the outcomes of the research (Creswell, 2003). The research site needed to be respected so that the site was left undisturbed after the research study. Visits were timed so that there was minimal intrusion on the flow of activities of participants (Creswell, 2003).

4.10 Conclusion

This chapter described the qualitative, exploratory-descriptive research design and outlined the research methodology. Data was collected via semi-structured interviews that were audio-recorded and transcribed verbatim. The data was subjected to the five stages of IPA. The model used to assess the data’s trustworthiness was discussed. Ethical concerns that emerged during the study were examined. The following chapter discusses and interprets the findings in the contexts of the Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework.
CHAPTER FIVE

Findings

5.1 Introduction

The emergent themes are explored within the contexts of the Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework. Each theme is illustrated using quotes extracted directly from the interviews in order to depict the essence of the theme and to present each participant’s voice throughout the research findings. The participants’ accounts are integrated into the two nominated theories of family resilience and where relevant, previous research is cited. The findings of the study are presented in a master table of themes (Appendix E) which comprises the superordinate themes together with their constituent themes and identifiers to indicate which of the participants invoked these responses. The biographical information of each participant, the epistemological and personal reflexivity, the role of the researcher and the assessment of the research have been provided in chapter four and will not be repeated.

5.2 The Family Unit

The first emergent theme that was common to all four participants was the description of the family unit. Any assessment of family resilience requires an understanding of what constitutes a family. These participants described varied family forms which included the participant being the head of the household (entirely or partially by sharing responsibility with another member); the inclusion of extended family members and non-biological children (of the household head) as part of their families and altered parental sub units (either absent or substituted). This finding ties in with Walsh’s (2002a, 2003b) assertion that well functioning families can be found in a variety
of family structures and that it is not family structures that matter but the processes that families engage in when they are faced with adversity. Walker et al. (2004) provided further evidence of varied family forms as has been described in chapter two. Examples from the participants’ accounts, depicting the varied family forms include:

- “She is the first born. She has a sister, and a brother...a younger brother and a cousin at home. And she has an aunt who lives in”
- “…never had a relationship with her father. She was raised by her grandmother and her grandfather. She only met her father in 1995 when the grandmother died”
- “They behave like her (head of household) own kids not like they are brother and sister”
- “We are a big family with my two brothers, my sister’s child and our aunty but she is not staying here, she is at her house with her husband. So ummm...I am the one who is in charge of my brothers and my sister’s child.”
- “I live with my two younger cousins. They don’t have any one else they know, I am their only parent. The neighbour was giving me guidance…”
- “Mother passed away and I am living with two children of my mother...taking them as my own...my aunt...she assists me sometimes. She (refers to community project volunteer) is like a mother to me”

The participants used the term household and family interchangeably to connote a commensal unit, a finding that was evident in another study concerning coping strategies (Agarwal, 1990). The inclusion of individuals who did not belong to a single nuclear family and children who were not off-spring of the head of the household were also observed in previous studies (Ansell & Van Blerk, 2004; UNICEF, 1999). It is inferred from this finding that households are fluid and their
membership changes constantly (Datta, 1998; Dodson, 1998; Izzard, 1985; Murray, 1981). Families are dynamic social units that tend to contract and expand as individual members move through space and the nature of relationships binding them changes (Letuka, Mamashela, Matashane, Mbatha & Mohale, 1994). Having concluded that it is not family structures that matter but the processes that families engage in when faced with adversity (Walsh, 2002a, 2003b), the following section explores these processes from the Resiliency Model of Family Stress, Adjustment and Adaptation.

5.3 The Resiliency Model of Family Stress, Adjustment and Adaptation

This model has been theorised in chapter three and the emergent themes are now linked to the adaptation phase. It is again highlighted that the level of family adaptation is determined by the cyclical interactions of the various components within the four domains of family functioning. Although each component is explored separately, one is reminded about the cyclical influences of individual components on each other.

It was realised that each family was unique as they differed in composition; life stage; the age of the head (upon assuming responsibility); the circumstances prior to and after the initial stressor and the social and cultural contexts within which they resided. At any stage where commonalities are drawn across the participants’ accounts the intention is not to detract from the uniqueness of each family but to highlight the more common processes that families typically engage in.

5.3.1. Pile-up (AA) of Family Demands

McCubbin and Patterson (1983) referred to a pile-up (AA) of family demands to describe an accumulation of sources of stress. The pile-up of demands includes the initial stressor and its related hardships; normative transitions occurring simultaneously to the initial stressor and previous family stressors that have accumulated over time (McCubbin & McCubbin, 1993, 2001;
McCubbin & Patterson, 1983). The initial stressor or family crisis (C) identified from the participants’ accounts refers to the death of the primary caregiver. Two participants reported their mothers as their primary caregivers and it was upon the deaths of their mothers that these participants assumed responsibility for their respective families. Participant C and D reported as follows:

- “I was living with my father’s brother and then I had to come back home to live with my mother because she was sick, then she died”
- “then I was left with my mother and she passed away 2002”

Participant A’s account was unique as she reported that prior to her uncle’s and mother’s deaths, she was responsible for the family. In this case it was difficult to identify the initial stressor as participant A had been heading the household for a while.

- “Even when they (refers to mother and aunt) were still alive, I was looking after everyone because they were drinking and going out”

Participant B on the other hand identified her mother’s death as the initial stressor but qualified that this was compounded by the death of her elder sister, as she and her sister had shared the responsibilities when her mother passed away.

- “It was better when she (sister) was around I never used to cook and I had less work…she (sister) passed away this year January. I can say when my mother passed away it was 1999 but there was my older sister who passed away this year in January”

A related hardship that developed over time and contributed to the pile-up of demands (AA) was that of caring for an ill family member (uncle, mother, sister and nephew). This has been reported by the four participants and involved ensuring that the person took his/her medication; had a bath; had clean, fresh clothes and assisting them with eating and toileting.
• “When my uncle was sick my mother and aunt didn’t know what to do, so I had to take care of him; make sure he had something to eat and wash his clothes for him”

• “…when my sister died I had to take care of her seven year old son and because my sister was HIV positive her son was also, and I had to make sure that he takes his treatment”

• “It was really difficult for me where I used to live I had never seen anyone who was sick and when I had to look after my mother, I didn’t know what to do. I didn’t even know how to help her. When I didn’t know how to take care of my mother because she was HIV positive I decided to come here at Masizakhe and ask for help”

• “I was looking after her. From when she was sick I was looking after her. Since then I was taking care of my mother and the house. I would make sure that her clothes are clean and that everything is fine. I would go to school and come back and do housework and look after my mother and the children”

Literature supported this finding that children’s performance of everyday chores extended to caring for the sick and although caring is usually an adult task, children were often the last resort (Ewing, 2002; Foster, 1996; Loewenson, 1998; O’Grady, 2004; Patterson, 2003; Robson, 2000; Robson & Ansell, 2000).

The participants also reported on the emotional impact of having experienced their family members’ deaths. These families experienced significant emotional distress that perpetuated the family’s vulnerability. A family’s vulnerability is determined by the accumulation of demands on the family unit (McCubbin & McCubbin, 2001). The participants’ accounts revealed emotional difficulties such as emotional connections being broken, sorrow, grief and anger.

• “…And the bond was lost there”
• “(became very tearful and looked down) when my mother died it was very difficult for us to accept her death…it hurts me a lot”

• “Sometimes I feel cross with my mother; every time I think about my mother it makes me really sad and angry…”

• “I cry and ask why God did HE take my mother…feel hurt and it makes me sad…painful not to have a mother”

The emotional impact of AIDS related deaths have been evidenced in the literature (Ewing, 2002; Gow & Desmond, 2002; O’Grady, 2004; Patterson, 2003). Prior to parental death due to HIV/AIDS, the children may experience their parents’ deteriorating physical and mental health. This may create emotional instability and uncertainty. These children eventually experience the psychological trauma of losing their primary caregivers (Ewing, 2002; O’Grady, 2004; Patterson, 2003). In some cases the stress of parental death is compounded by the experience of witnessing multiple deaths (Townsend & Dawes, 2004).

An associated stressor experienced by Participant C was that of the stigma, ambivalence and social isolation that is commonly experienced by HIV affected households.

• “It was very difficult because of the stigma and the neighbouring houses I would hear people talking about my mother and that they suspected that because I was taking care of my mother I was also HIV infected”

• “they didn’t really like me and I didn’t have much friends”

• “I can ask some for help but others are making me feel bad that my mother had HIV…I feel judged by them but few will help me”
Research has shown that vulnerable youth face considerable stigma and social isolation in their communities (Foster, Makufa, Drew, Mashumba & Kambeu, 1997). The remaining participants did not report experiencing social prejudice.

A detour from the normative, adolescent stage of the family life cycle was noted as the participants had to assume responsibility for their families at a young age. A sense of loss of childhood was inferred from the participants’ accounts as follows:

- “even when they (refers to mother and aunt) were alive I was looking after everyone because they were drinking and going out”
- “every time I have to be a parent to my cousin”
- “I was 14 years when my mother got sick; 15 when she died…accept the loss of normal childhood”

Even though the aforementioned quotes do not reflect the obvious reporting of a loss of childhood, the inference of a loss of childhood is drawn as one participant reported caring for her family while the adults were abusing alcohol and another participant reported having to be a parent to her cousin whilst she herself was an adolescent.

As evidenced in the literature it is common for older children to assume parenting roles during a prolonged parental illness due to HIV/AIDS. These adolescents learn responsibility, effective coping mechanisms and nurturing skills (Grodney, 1994; Loening-Voysey, 2002; Townsend & Dawes, 2004). There is some evidence of an increase in the amount of work performed by orphaned children in rural areas of South Africa that are affected by HIV/AIDS (Giese, Meintjies, Croke & Chamberlain, 2003). Participant B did not report the loss of childhood as a potential source of stress. It is speculated that her shared responsibility with her elder sister probably allowed her to experience more of her childhood in comparison to the others.
Unforeseen situational demands and contextual difficulties also contribute to the pile-up of demands (McCubbin & McCubbin, 1993, 2001; McCubbin & Patterson, 1983). The contextual difficulties that added to the pile-up of demands experienced by these families included financial difficulties, unemployment and educational obstacles.

- “When my mother died there was no money to bury her…also struggling financially”
- “had to support two school going kids”
- “my mother was the breadwinner, when she died everything changed”
- “She (mother) couldn’t afford all the things I needed for school”
- “When my mother died she had accounts to pay”
- “it was a bit difficult because the money wasn’t enough for the kids to be able to go to school”
- “The child support grant for everything even the schools”
- “The only problem that we mostly experience is the shortage of money, food and clothes”

Previous studies highlighted that the expenditure patterns of an HIV/AIDS affected household changed in the direction of reduced budgets for education, health care and food for other family members (Ainsworth, Fransen & Over, 1997; Badcock-Walters, 2002; Giese, 2002; Gow, Desmond & Ewing, 2002; Lewis, 2004).

Some of the financial difficulties experienced were funeral expenses, unsuccessful grant applications, school expenses, food, clothes and furniture expenses and outstanding accounts. Although Participant D was also a volunteer worker for the Masizakhe Community Project, she reported only having started there and was therefore not yet eligible for the stipend that the other volunteers received. Consequently, her financial constraints were further extenuated.
• “He (brother) didn’t qualify for foster grant”
• “had to buy furniture”
• “One of my biggest problems was to make sure that my sister’s son gets the grant and he didn’t so it’s very difficult”
• “when my mother died she had other accounts to pay”
• “applied for foster care grant two years ago…still waiting”

Various studies have highlighted the financial predicament of HIV/AIDS affected children (Ainsworth, Fransen & Over, 1997; Foster, 1997; Lewis, 2004; Steinberg, Kinghorn, Soderlund, Schierhout & Conway, 2000; Whiteside & Sunter, 2000; Wilson, Giese, Meintjies, Croke & Chamberlain, 2002). Bray (2003) documented that there was a significant difference between the rate of carers receiving social support grants and the numbers of those who were eligible. It is evident in this study that these adolescent headed families experienced considerable difficulty in accessing social support grants.

The four participants indicated that seeking employment was difficult because they had not completed their schooling and they acknowledged the importance of education.
• “looking for part time jobs”
• “volunteer at Masizakhe”
• “casual at the King Edward Hotel”
• “if I could get a proper job…”
• “don’t get pay…after three months I will get pay”
• “it is very difficult to get a job if you don’t have a qualification. My brother and my nephew must get an education”
• “I want to go to school. Education is important because it is very hard for me to get a proper job”

Literature revealed that many children’s education was interrupted as a consequence of HIV/AIDS and children commonly left school when their parents became sick or died (Ansell & Van Blerk, 2004; Badeck-Walters, 2002; Desmond & Gow, 2002; Foster & Williamson, 2000; Von Donk, 2003).

Previous family stressors that accumulated over time included alcohol abuse that was reported by three participants. The alcohol abuse experienced by these families was not a direct result of the initial stressor but had accumulated over time and increased the family’s vulnerability.

• “because they were drinking”
• “his mother…alcoholic”
• “but the mother would be drinking”
• “My aunt was always drinking and sleeping everywhere”
• “My mother used to drink a lot. She couldn’t afford all the things I needed”
• “I didn’t know my father until he got sick…he was an alcoholic…he used to fight with my mother”

It is interesting that even though Participant C reported experiencing an environment of alcohol abuse, she earned an extra income by selling traditional beer.

• “People come to drink traditional beer…it’s extra income”

Participants A and D, on the other hand, set the rule of “no drinking” in their households.

• “not allowed to drink alcohol…”
• “there is no drinking…”.
Similar to the aforementioned alcohol abuse, another family stressor over time was indicated by two participants who experienced poor maternal figures.

- “Mother would go away with boyfriends”
- “but the mother would be drinking”
- “…she (mother) couldn’t afford all the things I needed”

In addition to the alcohol abuse and poor maternal figures experienced, a social climate of violence and crime, and hardship and suffering was extracted from Participant A’s account:

- “he wouldn’t back off from a fight…stabbed him to death”
- “he was arrested”
- “experienced hardships… didn’t have electricity and food”

A possible stressor that accumulated over time for Participant C was her report of relocating:

- “where I used to live I had never seen anyone who was sick and when I had to look after my mother, I didn’t know what to do…”
- “people used to help me with a lot of things (at uncle’s house) and now that I come to her (mother’s) house I have to do all those things”
- “Because my mother used to drink a lot she couldn’t afford all of the things that I needed for school and I would always go to my uncle to ask him for help and then I decided to ask my mother for permission to go and stay with my uncle”

Movement or migration of children between extended family has been practiced in many societies as it was perceived that a particular household could provide more value to a child (Letuka et al., 1994). A recent study indicated that even when a parent is still alive, another relative might assume responsibility for a child on the grounds that he/she is better able to pay school fees and care for the child (Ansell & Van Blerk, 2004).
It is highlighted that Participant B did not report on any family stressors that have accumulated over time. This may indicate that this family had experienced fewer stressors or it could reflect a sparser account on behalf of Participant B. This section identified the stressors experienced by these adolescent headed families. In the following section the families’ internal resources and capabilities are explored.

5.3.2. Family Resources (BB)

Family resources have been described as tangible/ intangible personal and family system resources (Hanson, McLanahan, & Thomson, 1998; McCubbin & McCubbin, 2001). The resources emerging from the participants’ accounts were both intangible and tangible personal resources, and intangible, family system resources. All four participants reported some kind of financial assistance (tangible resource) either from a family member (aunt); a friend (boyfriend) or a key community figure.

- “(refers to community leader) took it (fridge) for me and I will pay her back”
- “relatives had to give me money”
- “our aunt who doesn’t really live there but supports us financially”
- “my aunt buys the groceries for us for a month”
- “my boyfriend give me R500 every month”
- “aunt was giving me money when my mother died…”

As has been highlighted in chapter two, relatives are an important source of economic support (Barnett & Whiteside, 2002; Haddad & Zeller, 1996; Oni, Okorie, Thabede & Jordan, 2002). It has been documented that South African households in the midst of a financial crisis were more likely to borrow money from relatives and less likely to borrow from banks (Oni, Okorie, Thabede & Jordan, 2002).
Apart from the afore-mentioned financial assistance, these participants also earned some money from the volunteer work at the Masizakhe Community Project. Participant C reported an additional income from the sale of traditional alcohol from her home. Studies have highlighted the adaptive value of adequate financial resources (Raveis, Siegel & Karus, 1998; Walsh, 1998). Families who are able to utilise financial assistance are more resistant to major crises and are better able to restore stability (Raveis, Siegel & Karus, 1998; Walsh, 1998).

