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PERCEPTIONS OF RESILIENCE BY CAREGIVERS OF CHILDREN IN A RESIDENTIAL CARE FACILITY

ANDREAS BARON

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PERCEPTIONS OF RESILIENCE BY CAREGIVERS OF CHILDREN IN A RESIDENTIAL CARE FACILITY

by

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PRETORIA
2013

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In the end, this was an easy choice:
This dissertation is dedicated to my wife
who has stood by my side year after year.
She was there when the ideas flowed,
and she was there when they stopped again.
Always inspiring and motivating me,
René, this goes out to you.
You are my mountain,
you are my sea.

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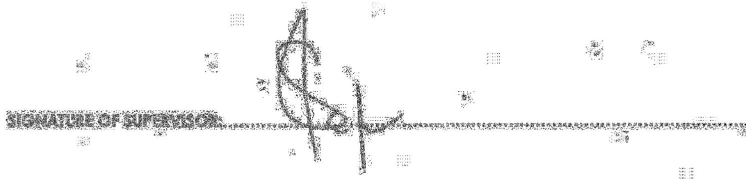

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ABSTRACT

Perceptions of resilience by caregivers of children in a residential care facility

This study, aimed at analysing the methods used by caregivers to construct their own resilience at a residential care facility for orphaned and vulnerable children, forms part of a larger study investigating the role of emotional awareness in caregivers. Convenience selection was used for the research site on account of accessibility, and purposive selection for the participants owing to their role as caregivers at the care facility. The qualitative case study method facilitated contextual investigation of the matter at hand. Data were collected by means of a focus group discussion with seven participants, individual interviews with four participants, and the researcher's informal observations in order to elucidate the main research question: *How do formal caregivers of orphaned and vulnerable children construct their own resilience?* Kumpfer's Resilience Framework served as the theoretical foundation for the study. Thematic analysis of the data yielded the following themes: demonstrating resilience when functioning within an unsupportive environment; demonstrating resilience when establishing a sense of control; demonstrating resilience through belief; and resilience born out of identity as a caregiver. Results were related to existing literature and the theoretical framework. Furthermore, a conceptual framework for the South African context is suggested.

KEYWORDS:

Resilience, resiliency, caregivers, orphaned and vulnerable children, stress, control, belief, coping, identity, conceptual framework

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CHAPTER 1
INTRODUCTION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

This study was undertaken within the ambit of a larger study conducted by Mohangi (2008), *Exploring the psychosocial and emotional awareness of adults who care for children in an institution,* based at a residential care facility for children affected by HIV and AIDS. Aspects investigated in the larger study included caregivers' coping responses, emotional awareness, and the potential influences that these elements might have on caregiving practices. The Mohangi study also sought to arrive at a better understanding of caregivers' motivation to care for vulnerable children, and the research themes arising from it provided guidelines for the current study. As a research assistant, I became interested in how caregivers remain motivated to care for orphaned and vulnerable children despite facing difficult and challenging situations on a daily basis. These demanding situations include having to take care of children who are ill or who have emotional and behavioural problems.

According to Fredriksen-Goldsen (2007), HIV and AIDS caregiving can have a negative effect on the psychological well-being of caregivers. Such effects may lead to fewer opportunities for development at a social, personal, and economic level. Other adverse effects of HIV and AIDS caregiving include burnout, emotional exhaustion, decreased feelings of personal achievement, and an increased detachment from those in their care (Ross, Holliman, & Dixon, 2003). A similar study on caregivers of Alzheimer's disease patients found that caregivers described the responsibility of caregiving as "overwhelming, stressful, and lonely" (Ross et al., 2003, p. 87). However, Mohangi (2008) found that a positive relationship between orphaned children and their caregivers resulted in a strong protective factor against negative outcomes. Thus it is likely that resilient caregivers could be better able to provide care for orphaned and vulnerable children. As researcher, it was important for me to explore and understand resilience from the caregivers' perspective.

1.2 RATIONALE

Considering that I have always been interested in the positive side of psychology, the combination of my interest and my experience with caregivers as a research assistant sparked my interest in exploring how these caregivers were able to work in difficult circumstances on a daily basis.

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The orphaned and vulnerable children in the residential care facility have all been affected by HIV and AIDS, which exert, as Foster (2004) points out, devastating effects on families and children. With soaring levels of orphaned children in South Africa following in the wake of the pandemic, caring by means of the traditional extended-family pattern for children who have lost one or both parents because of HIV and AIDS has been severely eroded; for example, many affected households are child-headed. These factors have put tremendous strain on South African care facilities, resulting in caregivers working in facilities that are faced with this reality on a daily basis (Foster, 2004; Lalthapersad-Pillay, 2008; Mutiso, Cheshire, Kemboi, Kipchirchir, & Ochieng, 2011).

HIV and AIDS constitute a serious global pandemic, with sub-Saharan Africa being the hardest hit region with an estimated 24,5 million people infected, resulting in 2,8 million deaths in 2005 (Emanuel et al., 2008). Such is the magnitude of the pandemic that it has become the leading cause of death in sub-Saharan Africa. In 2007, an estimated 1,4 million children between the ages of 0 and 17 years were living as orphans, having lost either one or both of their parents to AIDS (UNAIDS/WHO, 2008). In South Africa alone, the estimated number of deaths due to AIDS in 2007 stood at 350 000, with 5,7 million people infected (UNAIDS/WHO, 2008). Compared with data from 2012, an estimated 2,5 million children were orphaned because of AIDS, whereas an estimated 6,1 million persons were living with HIV in South Africa (UNICEF, 2014). This alarming increase in the number of orphaned and vulnerable children is in itself a strong argument for focusing more research on caregivers in care facilities.

In Southern Africa, HIV infection is the highest among 20- to 40-year-olds. Mortality among adults in this age group contributes to a rising problem with regard to orphaned and vulnerable children in the region. In 2008, it was projected that South Africa alone would have 3,1 million orphaned and vulnerable children by 2010 (Lalthapersad-Pillay, 2008). In fact, the National Census showed that there were a total of 3,4 million orphans between the ages of 0 and 17 years in 2011 (Statistics South Africa, 2012). This figure was eclipsed only a year later by a UNICEF (2014) estimate that put the number at 4 million. In 2011, KwaZulu-Natal was the province with the highest number of orphans (30%), followed by the Eastern Cape (17,4%), and Gauteng (13,5%) (Statistics South Africa, 2012). As indicated in Figure 1.1, the number of orphaned children in South Africa has steadily increased since 1996.

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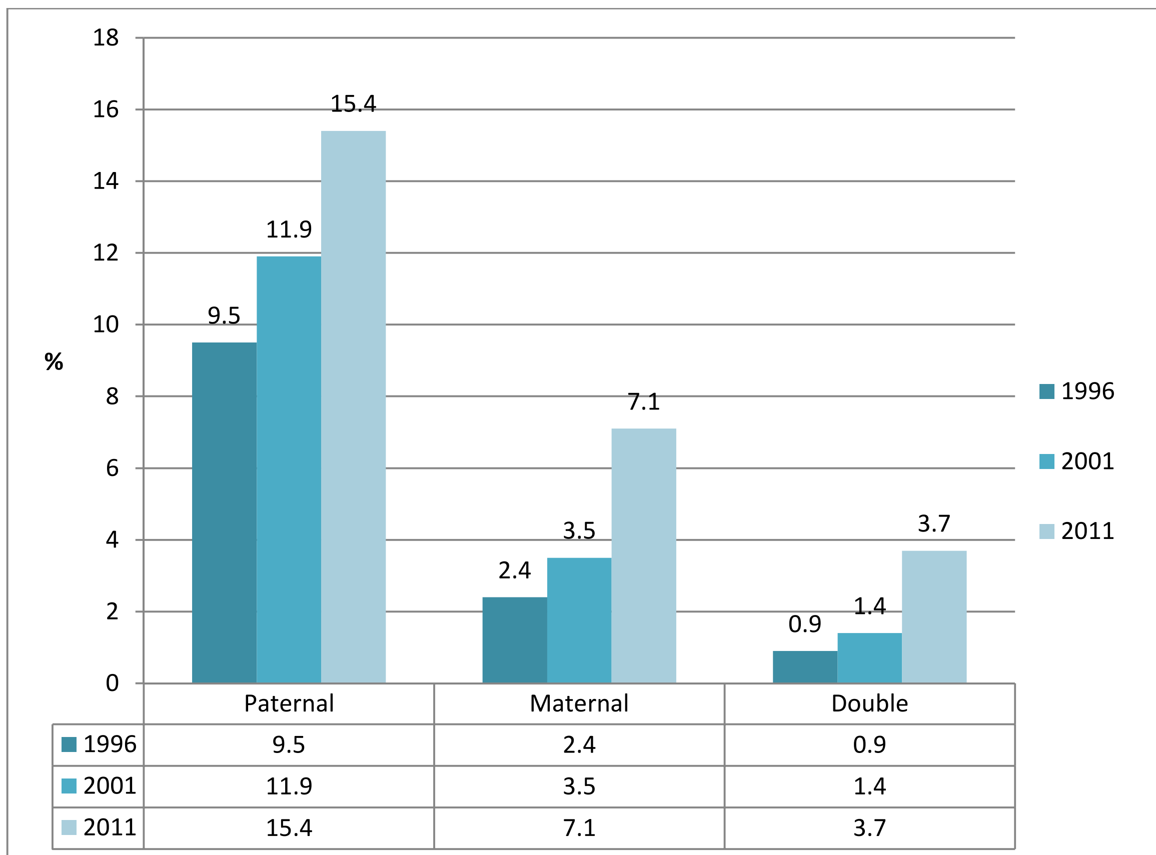

	Paternal	Maternal	Double
1996	9.5	2.4	0.9
2001	11.9	3.5	1.4
2011	15.4	7.1	3.7

Figure 1.1: Orphan type by census (Adapted[1] from Statistics South Africa, 2012)

In many African contexts, it has traditionally been the role of the extended family to care for orphaned children. However, with increasing numbers of households experiencing the effects of HIV and AIDS, fewer extended families are able to care for orphaned children. In South Africa many families lose their breadwinners to the pandemic (Foster, 2004; Townsend & Dawes, 2007). As a result, many families who already experience financial strain find that there is no possibility for them to look after additional family members. In a traditional sense, one would have been able to say that orphans in Africa did not exist due to the collective nature of the cultures (Foster, 2004). Often whole towns would help in raising a child should the need arise. However, with the current financial and health constraints in larger parts of Southern Africa, and especially in South Africa, this practice no longer holds true. Table 1.1 provides a brief summary of the social changes contributing to the decline of the extended families caring for orphaned children.

[1] Adapted: The factual information has remained the same as presented in the original source, but the format of the table or figure has been altered slightly.

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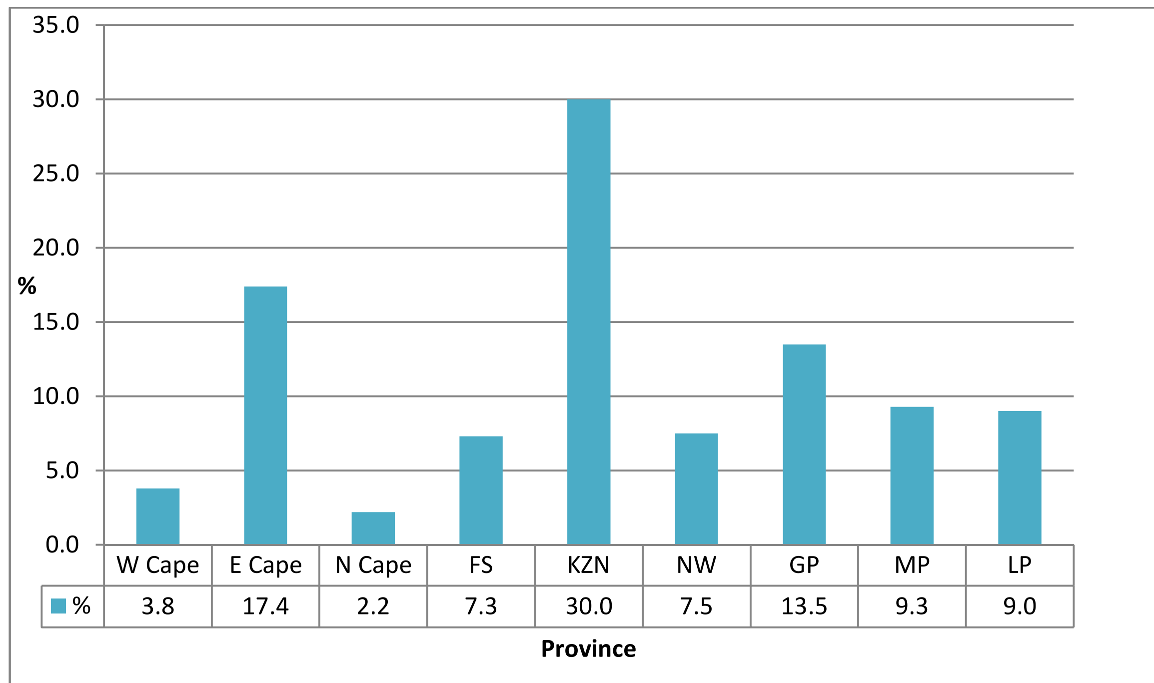

Figure 1.2: **Percentage of orphaned children by province** (Adapted from Statistics South Africa, 2012)

The significant and rapid increase in the number of maternal and double orphans has critically eroded the abilities and resources of adults who are responsible for caring for them. Linked to the increased number of orphans, the dwindling numbers of adults in their twenties and thirties have amplified the scope of the problem that caregiving institutions in South Africa face (Lalthapersad-Pillay, 2008). With many parents dying because of AIDS, orphaned and vulnerable children have to rely on extended families, foster parents, and community-based organisations or look after themselves in child-headed households. This situation not only adds to the tremendous strain and workload that caregivers in South Africa already have to cope with (Kuo & Operario, 2011), but also gives rise to the question of ideal options for caring for these children in distress. However, by arriving at a better understanding of stresses that caregivers are subject to and their resilience in coping with them, it may be possible to improve the option of institutional care (Foster, 2004).

Table 1.1: **Changes leading to the weakening of kinship systems in recent years** (Adapted from Foster, 2004)

Change	Effect on extended family
Labour migration, urbanisation and the cash economy	• Reduction in the frequency of contact with relatives • Social and economic dependence on extra-familial structures are increased. Possessions are perceived as personal property and no longer belong to the extended family

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Increased life expectancy and family size	• It is becoming increasingly difficult, if not impossible, for an extended family of three or four generations to reside together • Diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture
Formal education	• Education about social values occurs through schools and interactions of children with their peers, rather than through traditional mechanisms, lessening the ability of older people to exert social control over children

While Ross et al. (2003) refer to the abundance of empirical research on stressors of caregiving in general, Akintola (2008) points out that there is a dearth of such research on formal caregivers (see Section 1.6.1), including information on specific stressors and caregivers' coping techniques to deal with them. Very little research on formal caregivers has been undertaken and there has been limited research conducted on their resilience. Fredriksen-Goldsen (2007) concurs that adequate attention has not been paid to the predictors of caregivers' well-being, especially as most caregiving research has focused on family caregiving by older persons who suffer from chronic health conditions. The current study is situated in a context of negative effects of HIV and AIDS on the family system, and the subsequent increase in orphaned and vulnerable children. The positive influence that a good child–caregiver relationship has on such children should also not be discounted. Based on this context in which the current study situates itself, it is evident that a need exists for a deeper understanding of caregivers and aspects that make them resilient.

1.3 PURPOSE OF THIS STUDY

The purpose of this study was to explore and understand how caregivers perceive resilience. The factors that contribute to the resilience of formal caregivers working with orphaned and vulnerable children in a residential care setting were investigated. Additionally, the study was aimed at enriching understanding about how the caregivers perceived resilience within their specific working context. The intention was to focus on the resilience process in its totality and not only on certain aspects of it.

1.4 WORKING ASSUMPTIONS

This study was guided by the following literature-based assumptions:

i. Caregivers working with orphaned and vulnerable children are resilient. In a study in Kenya, caregivers were able to identify and discuss their coping mechanisms for workplace-related stress (Mutiso et al., 2011). While the presence of coping mechanisms

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does not cover the entire scope of the resilience process, it may yet indicate that caregivers are resilient to the degree that they are able to function within their work environment. Kumpfer (2002) defines environmental risk factors as the presence of chronic adversity in an individual's environment. Exposure to these factors creates risk, and the ability to cope or function within a risk environment may constitute a form of resilience on the part of the caregivers.

ii. Caregivers working with orphaned and vulnerable children experience adverse and challenging conditions in their work on a regular basis. In the previously mentioned study by Mutiso et al. (2011), the researchers discovered in their exploration of factors contributing to stress among caregivers in children's homes that 64,5% of the participants reported that they experienced stress sometimes, while 30,2% of them reported experiencing stress at the workplace often.

iii. Caregivers working with orphaned and vulnerable children are able to indicate directly or indirectly factors that might contribute to their resilience. As is evident from the study undertaken into caregiver resilience, participants were able to indicate resilience factors or aspects relating to resilience in the study by Papadatou (2006) and Mutiso et al. (2011).

iv. Resilient caregivers are able to provide better care for orphaned and vulnerable children in a residential care facility. According to Edward and Warelow (2005), one's ability to cope and demonstrate resilience in difficult situations is influenced by one's level of emotional intelligence. They also postulate that emotional intelligence can be developed or taught, which could indirectly influence resilience positively. This implies that the participants in the current study can, in part, rely on their emotional intelligence (which contributes to their coping attempts) and mould or build ("construct", as used in this investigation) their own resilience, which in turn allows them to function more effectively as caregivers.

1.5 RESEARCH QUESTION

In this section, the primary research question and subquestions are stated. These questions, which guided the research project, are answered in Chapter 4.

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1.5.1 PRIMARY RESEARCH QUESTION

This study aimed to answer the following primary research question: "How do formal caregivers of orphaned and vulnerable children construct their own resilience?"

1.5.2 SUBQUESTIONS

i. What are the factors that contribute to the resilience of caregivers of orphaned and vulnerable children?

ii. What motivates caregivers to care for orphaned and vulnerable children affected by HIV and AIDS?

1.6 CONCEPT CLARIFICATION

This section provides a brief clarification of certain key concepts relating to this study in order to avoid confusion or ambiguity in meaning. The concept of resilience is briefly introduced here, but will be elaborated upon in Section 2.2.

1.6.1 CAREGIVERS

Papadatou (2006) distinguishes between two main groups of caregivers, namely informal and formal. Informal caregivers include persons who are either family members or within the network of friends in the life of an individual suffering from health-related problems. Formal caregivers include both professionals and volunteers who have received education and training to care for individuals with health-related problems. The participants in this study are formal caregivers who have received training in child care from government and community institutions. Within the care facility, these formal caregivers fulfil the role of primary caregivers to the children. Henceforth they will be referred to only as caregivers.

1.6.2 RESILIENCE

Fredriksen-Goldsen (2007) defines resilience as "the behavioural patterns, functional competence and cultural capacities that individuals, families, and communities utilize under adverse circumstances, and the ability to integrate adversity as a catalyst for growth and development" (p. 56). This definition is similar to the twofold description of resilience provided by Ross et al. (2003), who state that resilience consists firstly of the ability to succeed or thrive, and secondly the ability to do this despite adverse conditions. Resilience is not static, but dynamic in entailing positive adaptation in adverse conditions (Papadatou, 2006; Ungar, 2005). In addition, it is important to note that resilience should be understood within the context it takes place (Fredriksen-Goldsen, 2007). In this study, resilience was therefore operationalised as those

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factors, interactions or processes that allowed caregivers to function effectively or optimally within their adverse working environment.

1.6.3 ORPHANED AND VULNERABLE CHILDREN

The term "orphaned and vulnerable children" (OVC) has replaced "AIDS orphans" because of the stigma and negative connotations attached to it (Lalthapersad-Pillay, 2008). The term OVC focuses not only on children who are orphaned, but also on children who are affected by some kind of vulnerability as a result of HIV and AIDS. According to Lalthapersad-Pillay (2008), USAIDS describes vulnerable children as "those children whose survival, well-being or development is threatened by HIV and AIDS" (p. 150). The residential care facility or research site used for the current study cares for children who have lost either one or both of their parents to AIDS-associated illnesses, who have been abandoned because of HIV and AIDS, or whose parents are unable to look after them because of the effects of HIV and AIDS. The caregivers working at the residential care facility are responsible for the daily well-being of orphaned and vulnerable children.

1.7 INITIAL LITERATURE REVIEW

In Southern Africa, HIV infection is highest among 20- to 40-year-olds (Lalthapersad-Pillay, 2008; see Section 1.2). Mortality among adults in this age group contributes to a rising problem with regard to orphaned and vulnerable children in South Africa. With many parents dying because of AIDS and its related illnesses, orphaned and vulnerable children have to rely on extended families, foster parents, or community-based organisations such as residential care facilities, or look after themselves in child-headed households. This adds to the tremendous strain and workload with which caregivers in South Africa already have to cope.

Researchers such as Luthar, Cicchetti and Becker (2000), and Fergus and Zimmermann (2005) mention the importance of a close and supportive relationship with caring adults as a protective factor in the development of children. Papadatou (2006), in answering the question of which characteristics facilitate the development of an effective caregiving relationship, identifies resilience as a prominent factor among those constructive abilities that an effective caregiver possesses. In a study undertaken by Youssef and Luthans (2007) on the impact of hope, optimism, and resilience on behaviour in the workplace, it was found that resilience contributes significantly to job satisfaction, happiness at work, and organisational commitment.

McMahon (2007) maintains that resilience is rooted primarily in interpersonal dynamics and therefore reaches beyond individual attributes. For this reason, Fredriksen-Goldsen (2007)

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proposed a conceptual model of caregiving resilience that is applicable to historically disadvantaged communities. This conceptual model consists of four salient factors:

i. Background characteristics, which influence the way that people deal with adversity within their culture, family, and community.

ii. Risk factors, which include those factors that may lead to adversity for caregivers, such as the health condition of the caregiver and care recipient, the hours of care provided, and caregiving strain, among others.

iii. Protective factors, which may arise within the caregiver's context and include constructs such as caregiver optimism, spiritual orientation, empowerment, and social support.

iv. Caregiving outcomes, which are associated with the levels of the caregiver's burden (Fredriksen-Goldsen, 2007).

In the current study, risk factors that caregivers are exposed to include the emotional drain of working with a number of terminally ill or abandoned children, dealing with oppositional and difficult behaviour, and a perceived lack of support from management. Resilience in caregivers therefore consists not only in personal attributes, but also in dynamic interactions with others and their context.

1.8 THEORETICAL FRAMEWORK

The theoretical framework describes the underlying theories that gave direction to this investigation. This study was guided predominantly by Kumpfer's (2002) Resilience Framework that combines six major predictors of resilience into one dynamic model. The model, which is discussed in full in Chapter 2, includes three sets of factors:

i. Environmental precursors (risk and protective factors).

ii. Characteristics of the resilient person.

iii. The person's resilient integration or positive outcome (Kumpfer, 2002).

The Resilience Framework also includes the dynamic processes that "mediate between the person and their environment and the person and the outcome" (Kumpfer, 2002, p. 180).

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1.9 RESEARCH PARADIGM: CONSTRUCTIVISM

The research paradigm within which this study was conducted was constructivist in nature (Adams, Collair, Oswald, & Perold, 2004; Morrow, 2007). The constructivist paradigm postulates that people's subjective experiences are "valid, multiple and socially constructed, and should be taken seriously" (Adams et al., 2004, p. 356). The constructivist paradigm argues that knowledge is constructed by individuals in the interactions they have with other individuals and environments. This means that knowledge is interactive, socially constructed, and contextual (Creswell, 2008; Lincoln, Lynham, & Guba, 2011).

The constructivist paradigm is also aimed at understanding the way that people construct meaning from their experiences (Donald, Lazarus, & Lolwana, 2006; Nieuwenhuis, 2007a). This understanding of their world is then shared through different discourses in particular contexts. The form of language that people use also influences the way they think and construct their reality (Nieuwenhuis, 2007a). In this study, I endeavoured to arrive at an understanding of how caregivers working at a residential care facility for orphaned and vulnerable children perceived resilience from their socio-cultural context and what they considered to be contributing factors to their own resilience.

1.10 RESEARCH DESIGN: CASE STUDY

I followed a single case study design, which is a research method that relies on a thorough and holistic investigation of a bounded system using multiple data collection methods and sources in order to answer the questions of "how" and "why" (Cohen, Manion, & Morrison, 2007; Nieuwenhuis, 2007b).

Nieuwenhuis (2007b) identifies the use of multiple data-gathering techniques as one of the key strengths of the case study method. Data collection is largely qualitative, but may include a quantitative component. Case study research allows for a high degree of fine detail to be captured and may serve as a complementary study for a larger study that might be less focused on these details (Cohen et al., 2007). Other strengths of a case study include the fact that results are generally easier to understand by academics and non-academics alike as it can be written in non-academic language. This design also allows generalisation to occur about one instance or from one instance to a class. Case studies also tend to be high in reality and they can be undertaken by a single researcher without the need of an entire research team (Adelman et al., & Nisbet & Watt as cited in Cohen et al., 2007).The residential care facility in which the caregivers worked constituted a case subject for this study.

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1.11 RESEARCH METHODOLOGY: QUALITATIVE APPROACH

The emphasis of qualitative research is on the quality and depth of information, attempting to grasp the uniqueness of each context. The qualitative research approach focuses on the social construction of people's ideas and concepts, and maintains that human activities need to be understood in terms of the meanings that people attach to them (Nieuwenhuis, 2007a). I therefore employed a qualitative research approach as I aimed to discover how caregivers themselves perceived resilience as a personal resource.

1.11.1 SAMPLING STRATEGY

In this study, I combined convenience and purposive sampling strategies. Both convenience and purposive sampling are non-probability sampling methods, usually associated with qualitative research (Cohen et al., 2007; Maree & Pietersen, 2007).

I chose the research site by means of convenience sampling because I had been working as research assistant at the site under an existing study. I selected seven caregivers purposively for participation in this study according to the criteria set out in Section 3.5.3.2.

1.11.2 DATA COLLECTION AND DOCUMENTATION

This section contains a brief presentation of the data collection methods used in this study, as well as the method employed for data documentation. Data were collected by means of a focus group discussion, individual interviews, and informal observations that were noted and reflected upon in a research diary.

1.11.2.1 Focus group discussion

A focus group discussion is a data collection strategy that is based on the assumption that group interaction contributes positively to widening the range of responses that are obtained, as well as to activating forgotten details and releasing inhibitions that may otherwise discourage participants from disclosing information (Nieuwenhuis, 2007b). In focus group interviews "the participants are able to build on each other's ideas and comments to provide an in-depth view not attainable from individual interviews" (Nieuwenhuis, 2007b, p. 90), because participants engage in discussion with each other rather than directing their comments solely to the moderator.

Themes covered during the focus group discussions included the emotional awareness of caregivers, barriers of emotional awareness, and caregiver resilience. Focus group discussions were recorded by means of a digital voice recorder, after which they were transcribed. An

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interpreter was present during interviews to limit linguistic barriers to the minimum (see Section 3.6.1).

1.11.2.2 Semi-structured individual interviews

According to Babbie (2005), a qualitative interview can be seen as an interaction between the interviewer and the participant during which the interviewer has a general outline for the inquiry, but not a predetermined list of questions. The aim of the qualitative interview is to collect data on "the ideas, beliefs, views, opinions and behaviours of the participant" (Nieuwenhuis, 2007b, p. 87). Semi-structured interviews are compatible with several methods of data analysis and are logistically easier to arrange than most other data collection methods (Wilig, 2008). Furthermore, they offer greater flexibility in terms of topic coverage, while remaining relatively conversational (Cohen et al., 2007; Smith & Osborn, 2003).

Out of the group of seven participants who took part in the focus group discussion, four were selected for the semi-structured interviews based upon their participation and insights during the focus group discussion. Caregivers who made significant contributions or who readily shared insights during the focus group interviews were considered for these individual interviews. The interview questions were guided by the information captured during the focus group discussion. Thus, I was able to explore and investigate in greater detail the trends and themes that emerged from the focus group discussion.

1.11.2.3 Informal observations: Research diary

According to Nieuwenhuis (2007b), observation is a systematic process in which behavioural patterns and occurrences are recorded by means of the researcher's senses without necessarily engaging with the participants. Observations can provide insider perspectives on group dynamics, but be subject to the risk of being highly subjective and biased (Nieuwenhuis, 2007b). Observations generally consist of two dimensions: the description of what is observed, and the researcher's reflections on what happened. In this study, the type of observation employed is that of the observer as participant, since the researcher was taking part in the research, but was not actively involved (Nieuwenhuis, 2007b). Observations for this study were mostly running records of the research setting as well as the interactions between the participants (Nieuwenhuis, 2007b). This was aimed at providing richness to the data captured for the study. Informal observations were recorded by means of field notes and a research diary. Observations are discussed further in Section 3.6.3.