The skills of financial discipline that were identified were the ability to budget, the ability to plan for the future, negotiating payment plans and improvising.

- “most of the things are not brand new they are second hand, but she (refers to community volunteer) was always helping to buy stuff. She would take some amount every time from the stipend to pay…”
- “budgeting and grocery shopping; sometimes buy biscuits…”
- “going to have a funeral plan for each dependent”
- “if I have money I buy a present to surprise them”
- “when I have the money from the child support grant I will take them to town and buy all the groceries and the things that we all need”
- “R200 or R150 I am buying food, R50 electricity…”
- “I am taking care of that R50 electricity; it lasts. No TV, no fridge, don’t use the lights for long”

As reported in other research, financial management and sound economic decision making skills contribute to family resilience (McCubbin & McCubbin, 1988; Olson et al., 1989).

The intangible personal resources identified by the four participants included that of spirituality.
• “goes to church…believe in God’s will”
• “God is here…He will take care”
• “because on Mondays, Wednesdays and Thursdays I have to go to church”
• “it is what God wants”
• “I pray to ask God to give her energy”
• “a prayer to rely on”
• “I attend church on Sundays…church is important and at night we pray…God has really helped me”

The participants described a strong faith in God and the church. It has been evidenced that religion and spiritual beliefs can provide meaning and purpose in times of crises (Beavers & Hampson, 1990). Religion may help to bind together the fragments of one’s life, restoring some sense of coherence and meaning (Parrot, 1999). Spirituality provides individuals with the ability to understand and overcome stressful situations (Angell, Dennis & Dumain, 1998). Spiritual resources that enhance resilience include rituals, ceremonies, prayer and religious/congregational affiliation (Angell, Dennis & Dumain, 1998; Walsh, 2003a; Werner & Smith, 1992).

The intangible family system resources that were identified included family organisation, family hardiness, family cohesion, family adaptability, family time together and family routines. A commentary of these resources follows.

5.3.2.1. Family Organisation

Family organisation refers to the agreement, clarity, consistency, fluidity and communication patterns in the family roles and rules structures (McCubbin & McCubbin, 1993, 2001). Participants A and D adopted similar organisational patterns, in that both families described the eldest sibling as the head of the household. As the head of the household, it was the eldest
siblings’ responsibility to nurture, protect and guide the younger members. These two heads of households adopted a strong, authoritative leadership style, a hierarchy between the head and other members was observed and the head was regarded as the newly instituted parental sub unit that would set the rules and discipline the others.

- “*because they are younger, they mess up my things. I always lock my room and have a double bed and the other three share a room*”

- “*they behave like they her own kids not like brother and sister. They respect her*”

- “*her (household head) role is as mother and father*”

- “*she (household head) sets the rules and disciplines them, she does the budgeting…she will tell them today we gonna do this*”

- “*she (household head) doesn’t want the brother and sister to feel like they are a burden so she doesn’t tell exactly how she is feeling…”*

- “*two children of my mother I am taking as my own*”

- “*they are sharing the room, I have my own room*”

- “*they respect me as a mother*”

- “*I set the rules and discipline them…”* 

- “*sometimes I want to tell them about myself and our parents but I know they are really young so I don’t*”

Gordon-Rouse, Longo and Trickett (2000) identified clear boundaries and rules as contributing towards family resilience. As evidenced in chapter three and portrayed by participants A and D, a breadwinner may suppress strong emotional reactions in order to protect other family members while children may stifle their own feelings and needs, in an attempt to help the family (Walsh, 1999, 2002a, 2003b).
Participant B reported sharing the responsibilities with her elder sister until her sister’s death. Thereafter she assumed responsibility for the family but was assisted by her aunt and adopted an ‘equal partners’ approach with the other family members. A co-operative, sharing and equal relationship was observed in this family.

- “*when they don’t want to help me at times I just tell my aunt and she will discipline them*”
- “*it was better when she was around I never used to cook and I had less work, it was easier to help each other*”
- “*it was us who decided to do that (take turns to do the work)*”

If the four participants were placed on a continuum of family organisation, participant C would be placed somewhere in-between the strong, authoritative patterns of participants A and D and the equality of participant B. This is speculated as participant C assumed responsibility for her family and became a parental figure for the younger members but did not display the strong, authoritative characteristics that were evident in participants A and D. Similar to participant B she also received guidance and assistance from her neighbour. Conger and Conger (2002) stated that affective (warmth and nurturance) and structural (rules and consequences) support to family members facilitate competent family functioning.

- “I take her like my big sister, because if I need something I go to her (neighbour)”
- “I tell them it is just us, we depending on each other…”
- “they always listen to me…parental guidance”
- “I am the one who handles the money…”
The communication processes that the families engaged in contributed to the families’ organisation. These included open communication, understanding, listening and an open expression of feelings.

- “all sit and talk when they have a problem, talk things through and understand each other…”
- “Brother understands that she can’t”
- “they always listen”
- “they make sure they do listen…to make the right decision”
- “we can talk openly, sometimes I talk to my friends about my problems, sometimes I talk to my brothers”
- “brothers are understanding when we don’t have something”
- “we sit down and talk, we can also cry…”
- “They do understand because I would tell them about the situation”
- “they always listen to me” “…they also want to be listened to…they see me cry and they will ask what is wrong…they come to me openly with problems”
- “because I tell them and I make them understand”
- “we just sit and talk…they can talk to me openly”
- “every time I cry I feel so much better, like something is out”

Although all the participants reported an open expression of feelings, one is alerted to the contradiction in Participant A and Participant D’s accounts. They initially reported suppressing strong emotional reactions in order to protect the younger family members. Thus, open emotional expression was one sided. Clear, open and direct communication amongst family members and empathy and tolerance of differences are essential factors that increase a family’s resilience.
(Bloch, Hafner, Harari & Szmukler, 1994; Walsh, 1998). Also, communication facilitates the comprehensibility of a crisis (Walsh, 1998). Diverse authors have pointed to the importance of communication in fostering well-being (Hawley & De Haan, 1996; McCubbin, McCubbin, Thompson, Hanson & Chad, 1997; Silliman, 1995).

5.3.2.2. Family Hardiness

Family hardiness is the family’s sense of control over the outcomes of life events and its orientation to stressful situations (McCubbin & McCubbin, 1993, 2001). Participants A and D reported an internal motivation over life events as follows:

- “Motivates herself”
- “there is no one you can blame, you will take decisions”
- “up to you to take the advice”

On the other hand, participants B and C provided evidence of an external locus of control:

- “I don’t blame anyone…a passage that I have to go through”
- “whenever something happens we know it was supposed to be like that, it is what God wants, God’s plan that it happens like that”
- “it is difficult for me because I blame my mother for dying on me”

Participants A, B and C described a positive orientation to stressful situations and participants B, C and D reflected on adopting acceptance, love and unity in response to their life situations.

- “Don’t have to worry about the things they don’t have but have to make the most of what they have…if we want to do it we do know where to go”
- “yes we can because we are not looking back at what has happened we are looking to our future positive”
“and to tell yourself that you would be able to do this and that and nothing is impossible and everything will be ok”

“respect and working together will help child headed households to accept what she has to do and love what she has to do and not do it because she has to”

“I am learning to accept and I know that I am not the only one and not the first one and I wanna be strong for the younger ones”

“accept the loss of childhood and accept the way things have turned out”

Walsh (1998) emphasised the importance of the family finding meaning in a crisis. The broad characteristic of family hardiness as an important resilience factor has been identified in previous studies (Anderson, 1998; Drapeau, Samson & Saint-Jaques, 1999; Linker, Stolberg & Green, 1999; Walsh, 1998).

5.3.2.3. Family Cohesion

Family cohesion refers to the bonds of unity within the family and the support, integration and respect shown amongst its members (McCubbin & McCubbin, 1993, 2001). A noteworthy observation was that participant D did not provide any descriptions that referred to a sense of belonging or family cohesion. However, she did report on respect within the family and a certain level of support and unity amongst family members.

“they help me sometimes…the one knows how to sweep, the other washes the socks”

“they respect me as a mother”

The remaining participants presented a strong sense of cohesion, sense of belonging and considerable support and unity amongst family members.

“all living there with the aunt and everyone else”

“no such thing as half brother or sister…have the same mother…not separated”
• “...it is a family home”
• “brings the family closer together when they share a birthday”
• “already support each other...help each other out”
• “we can rely on each other...”
• “I didn’t mind because they are my brothers, they are family”
• “we also go together when we have to go somewhere with the church...meals together”
• “but we all sleep in one room because the others are scared to sleep there and we like to talk at night”

Previous research (Barnard, 1994; Garvin, Kalter & Hansell, 1993; Hawley & De Haan, 1996; Sigelman & Shaffer, 1995; Walsh, 1998) confirmed support amongst family members as a resilience factor. Family members who feel supported by other family members show greater competence in dealing with problems (Johnson, 2000). Family cohesion has been identified as a prominent family resource together with family flexibility or adaptability (Hawley, 2000; McCubbin & McCubbin, 1993; Mederer, 1998).

5.3.2.4. Family Adaptability

Family adaptability refers to the family’s ability to shift course (McCubbin & McCubbin, 1993, 2001). Throughout their accounts, the four participants demonstrated their families’ ability to shift course. For example, participant A reported on accommodating various family members in their home on different occasions for long periods of time and participant B reported on other family members continuing her chores when she had other commitments to attend to.

• “so now there is the cousin, they have to share”
• “didn’t really have problems...grew up together so we are familiar”
“If I am not finished my 14 year old brother will finish the cooking; make sure my nephew gets his medicine”

Family adaptability has been described as an important component of family resilience (Hawley, 2000; McCubbin & McCubbin, 1993). Family adaptability or flexibility is the degree to which the family is able to change roles, rules and boundaries (McCubbin & McCubbin, 2001). This refers to maintaining a flexible balance between stability and change in order to maintain a stable family structure (Beavers & Hampson, 1993; Walsh, 1998).

5.3.2.5. Family Time Together and Family Routines

These two family system resources are indicators of family integration and stability (McCubbin & McCubbin, 1993). Using this as a guide it was inferred that these four families exhibited a high family integration and stability as the four participants described numerous family time together activities and family routines.

- “they like to visit…”
- “they all can sit and talk”
- “Hiring movies and sit and watch together”
- “brother and sister will prepare for school…sister cleans the house and I will come here (Masizakhe)”
- “wash the clothes and take turns cooking”
- “We are usually watching television before going to bed”
- “…shopping for clothes together and we have our meals together”
- “we like playing outside together sometimes they will play dolls…everybody just plays and have fun”
- “on mother’s day we go to my mother’s grave and ask her to guide me through”
• “they are playing at home with me”
• “…talk about the things they did at school”
• “we celebrate birthdays, we buy cake but if we don’t have money we just sing…we celebrate Christmas”

Daily routines can provide the family members with regular contact and order (Hochschild, 1997) and rituals bind the family together (Imber-Black, Roberts & Whiting, 1988). Family members’ participation in household chores and frequent contact with each other are contributing factors to family resilience (Gordon-Rouse, Longo & Trickett, 2000). Appendix F provides a summary table of the families’ resources linking each to identifiers and emergent themes. Having explored the families’ internal resources and capabilities, attention is now shifted to the families’ external support systems.

5.3.3. Social Support (BBB)

The social support resources that were available to these families included community support (Appendix F). They received support from the extended family, friends, community members, the Masizakhe Community Project and other institutions. Madhavan (2004) reported that while social support may be available to orphaned and vulnerable children, the evidence of it is lacking. Garvin et al. (1993) identified the availability of social support as a key factor in family resilience.

The participants’ accounts reflected partial assistance from the extended family. Participant A reported that she was raised by her grandmother (who passed away); her relatives contributed financially towards her mother’s funeral expenses and she identified a relative that they could turn to for help. However, she expressed disappointment that the other relatives did not visit.

• “Relatives had to give money”
• “Took her to the grandmother…raised by the grandmother”

• “expects other relatives to visit and see if they ok, they don’t”

It has been documented that relatives sometimes do not provide the care that children need or want (Ali, 1998; Ansell & Van Blerk, 2004).

Participant B indicated that her extended family played an active role in their lives by visiting; providing them with clothes and money and assisting with her nephew.

• “my family in Zwide, my cousin will bring something for my nephew, she does help us at times…what she buys for her children she will buy for us”

Many young heads of households reported close ties with their extended families (Foster et al., 1997). Barnard (1994), Reed and Sherkat (1992) and Walsh (1998) provided evidence that the support from relatives and friends made it easier for the family to adapt after a crisis. Families who are able to mobilise and utilise social support are more resistant to major crises and are better able to restore stability (Raveis, Seigel & Karus, 1998).

Participants C and D appeared to be disregarded by extended family because there were either no existing relative to assist them or those that were in a position to provide support experienced resistance from their own nuclear families. Also, geographical distances inhibited the extended family’s involvement or the extended family shirked responsibility (as in participant C’s case).

• “my aunt she is here, I don’t even know where she is and she doesn’t even come visit…she doesn’t check if we ok”

• “the other family are not so close because they live far from here”

• “aunt assists sometimes…don’t always come; her husband is not supporting her to help us; he gets angry”
Other studies also provided evidence of orphaned and vulnerable children being neglected by their relatives (Ayieko, 1997; Walker, 2002). The stigma associated with HIV/AIDS is such that children orphaned by HIV/AIDS are at risk of being turned away by extended families who are fearful of the consequences of caring for them (Freeman & Nkomo, 2006; Giese, 2002; Harber, 1998; Kelly, 2003).

The support offered by friends and community members were evidenced in all the participants’ accounts, except for that of participant D.

- “does have people she can turn, people in the community…feels safe and secure, they will help her and she will help them”
- “can ask for help in my community”
- “I talk to my friends”
- “She (community project volunteer) and my boyfriend helped me”
- “my neighbour, that I give him (baby) to her to look after”

Ledward and Mann (2000) provided evidence of adolescent headed families having supportive relationships with peers and unrelated community adults. It has been suggested that the availability of caring adults to serve as mentors and peer connections is likely to promote resilience (Masten & Coatsworth, 1998). This finding is evidenced by the participants’ accounts of receiving support from the Masizakhe Community Volunteers. Participant D reported that she would not ask for other people’s help (except from Masizakhe) and that she did not need friends. However, she reported utilising the neighbour’s resource and she qualified this by asserting that:

- “my neighbours are helpful only with storing food in the fridge”
The Masizakhe Community Project had been extensively mentioned by all the participants for variable support such as child care services, income, emotional support and role models. One questions whether the participants’ volunteer work with the project has influenced this finding.

- “working here as OVC (Orphaned and Vulnerable Children) volunteer”
- “attending here at OVC” (refers to the younger children who attend the after school care programme at Masizakhe)
- “Masizakhe and the people here will help with a lot of things”
- “after school they are going home, then they are coming here (Masizakhe) for after school care”
- “they come to OVC. Here in OVC maybe if they get homework they will help them”
- “I would come to ask for help in between, I would ask them how to look after my mother”
- “I can count on them (Masizakhe) to give me proper advice”

Community based initiatives similar to the Masizakhe Community Project have proliferated in the absence of systemic support initiatives by government structures (Ogden, Elsim & Grown, 2004). Communities have established initiatives to assist orphans and families affected by HIV/AIDS by providing home-based care, food, educational and healthcare assistance (World Bank, 1993). Community based social support has been described in chapter three as a valuable factor in family resilience (McCubbin & McCubbin, 1998; Reed & Sherkat, 1992; Walsh, 1998).

Participant C indicated receiving favourable assistance from a social worker, in contrast to participant D’s account.

- “There has been a social worker... because my younger cousin was sick...told them what our problems are”
• “social worker came when I was 15 years...said we must wait...no help; not understanding my problems”

It has been suggested that when family help is high, people rely less on associational and organisational help (Wilkinson-Maposa, Fowler, Oliver-Evans & Mulenga, 2005). As has been outlined in chapter two, some of the South African government’s attempts to provide support to HIV/AIDS affected households included the provision of formal safety nets to alleviate poverty through employment creation, to offer free basic education and health care, community development programmes, feeding schemes and grants (Foster, 2007). However, as is evidenced from the findings in this study, the participants had to mobilise around community initiatives like the Masizakhe Community project in order to receive similar services.

Evidence contrary to this was provided in a study of child headed households in Zimbabwe, where it was indicated that one of the obvious characteristics of these households was their social isolation (Roalkvam, 2005). It was documented that child headed households appeared to be invisible to their kinsmen, to the community surrounding them and to the state and that there were no effective relationships, social networks or groups that the children could rely on for support (Roalkvam, 2005). Unlike the evidence presented in the afore-mentioned Zimbabwean case, the findings of the present study reflect the involvement of community members in the lives of adolescent headed families. These findings highlight social support as a resilience factor.