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1.11.3 DATA ANALYSIS AND INTERPRETATION

The aim of qualitative data analysis is to identify and cluster together all general statements within the data to create categories within the data itself (De Vos, 2002). This process is not linear in nature, and different facets of data analysis, which may include noticing trends, collecting evidence, and thinking about the data, can occur simultaneously (De Vos, 2002; Nieuwenhuis, 2007c). Not only Cohen et al. (2007) but also Nieuwenhuis (2007c) state that the type of qualitative data analysis selected for a study should align with the purpose of the study as well as the type of study. This study utilises thematic analysis as the data analysis and interpretation method (Braun & Clarke, 2005). A further description of the data analysis process is provided in Section 3.6.1.

1.12 QUALITY ASSURANCE CRITERIA OF THE STUDY

While constructs such as validity and reliability are readily utilised in quantitative research as measures of the quality of a study, these cannot be carried over directly to qualitative research (Cohen et al. 2007; De Vos, 2002). This study, being qualitative in nature, therefore relied on maintaining the concepts of credibility and trustworthiness (De Vos, 2002). A further discussion of these concepts is provided in Section 3.9.

1.13 ETHICAL CONSIDERATIONS

According to Creswell (2008), ethical issues may arise in the collection of qualitative data. Owing to the depth of data collected from participants, special attention must be given to the confidential nature of the communications, as well as to protecting the anonymity of the participants' identities. The study aimed to uphold the highest ethical standards, and fulfils the regulations set by the University of Pretoria's Code of Ethics for Research (Committee for Research Ethics and Integrity, n.d.) regarding informed consent, voluntary participation, privacy and confidentiality, and anonymity. A further discussion of these concepts is provided in Section 3.10.

1.14 CHAPTER OUTLINE

In this section, the outlines of Chapters 2 to 5 are briefly described. An indication is provided as to what aspects of the study will be discussed in each chapter.

1.14.1 CHAPTER 2

Chapter 2 is devoted to an exploration of the contributions of other researchers in the field of adult and caregiver resilience, as well as the literature relevant to the study. The South African

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caregiving context is described and the theoretical framework of the study is discussed in depth. A conceptual framework for caregiving, as set out by Fredriksen-Goldsen (2007), is also introduced.

1.14.2 CHAPTER 3

The methodological aspects of this study as discussed in Chapter 3 include an overview of the research process ranging from sampling and data collection to the ultimate data analysis. A breakdown of the participants' particulars is provided, as well as an explanation of the sampling process. The qualitative approach that guided the study is considered and, finally, the constructivist paradigm that underlined the research methodology is analysed in detail.

1.14.3 CHAPTER 4

Chapter 4 contains a report on the results of the thematic data analysis, which led to the identification of four main themes and a number of subthemes linked to each of them. Furthermore, the results were linked to the literature reviewed in Chapter 2, and these findings are discussed in detail.

1.14.4 CHAPTER 5

In Chapter 5, the underlying theoretical framework is revisited and contextualised. Not only are the research questions answered in detail, but potential limitations of the study are also highlighted. Finally, recommendations for practice, training, and future research are provided.

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CHAPTER 2
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

Whereas some research has been done on stressors experienced by caregivers, research on caregiver coping or resilience is scarce (Akintola, 2008; Kuo & Operario, 2011). Many adult caregivers are vulnerable to health and socio-economic difficulties. Most academic research on caregiver resilience focuses on lay or family caregivers, with almost no literature available on caregivers working in institutions. This apparent lack of research may be attributed to the fact that institutional care for orphaned and vulnerable children is not very common in South Africa (Foster, 2004). However, with the challenges faced by traditional social support structures (such as the extended family) and the perturbing escalation in the numbers of orphaned and vulnerable children, a critical need has arisen for more research directed towards institutions that have to care for these children. To ensure that orphaned and vulnerable children receive the best possible care and to support their caregivers, research on the resilience of caregivers is also highly necessary (Foster, 2004; Kuo & Operario, 2011).

Reviews of research literature on the resilience of caregivers and the caregiving process consistently indicate the presence of factors contributing to resilience that helps to sustain caregivers (Fredriksen-Goldsen, 2007; Papadatou, 2006; Ross et al., 2003). Papadatou (2006) outlined seven such factors: personal values; beliefs and needs; mutual support; team, organisational, and environmental culture (each a separate element); and the availability of human and material resources. Similarly, Ross et al. (2003) found that characteristics of resilient caregivers include, among other factors, the ability to distance themselves physically and emotionally by taking time for themselves, having hobbies, support from a confidant, religiosity and the philosophical belief that their role as caregiver is meaningful.

2.2 RESILIENCE: TOWARDS AN UNDERSTANDING OF THE CONCEPT

The concept of resilience is complex and difficult to reduce to a single workable definition (Zimmerman & Arunkumar, 1994). While the literature indicates that the resilience process is composed of at least two aspects, namely exposure to significant risk and positive adjustment despite risk (Earvolino-Ramirez, 2007; Edward & Warelow, 2005; Fergus & Zimmerman, 2005; Luthar et al., 2000; Masten, 2001; McMahon, 2007; Ross et al., 2003; Zimmerman & Arunkumar, 1994), most definitions refer to the “individual’s characteristics, the nature of the context, the risk factors, and the counteracting, protective, and compensatory factors”

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(Zimmerman & Arunkumar, 1994, p.5), which still holds true for many contemporary researchers. With this plethora of academic discourses in the field of resilience, Zimmerman and Arunkumar in 1994 already warned against a great and varied number of definitions, claiming that this would hamper progress in the field of resilience research. In order to advance a workable definition of resilience for this study, reference needs to be made to the development of the concept of resilience.

Initially, resilience was conceptualised as internal qualities or character traits whose presence can predict success (Garmenzy, Masten, & Tellegen, 1984). Resilience has even been used interchangeably with terms such as invulnerable, or invincible, which is misleading, because this implies that these traits are permanent (Luthar et al., 2000). This was consistent with what Richardson (2002) has described as the first wave of resiliency research. According to this particular author, early resiliency researchers focused on creating an understanding of factors or characteristics that differentiate people who thrive under risk from those who do not. In the second wave of resiliency research, Richardson (2002) claims that researchers focused more on processes that would allow persons to acquire resiliency traits. However, researchers have more recently argued that resilience should be differentiated from trait-based conceptions (Fergus & Zimmermann, 2005), as resilience is something paradigmatically different from an internal personality trait (Ungar, 2005). Ungar (2005) maintains that the term *resiliency* should rather be used "to describe only the refined inner quality", whereas *resilience* should be reserved for describing "the phenomenon of surviving, thriving, hoping and coping" (p. 92). Earvolino-Ramirez in turn (2007) distinguishes between *ego-resiliency* as the individual's personality characteristic and *resilience* as the developmental process, arguing that ego-resiliency as an internal characteristic "does not presuppose exposure to substantial adversity, whereas resilience, by definition does" (p. 76). In view of this approach, resilience research should move away from defining resilience as an internal, individual, and static trait (Fergus & Zimmermann, 2005). This correlates with the third wave of resiliency research, which Richardson (2002) states has resulted in the currently accepted interpretation of resilience.

In the endeavour to arrive at a generally acceptable formulation of the concept of resilience, researchers have called for a distinction to be made between resilience, resiliency, and resources (McMahon, 2007). *Resilience* has come to be considered as a dynamic process that incorporates an individual's *resiliency* as a trait (internal) and positive factors or *resources* (external) that he or she may use as aids in overcoming risk (Fergus & Zimmermann, 2005). In the consideration of contemporary definitions of resilience, both resilience factors and processes are mentioned in addition to the exposure to risk and positive adjustment despite exposure to risk

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(Earvolino-Ramirez, 2007; Edward & Warelow, 2005; Fergus & Zimmerman, 2005; Luthar et al., 2000; Kumpfer, 2002; Masten, 2001; McMahon, 2007; Ross et al., 2003). Fergus and Zimmermann have postulated that resilience is sometimes used interchangeably with positive adjustment, coping, or competence. However, care should be taken when using these concepts, as they do all have a part to play in the resilience process, but none of them alone would meet the criteria for resilience as a combination of traits, factors, processes, exposure to risk, and positive adjustment (Kumpfer, 2002).

Based on the above conceptualisations, it is possible to discern certain commonalities and mutual characteristics in how resilience is conceptualised. Combined, these should provide a balanced and comprehensive idea as to what exactly resilience is believed to be. The definition that perhaps best encapsulates most of the above factors and appears to be the most applicable to the context of this study is found in Fredriksen-Goldsen (2007), who defines resilience as "the behavioural patterns, functional competence and cultural capacities that individuals, families, and communities utilize under adverse circumstances, and the ability to integrate adversity as a catalyst for growth and development" (p. 56).

Resilience research therefore explores how persons are able to experience healthy development despite the presence of risk factors that might stunt their development (Fergus & Zimmermann, 2005). Such research has shown that resilience should not be regarded merely as a singular phenomenon, but as a nexus of highly complex and multidimensional features (Fredriksen-Goldsen, 2007; Luthar et al., 2000). The complexities of resilience include, for example, the fact that it exists not only in individuals or groups, but also in relationships between and among people and groups (McMahon, 2007).

Another noteworthy complicating factor is that resilience is highly situational (McMahon, 2007). Persons exhibiting resilience outcomes in one context may not necessarily display the same levels of resilience in another. In 1994, Zimmermann and Arunkumar remarked upon the relative and contextual nature of resilience by noting that resistance to stress is relative in the sense that it is dependent on both the individual's experiencing stress and the environment within which stress is experienced. Resilience research contains many references to the interaction between individuals and their environmental factors, as well as citations of interpersonal dynamics (McMahon, 2007). Earvolino-Ramirez (2007) refers to protective factors that are "contextual, situational, and individual, and [that] lead to varying outcomes" (p.76), maintaining that individuals can and will respond with different degrees of resilience and vulnerability to different situations. Edward and Warelow (2005) concur by stating that the "potential for resilience

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involves an interplay between the individual and his or her broader environment" (p.102). Therefore, individuals have to play an active role in their own resilience construction (Zimmerman & Arunkumar, 1994).

Researchers have also identified different ways in which risk and protective factors may interact. Of special interest in analyses of such interactions is the protective factor or immunity-versus-vulnerability model that measures the relationship between stress and competence, which is aimed at determining how competence and incompetence may manifest themselves (Garmenzy et al., 1984; O'Leary, 1998; Zimmerman & Arunkumar, 1994). This aspect is further elaborated upon by Fergus and Zimmerman (2005), as well as Kumpfer (2002), whose Resilience Framework is dealt with fully in Section 2.3.

Fergus and Zimmerman (2005) discuss three models of resilience that explain how protective factors are able to affect the outcomes of the resilience process. These different models each describe different ways in which risk and protective factors can interact to alter the outcomes of certain life events (Fergus & Zimmerman, 2005). The three models are:

i. The compensatory model in which the compensatory factor acts in the exact opposite way of the risk factor, and also having a direct effect on the risk factor.

ii. The protective model that illustrates how protective factors influence or mitigate the potential negative outcomes of exposure to risk.

iii. The challenge model that reveals how either low or high exposure to risk may lead to negative outcomes, while moderate levels of risk exposure are associated with less negative outcomes (Fergus & Zimmerman, 2005).

The problem with the three models of Fergus and Zimmerman (2005) is that they do not detail and compute how resilience manifests itself, and they fail to fully investigate and measure the interactive nature of risk and protective factors. Since this study was aimed at identifying and understanding the caregivers' perceptions of resilience, knowledge gained from how they utilise protective factors to ameliorate the impact of risk is important.

Now that some of the salient aspects of resilience have been discussed, the theoretical framework of the study may be introduced. This framework rests upon the idea of resilience as a dynamic, contextual concept that encapsulates processes and factors, as well as the interplay between them.

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2.3 THEORETICAL FRAMEWORK

2.3.1 THE RESILIENCE DEVELOPMENTAL PROCESS

Some resilience researchers have been shifting their focus of attention from factors that may influence resilience, for example individual, family, and environmental factors as such, towards an understanding of the *manner* in which these factors may affect resilience (Luthar et al., 2000). It has therefore been essential to position this study within a theoretical framework that explains the resilience process as a developmental process. This is achieved by emphasising the interactive and transactional nature of activities that exist between the individual and the environment, thus acknowledging the significance of proximal processes.

Luthar et al. (2000) have noted that theories to be considered when working with resilience should include salient protective and vulnerability processes, and the transactions between the ecological context and the developing person. As people age and develop, they tend to master more skills. The same principle seems to apply to resilience, because generally there appears to be a correlation between the progress of time and competence (Luthar et al., 2000). Fergus and Zimmermann (2005) have also argued that resilience should be understood in relation to vulnerability models. Ungar (2005) places resilience firmly within an ecological context by stating that resilience "is understood to be an ecologically dynamic and mutually dependent process" (p. 92).

2.3.2 KUMPFER'S RESILIENCE FRAMEWORK

One of the main reasons for selecting Kumpfer's (2002) Resilience Framework for the current study is that it has been used previously to explain the resilience of adolescent learners in South Africa, indicating its adaptability to the South African context (Mampane, 2005). The present study acknowledges the role of the caregivers' environment, their active interaction within this environment, and how that affects their everyday activities. Thus, Kumpfer's Resilience Framework appears to be well suited as it situates the caregivers within their context, acknowledges their specific skills and resources, and notes the stressors to which they are exposed.

Kumpfer's (2002) Resilience Framework furthermore serves to organise into a dynamic framework the variables that denote higher levels of resilience. Kumpfer identifies six major constructs upon which the framework rests. Of the six constructs, four are described as areas of influence and two as "transactional points between two domains" (Kumpfer, 2002, p.183),

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allowing for interaction between the self, the environment and the outcome. The six constructs are:

i. Stressors or challenges

ii. The external environment context

iii. Person-environment interactional processes

iv. Internal self-characteristics

v. Resilience processes

vi. Positive outcomes

Each construct is discussed in detail below. The interaction between the constructs is represented in Figure 2.1.

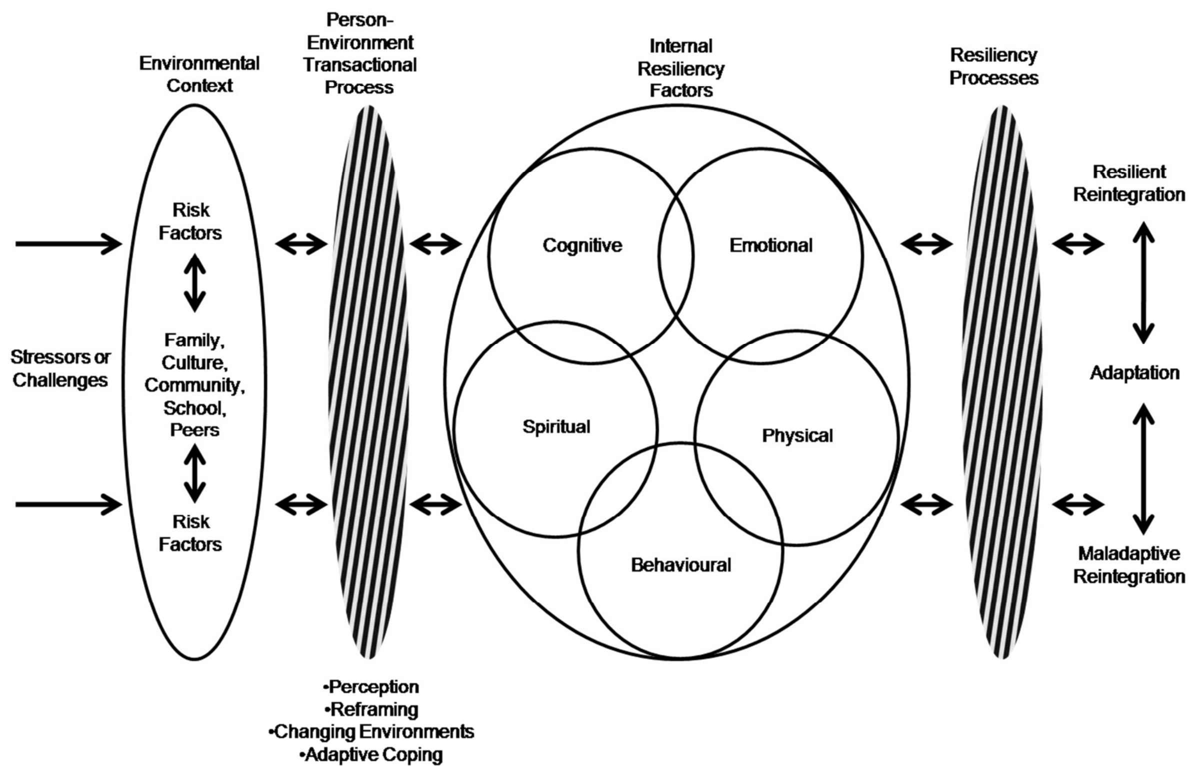

Figure 2.1: **Resilience Framework** (Kumpfer, 2002, p. 185)

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2.3.1.1 Stressors or challenges

In accordance with the definition of resilience, a stressor must be present in the resilience process since resilience can be demonstrated only in the face of some stressor or negative event (Kumpfer, 2002; Earvolino-Ramirez, 2007). The stressor triggers the resilience process by disrupting the individual's balance. Successfully negotiating a challenge or stressor can help an individual grow and can contribute towards the better handling of new stressors (Kumpfer, 2002). It is important to note that not all stressors or challenges are perceived in the same way. People perceive or experience stressors differently depending on their "perception, cognitive appraisal and interpretation of the stressor as threatening or aversive" (Kumpfer, 2002, p.183). In this study, caregivers' stressors were understood as those barriers that participants experienced as interfering with their effective work implementation.

2.3.1.2 The external environment context

Individuals' environmental context is a major factor in the resilience process. Their external environment can either help protect them against negative outcomes, or can contribute to such outcomes (Kumpfer, 2002). While Kumpfer focuses on the external environment of youth in particular, many of the same principles may apply to adults as well. Kumpfer notes that the most high-risk individuals are often included in resilience studies, not because of their own characteristics, but rather because of being exposed to a high-risk environment. Furthermore, Kumpfer defines risk factors by the presence of chronic adversity in individuals' environment. Resilient individuals typically manage to find "micro-niches of support" (Kumpfer, 2002, p.189) even within a high-risk environment. The current study focused on understanding how the work environment, which includes policies and work demands, might serve as a stressor, while also considering potential protective factors within that environment.

2.3.1.3 Person-environment interactional processes

Resilient individuals have the ability to adapt to their environments consciously or subconsciously and to seek out pro-social elements in these environments. Resilient individuals who have to function in high-risk areas tend actively to seek ways in which to find a better environment or to reduce the risk in their current environment (Kumpfer, 2002). Kumpfer identifies the following interactional processes between persons and their environments that assist the individuals to reduce risk in their environments:

- Selective perception
- Cognitive reframing

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- Planning and Dreaming
- Identification and attachment with pro-social people
- Active environmental modifications
- Active coping (Kumpfer, 2002, pp.191–192)

Kumpfer (2002) also indicates a link between individuals who are physically stronger, have higher levels of intelligence (especially verbal skills), or have an external locus of control and resilience. Furthermore, as Kumpfer notes, links have also been identified between a positive temperament or disposition and resilience. In the present study, attention was focused in particular on knowledge and understanding of how caregivers apply or utilise their resources, strengths, and abilities to ameliorate the effect of risk in their environment.

2.3.1.4 Internal self-characteristics

Internal self-characteristics serve to indicate the personal resources needed for obtaining success in different developmental tasks, cultures, and environments. It appears that resilient individuals have coping skills that aid them in minimising negative impact while also allowing them to access opportunities or resources. In discussing the internal self-factors of resilience, Kumpfer (2002) organised these factors into five overlapping areas or domains:

i. Spiritual or motivational characteristics

ii. Cognitive competencies

iii. Behavioural/social competencies

iv. Emotional stability and emotional management

v. Physical well-being and physical competencies (p. 197)

Internal characteristics relate to the individual characteristics or internal strengths that each caregiver might possess. Internal traits or resiliency factors fall within the first wave of resilience research (Richardson, 2002). These factors also constitute a part of the caregivers' personalities. These characteristics enable individuals to access, identify, and utilise the existing resources that motivate resilience to manifest (Mampane, 2004). Important as they are, it should be understood that individual or internal traits cannot by themselves be relied upon as indicators of resilience. It is rather the transactional nature of individuals' engagement processes with their environment—

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in which internal traits are utilised—that serves as the matrix for the fostering of resilience. Each internal resilience characteristic as discussed by Kumpfer will be considered in detail below.

(a) Spiritual or motivational characteristics

These characteristics include cognitive abilities and/or personal belief systems that help give individuals direction and allow them to be successful (Kumpfer, 2002). Factors that play a major role in this domain include individuals' ability to dream (that is, envisioning a positive future) and to develop a purpose in live (Kumpfer, 2002; McMahon, 2007). As early as 1959, Frankl noted that existential meaning, or a purpose in life, aided resilient individuals in overcoming difficult situations. Such individuals tend to have a belief system that provides them with existential meaning (Edward & Warelow, 2005). This allows them to find purpose in suffering or hardship, especially when able to find this purpose in relation to helping others. This process allows individuals to regain control over their environment, which is vital in maintaining hope in challenging situations (Kumpfer, 2002). Spirituality, which itself has been found to be a major predictor of resilience, usually goes hand-in-hand with a sense of belonging, community, direction, and fellowship (Kumpfer, 2002).

In this study, these factors were operationalised as the caregivers' ability to dream of and be hopeful for the future, be it within their current working context or outside of it. The presence of the ability to dream and to develop a purpose in life is an indication of motivational characteristics. How caregivers' spirituality and religion affected their working context was also investigated.

(b) Cognitive competencies

Among the cognitive competencies that allow individuals to achieve their dreams, intellectual and academic competencies feature prominently as intellectual components. Resilient individuals tend to have higher cognitive and academic competencies than those who are less resilient, and they also have a propensity for postponing gratification in order to reach their goals (Kumpfer, 2002).

As a result of having a higher intellect, resilient individuals also tend to be more capable of moral reasoning, with many becoming their own moral compasses by distancing themselves from the values of their families. Resilient individuals are also inclined to be insightful from an early age, as is demonstrated by their "asking penetrating questions" of themselves "and subsequently, providing honest answers" (Kumpfer, 2002, p. 203).

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Not only do resilient individuals have higher levels of self-esteem and self-efficacy, but they also have the ability to restore their self-esteem once their homeostasis has been disrupted (McMahon, 2007). These individuals have a strong sense of purpose and achievement (Edward & Warelow, 2005).

Self-efficacy, which is developed by facing and overcoming challenges and stressors, is associated with many different levels of resilience. In the present study, cognitive competencies are seen as those thought processes that allow participants to function effectively within their working environment (Earvolino-Ramirez, 2007). The effects of overcoming previous barriers may also be investigated.

(c) Behavioural or social competencies

These competencies have their foundation in the cognitive competencies and build on them. However, whereas cognitive competencies focus on thought only, the behavioural or social competencies involve an element of action as well (Kumpfer, 2002). Resilient individuals possess the ability and "street smarts" to adapt to different environments (Garmezy & Masten, as cited in Kumpfer, 2002, p. 205). The ability to solve problems effectively and to adapt to different situations also seems to contribute to resilience (McMahon, 2007). Since resilient individuals tend to have more confidence in their ability to solve problems, possibly due to previous successes, they also tend to be more motivated to tackle problems that arise (Kumpfer, 2002) since they display increased responsiveness and resourcefulness (Edward & Warelow, 2005). Good social skills, combined with the ability to seek social support and the willingness to make use of external resources are key elements in the development of resilience (Kumpfer, 2002). Research shows that positive relationships and social support are crucial for resilience as they provide an opportunity for communication (Earvolino-Ramirez, 2007).

In view of the above research, caregivers' ability to seek social support within their working environment was probed in the current study. Furthermore, behaviour related to their ability to seek solutions to practical problems in the workplace was also investigated, as both these competencies would enhance their capacity to function more effectively.

(d) Emotional stability and emotional management

Resilient individuals appear to master the ability to recognise their feelings and are able to control undesirable emotions. In general, resilient individuals tend to be more optimistic and hopeful about life and display a greater amount of creativity (Kumpfer, 2002; McMahon, 2007). These factors have also been identified as contributing towards higher levels of emotional

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intelligence (Edward & Warelow, 2005). In fact, being born with an easy-going temperament, combined with having an internal locus of control, are significant indicators for resilience (McMahon, 2007). Furthermore, resilient individuals are often able to employ humour as a coping strategy, which is a consistent finding in studies on resilience across all ages (Earvolino-Ramirez, 2007). Humour enables resilient individuals to "find the comic in the tragic" (Kumpfer, 2002, p. 208; McMahon, 2007). The ways in which caregivers understood and managed their emotions were also focused on in this study.

(e) Physical well-being and physical competencies

Individuals with physical health and strength are able to internalise that strength to see themselves as "psychologically strong" as well (Kumpfer, 2002, p. 209; McMahon, 2007). Persons of sound physical health can develop their physical talents and can attain accomplishments that are valued by others and themselves, leading to increased self-efficacy and an increased sense of self-worth (Kumpfer, 2002). In this study, the way in which caregivers maintained good health was considered under these competencies.

2.3.1.5 Resiliency processes

The final piece in the Resilience Framework is the outcomes as demonstrated by the behaviour of individuals. In overcoming risk while utilising internal resiliency factors, resilient individuals demonstrate the resiliency process. The emphasis here remains on understanding how they manage to overcome the impending risk: What is the outcome and how do individuals continue to demonstrate resilience in the context of adversity? In the Resiliency Model, which was first introduced by Richardson, Neiger, Jensen, and Kumpfer (1990), and later elaborated upon by both Kumpfer (2002) and Richardson (2002), four levels of reintegration are possible. These possible outcomes are dependent on the stressor, the environment, the internal characteristics of the individual, and the interaction processes between these factors:

i. Resilient reintegration—higher state of resiliency or strength.

ii. Homeostatic reintegration—same state as before stressor.

iii. Maladaptive reintegration—lower state of reintegration.

iv. Dysfunctional reintegration—major reduction in level of functioning (Kumpfer, 2002, p. 211; Richardson 2002).

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Exposure to any disruptive event or stressor can upset an individual's psychological homeostasis. Once this occurs, the individual may consciously or subconsciously choose the level of reintegration (Richardson et al., 1990). Persons who reach the level of resilient reintegration are typically those who experience growth from the experience, whom Enthoven (2007) describes as having the ability to bounce back beyond their risk factors, whereas people with homeostatic reintegration bounce back from challenging situations (to what may in the present study be called the *status quo ante* or the same state existing before). Exposure to stressors or challenges that gradually increase in intensity can help individuals to develop a better coping process, allowing them to have a higher chance at resilient reintegration (Kumpfer, 2002). It is not in the scope of this study to categorise participants into different levels of resilience as Kumpfer (2002) suggests, but resilient caregivers have been considered as those who have succeeded in negotiating either resilient reintegration or homeostatic reintegration.

After the study had theoretically been grounded firmly in Kumpfer's Resilience Framework, it was necessary to situate its framework in practice and in the local context. Below, the South African caregiving context is explored, followed by a brief conceptual framework for caregiver resilience.

2.4 THE SOUTH AFRICAN CAREGIVING CONTEXT

In contextualising the caregiving conditions in South Africa in this section, I discuss stressors typically experienced by caregivers in care facilities. These are then related to the Caregiving Resilience Model developed by Fredriksen-Goldsen (2007).

2.4.1 STRESS EXPERIENCES OF CAREGIVERS

Although caregiving is a noble role to fulfil, it can be highly stressful. According to Fredriksen-Goldsen (2007), caregiving has been found to affect the psychological well-being of caregivers negatively. Rait (1991) even comments that the distress experienced by caregivers has been named as the secondary epidemic of the HIV and AIDS pandemic. Akintola (2008) also informally associates caregiving with negative health outcomes.

In a recent cross-sectional survey on caregiver health in KwaZulu-Natal, Kuo and Operario (2011) found that as much as a third of a sample of caregivers met the threshold criteria for clinically significant depression, while almost two-thirds (63,8%) of the sample met the criteria for moderate anxiety. They also noted that caregivers for orphans reported significantly lower levels of general health and functioning, poorer physical health, as well as poorer mental health when compared with persons not caring for orphans. While the difference in physical health

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could be accounted for by socio-economic factors, the differences in mental health could not (Kuo & Operario, 2011). It should be noted that this study was not conducted on caregivers within caregiving institutions, but with informal, family caregivers. However, many of the stresses experienced may overlap with those of caregivers in caregiving institutions.

Similarly, in a recent study in Kenya, Mutiso et al. (2011) explored factors that contribute to stress among caregivers in children's homes. In the study, 64,5% of participants reported that they experienced stress sometimes, while 30,2% reported often experiencing stress at the workplace.

Table 2.1: Stressors of caregivers in Kenya (Adapted from Mutiso et al., 2011)

Organisational factors	Individual factors	Environmental factors
• **Task demand** • **Organisational structure** • **Organisational leadership** • **Role demand** • **Organisational life stage** • **Interpersonal demand**	• Economic difficulties • Family problems • Personality	• Economic uncertainty • Political uncertainty

As shown in Table 2.1, Mutiso et al. (2011) divided stressors into three categories: organisational, individual, and environmental. Many factors in the workplace itself contributed to the stress experienced by the caregivers. Factors such as task and role demand have the potential to be similar in a South African context, indicating possible stressors for caregivers in South Africa. Although it is difficult to speculate on the organisational structure and leadership components experienced in Kenya, their prominence in the study may indicate that they could also be stressors for South African caregivers. Outcomes of the stress experienced by the Kenyan caregivers included, but were not limited to, a decrease in job satisfaction, fatigue, lower rates of productivity, depression, headaches, and tension (Mutiso et al., 2011). All of these may exert a negative impact on caregivers' ability to care for children under their supervision. Factors contributing to coping or resilience in caregivers should also be explored.