5.3.4. Appraisal Processes

Thus far the internal family resources and social support systems that were available to these adolescent headed families were examined. In this section the families’ appraisal processes are explored. These appraisal processes include schema, coherence, paradigms, situational appraisal and stressor appraisal.
5.3.4.1. Family Schema

The components influencing the family schema included internal motivation, external locus of control and spirituality. These three dimensions have been examined in section 5.3.2.2. (Family Hardiness) and are therefore mentioned briefly.

- “I don’t blame anyone…a passage that I have to go through”
- “whenever something happens we know it was supposed to be like that, it is what God wants, God’s plan that it happens like that”
- “it is difficult for me because I blame my mother for dying on me”

The component of respect has been outlined in section 5.3.2.3. (Family Cohesion).

- “they behave like they her own kids not like brother and sister. They respect me”
- “respect and working together will help child headed households to accept what she has to do and love what she has to do and not do it because she has to”
- “they respect me as a mother”

The integration of values into the family schema was evident in participants A and D’s accounts. Participant A reported on the value of Xhosa traditions and participant D mentioned integrating values that her mother had imparted to her.

- “That’s how the Xhosa people are…respect the elders”
- “there is a Xhosa saying…”
- “my mother told me that I must work very hard…so I look”
- “the church instills moral values”

As has been evidenced by the participants’ accounts, a family’s schema creates the family’s unique character. The schema is formed by the family’s cultural and ethnic beliefs and values as well as the convictions and expectations that the family may have created and adopted over time
(McCubbin & McCubbin, 2001). Families who revealed a strong schema emphasised their investment in their shared family unit, and their shared values and goals (McCubbin & McCubbin, 1993).

5.3.4.2. Family Coherence

The families’ coherence ranged from an internal motivation (participants A and D) to an external locus of control (participants B and C) and participants A, B and C presented evidence of a positive outlook. A family’s coherence is its ability to perceive the world and life as manageable, comprehensible and meaningful. It is described as the motivation and appraisal to transform the family’s potential resources to actual resources (Antonovksy, 1987).

- “Don’t have to worry about the things they don’t have but have to make the most of what they have...if we want to do it we do know where to go”
- “yes we can because we are not looking back at what has happened we are looking to our future positive”

Coherence assumes qualities such as acceptance, loyalty, pride, respect and shared values (Marsh et al., 1996) and was indicated in the participants’ responses:

- “we can rely on each other…”
- “they behave like her own kids not like brother and sister. They respect me”
- “respect and working together will help child headed households-accept what she has to do and love what she has to do and not do it because she has to”

Several researchers (Antonovksy & Sourani, 1988; Garvin, Kalter & Hansell, 1993; Hawley, 2000; McCubbin & McCubbin, 1988; Sagy & Antonovksy, 1998) have indicated that families with a stronger sense of coherence adapt better to a crisis. In the Resiliency Model of Family Stress, Adjustment and Adaptation a relationship is assumed between a family’s sense of
coherence and their adaptation to a crisis (Anderson, 1998; Antonovsky & Sourani, 1988; McCubbin & Patterson, 1983). A family’s coherence is an important predictor of family resilience (Anderson, 1998; Antonovsky & Sourani, 1988; McCubbin & Patterson, 1983).

5.3.4.3. Family Paradigms

The family’s paradigms are shared expectations and rules which are created and adopted by the family unit to inform its development and functioning (McCubbin & McCubbin, 1993, 2001). Important contributions to the families’ paradigms included the need to complete schooling in order to seek employment; respect for elders; each family member abiding by the rules of the household and performing their assigned tasks. Participants’ accounts of these have been highlighted earlier and are not repeated here. Rules regarding discipline were noted and the shared expectations of family members’ participation in celebrations and family rituals were also observed. Reiss (1981) cited the role of rituals in maintaining and perpetuating a family’s paradigm.

- “I set the rules and discipline them…”
- “we celebrate birthdays, we buy cake but if we don’t have money we just sing…we celebrate Christmas”
- “on mother’s day we go to my mother’s grave and ask her to guide me through”

5.3.4.4. Situational Appraisal

The family’s schema, coherence and paradigms will influence the family’s situational appraisal. The family’s ability to assess its capabilities and resources against the consequences and the impact of the stressor will influence the family’s appraisal of the situation (McCubbin & McCubbin, 1993, 2001). Since participant A reported a positive outlook and an internal motivation, it can be speculated that this family will have a more positive situational appraisal.
Although participant D did not report a positive outlook, her account of internal motivation and unity, acceptance and love in dealing with life’s events, placed her family in line for a positive situational appraisal. Participants B and C presented with an external locus of control. However they embraced a positive outlook which included unity, acceptance and love. Theoretically, these components contribute towards a positive situational appraisal. An additional advantage was that all four participants were able to identify their limitations (refer to Appendix E–Identified deficits), a quality that enhances the family’s situational appraisal.

5.3.4.5. Stressor Appraisal

The stressor appraisal is the family’s definition of the stressor and its severity (McCubbin & McCubbin, 2001; McCubbin & Patterson, 1983; McKenry & Price, 1994). The sub themes of a positive outlook and unity, acceptance and love stand testament to the participants’ appraisal of the initial stressor. Based on this, it may be concluded that these families defined their stressors as manageable and comprehensible. The families’ appraisal of the stressor has been cited as a critical component in predicting family adaptation (McCubbin & Patterson, 1983; McKenry & Price, 1994). Having outlined the families’ appraisal processes, it is appropriate to consider the strategies that they adopted in eliminating or reducing the impact of the stressors.

5.3.5. Problem Solving and Coping (PSC)

The four participants displayed a range of problem solving and coping strategies. Participant A reported learning from her own experience of hardship and therefore attempting to provide a better life for her family members whilst participant C reported learning from the experience of raising her cousins. With regards to planning ahead, this was mostly in terms of finances (for example, funeral plans and budgeting for Christmas). The four participants reported being open to new ideas such as learning from and applying concepts from workshops (for example, the memory box) and supporting family members on new ventures. They also acknowledged that
people would advise them but the ultimate decision resided with them as a family (informed decisions). Participants A and D made decisions on behalf of their families whilst participants B and C collaborated with their family members (joint decision making). Stress reduction strategies included exercising, sharing with friends, counseling from the community project, journaling and keeping memory boxes. The technique of memory-box making is used in informal settlements and rural communities to enhance resilience in vulnerable children and especially orphans who are affected by HIV/AIDS (Memory boxes help to say goodbye, 2004; Morgan, 2004).

The problem solving and coping strategies adopted by these families shape their situational appraisals and family schemas (McCubbin & McCubbin, 1993, 2001). Thus far each family’s vulnerability or pile-up of demands has been explored. This was followed by an expansion of each family’s internal resources, social support systems, appraisal processes and problem solving and coping strategies. One is reminded about the cyclical interaction of these components. Having defined each family’s crisis and having explored each family’s resources and responses to their unique challenges, it is now appropriate to ascertain the outcome of this cyclical interaction of components.

5.3.6. Level of Adaptation

In this study it was difficult to ascertain the level of adaptation for each family as all the data was gathered from semi structured interviews. The qualitative nature of the data did not allow for a measure of family functioning. However, one can speculate that since these families have engaged primarily in adaptive processes, they have attained a reasonable level of bonadaptation. This speculation is based on the fact that these families have provided evidence of responding to their respective pile-up of demands (AA) by utilising their family’s resources (BB); by mobilising their social support systems (BBB); by displaying positive appraisal processes (CC; C) and by implementing problem solving and coping strategies (PSC).
This section has linked the emergent themes to the theoretical components of the Resiliency Model of Family Stress, Adjustment and Adaptation. The following section examines these themes from the Family Resilience Framework.

5.4 Family Resilience Framework

This section utilises Walsh’s (2003a, 2003b) Family Resilience Framework to explore the key processes that the families engaged in, in response to adversity. The pile-up of demands (AA) as outlined in the previous section refers to the adversity faced by these families and incorporates ecological and developmental dimensions of family stressors. The key processes include family belief systems, organisational patterns and communication processes.

5.4.1. Family Belief Systems

Family belief systems influence how the family views crises and helps members make meaning of crises situations, facilitate a positive outlook and offer transcendental learning (Walsh, 2003a; Wright, Watson & Bell, 1996). Similar to the concept of family belief systems, the Resiliency Model refers to a family’s hardiness and a family’s appraisal processes which include schema, coherence, paradigms, situational appraisal and stressor appraisal. The participants’ accounts reflected their family belief systems as follows:

- “but she motivates herself that God is here and He will take care of her”
- “there is no one you can blame, you will take the decisions”
- “don’t have to worry about the things they don’t have but make the most of what we have”
- “yes we can because we are not looking back at what has happened, we are looking to our future positive”
“respect and working together”

“They respect her and they behave like they are her own kids not like they are brother and sister…”

Literature provides evidence that resilient families approach adversity as a shared challenge and maintain a positive outlook in coping with the stress (Seligman & Csikszentmihalyi, 2000; Walsh, 2003a). Also, as has been evidenced by the participants’ accounts, most families find strength, comfort and guidance in adversity through connections with cultural and religious traditions (Angell, Dennis, & Dumain, 1998; Walsh, 2003a; Werner & Smith, 1992).

5.4.2. Organisational Patterns

The organisational patterns which contribute towards resilience are flexibility, connectedness and social and economic resources (Walsh, 2003a). Flexibility has been identified as a core process in resilience and was described as bouncing forward and changing to meet new challenges (Walsh, 2002, 2003b). Parallel to flexibility is the concept of family adaptability as defined by the Resiliency Model. The Resiliency Model also indicated family flexibility as one of the dimensions of the Resilient Family Type (T) (McCubbin & McCubbin, 2001). Flexibility has been illustrated in the participants’ accounts:

• “the other cousin wasn’t staying there before, so the two beds were for the sister and the brother. Now there is the cousin, so they have to share”

• “I think we have coped, I didn’t even know how to prepare them for school…but I know what to do and even if we have a problem I know we can cope”

• “didn’t really have problems…grew up together so we are familiar”

• “If I am not finished my 14 year old brother will finish the cooking; make sure my nephew gets his medicine”
• “we decide together what to eat, if someone feels like eating something then they will say please cook this”

Connectedness refers to the mutual support, collaboration, and commitment to facing challenges together (Walsh, 2003b). The family cohesion component of the Resiliency Model also addresses connectedness. Daily routines and rituals make important contributions to a family’s connectedness (Hochschild, 1997; Imber-Black, Roberts & Whiting, 1988).

• “we celebrate birthdays, we buy cake but if we don’t have money for cake we just sing…”

• “we celebrate Christmas, we wear new clothes and have some nice food”

• “we like playing outside together…”

• “we talk about their dreams and what profession they want to do when they older”

• “I didn’t mind because they are my brothers. They are family”

• “she is blessed by the way that they behave and the way they support her”

• “they already support each other whatever the other is enjoying doing…they help each other”

Social resources that enhance resilience include practical and emotional support offered by community members, role models and mentors and participation in community groups and religious congregations (Reed & Sherkat, 1992; Walsh, 1996, 2003b). One of the economic resources that foster resilience is the financial security that is offered by family members, the extended family, community groups and social services (Walsh, 2003b). Similarly, the Resiliency Model refers to the broad component of social support.

• “she (refers to community project volunteer) was always helping her to buy stuff”

• “there is a relative who she can talk to…turn to the community project for help”
• “she can turn to people in the community; she feels safe and secure that they will help her and she will help them”

• “she can talk to a friend who had a similar problem”

• “Masizakhe and the people here will help with a lot of things because if it wasn’t for them I wouldn’t be able to help my brothers out and do a lot of the things”

• “the relatives had to give her money”

• “because my aunt buys the groceries for us for a whole month”

• “if it is urgent I will go to one of the ladies at the church”

5.4.3. Communication Processes

Communication processes facilitate resilience by clarifying crises situations and by encouraging open emotional expression and collaborative problem solving (Bloch, Hafner, Harari & Szmukler, 1994; Walsh, 2003b). Whilst Walsh (2003a, 2003b) highlighted communication processes, the Resiliency Model refers to the communication processes that contribute to the family’s organisation and to the problem solving and coping skills.

• “the brother understands that she can’t give him money because the cousin is here and she also has to give the cousin money”

• “they all can sit and talk when they have a problem, they have to talk things through and understand each other”

• “they always listen and respect”

• “the brothers are understanding when we don’t have something”

• “doesn’t want the brother and sister to feel like they are a burden so she doesn’t tell them exactly how she is feeling…they can talk to her openly if they have emotional problems”
• “I just take a walk and talk to friends and forget about the problems”
• “by talking about her problem she received help”
• “we can talk openly, sometimes I talk to my friends about my problems. I sometimes talk to my brothers”
• “we try to solve a problem until we have an answer. We sit down and talk. We can also cry but we solve it”
• “I went for counseling here (Masizakhe). We all went for counseling”
• “I see a problem as that. A problem that has to be solved”
• “but I write in my journal and my memory box and when they are older I will show it to them”
• “they come to me with their problems openly; we can talk about it”
• “we are open to new ideas and we try out new things”

Clear and congruent messages facilitate effective family functioning whilst ambiguity and secrecy may block understanding and mastery (Imber-Black, 1995; Raveis, Siegel, & Karus, 1998; Walsh, 2003a, 2003b). Shared acknowledgement of reality and its circumstances fosters healing (Walsh, 2003a). It has been documented that a breadwinner may suppress strong emotional reactions in order to protect other family members (Walsh, 2003a, 2003b). This finding emerged in two participants’ accounts. Resilient families are able to share their feelings openly, comfort one another, find moments of pleasure and humour and are able to shift from a crisis-reactive mode to a proactive stance (Gilbert & Smart, 1992; Walsh, 2003a).

Evidence of similarities and areas of overlap exist between the Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework, both theoretically as outlined in chapter three and practically as evidenced by the conceptualisation of the emergent
themes according to these two theories. This conceptualisation not only provides evidence of adaptive processes within the adolescent headed families but also enhances the validity of the findings.

5.5 Conclusion

This chapter linked the emergent themes to the theoretical components of the Resiliency Model of Family Stress, Adjustment and Adaptation, highlighting the adaptation phase. These themes were further linked to the key processes offered by Walsh (2003a, 2003b) in the Family Resilience Framework. The concluding chapter addresses the limitations of this study and provides future recommendations.
CHAPTER SIX
Conclusions, Limitations and Recommendations

6.1 Introduction

The present chapter provides conclusions of the findings as they relate to the objective of the study. The contributions and limitations are outlined and recommendations for future research are provided.

6.2 Conclusions Based on the Present Study

The aim of the research was to explore and describe the resilience of HIV/AIDS’ adolescent headed families. For the purpose of this study family resilience was described as the processes by which families are able to adapt and function competently following exposure to significant adversity (Patterson, 2002).

The adversity experienced by these families was a combination of having experienced the deteriorating health of family members, having to care for ill family members and ultimately experiencing multiple deaths within their families. These stressors have also been highlighted in the literature (Ewing, 2002; Foster, 1996; Loewenson, 1998; O’Grady, 2004; Patterson, 2003; Townsend & Dawes, 2004). This was compounded by contextual difficulties such as financial problems, employment difficulties and educational barriers; a finding that is consistent with other studies (Ainsworth, Fransen & Over, 1997; Badcock-Walters, 2002; Giese, 2002; Gow, Desmond & Ewing, 2002; Lewis, 2004). Some families experienced a social climate of violence, crime, inconsistent mothering, alcohol abuse, relocations and the stigma associated with HIV/AIDS which was also evidenced in the literature (Smart, 2000; Whiteside & Sunter, 2000). Despite their adversity, these families engaged in adaptive processes.
The findings indicated that these adolescent headed families were generally functioning competently. This conclusion was drawn from the adaptive processes that were observed in the participants’ accounts and that were subsequently integrated into the two nominated family resilience frameworks. The adaptive processes that have been identified are summarised according to the Resiliency Model of Family Stress, Adjustment and Adaptation and the Family Resilience Framework.

The first important adaptive factor was intrafamilial strengths (Family resources BB) which were indicated by the high family cohesion, increased family adaptability, family organisation and family hardiness. Intrafamilial strengths were observed across the four families. Family cohesion was evidenced by the family members’ support and unity in their daily lives, their sense of sharing and belonging and their accounts of family time together, family rituals and family celebrations. This concept relates to the organisational pattern of connectedness as outlined in Walsh’s (2003a, 2003b) Family Resilience Framework. Family cohesion and family adaptability have been cited as integral adaptive factors in response to a crisis (Hawley, 2000; McCubbin & McCubbin, 1993; Mederer, 1998).