2.4.2 CAREGIVER RESILIENCE

One's job or career is seen as a central activity in one's life. It contributes to a sense of self and to one's self-esteem and forms part of one's identity. Work is also a connection to one's community as a method of contributing or giving back to that community. It also is a source of

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the necessary structure and routine in one's life. However, as seen above, work may also be a source of great stress and unhappiness.

Prolonged exposure to stress in the workplace can have many negative psychological effects and can affect one's work performance. According to Mutiso et al. (2011), there is a wide range of factors that may contribute to stress in the workplace, especially when dealing with children or young adults. Caregivers therefore need to establish coping mechanisms and must become more resilient in order to deal with the everyday challenges experienced when caring for orphaned and vulnerable children.

Mutiso et al. (2011) found that positive coping mechanisms implemented by caregivers of orphaned and vulnerable children in institutions in Kenya included confronting the source of stress and taking a few minutes to compose themselves. Less positive ways of dealing with stress were venting tension on someone else, taking a smoke break, or consuming alcohol after work. Constructive or not, these coping mechanisms allowed the caretakers to deal with the stress they experienced and to focus on their jobs of looking after and caring for their wards. Despite finding or devising ways of coping with their work stress, these caretakers felt that such stress hampered their ability to participate fully in the delivery of quality work (Mutiso et al., 2011).

In a study undertaken by Mohangi (2008) on the resilience of orphaned and vulnerable children, it has been found that the relationship between the caregiver and the child plays a major role in helping these children cope. Mohangi (2008) stresses the importance of the relationship with the primary caregiver and postulates that a positive and caring relationship with at least one caregiver can be seen as a protective factor. It is therefore imperative that caregivers themselves are able to maintain positive relationships with the children at the care facility, despite facing challenges on a daily basis. According to Mutiso et al. (2011), the "continued existence of children's homes highly depends on the availability of well-motivated, stress-free staff members to take care of the children" (p. 162).

Other researchers, such as Fergus and Zimmerman (2005), and Luthar et al. (2000), have corroborated the importance of a close and supportive relationship with caring adults as a protective factor in the development of children. Papadatou (2006), in answering the question about characteristics that facilitate the development of an effective caregiving relationship, has identified the resilience of the caregiver as a prominent factor in particular. Furthermore, in a study by Youssef and Luthans (2007) on the impact of hope, optimism, and resilience on behaviour in the workplace, it has been found that resilience contributed significantly to job

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satisfaction, happiness at work, and organisational commitment. These factors share a direct link with the factors that have been found to affect caregivers' ability to deal with stressors, as reflected in the study by Mutiso et al. (2011).

Protective factors may arise within the caregiver's context and include constructs such as caregiver optimism, spiritual orientation, empowerment, social support, and caregiving outcomes, which are significantly associated with the levels of caregiver burden (Fredriksen-Goldsen, 2007). McMahon (2007), as mentioned before, maintains that resilience is rooted in interpersonal dynamics and thus extends its reach beyond individual attributes. In view of this, and also mentioned before (see Section 1.7), Fredriksen-Goldsen (2007) has proposed a conceptual model of caregiving resilience applicable to historically disadvantaged communities, albeit focused on the caregivers of homosexual men living with HIV and AIDS. Although featuring historical disadvantagedness in gender-role context in the USA, the model may also be applicable to a South African setting in which historical disadvantagedness was rooted in severe socio-political discrimination along "racial" lines that left virtually no community in the country untouched.

Fredriksen-Goldsen's (2011) framework consists of four major concepts, listed here again for the sake of clarity:

i. Background characteristics

ii. Risk factors

iii. Protective factors

iv. Caregiving outcomes

As illustrated in Figure 2.2, these concepts appear to interact in a similar way as Fergus and Zimmerman's (2005) Protective Factor Model.

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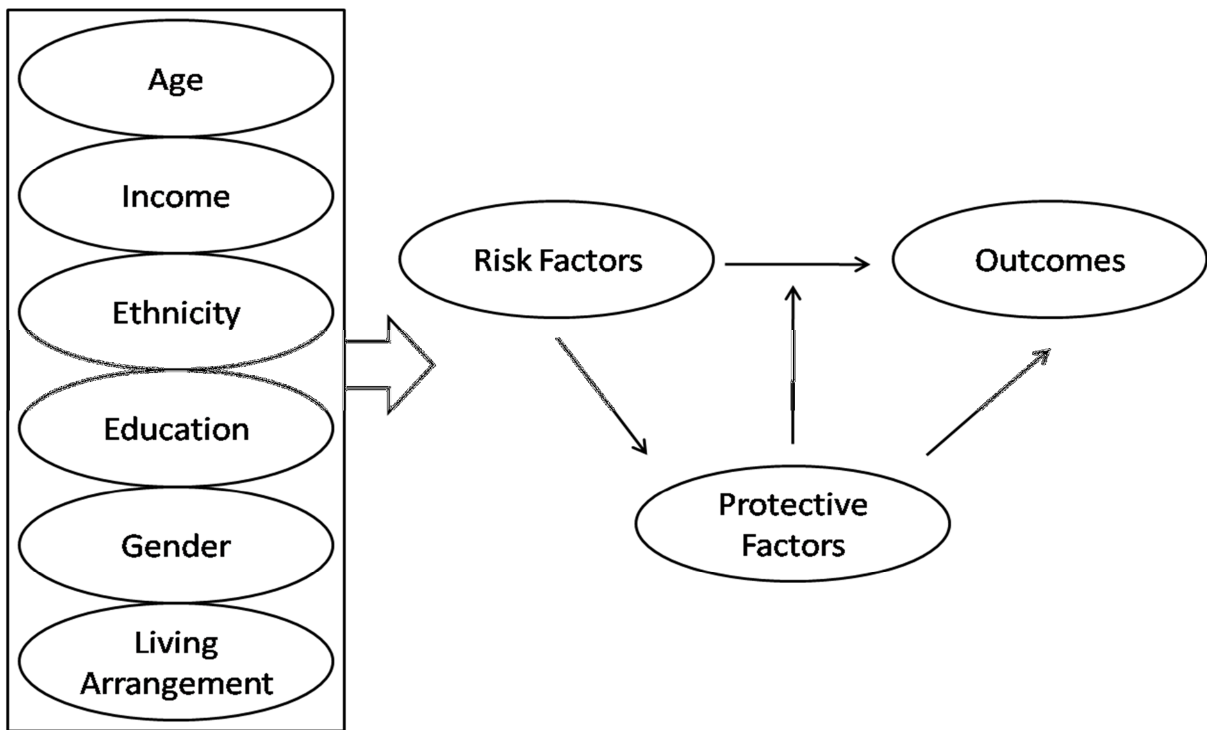

Figure 2.2: The Caregiving Resilience Model (Adapted from Fredriksen-Goldsen, 2007)

According to Fredriksen-Goldsen (2007), the caregiver's individual *background factors*, such as age, income, ethnicity, education, gender, and living arrangements may affect caregiver resilience and caregiving outcomes. Figure 2.2 illustrates that individual background factors contribute to individual and contextual risk and protective factors. The resilience outcome is a result of the interactive or transactional processes between risk and protective factors. The majority of these factors may also be found in the theoretical framework provided by Kumpfer's Resilience Framework (2002), and are therefore consistent with the theoretical grounding of this study.

Risk factors have a negative impact on caregiver outcomes. For her study, Fredriksen-Goldsen (2007) has identified the following risk factors: health of care recipient and caregiver, functional and cognitive impairment of care recipient, hours of care provided, caregiving strain and conflict in the caregiver's social network.

The *protective factors* that Fredriksen-Goldsen (2007) has identified included caregiver optimism, spiritual orientation, empowerment, and social support. She has also found that protective factors could emerge from individual, family, cultural, or community contexts, which clearly overlap with the Resilience Framework of Kumpfer (2002). In terms of caregiving outcomes, Fredriksen-Goldsen (2007) has indicated that caregiving is associated with higher

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levels of distress. This is consistent with findings from Mutiso et al. (2011) and Kuo and Operario (2011).

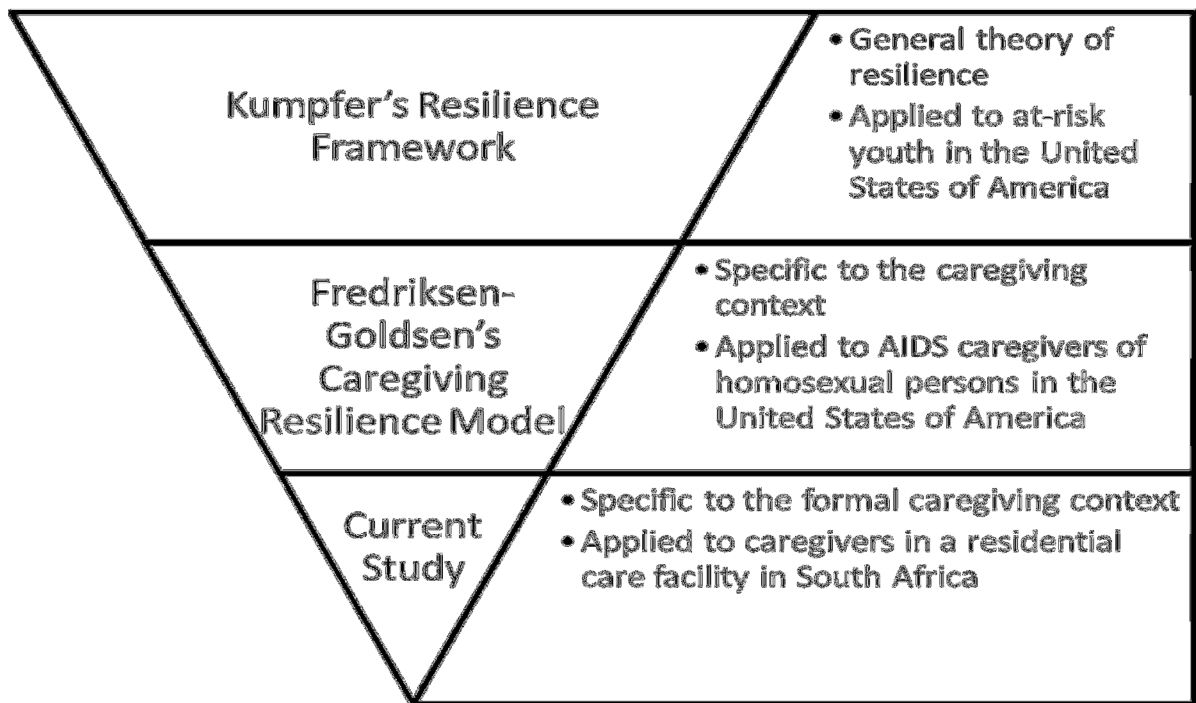

Figure 2.3: Relationship between frameworks

Kumpfer's Resilience Framework significantly guides this study. However, since it is a theoretical framework based mostly on studies on American or European children or adolescents, it may not always be applicable to the South African caregiving context. For this reason, the Caregiving Resilience Model (Fredriksen-Goldsen, 2007) was also discussed. While Fredriksen-Goldsen's model is more specific in that it applies to caregivers specifically, it was not developed for the South Africa caregiving context, as illustrated in Figure 2.3. However, the two models complement each other in their systemic approach and recognition of inter- and intrapersonal risk and protective factors in the facilitation of resilience.

2.5 CONCLUSION

In this chapter, the literature relating to resilience, caregiving, caregiving stress, and caregiving coping or resilience was reviewed. Special attention was paid to the theoretical and conceptual grounding for this study in terms of Kumpfer's Resilience Framework (2002) and Fredriksen-Goldsen's Caregiving Resilience Model (2007).

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The scope of the HIV and AIDS pandemic and its influence on traditional modes of orphan care were considered in view of the clear need for a deeper understanding of what motivates caregivers to do the work that they do. Also apparent was the need to investigate what keeps caregivers strong or resilient enough to continue functioning and caring for orphaned and vulnerable children,

With the study grounded in current research and theory, the next chapter will explore the study's methodological framework in terms of the research orientation, investigative methods, epistemological framework, and data collection techniques.

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CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

According to Babbie (2005), research, in its simplest form, is the search for answers to questions. In this section, I describe the selection of the most appropriate means for arriving at answers to my research questions, which entailed the choice of a research design and methodology best suited to guiding the study. A discussion regarding the research process includes the research paradigm, investigative methods, and data collection techniques. Finally, the role of the researcher and the ethical considerations regarding the study are elaborated upon.

3.2 RESEARCH PURPOSE

This research is descriptive in nature and attempts to explain the construction of resilience by formal caregivers of orphaned and vulnerable children in a residential care facility in South Africa. Guided by the constructivist paradigm, the purpose of this study was to understand and describe how formal caregivers perceive and construct their resilience. Furthermore, in this study I sought to understand the factors that might or might not contribute to the resilience of formal caregivers in the selected residential care facility.

3.3 RESEARCH QUESTIONS

From the primary research question ("How do formal caregivers of orphaned and vulnerable children construct their own resilience?"), two subquestions followed:

i. What are the factors that contribute to the resilience of caregivers of orphaned and vulnerable children?

ii. What motivates caregivers to care for orphaned and vulnerable children?

3.4 RESEARCH PARADIGM: CONSTRUCTIVISM

Adams et al. (2004) define the concept of research paradigm as a general theoretical orientation within which a study is located. The research paradigm dictates ontological, epistemological, and methodological foundations on which a study rests, meaning that it not only shapes how one thinks about the world, but also how knowledge is structured and interpreted within the study (Guido, Chávez, & Lincoln, 2010). Henning, Van Rensburg, and Smit (2004) attest that no

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research can be conducted in a theoretical vacuum; therefore, it is appropriate to explore the underlying meta-theory that guides this investigation.

The research paradigm serving as frame for this study is constructivist in nature (Adams et al., 2004; Morrow, 2007; Lincoln et al., 2010). The constructivist paradigm endeavours to understand how individuals and groups view and understand their world (Donald et al., 2006; Nieuwenhuis, 2007a). Research approaches of this nature consequently consider people and groups to be active participants in the construction of meaning throughout their lives. The constructivist paradigm postulates that individuals and groups are able to construct and re-construct their view of the world by adapting to different contexts and different times (Donald et al., 2006), indicating the highly subjective and personal nature thereof.

Maintaining that reality is not external to the individual (Lincoln et al., 2010), the constructivist paradigm postulates that multiple realities exist, and that these are dependent on the context of individuals and groups (Struwig & Stead, 2001; Lee, 2012). It follows from this view that knowledge cannot be considered completely objective or value free, but rather instrumental to validating people's subjective experiences.