Family adaptability was accounted for by their varied family forms, their continuation of household chores in the absence of the head member and their ability to prioritise the family units’ resources fairly according to the urgency of individual member’s needs. This describes the flexibility of the family as referred to in the Family Resilience Framework.

Family organisation was depicted in their family roles and rules and their communication patterns. This ranged from an authoritative leadership to a shared, co-responsibility. The reversal of roles and multiple roles being assumed by the eldest siblings have been cited in the literature (Conger & Conger, 2002; Gordon-Rouse, Longo & Trickett, 2000; Gow & Desmond, 2002).
Communication patterns included open communication, understanding, listening and expressing feelings. These communication patterns are essential for a family’s resilience (Bloch, Hafner, Harari & Szmukler, 1994). It was noted that in the two families where authoritative leadership dominated, the expression of feelings were one-sided as the heads of the family expressed a need to protect the other family members from their own emotion. Walsh (1998, 2003a, 2003b) also referred to communication processes as key factors in family resilience.

Family hardiness was depicted in their appraisal processes that ranged from internal motivation to an external locus of control, a positive, accepting, loving and united orientation to life events and a heightened sense of respect amongst family members. This relates to the belief systems as outlined in the Family Resilience Framework. Family hardiness as an important resilience factor has been evidenced previously (Anderson, 1998; Drapeau, Samson & Saint-Jaques, 1999; Linker, Stolberg & Green, 1999; Walsh, 1998).

The second most prominent adaptive factor was the assistance received from the community project. The social support (BBB) provided by this project included employment opportunities, emotional support, guidance on parenting and caring for HIV infected individuals, services such as after school care, network support (sense of belonging) and the provision of role models. Garvin et al. (1993), McCubbin and McCubbin (1993; 2001), McCubbin and Patterson (1983) and Walsh (1996) provided evidence of social support as a key factor in family resilience.

The reliance on extended family for support was partial. Some families indicated a strong involvement of extended family whilst others expressed disappointment in extended family. It was noted that in the case of extended family involvement, it was primarily as a source of financial support. Previous studies have highlighted the adaptive value of financial support (McCubbin & McCubbin, 2001; Raveis, Siegel & Karus 1998; Walsh, 1998).
Friends and other community members were also significantly mentioned as a source of social support. Support from relatives and friends have been implicated in an easier adaptation to a crisis (Barnard, 1994; Reed & Sherkat; 1992) whilst some studies provided competing evidence (Ansell & Van Blerk, 2004; Ayieko, 1997; Walker, 2002). Social and economic resources have been outlined in the Family Resilience Framework as an organisational pattern of family functioning.

The families’ appraisal processes that contributed to resilience included a schema (CCCCC) that was influenced by respect, spirituality (Angell, Dennis & Dumain, 1998; Beavers & Hampson, 1990), a positive outlook, an internal motivation vs. external locus of control and an integration of cultural and parental values. The families exhibited a positive sense of coherence (CCCC) that was governed by a positive, loving, accepting and united approach to life. A strong sense of coherence fosters resilience (Antonovsky & Sourani, 1988; Garvin, Kalter & Hansell, 1993; Hawley, 2000; McCubbin & McCubbin, 1988). The families’ paradigms (CCC) included shared expectations and rules regarding daily tasks, family time, family rituals and celebrations. These families also displayed positive situational and stressor appraisals that were influenced by the afore-mentioned family schema, family coherence and family paradigms.

The four families employed various problem solving and coping mechanisms such as learning from experience, being open to new ideas, planning for the future and making collaborative, informed decisions. Other strategies included stress reducing activities, remaining solution focused and utilising social support resources. Based on the adaptive processes that have been summarised, it was deduced that these adolescent headed families displayed considerable resilience in the face of adversity.
6.3 The Value of the Research

The present research was a response to the shift from the pathogenic orientation to salutogenesis in the field of social and health sciences and was also a response to the call for more studies on family resilience. This research makes valuable contributions to the positive psychology paradigm as it has conceptualised the impact of HIV/AIDS on adolescents from a strengths-based perspective.

Furthermore, it provides insights into the resilience of adolescent headed families and provides a generic framework for the resilience that exists within these families. This exploratory study provides points of departure for future research in the field of HIV/AIDS and Family Resilience. It also contributes to the growing body of research and literature of family resilience studies in South Africa.

Findings from this study generated information that may inform intervention strategies to promote family resilience, identified problems experienced by HIV/AIDS’ adolescent headed families and affirmed the existing efforts of these families. The findings generated will also provide guidance for the development of specific intervention programmes by the Masizakhe Community Project in order to assist these families further.

This research has afforded the participants an opportunity to narrate their stories and most of them expressed the therapeutic value of the interviews. The participants received feedback regarding the findings and this aimed to increase the participants’ awareness of their own risk and protective factors. It may have empowered them to identify and change unsuccessful patterns of family functioning that are detracting from their resilience by adopting more adaptive processes.
6.4 Limitations of the Research

There are various limitations to the present study. Due to the qualitative nature of the study and the use of semi structured interviews, a measure of family resilience could not be obtained. Also, the emergent adaptive processes could not be subjected to parametric procedures in order to identify significant relationships. The study was qualitative in nature and does not have the competency to declare statistical validity of the findings. However, it is acknowledged that this was not the aim of the present study and that the use of qualitative research was appropriate in addressing the aim. Thus, the strength and limitation of the qualitative research is acknowledged.

Due to the small sample size and the purposive sampling strategy that was employed, the sample was not representative of the general population. Therefore, the conclusions drawn from this study are not representative of the larger population of adolescent headed families. Again, it is highlighted that the aim was to explore and describe the resilience of adolescent headed families within the Masizakhe Community Project.

There is a limitation attached to collaborating with a specific organisation and concerns of sample bias were raised. All the participants were receiving services as well as volunteering at the Masizakhe Community Project. Furthermore, only female heads of households were approached for this study. The key role player seemed uncertain whether any male household heads had been approached and was also uncertain whether any male household heads were affiliated with Masizakhe. The sample was further limited in that only project volunteers were recruited and non-volunteers (if there were any) were not approached. This constrained sample may have influenced the findings somewhat.

Some difficulty in terms of language was experienced. At times the participant shared volumes in her response yet the translator reduced it to a few sentences. However, these translations were verified upon transcription by the independent translator. Also, in the first
interview the translator did not translate in the first person and this made it difficult to follow her conversation. These difficulties highlighted the reliance of qualitative methods on language. The emerging phenomenon may have been represented differently, had the study been conducted and written up in one language.

The emotional impact of the participants’ accounts on the translator and the interviewer was also acknowledged. This led to the question of why debriefing sessions for the translators and the interviewer were not included in the design. This limitation was accommodated during the research process by arranging debriefing sessions when the need arose.

Phenomenological research relies to some degree on the ability of the researcher to adequately describe results. The study is therefore limited by the researcher, whose ability to describe emerging results may have filtered some of the richness of the phenomenon. The study may have also been limited by the researcher as a result of multiple differences between herself and the participants in terms of culture and language.

A pilot interview would have been beneficial as this would have given the interviewer a first opportunity to role play the interview questions, ease into the interview method and work with the translator. This would have allowed further decisions to be made with regards to other areas to probe, and also the challenges in working with a translator would have been identified prior to the commencement of data collection.

6.5 Recommendations

It is recommended that the present study be replicated in the future with larger and more variable samples. This will generate richer and more diverse findings. A sample including male heads of households is suggested as this may highlight differences in male and female headed families. This recommendation is made as research has indicated that a family’s level of
education and socioeconomic status, as well as gender, have an influence on the sense of coherence of a family, whilst sense of coherence is a predictor of family adaptation (Sagy & Antonovsky, 1998).

It is further recommended that future research incorporate quantitative information into the data collection as this will serve to quantify and explain the descriptive data. Quantitative data may contribute to identifying relationships amongst adaptive processes and measuring family resilience with the intention of providing a level of adaptation on a continuum from maladaptation to bonadaptation. Furthermore, correlations between the various adaptive processes and family resilience may be explained.

Longitudinal research into the resilience of HIV/AIDS’ adolescent headed families may provide insights into the dynamic nature of families and their adaptive processes over time which this research lacks. It is thus recommended that research of this nature be pursued over longer periods of time in order to capture the continual and changing experience of resilience.

In replicating this study, it is suggested that debriefing sessions for the translators and the interviewers be included in the design, pilot interviews be conducted and as far as possible the first language of the participants be accommodated. Also, triangulation of methods and the use of an independent coder should be considered in order to further verify the findings. However, the findings for the present study have been verified by employing theory triangulation, member checks and peer review as has been outlined in chapter four.

The final recommendation is that a summary of the findings and specific recommendations be made available to the Masizakhe Community Project. These recommendations will provide guidance in developing intervention programmes for adolescent headed families, identify areas of concern and affirm the existing strengths of both the community project and the adolescent headed families.
6.6 Conclusion

The present study was an attempt to explore and describe the resilience of HIV/AIDS’ adolescent headed families. Although the results cannot be generalised, the value of the contributions of this study cannot be disregarded. The results of this study provide valuable information regarding the sample under investigation and also provide invaluable avenues for future research projects. Recommendations included replicating this study with larger, more diverse samples and incorporating quantitative data.

This chapter has linked the conclusions drawn from this study to the aim by integrating the findings into the two nominated theories of family resilience. The valuable contributions of this study were noted and the limitations were discussed. Finally, relevant recommendations were outlined.
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APPENDIX A: iThemba AIDS Foundation
iThemba AIDS Foundation ("iThemba") is a Christian charity bringing hope to people affected by HIV/AIDS in sub-Saharan Africa. That’s why we’re called iThemba, the Zulu word for hope. Founded in the UK in 2002, the iThemba group includes a UK registered charity and a 501(c) (3) tax-exempt organisation in the US. We also have plans to open a South African charity in the near future.

A huge need
HIV/AIDS has been described as the greatest public health disaster in recorded history. More than 42 million people worldwide have been infected. By the end of this decade the figure will have more than doubled to 87 million people.

Working with local people, for local communities
We work in partnership with people who want to actively respond to a problem that is devastating their communities. The local initiatives make a difference in six main areas: home-based care, orphan care, community support for antiretroviral therapy, microfinance initiatives, education and counselling and testing.

iThemba also works to educate and mobilise people to respond to the HIV/AIDS pandemic. Our partnership website engagehivaid.com informs and encourages young people to actively play a part.

Hope for today, tomorrow and eternity
iThemba’s partners are working to meet the physical, emotional and spiritual needs of people and communities affected by HIV/AIDS.
They are committed to best practice in all aspects of their work which includes excellent practical care, well-managed projects and financial accountability. All have supportive staff structures, promoting the emotional and spiritual wellbeing of staff and volunteers.

100% action

As a charity, we rely on the generosity of our supporters and in turn offer a guarantee – 100% of all donations go directly to our partner projects.

Executive Team

Dr Elisabeth Ling

Liz is the Field Director for iThemba and oversees all the work on the ground. After studying at London University, Liz worked as a doctor in the Swindon area before moving to South Africa in 2004. Now based in Port Elizabeth, she heads up iThemba’s Africa office. Much of her time is spent traveling, supporting iThemba’s current partners and identifying new churches/organisations to work with. Liz is also studying part-time at Stellenbosch University, in order to understand how iThemba can improve its support of local African churches. While in the UK, Liz was a member of St Ebbe’s Church in Oxford, which continues to support her in her work.

Sarah Smith

Sarah works part-time for iThemba, developing our marketing and web-based activities. After studying International Business with French at Aston University, she worked in Marketing at Bible Society. Sarah has a passion for making a difference through her work and specialises in
charity marketing. She is actively involved in her local church and enjoys walking with her husband Matt and spending time with friends.

**Nikki Timuri**

Nikki is South African and is a Project Support Worker in Port Elizabeth. She is married to Stan and has two children, Harmony and Promise. Her particular role is to provide emotional and spiritual support to project volunteers and their clients. Nikki says that the highlight of her job is seeing the lives of HIV-positive people shine with hope in Christ as they learn to overcome their fear of the future.

**Wambui Gititu**

Wambui is Kenyan and works part-time as Liz’s PA. She is responsible for many of the day-to-day administrative tasks in the office. She studied for her first degree, in Communications, at Daystar University, Nairobi and is now pursuing a Masters Degree in Sociology at the university in Port Elizabeth. As part of her studies she is researching the role of team-building within community-based organisations.

**Caroline Lavington**

Caroline provides finance and administration support for iThemba. She enjoys spending time with her daughter and friends and playing tennis.

**Masizakhe Project**

**Kwazakhele Township, Port Elizabeth, South Africa**

The Masizakhe Community Project brings together Christians from several local churches and is one of the first community-based organisations supported by iThemba.
The project operates in a difficult district, where residents tend to be men living away from their families while working in the city. Local women are very vulnerable to exploitation. With prostitution caused by extreme poverty, alcohol and drug abuse, violence and crime are common. It is estimated that the HIV prevalence rate in the community is a staggering 45–60%.

Beatrice set up the project the same year her daughter died from an AIDS-related illness. Today she heads up a team of volunteers who support the local community through home-based care and skills training programmes, counselling services, a preschool for children affected by HIV/AIDS, food parcels and a soup kitchen.

**Helping children affected by HIV/AIDS**

The preschool provides a safe place for children who are orphaned or whose mothers are unwell and HIV-positive. The premises are cramped, but the children are cared for and receive healthy meals. Beatrice hopes they can move to a bigger building in the future so that more children can be helped.

For many orphans food security is a big issue and Masizakhe provides food parcels for them. This is a vital service to help ensure that children do not become victims of crime or find they need to turn to crime in order to feed their family.

**Falling demand for home-based care**

Home-based care provided by the volunteers has proved to be invaluable for people dying as a result of AIDS-related illnesses. However, Masizakhe is finding that the number of bedridden patients is falling thanks to antiretroviral drugs for HIV-positive people in the area. It is worth remembering though that as many as 85% of South Africans who needed antiretrovirals were not yet receiving them by mid-2005.
A brighter future

As they care for their community, all those involved at Masizakhe are very clear about their motivation for the work they do – their Christian faith inspires them to reach out to local people and help them both in practical and spiritual ways as they face the challenges of HIV/AIDS and help those affected to feel supported and loved.

St Paul's Outreach

Veeplaas Township, Port Elizabeth, South Africa

St Paul’s Outreach, a church and community-based organisation, offers a variety of vital services to people affected by HIV/AIDS. It began its work in 2003, running a twice-weekly soup kitchen from the church building. With training and support the work has expanded and now includes HIV counselling, home care services, skills training programmes, a pre-school for HIV-affected children and an after-school club.

iThemba supports all aspects of the project.

The ground around the church building has been taken over by two large vegetable patches, which have inspired others to start growing their own vegetables at home. St Paul’s has given out seeds, encouraging people to eat fresh fruit and vegetables on a regular basis.

Many of the children at the preschool and after-school facility are orphans. These facilities take the pressure off over-burdened grandmothers and carers, allowing them time to work to meet the needs of their families. The children do not only learn about HIV/AIDS issues, but also health and hygiene, road safety and expressing themselves through art.
Changing lives, changing communities

The aim of all these activities is to enable the community to cope in the face of HIV using traditional strategies. By assisting in a small way, the community can be sustained. St Paul’s Outreach is not only changing the lives of the individuals it helps directly, but also the surrounding community. Local people appreciate what the project is doing for members of their own families. St Paul’s works hand in hand with local clinics helping HIV-positive people deal with the trauma and fear of rejection by their families.

Nikki Timuri, iThemba’s project worker in Port Elizabeth, visits weekly to work with those who come to the soup kitchen and the project volunteers, developing the spiritual aspects of the work. The project does not only benefit the people it serves, but also its workers who receive training specific to their work – whether they be counsellors, home-visitors or book-keepers, they have the opportunity to develop and learn new skills, which in turn helps their community.

Ikhwezi Support Group

Kwa-Nonqubela Township, South Africa

Ikhwezi is a grass-roots project involving a team of seven volunteers who work from the caretaker’s cottage in a local primary school. They offer counselling and home-based care, run gardening and sewing projects, and have a significant HIV prevention programme, which includes work in local schools and condom distribution. The team also works closely with the local clinic, providing support to HIV-positive people who are taking antiretroviral medication. iThemba supports the vast majority of the running costs, including stipends for volunteers, nursing supplies and volunteer training.
Home visiting

Home care visitors help people who are unable to feed themselves and have no one at home to help. It’s about showing people respect and preserving their dignity. For people who are bedridden, simple actions like washing them and changing their bed, make them feel comfortable, loved and cared for.

Bringing hope to young people

The schools work is growing and volunteers, Portia and Nomvelo, give five Life Orientation classes on HIV/AIDS each week, speaking to around 250 children. The older children complained that when regular school teachers taught about abstinence, alcohol and other issues, their lives didn't match up. Now that Ikhwezi volunteers teach these lessons the children have new role models who live out what they teach. Four abstinence groups have started at local schools to encourage young people to change their lifestyles. Bulelwa is just one of those young people.

Encouraging and counselling

Not infrequently HIV-positive people are driven out of their homes when they disclose their status or their status has been guessed. The counselling service helps people deal with this and other issues. Bandile is just one of many who has been helped.

(Retrieved from www.ithemba.org.uk)
APPENDIX B: Introductory Letter to Participants

English and Xhosa versions
Dear Research Participant

I am currently working towards a Masters Degree in Clinical Psychology. In order to complete this qualification, I have to conduct research that will contribute to academia and society. I have decided to focus on the resilience of adolescent headed families. The aim of this research is to explore and describe the resilience of adolescent headed families. It is thus with this goal in mind that I would like to enlist your help.

This research study will provide insights into the resilience of adolescent-headed families; contribute to the research and literature on family resilience; will form the foundation for future research projects on adolescent headed families; will provide guidance for the development of intervention programmes to assist families and will affirm the existing strengths of families.

The information for this study will be gathered via interviews that will be audio recorded. I anticipate that this will involve at least two interview sessions lasting no longer than two hours each; one optional debriefing session of forty-five minutes and one final session of forty-five minutes for feedback and verification of findings. The interviews will be scheduled for a time and venue that is convenient for you. I will transcribe the information from the interviews and upon completion of this study the audiotapes will be discarded. I will ensure that all transcriptions do not disclose any names or identifying information, thus maintaining anonymity and confidentiality. In the event of having to use a translator, the translator will also be briefed about issues of confidentiality and will also sign the relevant section of the consent form. In the event of any emotional distress arising from these interviews, I will assume responsibility for immediate containment, offer an optional debriefing session and thereafter if required, refer you appropriately. You will be able to ask questions at any time during the study. Participation in this study is voluntary and you may choose to withdraw at any stage. A decision not to participate will be regarded with respect.

I invite you to participate in this study. If you decide to participate, you will be required to provide consent by signing the attached consent form. The consent form highlights your rights as a research participant and is of utmost importance.

In the event that you may need to contact me, you may do so either via e-mail: hershillabeeka@yahoo.co.uk or telephonically on 083 657 9531.

Regards,

Hershilla Beeka
(Researcher)

Prof. M.B.Watson
(Head of Department-Psychology)

Dr. D Elkonin
(Research Supervisor)

Ms. O. Brown-Baatjies
(Research Co-Supervisor)
Mthathi – nxaxheba obekekileyo.


Olu phando luya kutsho kuthi qwenge ngokuphathelelele noku kumelana nemeko kweentsapho ezoxxomakeke kubantwana abaselula, lube negalelo kuphando neencwadi zokumelana kweentsapho neemeko ezimaxongo; iqulunqe isisekelo sophando kwilixa elizayo ngokungqamene neentsapho ezixhoma keke ebantwane; kananjalo inike umhlahla – ndlela wokuquluqwa kweenkqubo zokulungisa nokuncedisa iintsapho kwaye luya huchazwa ubungangamsa bezi ntsapho.


Ozithobileyo,

(Umphandi nzulu)   (Intloko yecandelo le)   (Abaphononongi bophando)

Psychology)
APPENDIX C: Consent Form
### INFORMATION AND INFORMED CONSENT FORM

<table>
<thead>
<tr>
<th>Title of the research project</th>
<th>Resilience in HIV/AIDS' adolescent headed families</th>
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<tr>
<td>Reference number</td>
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<tr>
<td>Principal investigator</td>
<td>Hershilla Beeka</td>
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<tr>
<td>Address</td>
<td></td>
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<tr>
<td>Postal Code</td>
<td></td>
</tr>
<tr>
<td>Contact telephone number</td>
<td>083 657 9531</td>
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#### A. DECLARATION BY OR ON BEHALF OF PARTICIPANT
(Person legally competent to give consent on behalf of the participant)

| I, the participant and the undersigned I.D. number |  |
| OR I, in my capacity as of the participant I.D. number |  |
| Address (of participant) |  |

#### A.1 I HEREBY CONFIRM AS FOLLOWS:

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Hershilla Beeka of the Department of Psychology in the Faculty of Health Sciences of the Nelson Mandela Metropolitan University.
2. **The following aspects have been explained to me, the participant:**

| 2.1 | **Aim:** The investigators are studying resilience in adolescent headed families created by HIV/AIDS. The information will be used to contribute to family resilience literature and to highlight strengths in adolescent headed families. |
| 2.2 | **Procedures:** I understand that I will be interviewed by the investigator and that the interview will be audio recorded. A translator will be used if I prefer to communicate in Xhosa. |
| 2.3 | **Risks:** Emotional distress may arise from the interviews. |
| 2.4 | **Possible benefits:** As a result of my participation in this study I will contribute to the knowledge of adolescent headed families in the Eastern Cape. |
| 2.5 | **Confidentiality:** My identity will not be revealed in any discussion, description or scientific publications by the investigators. |
| 2.6 | **Access to findings:** Any new information/or benefit that develops during the course of the study will be shared as follows: Participants will participate in a feedback session with the investigator in order to verify findings. |
| 2.7 | **Voluntary participation/refusal/discontinuation:** |
| | My participation is voluntary | YES | NO |
| | My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle | TRUE | FALSE |

3. The information above was explained to me/the participant by

Hershilla Beeka

in | Afrikaans | English | X | Xhosa | X | Other |

and I am in command of this language/it was satisfactorily translated to me by

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

5. Participation in this study will not result in any additional cost to myself.
A.2  I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT

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<th>Signature or right thumb print of participant</th>
<th>Signature of witness</th>
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<th>Full name of witness</th>
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B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I, Hershilla Beeka declare that

- I have explained the information given in this document to

  (name of patient/participant)

  and/or his/her representative

  (name of representative)

- he/she was encouraged and given ample time to ask me any questions;

- this conversation was conducted in

  Afrikaans  English  Xhosa  Other

- and no translator was used / this conversation was translated into

  (language)  by

- I have detached Section D and handed it to the participant

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C. DECLARATION BY TRANSLATOR

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confirm that I

- translated the contents of this document from English into          |
  (indicate the relevant language) to the participant/the participant’s representative;

- also translated the questions                                      |
  posed by                                                           |
  as well as the answers given by the investigator/representative; and

- conveyed a factually correct version of what was related to me.

Signed/confirmed at                                                   |

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential

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<td>Signature of witness</td>
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<td>Full name of witness</td>
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</table>
Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study

Kindly contact

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<tbody>
<tr>
<td>Hershilla Beeka</td>
</tr>
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</table>
APPENDIX D: Interview Schedule

English and Xhosa versions
-In your own words, please describe your family to me

Probes:

Members, ages, gender, position.

-Over a life cycle families experience many changes as a result of growth within the family and also because of external circumstances. Tell me about the changes you and your family have experienced over the years

Tell me about each family member’s change

Emotional; substance problems; conflicts; members not completing tasks / resolving problems;

Financial problems;

Member unemployment; changes in employment

Family relocated;

Any member became seriously ill; injuries; disability;

Deaths

Beginning/ Ending of significant relationships;

Member left home; moved back home; new person moved in

Jail; violence; suspension from school, ran away from home

-Given all the changes that you have mentioned, tell me how your family has worked through these changes.

Members working together to solve problems; can overcome all problems.

We don’t have to work together; can’t rely on each other.

-Tell me about how your family has approached changing the things that have happened and adjusting to new events that are happening:

Willing to try new and exciting things; repeatedly doing the same thing; support each other to
try new things; its better to keep things as they are

-What meanings does your family make of problems/stresses?
  Lives are beyond our control; life is controlled by accidents; bad luck; it is our own fault

-Describe in as much detail as possible what a typical day is like for your family
  Who takes care of the children most of the time?
  Members who go to work/ who stay at home;
  When does the family sit down and talk;
  What do you all do together?
  Responsibilities for different chores;
  Are there certain members who do more things together than others?
  What your family does for fun;
  Family meals and bedtime routine;
  Involvement with extended family;
  All members know where the others are;
  Who manages, disciplines members; are there rules

-Tell me about traditions and special celebrations
  What special moments does your family celebrate?
  Birthdays, anniversaries, religious days; other special occasions;
  Who does what; who is invited; rules?

-When your family experiences a problem, whom can you turn to for assistance?
  Community, Relatives, friends, Religious groups, other support systems; Feel secure in this community; we make the effort to help others and they help us

-Describe the ways in which your family has coped
  Talking about personal feelings and concerns; trusting each other; Being strong, hopeful
Delegating tasks at home; Unity as a family-rewarding family members

Develop relationships with others- seek encouragement and advice

Behaviours to reduce stress and tension; Taking care of self and others

Talking to others with a similar experience;

Turn to spiritual support; seeking professional help

Defining the problem in a more positive way so that we do not become too discouraged

-Describe how you all communicate with each other when your family struggles with problems or conflicts that upset you

Yell and scream; fighting and bringing up past issues; blame each other

We walk away; withdraw and remain silent;

We talk things through; we respect each other and try to reach a solution; we feel closer to each other

We listen to each other; it is easy to express our feelings and concerns

Easier to talk to other people

Family members pair up.
umhlalha – ndlela wodliwano – ndlebe

- Ngamazwi akho, khawundichazele ngosapho lwakho.

Qwalasela:

Amalungu, iminyaka yokuzalwa, isini, uyintoni

- Ebomini, iintsapho zifumana ukutshintsha nganxa yokukhula kusapho kwakunye
neemeko zangaphandle. Ndixelele ngeenguqu othe wena nosapho lwakho nazifumana
ngokuya kuhamba kweminyaka.

Ndixelele ngeenguqu zelungu ngalinye.

Ngokwasemphefumlweni; iingxaki zeziselo ezinxilisayo; iingxabano; amalungu osapho
angazimiselamga ukuqabelisa imicimbi okanye umsebenzi; angazisombululiyi iingxaki,
iingxaki zemali.

Amalungu angaphangeliyo; iinguqu ngokwempangelo.

Ukutheleka kosapho.

Ilungu eliye lagula kakhulu; ukonzakala; ukukhubazeka.

Ukufa.

Ukuqala okanye ukuphela kobudlelwane.

Ukubhaca kwelungu; libuyele ekhaya; umntu omtsha azokuhlala.

Intolongo; ubundlobongela; ukugxothwa esikolweni; ukubaleka ikhaya.

- Ngokuba undichazele zonke ezi nguqu, ndixelele ukuba usapho lwakho luthathe
manyathelo mani ukuzama ukumelana nezi nguqu.

Amalungu osapho asebenzisanayo ukulungisa ingxaki; angalwa nazo zonke iingxaki.

Asifanelanga ukuba sisebenzisane; asinakuxhomekeka omnye komnye.
- Ndichazele ukuba usapho lwakho lwenze njani ukutshintsha izinto ezehlileyo nokumelana nezo zintshaizinto ezenzekayo:

Bayakuthakazelela ukuzama izinto ezintsha; benza into enye rhoqo; kuyancediswana ukuzama izinto ezintsha; kungcono ukuyeka izinto ngohlobo ezilulo.

- Usapho lwakho luyitolika njani ingxaki noxinizelelo?

Impilo ingaphaya kwamandla ethu; ubomi bulawulwa ziingozi; amashwa; kungenxa yethu.

- Chaza kangangoko unako ukuba injani imini eqhelekileyo kowenu (xa niqhuba ngokwemihla ngemihla)

Ngubani ohoya abantwana amaxesha amaninzi?

Amalungu aphangelayo okanye abahlaleleleyo

Usapho lwakho luhlala nini phantsi, luthethe?

Yintoni eniyenza kunye, ninonke?

Uxanduva lwemisebenzi phakathi kwekhaya.

Akhona amalungu awenza izinto kunye kunamanye?

Nenza ntoni xa nizonwabisa?

Ixesha lokulala nalawo ezidlo.

Ubudlelwane nezizalwane

Onke amalungu ayabazi abanye baphi?

Ngubani olawula, aluleke amalungu osapho; ikho imithetho?

- Ndichazele ngamasiko nezinye izinto enizenzayo ukuvuyisana.

Zeziphi izinto ekuvuyiswana nazo okanye ngazo?

Imihla yokuzalwa; izikhumbuzo; ezenkolo; ezinye

Ngubani owenza ntoni, kumenywa bani; imithetho?
- Xa usapho lwakho lufikelwa yingxaki, ngubani ekubhenelwa kuye xa kudingwa uncedo?

  Abantu bokuhlala; izizalwane; izihlobo; abezenkolo; ezinye iindawo zoncedo; kukhuselekile endaweni enihlala kuyo; senha iinzame ukunceda abanye abantu kwaye bayasinceda.

- Chaza indlela usapho lwakho olumelene ngayo nemeko.

  Ngokuthetha ngeemvakalelo neengcinga; ukuthembana; ukomelela; ithemba

  Ngokunikezela ngoxanduva phakathi kwekhaya; ubumbano njengembuyekezo kusapho.

  Ukuqulunqwa kobudlelwane nabanye – cela inkuthazo neengcebiso.

  Indlela yokuziphatha ukuhlisa izinga loxinizelelo; ukukhathalela isiqu sakho nabanye.

  Ukuthetha nabanye abehlelwe yinto efanayo nale ikwehleleyo.

  Bhenela kwinkxaso yasemoyeni; ukufuna uncedo kwabafundele oko.

  Ukucazulula ingxaki ngendlela eiyio nomxhelo omhle ukuze singathezeki amandla.

- Chaza ukuba ninxibelelana njani xa usapho luxakanisekile zingxaki okanye ingxabano?

  Niyaxwaxwana, ukulwa nokubuyisa izilandu, nigxekane

  Niyagqwashumla, uphume; buya umva uthi cwaka

  Kuyathetha thethwana; niyahloniphana kwaye nizame isisombululo; siziva simanyene

  Siyamamelana; kulula ukuvakalisa izimvo zethu

  Kulula ukuthetha nabanye abantu

  Amalungu osapho adibana ngababini
APPENDIX E: Table of Master Themes
The following table presents the emergent themes from the interviews conducted with the four participants. The biographical information of each participant has been provided in chapter four. In order to understand the table, a simple coding system enabling the quote to be accessed in the original interview material has been employed, as follows.