Epistemologically, these multiple realities are understood through the construction of a personal (subjective) understanding and meaning of them, based on a personal frame of reference (Lincoln et al., 2010). In terms of the paradigm, it is accepted that experiences are socially constructed, and may therefore differ from person to person. However, the paradigm concedes that all experiences are valid to the person experiencing them and should therefore be taken seriously (Adams et al., 2004). The aim of a researcher is to derive a shared meaning in conjunction with the participants. In order to accomplish this, researchers using a constructivist model need to explore the multiple voices and experiences of the participants, typically by employing a qualitative research approach and methodology (Guido et al., 2010; Lee, 2012) as discussed in Section 3.5.1. This point of view assumes that that knowledge itself is influenced by and constructed through social interactions with others, and by extension, has a close connection to social, historical, and cultural contexts.

With these postulates as guiding principles, the researcher working from a constructivist perspective therefore has to attempt to understand the experiences of participants by interacting with and listening to them. Most qualitative research assumptions are constructivist in nature and attest to:

- the study of individuals in the natural world;

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- learning about the meanings that people make of their experiences;
- investigating individuals in social interaction and in context (Morrow, 2007).

Consequently, both the constructivist paradigm and qualitative research method are highly suitable to this study, which explores and aims to understand the perceptions of resilience by caregivers working at a residential care facility for orphaned and vulnerable children (Adams et al., 2004).

3.5 RESEARCH DESIGN

3.5.1 RESEARCH METHODOLOGY

Whereas qualitative research initially struggled to gain a foothold in the social sciences, it is one of the most influential methodological paradigms today (Outhwaite, 2007). Traditionally, research was predominantly objective and positivist, aimed at discovering general laws from a nomothetic perspective (Nieuwenhuis, 2007a). Qualitative research, however, accepts that knowledge is not only formed by objective, observable events, but also by attempting to understand people's meaning-making, motivation, beliefs, understanding of the self, and values (Henning et al., 2004).

According to Nieuwenhuis (2007a), qualitative research is concerned with "understanding the processes and the social and cultural contexts which underlie various behavioural patterns" (p. 51). Qualitative research focuses strongly on how participants make meaning and it interprets the research phenomenon, emphasising quality and depth of information, as well as the uniqueness of context. It is usually employed when studying people or systems by interacting with them and observing them in their natural environment. In qualitative research, human activities are understood in terms of the meanings people attach to them while focusing on the social construction of ideas and concepts (Nieuwenhuis, 2007a). Since qualitative research is primarily aimed at establishing an idiosyncratic understanding of the phenomenon under study, its chief purpose is therefore not to generalise findings but rather to obtain an in-depth understanding of the participants' experiences and perceptions (Nieuwenhuis, 2007a; Creswell, 2008). In order to achieve this, a naturalistic approach towards data collection techniques is typically followed (Lincoln et al., 2010). Data collection techniques usually centre on collecting in-depth information from the participants in order to arrive at an understanding of the phenomenon under study from the participants' perspectives (Struwig & Stead, 2001).

In the current study, a qualitative methodology was selected in view of its aim to gain insight into caregiver resilience. Since objective measurement of resilience or the establishment of

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general rules governing the resilience of caregivers was not attainable, the study was directed at obtaining an appreciation of the resilience of caregivers through reportage in their own personal accounts. Consequently, the main focus of the data collection strategy was concentrated on self-reported accounts of personal perceptions that entailed utilisation of a focus group interview followed by in-depth individual interviews. Informal observations recorded in a researcher diary played a secondary role in this study.

3.5.2 CASE STUDY DESIGN

A case study strives towards a thorough and holistic investigation of a bounded system or single social and contemporary phenomenon using multiple data collection methods in order to gain an in-depth understanding of participants' interactions and "how they make meaning of the phenomenon under study" (Nieuwenhuis, 2007b, p. 75; Yin, 2014).

Nieuwenhuis (2007b) notes that case studies have been effectively utilised in studying the individual as a unit of analysis. In order to gain a more comprehensive understanding about people, case studies allow the researcher to gain access to information that is not always accessible with numerical analysis (Cohen et al., 2007). Elaborating on this point, Platt (2007) presents a case for the intrinsic value of case studies in that they fill blind spots in descriptive knowledge and can make meaningful contributions in science research. Case studies can offer valuable data, because generalisations can be formulated about one instance, or extrapolations can be made from one instance to a generic class.

With actual cases ranging from the individual to studies of small social units, a clear definition of what and who constitute the case is important (Platt, 2007, Yin, 2014). Irrespective of the wide variety of arguments as to what exactly constitutes a case, a case study can be used to investigate a social unit's dynamics holistically (Platt, 2007). This corresponds well with the generally accepted principle that a case study should cover a bounded system in the investigation (Henning et al., 2004; Nieuwenhuis 2007b; Platt, 2007). For such a system to be established, it is necessary to focus on a phenomenon with clearly identifiable boundaries (Henning et al., 2004; Yin 2014). Case study research allows for high degree of fine detail to be captured and may serve as a complementary study for a larger study that might be less focused on finer details (Cohen et al., 2007).

Regarding the possibility of extrapolation mentioned above, some researchers are of the opinion that the tendency of case study design to focus on a single case or instance has a limiting effect on its potential to be generalised. Nieuwenhuis (2007b), however, argues that generalisation is

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not the primary purpose of case studies in any event. According to Platt (2007), "the conventional critique of case study approaches assumes, often without finding it necessary to elaborate this explicitly, that the aim of all research is to test general theory, following the hypothetic-deductive paradigm as elaborated in the philosophy of social science" (p. 113).

Platt (2007) argues that case studies fulfil a preliminary role in empirical research by being utilised as "pilot studies, probes of the plausibility of theories to see whether they are worth more thorough exploration, or material which suggests hypotheses" (p. 112). While some researchers dismiss the function of case studies as having only low-level preliminary value as compared with empirical research, it should be borne in mind that it is not possible to test hypotheses without first exploring which realities need to be accounted for (Platt, 2007). Other possible limitations of the case study method include bias and subjectivity on the part of researchers who are prone to observer-bias and whose personal approaches are difficult to cross-check (Cohen et al., 2007).

The present research followed a single case study design, exploring caregiver accounts of stress and coping, representing factors and processes from which inferences of resilience could be drawn. Therefore, the residential care facility where the caregivers worked constituted a case for this study. The unit of analysis within the case study was caregivers working directly with the orphaned and vulnerable children in the care facility. While the care facility also employed other staff such as cooks and cleaners, they were excluded from the unit of analysis as their primary role did not involve caring for the children. Multiple data collection techniques were utilised in the study, with the aim of providing an in-depth understanding of how the caregivers perceived their own resilience.

3.5.3 RESEARCH SAMPLE

A sample is a smaller group of the population of a study who are included in the actual study (Cohen et al., 2007). In the process of sampling, different techniques may be used to conform to the nature of the study. This study, being qualitative in nature, required significantly fewer participants than a survey, for example. The sampling techniques were consequently geared towards the selection of a smaller sample, while keeping account of the purpose of the study. Sampling took place on two levels: firstly, the research site was conveniently and purposively selected, and secondly, the participants were purposively selected according to the criteria in Section 3.5.3.2.

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3.5.3.1 The research site

The research site was carefully selected to provide insider information pertaining to the research topic (Creswell, 2008). The research site proved convenient, because I had been working as a research assistant in an existing study at the particular site.

The site itself is a residential care facility for orphaned and vulnerable children, located on the outskirts of Pretoria, South Africa. The residential care facility caters to the needs of 44 children and adolescents. Of the children and adolescents receiving care, 80% are HIV positive. The remaining 20% of children and adolescents have been negatively affected by HIV and AIDS in some way, such as loss of the primary caretaker in their family. The institution mainly employs female workers who fulfil different roles. There is a manager, caregivers, cook, teacher, and cleaning staff. The only recorded mention of a male staff member was related to a security guard who patrols the grounds at night. This bounded care facility, with its clearly demarcated boundary and staff members, constitutes the research site (see Figures 3.1 and 3.2).

Figure 3.1: Main entrance of the residential care facility

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Figure 3.2: Main play area of the residential care facility

3.5.3.2 The participants

A non-probability sampling method was used for the purposive selection of seven participants in this study. Purposive sampling is a non-probability sampling method that is generally associated with qualitative research (Cohen et al., 2007; Maree & Pietersen, 2007). Non-probability sampling methods are frequently used in smaller studies, according to which the participants are selected with a view to targeting a specific group with a specific purpose. Such a group does not have to represent a larger population; it merely has to represent itself (Cohen et al., 2007; Creswell, 2008).

The present study formed part of a larger project that administered the BarOn EQ-i™ Emotional Quotient Inventory to 15 participants. The criteria for selecting participants for current study were as follows:

i. the role of participants as caregivers in the facility;

ii. the availability of participants on the prearranged date for data collection;

iii. the participants' score on the BarOn EQ-i™ that lay in the Effective Functioning range.

However, on the prearranged date for data collection, one caregiver who participated in the BarOn EQ-i™ had retired, while three others were not available. It was therefore decided to allow two caregivers who had scored in the Area of Enrichment range on the BarOn EQ-i™ to participate so as to have enough participants in the focus group (see Table 3.1). The higher the scores, the more positive the prediction for effective functioning in meeting daily demands and

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challenges. On the other hand, low EQ scores suggest an inability to be effective, and the possible existence of emotional, social, and/or behavioural problems. Seven participants were selected and available for participation in the focus group discussion (Bar-On, 2006).

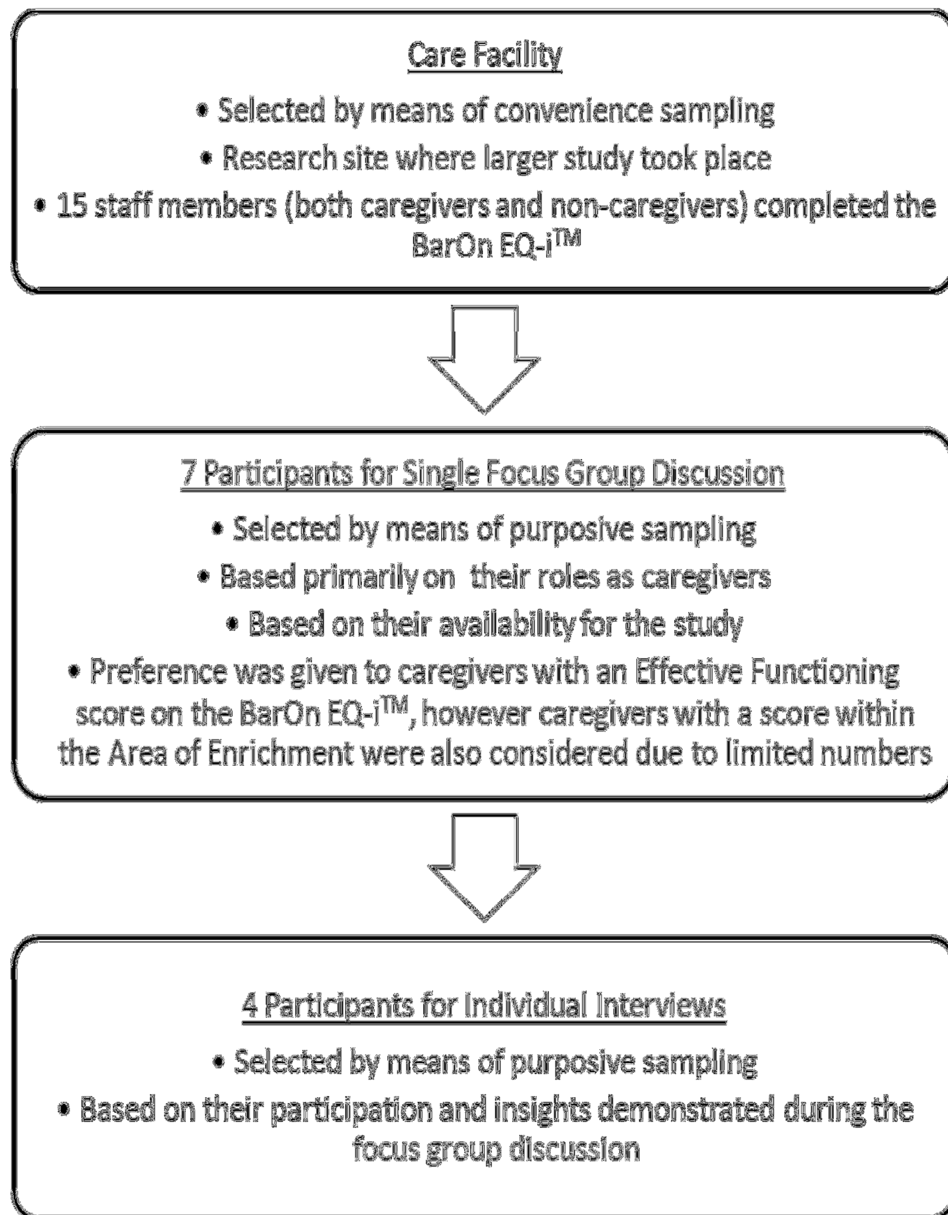

Figure 3.3: The sampling process

As is evident from Table 3.1, the sample consisted only of participants fulfilling the role of caregiver at the facility. While two of the 15 staff who participated in the BarOn EQ-i^{TM} scored within the Enhanced Skills range, neither was available for the study. Participant 9 was unavailable on the prearranged day for the focus group discussion, and Participant 15 was not a caregiver at the care facility. Participants 2 and 4 scored within the Area of Enrichment range,

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but were selected to participate because of the small number of participants that were available for the focus group discussion.

Table 3.1: Participant details

Participant	Total EQ*	Job title	Focus group	Individual interviews
P1	EF[†]	Caregiver	X	X
P2	AE	Caregiver	X	
P3	EF	Caregiver	X	
P4	AE	Caregiver	X	X
P5	EF	Caregiver	X	X
P6	EF	Caregiver	X	X
P7	EF	Caregiver	X	
P8	EF	Caregiver	Not available	
P9	ES	Caregiver	Not available	
P10	AE	Caregiver	Not available	
P11	AE	Caregiver	Retired	
P12	EF	Education assistant		
P13	EF	Cleaner		
P14	EF	Cleaner/Cook		
P15	ES	Office manger		

* AE: Area of Enrichment; EF: Effective Functioning; ES: Enhanced Skills
[†] Scores: 50–85: Area of Enrichment; 85–115: Effective Functioning; 115–150: Enhanced Skills (Bar-On, 2002)

3.6 DATA COLLECTION STRATEGIES

Although the methodologies associated with case studies are traditionally qualitative in nature (Henning et al., 2004), Platt (2007) argues that a wider range of data collection methodologies should be considered as long as they suit the purpose of the planned investigation. When decisions regarding methodology are made, it is deemed wise to consider each component independently rather than grouped together (Platt, 2007). The data collection strategies in this study are qualitative in nature.