A (n) = Participant A
B (n) = Participant B
C (n) = Participant C
D (n) = Participant D
T (n) = Translator
FS = feedback session

Where (n) is a digit representing the response in sequence as is occurred in the interview.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Participant A</th>
<th>Participant B</th>
<th>Participant C</th>
<th>Participant D</th>
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</thead>
<tbody>
<tr>
<td><strong>Family Unit</strong></td>
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<tr>
<td>-restructured family</td>
<td>A2; T3 “I am the first born…brother, younger brother…cousin…aunt…who lives…”</td>
<td>B1 “we are a big family…two brothers, my sister’s child…and our aunty…supports us financially”</td>
<td>C1; T1 “I live with my two younger cousins”</td>
<td>D1 “mother passed away and I am living with two children of my mother…”</td>
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<tr>
<td></td>
<td>A51 “all different fathers”</td>
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<tr>
<td>-extended family</td>
<td>A50; T63 “…raised by my grandmother and my grandfather”</td>
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<td></td>
<td>A18; T20 “grew up as brother and sister not as cousins.” A20; T22 “All living together with aunt and everyone else”</td>
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<tr>
<td>-parental subunit (absent/substituted)</td>
<td>A3 “we were living alone here with my uncle” A50; T63 “never had a relationship with father”</td>
<td>B14; T5 “My mother was the breadwinner” B15; T6 “…my aunt was taking care of us” B35; T17 “she is also</td>
<td>C68; T34 “…kids my own age they are living with their parents and…” C79; T43 “I used to visit</td>
<td>D1 “…there is no elder then me…I don’t have a parent, my mother and father passed”</td>
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<td>C52; T26 “they don’t have any one else they know, I am their only parent”</td>
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<td>C5; T3 “I was living with my father’s brother and then I had to come back home” C93; T57 “when I lived with my mother, my cousin and their mother were still living there”</td>
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<td>D16 “no other family, grandparents passed away”</td>
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<td>D16 “no other family, grandparents passed away”</td>
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<tr>
<td>Topic</td>
<td>Extracts</td>
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</tbody>
</table>
| Household head | A9; T7 “they are younger, they mess up my things…lock my room…other three share a room”  
               | A61; T80 “they behave like they her (head) own kids not like they are brother and sister”  
               | B24; T12 “It was us who decided to do that, with my brothers and myself”  
               | B12; T3 “my sister and I were helping each other out…(sister passed away in January 2007)”  
               | B1 “I am the one who is in charge of my two brothers”  
               | B10 “I share with my sister’s son and my brothers are sharing”  
               | C54; T29 “my mother…”  
               | C52; T26 “they don’t have anyone else they know, I am their only parent”  
               | D57 “Beatrice understands me, she is like a mother to me”  
| Loss         | A3 “mother passed away 2004…uncle passed away 2003…”  
               | A50; T63 “when the grandmother died”  
               | B4 “she (sister) passed away this year January”  
               | B11 “I can say when my mother passed away it was 1999”  
               | C94 “my father passed away when I was three years old”  
               | C5; T3 “…with my mother because she was sick…then she died”  
<pre><code>           | D7 “my father passed away 2000. then I was left with my mother. and she passed away 2002” |
</code></pre>
<p>| -Deteriorating health | A55; T69 “when my uncle was sick…they were not really helping…” A3 “she was very ill I was looking after her” | B87 “it was difficult to see my mum sick…she likes working…she wouldn’t rest and I didn’t like that” B15; T6 “seven year old son-make sure that he takes his treatment” | C32; T10 “where I used to live I had never seen anyone who was sick…when I didn’t know how to take care of my mother…” D8 “I was looking after her when she was sick” D34; T11 “make sure her clothes are clean…” D64 “my father was very sick…” |
| -Loss of childhood | A4; T5 “even when they were alive, I was looking after everyone because they were drinking and going out” | C77; T41 “…every time I have to be a parent to my cousin…” “14 years when my mother got sick; 15 when she died” (FS) “accept the loss of normal childhood…” |
| -Emotional Impact | A21; T23 “and the bond was lost there” | B14 (became very tearful and looked down) “when my mother died it was very difficult for us to accept her death…” B61; T35 “it hurts me a lot” | C75; T37 “sometimes I feel cross with my mother; every time I think about my mother it makes me really sad and angry…I feel cross with my aunt” D30; T10 “I cry and ask why God did take my mother…feel hurt and it makes me sad” D62; T29 “painful not to have a mother” |</p>
<table>
<thead>
<tr>
<th>Financial Circumstances</th>
<th>A27; T20 “when my mother died no money to bury her”</th>
<th>B14; T5 “my mother was the breadwinner, when she died everything changed”</th>
<th>C78; T42 “she couldn’t afford all the things I needed for school”</th>
<th>D29; T9 “the child support grant for everything even the schools”</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Financial difficulties</td>
<td>A5 “he didn’t qualify for Foster Grant” A16; T16 “had to buy furniture” A35; T42 “had to support two school going kids” A26; T28 “also struggling financially”</td>
<td>B19; T8 “one of my biggest problems was to make sure that my sister’s son gets the grant and he didn’t, so it’s very difficult”</td>
<td>C103; T66 “when my mother died she had other accounts to pay”</td>
<td>D18; T2 “…is the shortage of money”</td>
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<td>B7 “I am a volunteer here at Masizakhe (only source of income)”</td>
<td>C38; T16 “it was a bit difficult because the money wasn’t enough for the kids to be able to go to school”</td>
<td>D23 (FS). D21 “only started a month. stay three months you don’t get pay”</td>
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<td>A17; T19 “most of the things are not brand new…some amount from my stipend to pay…Beatrice took it for me and I will pay it back” A75; T108 “budgeting and grocery shopping; sometimes buy biscuits…” A27; T29 “going to have funeral plan”</td>
<td>B79; T50 “if I have money I buy a present to surprise them”</td>
<td>C89; T53 “when I have the money from the child support grant I will take them to town and buy all the groceries and the things we all need”</td>
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<tr>
<td>Financial support</td>
<td>Employment -Unemployment -Volunteer work</td>
<td>Education</td>
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<td><strong>A5</strong> “I have the stipend here” <strong>A17; T19</strong> “Beatrice took it for me and I will pay her back” <strong>A27; T29</strong> “relatives had to give me money”</td>
<td><strong>A8</strong> “looking for part time jobs” <strong>A5</strong> “volunteer at Masizakhe”</td>
<td><strong>A5</strong> “my sister stopped studying…brother and cousin are still studying…he is now 18 in std 8”</td>
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<td><strong>B1</strong> “and our aunt who doesn’t really live there but supports us financially” <strong>B56; T29</strong> “my aunt buys the groceries for us for a month”</td>
<td><strong>B25</strong> “casual at King Edward Hotel, they call me when they needed me” <strong>B7</strong> “volunteer here at Masizakhe”</td>
<td><strong>B7</strong> “my two brothers are at school” <strong>B60; T33</strong> “it is very difficult to get a job if you don’t have a qualification.”</td>
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<td><strong>C62; T31</strong> “people come to drink traditional beer, it’s extra income…” <strong>C103; T66</strong> “My boyfriend …give me R500 every month…” <strong>C36; T15</strong> “mother…disability grant something wrong with her hands (single income)”</td>
<td><strong>C114; T77</strong> “if I could get a proper job…” <strong>C24</strong> “working here at Masizakhe”</td>
<td><strong>C66</strong> “it was in 2003 I was in grade ten” <strong>C67</strong> “I want to go to school. Education is important”</td>
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<tr>
<td>“Aunt was giving me money when my mother died…child support for the two children” (FS).</td>
<td><strong>D2</strong> “working here in Masizakhe” <strong>D21</strong> “don’t get pay…after three months get pay”</td>
<td><strong>D40; T14</strong> “wanted to pass matric. but I haven’t been able to go to night school because”</td>
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</tbody>
</table>
my brother and my nephew must get an education” because it is very hard for me to get a proper job” I know the kids …alone” D34; T11 “I was in std 6..I would go to school and come back do housework and look after my mother and the children”

<table>
<thead>
<tr>
<th>Social Climate</th>
<th>A24; T26 “he wouldn’t back off from a fight…stabbed him to death” A16; T16 “he was arrested”</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Violence and Crime</td>
<td>A4; T5 “because they were drinking” A24; T26 “his mother…alcoholic” A45; T55 “but the mother would be drinking”</td>
</tr>
<tr>
<td>-Alcohol abuse</td>
<td>A49; T61 “mother would go away with boyfriends”</td>
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<tr>
<td>-Poor maternal figure</td>
<td>C40; T17 “my aunt was always drinking and sleeping everywhere” C78; T42 “my mother used to drink a lot, she couldn’t afford all the things I needed”</td>
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<td></td>
<td>“didn’t know my father until he got sick…he was an alcoholic…he used to fight with my mother” (FS).</td>
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<tr>
<td>-Hardship and suffering</td>
<td><strong>A65; T88</strong> “experienced hardships…didn’t have electricity and food”</td>
</tr>
<tr>
<td>-Stigma</td>
<td><strong>C42; T20</strong> “stigma…I would hear people talking about my mother and that they suspected that because I was taking care of my mother I was also HIV infected”</td>
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<tr>
<td>-Social isolation</td>
<td><strong>C44; T22</strong> “they didn’t really like me and then I didn’t have much friends”</td>
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<tr>
<td>-Ambivalence</td>
<td><strong>C111; T73</strong> “I can ask some of them for help but others are making me feel bad that my mother had HIV…I feel judged by them but few will help”</td>
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<td><strong>D57</strong> “they didn’t understand me…people are not understanding me” <strong>D55</strong> “I don’t have a friend and I don’t want a friend. I don’t need a friend. don’t want to experience the bad influences of friends…”</td>
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<tr>
<td>-Relocation transition</td>
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<tr>
<td><strong>Spirituality</strong></td>
<td><strong>A79; T116</strong> “goes to church…believes in God’s will” <strong>A57; T32</strong> “God is here…He will take care…”</td>
</tr>
<tr>
<td><strong>Appraisal processes</strong></td>
<td><strong>-Internal motivation</strong></td>
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<tr>
<td><strong>A57; T72</strong> “motivates herself” <strong>A66; T90</strong> “there is no one you can blame, you will take the decisions” <strong>A63; T84</strong> “up to you to take the advice”</td>
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<tr>
<td>External Locus of Control</td>
<td>Positive Outlook</td>
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<td>A77; T112 “don’t have to worry about the things they don’t have but make the most of what they have…if we want to do it we do know where to go…”</td>
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<td>B58; T32 “yes we can because we are not looking back at what has happened we are looking to our future positive”</td>
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<td>C74; T36 “it is difficult for me because I blame my mother for dying on me”</td>
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<td>C82 “I am learning to accept and I know that I am not the only one and not the first one and I wanna be strong for the younger ones”</td>
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<tr>
<td>Community Project for Work</td>
<td>Community Project for Services</td>
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<tr>
<td>“Attending here at OVC” (refers to the younger children who attend the after school care programme at Masizakhe)</td>
<td>“After school they are going home…then they are coming here (Masizakhe) for after school care”</td>
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<tr>
<td>“Community project for help”</td>
<td>“Masizakhe and the people here will help with a lot of things”</td>
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<td>“I can rely on them to give me proper advice”</td>
<td>“When I didn’t know how to take care of my mother I decided to come here (Masizakhe) and ask for help and Pamela (volunteer) would advise me and tell”</td>
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<tr>
<td>“I would come to ask for help in between, I would ask them how to look after my mother”</td>
<td>“I can count on them to give me proper advice”</td>
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Worker C71 “they allow me to bring her (baby) to work”

C18 “they come to OVC. here in OVC maybe if they get homework they help them”

C25;T6 “they come here to have porridge”

C18 “they come to OVC. here in OVC maybe if they get homework they help them”

D37;T13 “I would come to ask for help in between, I would ask them how to look after my mother”

D57 “I can count on them to give me proper advice”
<table>
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<tr>
<th><strong>-community members and friends</strong></th>
<th><strong>A63; T84</strong> “people will give advice”</th>
<th><strong>B82</strong> “can ask for help in my community”</th>
<th><strong>C81; T46</strong> “Pamela and my boyfriend (helped emotionally).”</th>
<th><strong>D60; T26</strong> “I don’t ask for other people’s help…”</th>
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<tr>
<td></td>
<td>A78; T114 “people in the community…will help her”</td>
<td>B83 “I talk to my friends”</td>
<td>C21 “(neighbour) that I give him to her to look after”</td>
<td>D72 “I wont ask them for help”</td>
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<td>A79; T120 “talk to a friend with…”</td>
<td>B41; T21 “is also a volunteer…she will help with my kids…I can finish up”</td>
<td>C23 “I take her like my big sister, because if I need something I go to her…”</td>
<td>D55 “…I don’t need a friend”</td>
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<td>C110; T72 “there has been a social worker from Dora Nginza because my younger cousin was sick…told them what our problems were…”</td>
<td>D25 “I go to the neighbour …lunch in the fridge”</td>
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<td>D26 “my neighbours are helpful only with storing food in the fridge”</td>
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| **-Assistance from Social worker** | **A50; T63** “took her to the” | **C91; T55** “no” | **D16** “only that aunt.” |

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<tr>
<th><strong>Family support</strong></th>
<th><strong>-grandparents</strong></th>
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-relative involvement

grandmother…raised by the grandmother and grandfather”

A58; T74 “expects other relatives to visit and see if they ok, they don’t”

A27; T29 “relatives had to give money”

A78; T114 “there is a relative…can talk to”

A60; T78 “they always listen…”

A64; T86 “already support each other…help each other out”

B12; T3 “my sister and I were helping each other out”

B33 “my aunt is helping a lot”

B37; T19 “we can rely

grandmothers or older people I can turn to”

C75; T37 “my aunt, she is here, I don’t even know where she is and she doesn’t even come to visit…she doesn’t even check if we ok”

C80; T44 “I knew that my mother’s sister would not take responsibility”

C91; T55 “they (other family) are not so close because they live far from here”

D32 “aunt assists sometimes…don’t always come; her husband is not supporting her to help us; he gets angry with her” (FS).

D1 “I don’t want her (aunt) to solve my problem; I want her to listen to me”

D15 “they help me sometimes…the one knows how to sweep, the other washes the
<p>| Organisational Patterns | A21; T23 “all living there. with the aunt and everyone else” A53; T67 “no such thing as half brother or sister…have the same mother…not separated” A50; T63 “house belonged to the great grandparents, it is a family home” A71; T110 “brings the family closer together when they share a birthday” | B85; T55 “I didn’t mind because they are my brothers, they are family” B72; T43 “we also go together when we have to go somewhere with the church, we go shopping for clothes together and we have our meals together” B37; T19 “we can rely on each other” B46; T24 “if I am not finished my 14 year old brother will finish the cooking-makes sure my nephew gets his medicine” | C104; T67 “I tell them it is just us; we depending on each other when someone else needs something the other must wait and their turn will come” C88; T50 “…but we all sleep in one room because the others are scared to sleep there and we like to talk all night” |
| cohesion | socks” | | |</p>
<table>
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<tr>
<th>Patterns of family functioning</th>
<th>-family time</th>
<th>-integration of values</th>
<th>-respect</th>
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<tbody>
<tr>
<td>A15; T14 “they like to visit; they come and visit often” A59; T76 “they all can sit and talk” A71; T100 “hiring movies and sit and watch together…”</td>
<td>B63; T36 “we are usually watching television before going to bed” B72; T43 “we also go together when we have to go with the church, we go shopping for clothes together and we have our</td>
<td>A31; T34 “that’s how the Xhosa people are…respect the elders” A38; T45 “there is a Xhosa saying…”</td>
<td>A60; T78 “always respect her” A61; T110 “they respect her” (refers to head of household)</td>
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<tr>
<td>C88; T50 “we like to talk all night” C89; T67 “…I will take them to town and buy groceries and things that we all need” C72 “we are watching TV” C88; T52</td>
<td>D33 “my mother told me that I must work very hard…so I look” “the church instills moral values” (FS)</td>
<td>D43; T15 “they respect me as a mother” “they must respect their elders” (FS).</td>
<td></td>
</tr>
<tr>
<td>Reversal of roles/multiple roles</td>
<td>A59; T76 “her (head) role is as father and mother”  A55; T69 “mother and aunt didn’t know what to do, so I had to take care of him, make sure he had something to eat”  A3 “I was the helper for him (uncle)…she was very ill, I had to take care of her (mother)”  A61; T80 “they behave like they her own kids not like they are brother and sister”</td>
<td>B87 “it was difficult to see my mum sick and then to look after the family…she wouldn’t rest and I did not like that”</td>
<td>C32; T10 “when I had to look after my mother, I didn’t know what to do…”  C35; T13 “when I have to help my mother wash herself I would have to use gloves…”  C52; T26 “they know I am their only parent”  C53; T27 “they are treating me as a cousin because they know they have a mother, but otherwise they know I am their parental guidance”</td>
</tr>
<tr>
<td>Daily Routines</td>
<td>Family Rituals</td>
<td>Celebrations</td>
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<tr>
<td>A67; T92 “brother and sister prepare for school…sister clean house…I will come here (Masizakhe)” A68; T94 “wash the clothes and take turns cooking” A29; T31 “Relies on him (brother) when she has to go away, he has to cook” A30; T32 she (sister) helps around the house”</td>
<td>A74; T106 “Don’t really say goodnight. Sometimes they would ask can they turn off the light, then they know they are going to sleep”</td>
<td>A76; T110 “Don’t have cultural celebrations because there isn’t any elders…”</td>
<td></td>
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<tr>
<td>B37; T19 “I just cut up the veggies and they will cook” B38; T20 “my two brothers prepare their beds and clean the room” B64; T37 “my two brothers do their own washing and I wash for myself and my nephew” B64; T37 “when we have to wash the linen and curtains we help each other out”</td>
<td>B63; T36 “my nephew who wants to go to bed and would ask me to open up the bed for him…tell the others that I am going to bed—they must make sure that the door is locked”</td>
<td>B79; T50 “we celebrate birthdays, we buy cake and some snacks and we…”</td>
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<tr>
<td>C51; T25 “but we help each other out with the cleaning of the house and my two cousins help each other wash the dishes” C70 “I clean the house in between and wash the clothes and cook”</td>
<td>C90; T54 “on mother’s day we go to my mother’s grave and ask her to guide me through”</td>
<td>C90; T54 “we celebrate birthdays, we buy cake but if we don’t have”</td>
<td></td>
</tr>
<tr>
<td>D11 “at nine o’clock I do my work for Masizakhe until one o’clock” “I iron the uniform for them and make the porridge…and lunch” D34; T11 “I would go to school and come back and do housework and look after my mother and children”</td>
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<tr>
<td>Discipline</td>
<td>Rules</td>
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<tr>
<td>A31; T34</td>
<td>“have rules and the boyfriend is not allowed…” “set some rules (head), they always follow them (other children)” A75; T108 “Not allowed to drink alcohol…have curfew…especially the females cannot sleep over…”</td>
<td></td>
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<tr>
<td>B78; T49</td>
<td>“they have a curfew of 9pm. if they are going to sleep at a friend’s they must ask for permission” B24; T12 “it is us who decided that (to take turns to do the work)”</td>
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<tr>
<td>C112; T75</td>
<td>“…somebody does something wrong they don’t get a hiding, they have to do some extra work… well behaved I will buy them something if I have the money…tell them they have been good and that I appreciate that”</td>
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<tr>
<td>D27; T6</td>
<td>“there is no drinking and no men going in and out…” “no swearing and they must respect their elders” (feedback session). D71 “I set the rules and discipline them. they have to do extra cleaning when they doing wrong. I tell them the things they doing is wrong and tell the right thing to do…if well behaved I tell them…we celebrate Christmas, we wear new clothes and have some nice food…church”</td>
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</tr>
</tbody>
</table>
| organisation | A57; T72 “She (head) has to take responsibility for everything and everyone”  
A69; T96 “she makes sure that her sister gets her rest”  
A75; T108 “she (head) sets the rules and disciplines them, she does the budgeting…she will tell them today we gonna have this” | B1 “I am in charge of my brothers and my sister’s child”  
B76; T48 “When they don’t want to help me at times I just tell my aunt and she will discipline them”  
B86 “it was better when she (sister) was around I never used to cook and I had less work, it was easier to help each other”  
B80; T51 “my aunt will decide because she gives us the money but we decide together what to eat” | C52; T25 “i wash everybody’s clothes…”  
C60 “I am (the one who handles the money and decides when to go shopping, what groceries to buy, what to pay)”  
C65 “I am taking care of my business”  
C72; T35 “I am ironing the clothes that I wash and make sure the children wash before they go to bed” | D1 “I am taking them as my own children because there is no one else elder then me”  
D43; T15 “they respect me as a mother” |

| Communication Processes | A59; T76 “all sit and talk when they have a problem, talk things through and understand each other…”  
A36; T43 “the brother understands that she can’t” | B83 “we can talk openly, sometimes I talk to my friends about my problems, sometimes I talk to my brothers”  
B56; T29 “the brothers are understanding” | C104; T67 “they do understand because I would tell them about the situation…” | D53; T23 “because I tell them and make them understand…”  
D48; T19 “we just sit and talk…they can talk to me openly about” |
### Listening

| A60; T78 | “they always listen to her. A63; T84 “they make sure they do listen…to make the right decision” |
| A78; T118 | “she (head) doesn’t want the brother and sister and cousin to feel like they are a burden so she doesn’t tell them exactly how she is feeling…she can speak about personal problems but she can’t tell everything…they can talk to her openly if they have emotional problems” |

### Expression of Feelings

| B83 | “we sit down and talk, we can also cry…” |

### Problem Solving and Coping

| C52; T26 | “they always listen to me” C76; T39 “… they also want to be listened to” |
| C76; T39 | “they see me cry and they will ask what is wrong…they come to me openly with their problems” |
| D30; T10 | “every time I cry I feel so much better, like something is out” D48; T19 “sometimes I want to tell them about myself and our parents but I know they are really young so I don’t” |

| A65; T88 | “she (head) experienced hardship…now |
| C76; T39 | “I have learnt through raising my |
| -planning ahead | trying to make things better for the others so that they don’t go through the same as she did”  
| A27; T29 “there was no money to bury her, so I decided that after that I am going to have a funeral plan for each…”  
| -open to new ideas | A64; T86 “always support each other whatever the other is enjoying doing”  
| -informed decisions | A63; T84 “They make the right decision, people will give you advice but its up to you to take the advice”  
| | B69; T40 “I am coping at the moment because of the information that I got at the workshop”  
| | C80; T44 “my mother had a funeral cover so it wasn’t difficult to have her funeral and a proper burial for her”  
| | C106; T69 “we are open to new ideas and do try new things”  
| | C105; T68 “we do listen to them, to the people who advise us and we will choose the ones that we feel are suitable to us”  
| | D66; T33 “ I lay bye the clothes for one child this month…the other child next month by Christmas we have the clothes”  
<p>| | D50; T22 “tell the children to keep a memory box…show them how to do their own” “make my own decisions, don’t just accept what others are saying” (feedback session). |</p>
<table>
<thead>
<tr>
<th>Stress Reduction Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A82; T126</strong> “I used to do weights, I just take a walk and speak to friend’s and forget about the problems”</td>
</tr>
</tbody>
</table>

**B28; T13** “I went for counseling here by Beatrice, we all went…we could accept the loss…we coped as a family”

**D48; T19** “I write in my journal and my memory box, keep photos of my family”

**D49; T20** “I feel so much better when I write”

<table>
<thead>
<tr>
<th>Friend and Community</th>
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</thead>
<tbody>
<tr>
<td><strong>A78; T114</strong> “…does have people she can turn to, people in the community…feels safe and secure, they will help her and she will help them”</td>
</tr>
</tbody>
</table>

**A79; T120** “talk to a friend who had a similar problem…talking about her (head) problems she received help”

**A82; T126** “I used to do weights, I just take a walk and speak to friend’s and forget about the problems”

**B83** “it helps to talk to others who are heading a household like me, she understands what I am going through”

<table>
<thead>
<tr>
<th>Joint Decision Making and Problem Solving</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B29; T14</strong> “My friend referred me to Beatrice (Masizakhe) for help”</td>
</tr>
</tbody>
</table>

**B29; T14** “My friend referred me to Beatrice (Masizakhe) for help”

**B28; T13** “I went for counseling here by Beatrice, we all went…we could accept the loss…we coped as a family”

**C84; T48** “Pamela or the neighbour or Beatrice (for help)”

**D17** “I will come to Beatrice to tell her my problem”

**D63** “Beatrice understands me…she is like a mother to me”

**C76; T39** “…I will tell them and ask them to help me raise them…”

**D48; T19** “I write in my journal and my memory box, keep photos of my family”

**D49; T20** “I feel so much better when I write”
<table>
<thead>
<tr>
<th>Identified deficits</th>
<th>-solution focused</th>
<th>D68;T37 “I see a problem as that. A problem that has to be solved.”</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>-Basic needs</td>
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<tr>
<td></td>
<td>A65;T88 “didn’t have electricity and food and go to bed without food…have a curtain rail for the curtain”</td>
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<td></td>
<td>A75;T108 “sees how much money is used, so they don’t abuse it”</td>
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<td>A16;T16 “…had to buy furniture that sofas, television and fridge…”</td>
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<td></td>
<td>-General needs</td>
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<tr>
<td></td>
<td>A83;T128 “support groups to help those kids…have guidance on how to be adult…role models”</td>
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<td>B52;T26 “no one taught me before how to handle everything…”</td>
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<td>B75;T47 “no I don’t need to speak to a “</td>
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<td></td>
<td>C32;T10 “I didn’t know what to do; I didn’t even know how to help her”</td>
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<td>C116; T79 “I didn’t even “</td>
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<td></td>
<td>C38;T16 “the money wasn’t enough…I will need more”</td>
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<td></td>
<td>C67 “I want them to have an education”</td>
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<td></td>
<td>C144;T77 “I need to learn first to find a job”</td>
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<td></td>
<td>D18 “the only problem is the shortage of money, food and clothes”</td>
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<tr>
<td></td>
<td>D74;T37 “need a TV, fridge and that the beds are too old. we need a wardrobe for the clothes cos we use the washing basket”</td>
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<tr>
<td></td>
<td>D65; T31 “the childheaded families need a support group where they tell them</td>
<td></td>
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</tr>
<tr>
<td>Reinforcement</td>
<td>A32;T35 “they (community) have commented… like the way we are behaving…it looks like it’s a home not missing a mother”</td>
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<tr>
<td></td>
<td>“only spoke to somebody in the community (not to anybody professionally)” professional person they will all say the same thing again”</td>
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<tr>
<td></td>
<td>know how to prepare them for school…how to talk to them…” C110; T82 “feel better now…spoke to someone (interviewer)” how to be string and how to keep a float” D32 “I just want to speak and cry and somebody to listen” D31 “no counseling hen my mother died”</td>
<td></td>
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<tr>
<td>D44;T17 “compliments about the way I am treating the kids on my own” D26 “compliment that I am taking good care of the home and the kids”</td>
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</tbody>
</table>
Appendix F: Summary Tables of Results
Family Resources (BB)

<table>
<thead>
<tr>
<th>Family resource</th>
<th>Identifiers</th>
<th>Theme/Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tangible personal resource</strong></td>
<td>A5; A17; A27; B1; B56; C62; C103; C36; D/FS</td>
<td>-financial support</td>
</tr>
<tr>
<td><strong>Intangible personal resources</strong></td>
<td>A79; A57; B37; B49; B73; C108; C113; D59</td>
<td>-spirituality</td>
</tr>
<tr>
<td></td>
<td>A17; A75; A27; B79; C89; D23; D24</td>
<td>-financial discipline</td>
</tr>
<tr>
<td><strong>Intangible family system resources</strong></td>
<td>A3; A9; A59; A55; A36; A61; A57; A69; A75; A60; A63; A78; B12; B1; B10; B24; B83; B56; B76; B86; B80; C35; C52; C53; C60; C65; C72; C76; C104; D34; D14; D43; D1; D9; D53; D48; D43; D30</td>
<td>-household head; reversal of roles/multiple roles; structure/organisation; communication processes</td>
</tr>
<tr>
<td>-family organisation</td>
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<tr>
<td>-family hardiness</td>
<td>A57; A66; A63; D68; B73; C74; A77; B58; C113; B88-89; C82; D/FS</td>
<td>-internal motivation; external locus of control; positive outlook; unity, acceptance, love</td>
</tr>
<tr>
<td>-family cohesion</td>
<td>A21; A53; A50; A71; A60; A61; B85; B72; C104; C88; C52; D43; D/FS</td>
<td>-cohesion; sense of belonging; respect</td>
</tr>
<tr>
<td>-family adaptability</td>
<td>A11; A36; A37; B37; B46</td>
<td>-flexibility</td>
</tr>
<tr>
<td>-family time together</td>
<td>A15; A59; A71; B63; B72; C88; C89; C72; C88; D12; D48</td>
<td>-family time</td>
</tr>
<tr>
<td>-family routines</td>
<td>A67; A68; A30; A76; A74; B37; B38; B64; B79; B63; C51; C25; C90; D11; D34; D66</td>
<td>-daily routines; family rituals; celebrations</td>
</tr>
</tbody>
</table>
### Social Support (BBB)

<table>
<thead>
<tr>
<th><strong>Community Support</strong></th>
<th><strong>Identifiers</strong></th>
<th><strong>Theme/Sub theme</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-family members</td>
<td>A60; A64; B12; B33; B37; D15</td>
<td>-family members’ support and unity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-grandparents; relative involvesment</td>
</tr>
<tr>
<td>-extended family</td>
<td>A50; A58; A27; A78; B81; B15; B6; C91; C75; D16; D/FS; D32; D1; C80; C91</td>
<td></td>
</tr>
<tr>
<td>-friends</td>
<td>A63; A78; A79; B82; C81; C21; C23; D60; D72; D55; D25; D26</td>
<td>-community members and friends</td>
</tr>
<tr>
<td>-community</td>
<td>A78; A79; B57; C18; C32; D37; D57; D/FS; A5; A8; B7; C24; C71; D2; A63; B82; B83; B41; C81; C21; C23; D60; D72; D55; D25-26; A7; B44; C25; D70</td>
<td>-community project for support; community project for work; community members and friends; community project for services</td>
</tr>
<tr>
<td>-other</td>
<td>C110; D/FS</td>
<td>-assistance from social worker</td>
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</table>

### Social support

<table>
<thead>
<tr>
<th><strong>Theme</strong></th>
<th><strong>Identifiers</strong></th>
<th><strong>Sub theme</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-emotional support</td>
<td>A78; A79; B57; C18; C32; D37; D57; D/FS</td>
<td>-community project for support</td>
</tr>
<tr>
<td>-esteem support</td>
<td>A5; A8; B7; C24; C71; D2</td>
<td>-community project for work</td>
</tr>
<tr>
<td>-network support</td>
<td>A5; A8; B7; C24; C71; D2; A78; A79; B57; C18; C32; D37; D57; D/FS; A63; B82; B83; B41; C81; C21; C23; D60; D72; D55; D25-26</td>
<td>-community project for work; community project for support; community members and friends</td>
</tr>
<tr>
<td>-appraisal support</td>
<td>A32; D44; D26</td>
<td>-affirmation</td>
</tr>
<tr>
<td>-altruistic support</td>
<td>A7; B44; C18; C25; D70</td>
<td>-community project for services</td>
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## Appraisal Processes

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<thead>
<tr>
<th>Appraisal Process</th>
<th>Identifiers</th>
<th>Theme/Sub theme</th>
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<tbody>
<tr>
<td><strong>Schema (CCCCC)</strong></td>
<td>A57; A66; A63; D68; A79; B37; B49; B73; C108; C113; D59; B73; C74; A31; A38; D33; D/FS; A60; A61; C52; D43;</td>
<td>-internal motivation; spirituality; external locus of control; integration of values; respect</td>
</tr>
<tr>
<td><strong>Coherence (CCCC)</strong></td>
<td>A57; A66; A63; D68; B73; C74; A77; B58; C113</td>
<td>-internal motivation; external locus of control; positive outlook</td>
</tr>
<tr>
<td><strong>Paradigms (CCC)</strong></td>
<td>A60; A61; C52; D43; D/FS; A15; A59; A71; B63; B72; C88; C89; C72; D12; D48; A67; A68; A29; A30; B37; B38; B64; C51; C70; C25; D11; D34; A74; B63; C90; A76; B79; D66; A31; A75; B78; B24; C112; D27; D71; D/FS</td>
<td>-respect; family time; daily routines; family rituals; celebrations; rules</td>
</tr>
<tr>
<td><strong>Situational Appraisal (CC)</strong></td>
<td>A77; B58; C113</td>
<td>-positive outlook</td>
</tr>
<tr>
<td><strong>Stressor Appraisal (C)</strong></td>
<td>B88-89; C82; D/FS</td>
<td>-unity, acceptance, love</td>
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</tbody>
</table>
## Problem Solving and Coping Resources

<table>
<thead>
<tr>
<th>Identifiers</th>
<th>Theme/Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>A65; C76</td>
<td>-learning from experience</td>
</tr>
<tr>
<td>A27; C80; D66</td>
<td>-planning ahead</td>
</tr>
<tr>
<td>A64; B69; C106; D50</td>
<td>-open to new ideas</td>
</tr>
<tr>
<td>A63; C105; D/FS</td>
<td>-informed decisions</td>
</tr>
<tr>
<td>A82; B28; D48; D49</td>
<td>-stress reduction strategies</td>
</tr>
<tr>
<td>A78; A79; B29; B83; C83; C84; D17; D63</td>
<td>-friend and community</td>
</tr>
<tr>
<td>B52; B24; C76;</td>
<td>-joint decision making and problem solving</td>
</tr>
<tr>
<td>B83; D68</td>
<td>-solution focused</td>
</tr>
</tbody>
</table>
APPENDIX G: Process Notes
Process Notes-Participant A

The first interview between the researcher and participant A took place on the 1st October 2007 (Monday) in Kwazakhele, Port Elizabeth. The interview was scheduled for 09.30am, however upon arriving at the Masizakhe Community Project’s premises, it was realised that the key role player was delayed due to transport difficulties. Thus the interview only began at 10.30 am and lasted for 2 hours.

Environment/ setting

The Masizakhe Community project is located in Kwazakhele Township, Port Elizabeth. The interview took place in one of the community project’s containers (a cargo container probably used on a train), which is usually used in the afternoons for after school care for OVC (orphaned and vulnerable children). Therefore, the interview took place in the morning in order that this container may be used by the project in the afternoon. The container is a rectangular shaped, metal structure that is painted red and white and stands on vacant land across a tiny road from the Masizakhe offices. It was dark and empty when we arrived, no furniture, no wall hangings, and no curtains, absolutely bare; nothing in the room- Only one plug point which was pointed out to me for the audio-recorder. Quickly four chairs were arranged for the interview. One chair was for the participant, one for the interviewer/ researcher, one for the translator and another chair to place the audio equipment on. It was a cold, rainy and windy day in Port Elizabeth and the container, even though empty, it was noisy as the one window frame rattled in the wind and various banging sounds against the roof could be heard. Twice during the interview the door flew upon and banged against the wall. Despite these outside influences the interview proceeded smoothly and was complete two hours later at 12.00pm. A translator was used for this interview.
The container provided a private and confidential environment for the interview to take place and the participant appeared comfortable here.