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3.6.1 Focus group discussion

Focus groups can be classified as group interviews and must therefore be regarded as a social encounter (Cohen et al., 2007). Often debate, and even conflict, among the participants are encouraged and group dynamics are seen as assisting in data generation, which forms part of the procedure (Nieuwenhuis, 2007b). Focus groups differ from other kinds of interviews in that the questions utilised are designed to elicit collective views about the topic under investigation (Cohen et al., 2007; Denzin & Ryan, 2007).

Morgan (1988) raises the following points that should be addressed when conducting a focus group:

- Deciding on the number of focus groups that should be run for a topic.
- Deciding on the size of the focus group (four to twelve people per group are acceptable).
- Over-recruiting by 20% since the possibility exists that participants may fail to turn up.
- Sampling properly so that every participant fulfils the criteria for participation in the study.
- Striking a good balance between being too directive and ensuring that the discussion remains focused on the topic.

Aspects to consider when planning a focus group discussion include the manner in which data will be recorded and the level of detail to be included. This is typically determined by the type of analysis that will take place. In this study, in which thematic analysis was utilised (see Section 3.6.1), a verbatim transcription as recommended by Wilkinson (2003) appeared sufficient. To ensure adequate but balanced participation, the moderator should manage participants who may be too verbal and encourage participants who do not contribute much to the group (Cohen et al., 2007; Nieuwenhuis, 2007b).

Since the sample size of focus groups is typically small, it may constitute a limitation. In the instance of this study, the sample of seven participants was too restricted to permit reliable generalisation of the findings of the focus group discussion (Wilkinson, 2003; Cohen et al., 2007; Nieuwenhuis, 2007b).

Other typical limitations of focus group discussions may include difficulty in convening all participants at the same time and place (Nieuwenhuis, 2007b), difficulty in analysing data succinctly (Cohen et al., 2007), and the fact that focus group discussions may not always be a

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suitable data-collection technique for sensitive topics (Wilig, 2008). Cohen et al. (2007) also acknowledge that data collected from a focus group may lack overall reliability. In the current study, it did indeed prove difficult to convene all of the participants at the same time and place even after careful prearrangements. On the day, only five participants availed themselves for the focus group discussion, with the result (as mentioned above) that two other available participants were allowed to participate in the focus group discussion.

For the purpose of this study, a single focus group discussion seemed appropriate as the phenomenon under investigation occurs in social processes among the participants, and between the participants and their environment. A focus group discussion is able to provide valuable data based on the interactions among participants, which is one of the levels at which resilience also manifests itself. Furthermore, the sample size of seven participants lent itself ideally to the format of a focus group discussion since the number of participants was sufficient for providing a glimpse of their interactions but not too large to hamper guidance by the researcher. It was, consequently, possible to keep the topics discussed in the focus group related to the question of resilience in coping.

3.6.2 SEMI-STRUCTURED INTERVIEWS

All interviews, including research interviews, assume that the individual's perspective is an important aspect of understanding the phenomenon under study (Henning et al., 2004). Semi-structured interviews are generally used in research settings to corroborate the data that emerged from other data sources (Nieuwenhuis, 2007b). Out of the seven focus group participants for this investigation, four were selected for individual interviews based on their participation during the focus group discussion.

The interviews were guided by the information gained from the focus group discussion in order to explore and investigate trends or themes discovered during the focus group discussion (Braun & Clarke, 2006; Nieuwenhuis, 2007b). The individual interviews were recorded at the care facility in a closed room with a single participant at a time. Since participants use interview discussion to communicate their thoughts and feelings about the research phenomenon and process, it is essential for researchers to listen in detail to the content of the interview, while upholding the communication (Henning et al., 2004).

A potential limiting factor when using semi-structured interviews as a method of data collection is that the quality of the data collected depends strongly on the rapport between the researcher and the participant (Cohen et al., 2007; Wilig, 2008). Semi-structured interviews require careful

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preparation and planning (Wilig, 2008), but even so, some important topics may be omitted by accident (Cohen et al., 2007). Smith and Osborn (2003) note that the researcher has less control over the data collected than in a structured interview and, since the differences between interviews may make data more difficult to analyse, the comparability of results may be reduced (Cohen et al., 2007; Smith & Osborn, 2003). In this study, limitations to the individual interviews included limited time available to interview each participant, since all four had to be interviewed on the same day. However, this meant that, while allowing for the semi-structured nature of the interviews, similar questions were asked to all four participants, which had a positive influence on the comparability of the data obtained.

The use of semi-structured interviews allowed for the collection of in-depth data on the phenomenon being studied. It also facilitated delving deeper into a number of issues that participants raised in the focus group discussion.

3.6.3 INFORMAL OBSERVATIONS

Observations allow researchers to collect data as events occur, and may be particularly useful in settings in which participants may have difficulty in expressing themselves, or in which non-verbal behaviour is recorded (Cohen et al., 2007; Creswell, 2008). Observations enable researchers to study the research environment and participants in their naturalistic setting (Struwig & Stead, 2001), while yielding data on a number of different settings (Cohen et al., 2007).

The physical setting of a study may be observed. This would include descriptions and photographs of the environment within which the study takes place (Struwig & Stead, 2001; Cohen et al., 2007). In the current study I included photographs and recorded descriptions of the facilities at the care facility, without exposing identifying information of the setting. Observations may also cover the human setting, which focuses on biographical descriptions of the persons being observed (Cohen et al., 2007). In this study, I recorded notes on the age, gender, ethnicity, and other characteristics of the participants. Furthermore, observations can cover the interactional setting in which behaviour of and between participants may be recorded, whether verbal or non-verbal (Cohen et al., 2007). In this study, the interactions and body language of the participants were observed during the focus group discussion as well as the individual interviews. Lastly, researchers may observe the programme setting (Cohen et al., 2007), which includes observations relating to the resources available to the care facility and the way that the facility is organised.

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Informal observations were recorded in field notes and a research diary. Observations served a secondary role in the study, as the single focus group discussion and four individual interviews served as the main sources for obtaining data on the perceptions of the participants. The observations were used to gather data of interactions during the data collection process, as well as on the physical setting of the facility. Observations were only noted on three separate days when the BarOn EQ-i^{TM} was administered, the focus group discussion took place, and the individual interviews were conducted. On the day scheduled for the BarOn EQ-i^{TM} a brief tour of the premises was allowed, but interaction with the children at the facility was kept at a minimum.

Observation is, in itself, a highly selective and subjective method of collecting data (Nieuwenhuis, 2007b). Although observations can have a very low level of trustworthiness, they can be improved by means of member checking (respondent validation) and the comparison of notes and insights with other observers (Nieuwenhuis, 2007b). It should also be borne in mind that observations are context specific (Cohen at al., 2007). While collecting information, I consistently clarified with the participants whether I had understood the meaning and context of the data correctly. Furthermore, on the days that data collection took place, other researchers from the larger study were present, and I was able to compare notes and observations with them.

Informal observations recorded in a research diary were selected as a data collection method for this study to serve as a third source of data. This allows for triangulation of data to take place, enhancing the trustworthiness of the study. The informal observations focused mainly on the physical appearance of the care facility, as well as the interactions of participants during the focus group discussion and subsequent individual interviews. Furthermore, the observations focused on the adult participants in the study and not on the children in the care facility or the participants' interactions with the children. Although this might be considered a limiting factor, the main focus was on the participants' perceptions of factors and processes that allow them to function effectively, as obtained through self-report measures.

3.7 DATA ANALYSIS AND INTERPRETATION

According to Cohen et al. (2007), the analysis of qualitative data "involves organizing, accounting for and explaining the data" (p. 461). This means that the researcher attempts to make sense of the data while bearing the participants' context and view of the situation in mind. While there appears to be no single correct method to analyse qualitative data, Cohen et al. (2007) state that the analysis of data should be fit for the purposes of the study.

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This study used thematic analysis as a means of analysing and interpreting the qualitative data gained from the focus group discussion and individual interviews. Thematic analysis is a method for identifying, analysing, and reporting on patterns or themes in qualitative data, which does not require detailed theoretical knowledge of approaches and is ideal for inexperienced researchers in the qualitative field (Braun & Clarke, 2006). Thematic analysis is also not interlinked with any existing theoretical framework, which allows it to be used within a theoretical framework of the researcher's choice. This makes thematic analysis a highly flexible data analysis method (Braun & Clarke, 2006).

The following six steps as outlined by Braun and Clark (2006) were implemented for conducting the thematic analysis for this study:

i. Familiarisation with the data through perusing the data meticulously and repeatedly, and noting initial ideas.

ii. Generating initial codes through the systematic coding of features across the data set and collecting the data applicable to each code.

iii. Searching for themes through grouping codes into themes and collecting all the data applicable to each theme.

iv. Reviewing themes through checking whether the themes and the coded data could fit together, as well as how the themes corresponded to the entire data set.

v. Defining and naming themes through continually analysing and refining each theme, as well as the overall narrative of the analysis, which resulted in clear definitions for each theme.

vi. Producing the report through selecting examples of the extracts, relating the analysis back to the research question and literature, and reporting on the analysis.

3.8 LIMITATIONS OF THE STUDY

Limitations to this study may have arisen because of the research design employed, the data collection methodologies applied and the context within which the study was conducted. Quintessential limitations of a case study design include its tendency to be specific to a particular context and to have a small sample. In the current study, both these limitations were present, resulting in findings that do not allow for unmediated extrapolation or generalisation to other settings. With regard to limitations associated with the specific sample and participants, the

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availability of participants adhering to the criteria was a limiting factor. Owing to the unavailability of such participants, two participants who did not meet all the specified criteria were allowed into the study so as to ensure a sufficient complement of participants for the focus group discussion.

Contextual limitations of the study included language and time constraints. Language was a partial barrier as English was not the mother tongue of any of the participants. Although most of the participants were fluent in English, the services of an interpreter were used when the need arose. Time also was a limiting factor as this study formed part of a master's degree course in Educational Psychology, which restricted the time available for research.

3.9 ENHANCING TRUSTWORTHINESS

Maree and Van der Westhuizen (2007) emphasise the crucial importance of quality assurance (or data verification) in research. However, the replication of data in qualitative research is not possible, partly because of its focus on the creation of meaning (Cohen et al., 2007). Qualitative studies, therefore, need to rely on detailed descriptions of both the participants and the context or research setting in order to maintain validity, which has been done in this study. Furthermore, photographs of the research setting have been included and informal observations have been noted in a research diary. This constitutes a thick description of the research process, which contributes to an audit trail (Kelly, 2006).

Reliability or trustworthiness in qualitative research is obtained when the results are consistent with the data that are collected (Maree & Van der Westhuizen, 2007). Consistency between data and results can be achieved by means of maintaining the following criteria: credibility, transferability, dependability, and conformability (Maree & Van der Westhuizen, 2007). These criteria were upheld in this study by utilising different techniques. First of all, the process of member checking was employed by constantly reflecting back on what was heard and clarifying this with the participants. Furthermore, two colleagues corroborated the themes in order to prevent researcher bias. Lastly, various data collection techniques were utilised in order to triangulate the data (Cohen et al., 2007; Maree & Van der Westhuizen, 2007).

3.10 RESEARCH ETHICS

According to Cooper and Emroy (1995), the goal of ethics in research is to ensure that no harm is done during the research process and that no one is affected by any adverse consequences as a result of the research activities. In this study, care was taken to follow the guidelines set out by

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the University of Pretoria's Code of Ethics for Research (Committee for Research Ethics and Integrity, n.d.) regarding the following ethical concerns:

i. *Informed consent:* Participants were informed about the exact nature of the research, as well as any potential risks or benefits associated with participating in this study. Participants had already signed informed consent forms for the larger study under which this study fell, thus including consent for the current study. In addition, verbal informed consent was obtained from participants and information regarding such consent was thoroughly explained to them. The participants were allowed sufficient time to consider this information before signing an informed consent form.

ii. *Voluntary participation:* This entailed that participants in this study did so entirely out of their own free will and were under no circumstances coerced or bribed into participating. Participants were also allowed to terminate their participation in the research process at any given time.

iii. *Privacy and confidentiality:* Privacy refers to participants' rights to decide what information to share during the research process, whereas confidentiality refers to the researcher's responsibility to uphold the participants' rights to privacy by not disclosing any information for which the participants did not provide consent. In this study, the participants were interviewed in a closed room, away from other role players at the care facility. While initially hesitant, participants soon opened up and spoke freely in the interviews.

iv. *Anonymity*: This refers to participants' right to have their identity protected and the researcher's obligation not to make any connection with participants public (Cohen et al., 2007). In this study, as well as in the larger study, all researchers took scrupulous care to protect the identities of the participants.

3.11 CONCLUSION

In this chapter, the research paradigm and methodologies were discussed. A case study, with participants who were selected by means of non-probability sampling methods, was employed to answer the research question. The next chapter covers the results and findings of the study. The main research results from the thematic analysis of the collected data will be provided in detail.

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CHAPTER 4
RESEARCH RESULTS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

In the previous chapter, containing an analysis of the research methodology for this study, the constructivist meta-theoretical research paradigm was elaborated upon and the sample was described in detail. The limitations of the research and ethical considerations were remarked upon in conclusion.

The current chapter will be devoted to an exposition of the research results, with the findings of this study being anchored in the existing literature. The data were analysed by identifying recurring themes and subthemes, which, through an inductive approach to data analysis, emerged from the data itself without the constraints of existing theoretical frameworks (Braun & Clarke, 2006). The analysed data served to formulate a representation of participants' views on resilience and factors that could possibly have enhanced their personal and collective resilience construction processes.

A key to the abbreviations used in the representation of the data is found in Table 4.1. Distinctions are made between data collected from the focus group interview, the individual interviews, as well as the researcher's informal observations and research diary notes.

Table 4.1: Abbreviation key

Source	Abbreviation
Focus group interview	FG
Individual interview	II
Participant	P
Notes from research diary	RD
An	Andreas (Researcher)
Co	Co-researcher

4.2 RESULTS OF THE THEMATIC ANALYSIS

In this section of the chapter, the various themes and subthemes are explored in detail. Four main themes emerged:

i. demonstrating resilience when functioning within an unsupportive environment;

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ii. demonstrating resilience when establishing a sense of control;

iii. demonstrating resilience through belief;

iv. resilience born out of identity as a caregiver.

Each theme and its related subthemes are discussed individually. In Chapter 5, the theoretical framework is revisited as I contextualise my findings within a framework for South African caregivers. The themes and subthemes are set out in Table 4.2.