About the participant
Participant A is a 24 year old female with tom-boyish characteristics. She was dressed in a jeans and jersey and wore a hat. She had a plaster (band aid) on her small right finger. She was enthusiastic and motivated to participate. She maintained appropriate eye contact with the interviewer and the translator. She appeared to be at ease during the interview. Her speech was soft at times, otherwise reasonably clear and audible. She answered the questions appropriately and asked questions if she wasn’t clear about what was being asked to her. Her mood appeared stable, euthymic. Her affect was congruent to her euthymic mood. She teared briefly once during the interview. Otherwise she was very contained. She attended to all questions and was able to concentrate throughout the interview.

My own thoughts
I was surprised when during the interview; the participant reported she was 24 years old. The criterion for participant selection was 18 years to 21 years. However, I had already informed her about the study and invited her to participate and she had volunteered to participate. It was only when the first question was asked to her, did I realise her age. At this stage I felt it was unethical and unprofessional to abandon the already established research relationship/ contract so I decided to proceed. An early learning that I would in the future need to first clarify and confirm the participants criteria with the Masizakhe volunteer prior to being introduced to the participant and prior to introducing the research study to the participant and inviting the participant to participate in the study.
I was initially anxious when I realised that the volunteer who was selecting participants for this study was late. I was worried whether the interview was going to take place and I questioned whether she had arranged participants as we had agreed upon. I felt much ease when we went into the container and the participant agreed to participate. I felt relief to know that this research study was finally on the way. I experienced some difficulty in terms of language. I felt at times that the participant was giving volumes in her response yet the translator reduced it to a few sentences. However, this will be verified upon transcription by the independent translator.

My preconceived ideas

I expected that I would arrive there and the interview room would be arranged and set up and the participant would be ready. I expected to meet a young, immature participant, a child who had to act “adult-like”-A child who would relate a story of hardship and suffering initially and not coping at all with life circumstances and then eventually proving to be resilient.

I expected that the participant would be extremely emotional and fragile at the mention of her parents and the loss of them and that I would need to do lots of containing of the participant’s emotions. I expected the participant to talk a lot about her parents’ illnesses and the period just after their death. I was surprised at the emotional strength of this participant and how mature she presented herself.

I also realised the emotional impact this story had on me and on the translator. How come I have not proposed debriefing sessions for myself and for the translator– limitations of the design and need to be recommended in the future. I will arrange for the translator to be referred to one of my colleagues for debriefing.

The translator and I need to speak in first person. I will inform her about this. Maybe this could have been sorted out if I had a pilot interview.
Process Notes-Participant B

The first interview between the researcher and participant B took place on the 3rd of October (Wednesday) 2007 at 9.45am until 11.00am. It lasted for 1hr and 15min. It took place at the Masizakhe Community Project container- the same venue as used for the previous interview with participant A. The interview was translated. It was scheduled for 9.00am but the participant arrived late.

The environment/setting

Again, the interview took place in the container as described earlier. It was a very windy yet hot day. The chairs for the interview had to be arranged again as the container stood empty. About the area surrounding this container- it is dry, unpaved, gravel land. There were many stray dogs wandering about, a few children running around and a few adults walking pass. Across the road in the Masizakhe offices, the little pre school children could be heard having their morning class. Next to the offices were small “four-by-four” homes painted in various colours. The one house stood out as there was lots of movement there. People go in and out to buy a home made alcoholic beverage- it seemed to be really popular.

About the participant

Participant B is a 20 year old female. She understood a reasonable amount of English but utilised the translator quite often to express herself better. She appeared very young (younger than her chronological age) and was dressed neatly and was well groomed. She had a conspicuous scar on her chin (surgical scar) and had a tongue ring. She appeared slightly shy initially and a bit nervous but eased into the interview. She mainly had a downward gaze especially when talking about more emotional issues. Her mood can be described as euthymic however she was tearful.
especially when talking about the loss of her mother and her sister. This was congruent. She appeared to become a bit tensed almost with a tendency of trying really hard to hold back her tears. She answered the questions adequately and was not reluctant to ask for further explanations. However, she had difficulty talking about her mother and sister and their deaths. This appears to be an unresolved and still very fresh emotional issue for her.

My own thoughts

I was preoccupied before the interview whether the Masizakhe volunteer had arranged a participant who met the criteria for the study. I was relieved when I double checked the participant’s suitability before inviting the participant to participate in the interview. Again though, I must realise that at Masizakhe there is no age limit to define a child or adolescent head of a household. As long as a parent has passed away and the first born child assumes responsibility for the house and family, this person is referred to as a “child head”.

I was again frustrated that the interview began later than the scheduled time. The participant was there but was talking to the volunteers of the Masizakhe Project, only when I further enquired at 9.30am where the participant was, did they tell me that she was there. I felt as though the research initiative was not being given the importance it deserved, or there wasn’t a need to be respectful of time. Or were they experiencing some difficulty in being committed to the stipulated time of the interview.

Again, the participant met all the criteria as stipulated but in addition, like participant A, she is also a volunteer at the Masizakhe Community Project. I wondered if all the participants will be volunteers and am pondering the effect of being a volunteer at this project on the responses during the interview and the eventual findings. I will need to keep this in mind. Also, during the
interview I picked up a strong reliance on this project, a parallel to participant A’s interview. I question whether this emphasis on Masizakhe is congruent and genuine or whether it is “faking good” which is not uncommon amongst research participants. Also, if all are volunteers there may be few discussions with regards to the questions being asked and those who are still to be interviewed may have rehearsed their responses.

I discussed with the translator about speaking in first person and this feedback was received positively and carried out in this interview. This worked much better in the interview and the translator appeared more comfortable translating. She translated line by line and this time round I did not feel as though she was reducing the responses. I also further informed her that at any stage during the interviews should she feel distressed emotionally, I will refer her to a colleague for debriefing.

I think that I was more at ease in my role as interviewer having already conducted one interview. I felt more confident due to the experience of having done the first interview.

My preconceived ideas

Based on the interview with Participant A, I expected that Participant B would also be emotionally strong and contained. I expected her to also be more adult-like however; she matched my previous preconceived idea of a child-like person who has to fit into adult shoes. Basically my preconceived ideas from before the first interview with Participant A were answered in this interview.
Process Notes- Participant C

The first interview between the researcher and Participant C took place on the 4th October (Thursday) 2007 at the Masizakhe container as with the other interviews. The interview was 1 hour 30 minutes long and was from 10.00am to 11.30am. It was translated.

The Environment/setting

Once again the interview as held in the Masizakhe container. Today was a clear, bright day with some cloud cover. At least the wind wasn’t strong, so the container was quiet and the interview was not disturbed by various banging or rattling sounds on the metal structure. It was pleasant to have a quiet environment to work in. Around the township various community volunteers walked around cleaning up the streets. This was definitely a pleasant sight. Otherwise, not much else has changed in terms of the environment in which the interview was held.

About the Participant

Participant C arrived late for the interview. She arrived at 10.00am even though we were scheduled to begin at 9.30am. She is a twenty year old female. She was neatly dressed in jeans and tracksuit top and she wore a woolen hat on her head, she wore two silver rings on her fingers. She was of slender physique and understood English fairly well, she hardly used the translator for translation of the questions being asked but she did respond in Xhosa to the questions as she seemed more comfortable to express herself in Xhosa. She was tearful at times but this was congruent. She was motivated and excited to participate and answered all the questions thoroughly; she seemed to be enjoying the interview. She also volunteered information. She maintained appropriate eye contact and her speech was clear and audible.
My own thoughts

I wondered if the participant will again be a volunteer at Masizakhe- and yes she was. I also asked the key role player whether there were any male participants and she commented that she doesn’t think any of the males were approached for the research, she seemed unsure of this. I was hoping to interview a male head of household-anticipating something different, I suppose.

I wondered if this participant was going to sing praises of the community project but much to my surprise she didn’t over emphasise or exaggerate the community project’s role in her life.

This was again another interview that didn’t begin on time and I was not as frustrated or anxious as I think I am growing accustomed to this lack of punctuality that pervades here. I wondered if it’s a case of “if you can’t beat them, then join them”. But I was soon to learn that there was a reason for this participant arriving late.

I was a bit concerned when another volunteer told me that I was going to interview her today and she was 24 years old… I thought “oh, no they are not getting the criteria I outlined to them earlier”. I was relieved when this was clarified.

My preconceived ideas

I was surprised when she said that she had a 7 month old baby of her own. This surprised me because she was slender in physique and appeared so young physically. Also, it dawned upon me that all these potential participants are not merely sitting around waiting to be interviewed by me, they do have lives. Such as, this participant was washing her family’s clothes that is why she was late. I realised that I needed to start placing the participants into the broader context in which they lived their lives.

Quite honestly at this stage in the interviewing I hadn’t held any of my preconceived ideas from the first two interviews as this time I didn’t know what to expect as the first two participants were
very different. All that I was sure of was that I would definitely be hearing a different life story from a different voice.

Process Notes- Participant D

The first interview between the researcher (interviewer) and Participant D took place on the 5th October (Friday) 2007 at the Masizakhe Offices in Kwazakhele, Port Elizabeth. The interview took place at 10.15am to 11.30am and was translated.

The Environment/ Setting

Today the township seemed to have a different energy. It appeared more “alive” more vibrant, the people seemed excited and jubilant. I am not sure if this was in preparation for the weekend ahead or because it was a hot, summer’s day. The wind had subsided and the rains had passed and the sun burst through leaving no trace of the gloom of the previous days. As I waited in my car outside the offices for the participant to arrive, I was approached by an old man who was intoxicated. He was on his way to the house adjacent to the Masizakhe offices. I mentioned before that this house sold a popular, cheap traditional alcoholic beverage. Any way he enquired from me in Afrikaans: “what are you doing here? How long are you going to live for? You living a nice life; with a car.” I felt that he was invasive to approach me and ask what I was doing there and also for him to assume that I have a good life because I own a car. Furthermore, I think he assumed that I was infected that is why I was at Masizakhe and hence him asking how long was I going to live for. It dawned on me that this was the reality for most people who seek help from a community project like Masizakhe. That other people assume that all people affiliated to the project in someway are infected and not necessarily affected. They are judged as being infected when they attempt to get help for their situations. I also realised that for this old man owning a
car was a big thing as not many people in the township had vehicles and they relied on public transport. This little dialogue, once again highlighted the context within which most of the research participants live.

The interview was once again held in the Masizakhe container. This had become the usual venue for the interviews to take place and this was purely due to the practicality of this one container having electricity whilst the other did not have. The electricity was needed for the audio recorder. Not much had changed in terms of the setting, except that it was quite hot in here due to it being a metal structure and it being a hot day outside, so the heat was retained in this container. Also the “vibe” from outside could be heard throughout the interview session.

About the Participant

Participant D is a twenty year old female. She is approachable and friendly. She was dressed in a lime green skirt and a black t-shirt and wore sandals. She appears much older than her chronological age and is overweight. Her mood was euthymic, she was slightly tearful at one stage during the interview. Her speech was coherent; she insisted on responding to most of the questions in English even though at times she battled with the English language. She appeared to understand most of the questions when they were asked in English but at times utilised the translator. She maintained an appropriate eye contact and attended to all the questions.

My own thoughts

I was surprised that she was 20 years old, as she appeared older. I thought to myself that probably her life experiences had withered her. I eagerly asked the key role player whether the participant was male or female; as once again I was hoping to interview a male participant today. Never the less, I realised that each individual is unique and each one had painted a different story.
Today I was feeling exhausted, a physical, mental and emotional exhaustion that is probably expected from interviewing people about a sensitive topic. My own energy was in stark contrast to that of the energy of the surrounding township and its people. Investigator fatigue can disrupt an interview process and hence it is suggested that interviews be well paced out.

I felt as though the participant wanted to be independent of the translator and that she attempted very hard not to have to ask her to translate for her; as though she wanted to show me that she could speak English. Once again, language as a barrier was demonstrated in this interview as I wondered if the participant would have been more forthcoming if she was more proficient in English or if the interviewer was Xhosa speaking and did not have to rely on a translator. Hence, by-passing a third person (the translator) during the interview, would make the participant more comfortable and open.

I was most comfortable in my role as interviewer as I felt more familiar with the questions and also had the confidence of having conducted three previous interviews. I found myself asking questions more flexibly than in the previous interviews. Is this a limitation of the interview method as it depends on interviewer expertise?

My preconceived ideas

I expected to meet a young looking participant like the two from the previous two days. Also I anticipated that she would also be a volunteer at Masizakhe. I also anticipated that she would report receiving endless support from friends, family and the community—quite the contrary was reported by her.

I must admit that when the participant did not arrive by 10.00am, I assumed that maybe she would not arrive at all as it was a Friday and this was the beginning of the weekend and most people prefer not to be “bogged down” by work, etc.
My learning thus far

I learnt that research is indeed a process as I had made contact with Masizakhe well in advance outlining the inclusion criteria for sample selection as well as confirmed the dates for interviewing in advance. However, upon arrival at Masizakhe they appeared not to be ready for me and also they had confused the age group for potential participants. I am at a loss for further suggestions to prevent these hurdles from occurring as I had presented this information to the key role player in a meeting with her as well as in a written format. Also prior to the interviews I had contacted her telephonically to confirm the arrangements. Never the less, it was important for me as a researcher to mould into their ways and to be sensitive of their own situations. For example, with each interview beginning later than scheduled, I had to embrace that the interview would eventually happen.

The IPA method proved beneficial as it addressed the research question and also it provided a suitable tool (interview method) for data collection. The semi structured interview was appropriate for the research question, the sensitivity of issues being raised, the sample characteristics and the language preferences of the participants. The participants appeared to enjoy and appreciate this level of human contact with the researcher and appreciated that they were being invited to talk about their lives. The interviews also seemed to be of therapeutic value to the participants. Also the semi structured nature of the interview allowed me to be flexible and to probe where necessary without feeling pressured to having specific questions answered within a specified time period; also I could ask questions in a sequence that seemed suitable for the pace and atmosphere of the interview session and not follow a list of questions strictly; and I could revisit certain areas at a later stage and explore further.
I also felt that a pilot interview would have been beneficial as this would have given me a first opportunity to role play the interview questions, ease into the interview method and work with the translator. This would have allowed me to make further decisions with regards to other areas to probe, it would have put me at ease from the first interview as I would have had the experience of the pilot interview and also I would be able to identify challenges in working with a translator prior to the interviews beginning. For example, even though the translator was from the NMMU language department, her expertise is in languages but not necessarily translation. That is, I had to point out to her the need to translate in the first person and to translate at shorter intervals otherwise content would be lost if the participant talks for much longer and then she attempts to translate. Also, she did not necessarily translate every word that was exchanged between herself and the participant.

There is a limitation attached to collaborating with a specific organisation. That is, I felt that the sample was restricted to people that were affiliated to Masizakhe in some way. However, it was further limited in that they tended to identify participants that were volunteers at this project and not any others who were not volunteers but registered and receiving services from Masizakhe but not “working” for them. I feel this limited the sample selection and may limit the findings.

I also learnt very early to confirm the potential participants’ criteria before inviting them to participate. I also feel that research into the predominant culture in this geographic area would have proved helpful, even though this cultural ignorance on my behalf did not hamper the study in any way, I do feel that such insights would allow for a deeper understanding and better connection and involvement with the sample being studied.
I was enthusiastic to meet and interview all six participants within a week but soon realised that the translator and I became tired after the first interview and that the interview had to be paced out in order for all involved to be functioning optimally. An important aspect was that process notes were written up after every session and transcription also took place as soon as possible after the interview. This was helpful as information was about the interview and the participant was retrieved and recalled with ease.

I was disappointed that the sample only comprised of females. I was hoping to have interviewed a male head of a household. I am not sure whether there aren’t any male heads of households registered with Masizakhe or whether they were not approached by the key role player to participate. Upon enquiring, this was not clarified. Also, the Masizakhe Community Project identified 5 “child headed households” of which two were above 21 years of age. This had left me with a sample size of three. My target was set for a minimum of 5 and a maximum of 6. However, I did conduct 4 interviews. As has been explained earlier, the first participant that was recruited was 24 years old but had already agreed to participate before it was discovered that she was 24 years old. I was limited to interviewing child heads that were registered with Masizakhe as this was stipulated in the research contract between myself, iThemba and Masizakhe.