Table 4.2: Themes and subthemes

Themes	Subtheme
1. Demonstrating resilience when functioning within an unsupportive environment	1.1 Rejection
	1.2 Lack of managerial support
	1.3 Working conditions
2. Demonstrating resilience when establishing a sense of control	2.1 Coping
	2.2 Asserting control over the children in their care
	2.3 Demonstrating resilience by planning for the future
3. Demonstrating resilience through belief	3.1 Resilience through religion
	3.2 God-given gift for working with children
4. Resilience born out of the identity of caregiver	4.1 Responsibilities at home and at work
	4.2 Constructed caregiver identities

4.2.1 THEME 1: RESILIENCE WITHIN AN UNSUPPORTIVE ENVIRONMENT

This theme highlights that despite the potentially unsupportive and stressful working environment of the participants, they appear to be able to fulfil their duties successfully. Within this theme, three subthemes emerged based on the caregivers' experiences within their working context: having to cope with rejection from the children in their care, the perceived lack of managerial support, and the general working conditions such as long working hours and inadequate salary. Table 4.3 outlines the inclusion and exclusion criteria for the subthemes.

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Table 4.3: Inclusion and exclusion criteria for Theme 1

	Subtheme	Inclusion Criteria	Exclusion Criteria
1.1	**Rejection**	Any reference to negative comments from children, or children who refuse help	Reference to any efforts rejected outside of the work context
1.2	**Lack of managerial support**	Any reference to the management team's general attitude and lack of support to the caregivers	Reference to a lack of support from colleagues or at home
1.3	**Working conditions**	Any reference to working hours, official leave, salary or other factors influencing their daily working context	Reference to conditions at home, or outside of the work context

4.2.1.1 Rejection

As part of the discussion on challenges that participants typically have to cope with at work, the conversation moved towards the relationship between the participants and the children in their care. Participants identified themselves as being mothers to the children in their care (for a discussion of this aspect, see Section 4.2.4). However, it appeared that the children might use this constructed mother role to lash out at the caregivers and to hurt them emotionally. The children tended to tell the participants that they were not their parents in order to hurt participants' feelings, although the participants fulfilled this role for them at the care facility. A response from Participant 4 illustrates such instances:

> P4: So that is the challenge that I have, because sometimes it is difficult working with kids. More especially, some of them they do not appreciate things; instead of appreciating, they will tell you a lot of hard words. Like "You are not my mom" (FG, lines 172–77).

She also had the following to say:

> You know these kids, the problem it's like they don't appreciate that the first thing nè, and then they have … like … this thing of saying like you're not my mother—you can't tell me this and that. So it's very difficult. It's really, really difficult. Sometimes I feel like I can cry (P4, II, lines 61–65).

However, this was not the only way in which the children rejected the participants. The children called the participants derogatory names, mocked them or even swore at them, while others would show disregard for the participants' instructions, as was evident in the discussion between Participant 3 and Participant 6:

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> P6: So you can see that she has this thing, just because you are not her mother [inaudible]. They call us names [inaudible]. [Turning to P3] What's that name she used to tell us?
>
> P3: Bitch, f**k you, go to hell. [Murmuring between themselves.] You feel useless to them. They call you names like f**k you bitch, go to hell.
>
> P6: And they must work on that thing. And they will say, "You will work for us." They used to tell us, "You are here to work for us" (FG, lines 760–69).

The participants appeared to be constantly hurt by the children's rejection. Regarding their reactions to the swearing incident, it was observed that after mentioning the swearing they all nodded and concurred verbally while being visibly upset by the account. It may be harmful to the participants' own mental health to be exposed to negative emotional interactions on a regular basis. Furthermore, these negative interactions may contribute to a negative working environment filled with stressors and lacking protective factors. Together with the fact that the participants spend a lot of time at work, it appears understandable that they may feel overwhelmed from time to time.

During the focus group interviews, the participants were unanimous in reporting that the way in which the children treated them was a source of stress at the workplace. Participants spoke of their love for working with children and cited this as their main reason for having accepted employment at the care facility. However, the negative interactions with the children appeared to be chipping away at that love, leaving the participants unsure of how to feel about their jobs and the children in their care. In my research diary, I reflected on this point:

> It appears as if many of the caregivers feel ambivalent towards their workplace and the children in their care. Many have proclaimed their intense love for working with children, yet they also expressed a lot of negativity toward the same children. It appears as if their love for working with children is what drove them to take a job at the care facility. However, much more time during the focus group interview was spent on complaining about the children's behaviour than on their original motivation for working [at the care facility].

In view of the comments from the caregivers, it may be assumed that they have a love for working with children, but that this love is often and repeatedly rejected by the objects of their love. Hence, the caregivers feel hurt and despondent, which appears to exacerbate their stressful working environment.

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4.2.1.2 Lack of managerial support

The participants perceived a lack of support from the care facility's management team. Participants vehemently and repeatedly expressed their dissatisfaction with the level of support that the care facility's management team gave them. From the participants' viewpoint, the managerial team did not support their decisions. For example, there were indications of a lack of support that caregivers experienced when children needed to be disciplined, as reflected in a response from Participant 2:

> Co3: In terms of support, are you getting sufficient support from the institution?
>
> P2: No (FG, lines 1240–42).

Furthermore, the caregivers mentioned that they were not given opportunities to organise meetings with the managerial team to express their concerns. The managerial team also did not seem to encourage or support meetings among the caregivers themselves:

> P4: No, they [management] don't want to help us to take a meeting, to handle a meeting somewhere in the centre.
>
> Co1: So as a group you don't have an opportunity to sit like this and talk, you don't do that? So you don't share your experiences?
>
> In unison: No (FG, lines 346–51).

The participants' concerns regarding the way in which the care facility was managed did not stop there. According to Participant 4 (with confirmation from all other participants in the focus group discussion), the perceived lack of support also extended to the way that participants handled the children under their care. According to Participant 4, it was difficult for caregivers to predict the way that the managerial team would respond to situations, consequently undermining the confidence of the participants in their own situational decision-making:

> P4: [We are] scared even to tell the child, "Leave this", because she is going to scream and run downstairs to report you and you have done nothing wrong. And there they [managerial staff] come, "What did you do?" Sometimes they believe you, sometimes they say you're lying, maybe you beat the child.
>
> Co2: So it's this constant fear that you experience of getting into trouble?
>
> All: Yes.

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> Co2: And does this lead you to be stressed at work as well?
>
> P4: Yes (FG, lines 1099–1109).

This is an instance in which the participants experienced negative interactions both with the children under their care and with the management team of the care facility. The general feeling of the participants towards management was negative, while most felt ambivalent towards the children. I further observed the following in my research diary:

> When they began to discuss their concerns and issues with management, they became very animated and vocal, often talking over each other to make their voices heard. Clearly, the concerns with management run deep. However, there was a general consensus among the participants that they would do what they had to do, indicating that they are able to function within a difficult environment.

In view of the animated discussions surrounding the care facility's management team and the comments from the participants, it can be assumed that the participants perceived dismissiveness from the management team as another source of stress in their working environment.

4.2.1.3 Working conditions

Besides expressing their concerns regarding the way they were being treated by the children and the management team, the participants also expressed dissatisfaction with their general working conditions. Their dissatisfaction concerned in particular their salaries, official leave benefits, and their working hours. The participants' negativity surrounding these issues was exacerbated by the management team's often inconsistent stance towards handling these issues (which is discussed in Section 4.2.1.2):

> P3: Because everything you want here, you can't find it easy. It's either you want to go on leave, it's a problem, there's nothing. I don't know how to explain. Everything is difficult.
>
> P6: Like I'm saying like starting from your days, when you want to take [leave]. Starting from the pay, we are not happy with the pay. When we want to go to leave, it's a problem, and sometimes they will refuse, you can't go to leave; sometimes they say it's unpaid leave. We know there is the law that says it's unpaid, but for here it's not going like... disappointing. So hey, it's difficult for us (FG, lines 1361–73).

Participant 7 had a different interpretation of the message that the management team was sending:

> P7: They [management team] are hating us (FG, line 1472).

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This perceived message was enforced by participants' views on the management team's treatment of them during personal emergencies:

> P8: If you can say I am going to the funeral, my Aunt has passed away, they say it's unpaid. You go there, you get no pay. But you have got some days, you've got family responsibilities, you've got the annual leave, but it's unpaid. If you say my daughter is sick, they say you will take your annual leave. You end up not going on leave, because all your days are finished, are taken (FG, lines 1380–88).

In spite of their preponderantly negative comments, the participants were also able to identify changes that had to take place in order for them to feel more fulfilled in their jobs. From the quotations below, it is possible to infer that the participants did feel a need to obviate the perceived negativity about the care facility's management team and the children under their care:

> Co3: What needs to change for you to be happy in your jobs?
>
> P6: If I can say the Management, us and the children can come in the one place and understand each other. Then everything will be OK.
>
> P7: Ja, if, like she said, we don't have problems with the children, we like working with the children. But what is not good to us is the things which come from the Management. I think if the Management can listen sometimes to what we want from them, then everything can be alright. But then many of the times, the Management does not get what we want. So it's difficult. And here, we don't strike. Even if we want something they don't give us, we just come to work. We can't strike. If you strike, you are fired (FG, lines 1425–28 and 1433–42).

4.2.1.4 Discussion of findings for Theme 1

The participants function within an environment in which they experience stressors constantly. Feeling pressurised and unsupported, many of them have created their own practical coping strategies that they can employ when they feel overwhelmed. This theme positions itself as the first step of the resilience process: exposure to risk factors or stressors (Kumpfer, 2002). Exposure to risk factors is an important first step, as the resilience process cannot be activated without its presence. This theme therefore sheds light on the context within which the participants' resilience manifests itself. In the discussion of Themes 2 to 4 (refer to Section 4.2.2–4.2.4), Theme 1 serves as the contexts proving risk within which the different aspects of the participants' resilience manifest themselves.

If we revert to defining resilience as suggested, namely "the ability to bounce back or cope successfully despite substantial adversity", we see that the participants adhere to these criteria for

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resilience (Earvolino-Ramirez, 2007; see Section 2.2.1). With a view to the comprehensive definition of resilience in response to stressors as formulated by Fredriksen-Goldsen (2007; see also Section 2.2.1), who also refers to behavioural patterns and functional competence, one cannot deny that the participants in this study do indeed display resilience in their everyday working context. The strength of the participants in this study appears to lie in their ability to identify solutions to their problems. They appear to see many stressors or risk factors as resolvable. For example, in their concerns about the communication and management style of the facility's management team, the participants were able to identify possible solutions or frame the outcome that they would like to see achieved. This demonstrated that the participants were able to identify solutions to the stressors that they experienced in their working environment.

From the gathered data, it became clear that the participants had many complaints regarding their work environment. Concepts such as job satisfaction and work happiness exerted an influence on the commitment that participants have for the care facility (Youssef & Luthans, 2007). If participants experience low levels of job satisfaction and work happiness, it may have a negative impact on their commitment to caring for the children. However, in similar research undertaken by Youssef and Luthans (2007), they found also that the presence of resilience contributed to job satisfaction and work happiness, indicating that resilient individuals typically experience their jobs more positively than less resilient persons. Although the participants in this study were not overly positive about their jobs, they spoke fondly of the children, even if they experienced them as difficult to deal with. If the organisational stressors of the participants of this study are compared with those found by Mutiso et al. (2011; see Section 2.4.2), similarities can be identified. The caregivers in the latter study also viewed their organisational structure and leadership as stressors. It appears therefore to be a common phenomenon that rather than protecting their staff, management teams add to the burden of stressors that caregivers face in their working context.

Kumpfer (2002) states that exposure to stressors is the first step in the resilience process, with exposure acting as a catalyst to the process. In the instance of the present study, participants are chronically exposed to stressors, indicating that their resilience process recurs at the beginning of each working day.

4.2.2 THEME 2: DEMONSTRATING RESILIENCE WHEN ESTABLISHING A SENSE OF CONTROL

In their endeavour to cope with a stressful and negatively perceived working environment, the participants resorted to using coping mechanisms that allowed them to regain their composure when they felt that they were losing control. In this theme, the categories explore practical

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coping mechanisms that the participants employed, as well as ways in which they were able to successfully manage the behaviour of the children in their care. Furthermore, this theme also elaborates on participants' attempts to gain a sense of control over their futures. Coping strategies may include distancing techniques or simply ignoring difficult behaviour. The inclusion and exclusion criteria are listed in Table 4.4.

Table 4.4: Inclusion and exclusion criteria for Theme 2

Subtheme	Inclusion Criteria	Exclusion Criteria
2.1 Coping	Any reference to behaviour that allows participants to function at work	Reference to behaviour that allows them to function outside of work only
2.2 Asserting control over the children in their care	Any reference to participants taking control of misbehaving children, or taking control of the circumstances at work	Reference to difficult situations involving the management team of the care facility
2.3 Demonstrating resilience by planning for the future	Any reference to participants dreaming or having hopes for the future	Reference to the present and the past

4.2.2.1 Coping

The participants mentioned a variety of practical coping mechanisms that they employed during the course of the day in order for them to function. They used their coping mechanisms to gain control in a stressful environment, which might be regarded as overt indicators of their resilience process. In general, it appeared that each of the participants had their own coping mechanisms within their stressful working environment.

The excerpts from the focus group documentation illustrate a few coping techniques that the caretakers used to deal with difficult situations. Some needed to distance themselves from the situation to give them the opportunity to cry and vent their emotions:

> P4: It is so difficult. I think maybe we need something like debriefing. You just go into your room, cry, and after that I tell myself, "No, I am going back there." There is nothing [else] that you can do, more especially if it's for your life. You think I am going to benefit something for my kids [children in my care] anyway. You just cry and thereafter you dry your tears and you go back to them (FG, lines 191–97).

Another copes by talking through, and rationalising, the problem or situation:

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P4: I cry and then, after crying, then I pray. Oh my God, help me to handle this because really, really, really, on my own I cannot (FG, lines 977–79).

Prayer is also used as a coping mechanism. However, as is reported in Section 4.2.3, the use of prayer extends further than as a mere coping mechanism: it also points to religion as a motivating factor and as a source of strength in stressful working environments. Furthermore, participants mentioned the role that supportive colleagues played in helping them to cope with their work:

P6: I think, uh, that is it 'cause the colleagues, my colleague, uh, are well to me.

Co1: So you feel that you get a lot of support from the people that you work with?

P6: Yes (II lines 94–98).

4.2.2.2 Asserting control over the children in their care

Many of the participants struggled to manage the behaviour of the children under their care effectively, which left them feeling dejected. As caregivers at the care facility, the participants have the responsibility of seeing to the well-being of the children. In order to do this effectively, the participants feel that they should be empowered by the management team. The management team does not deal with the everyday interactions with the children at the care facility, since it is the caregivers' primary role. However, the participants believe that control is taken away from them in instances where the management team questions their actions or decisions (as illustrated in Section 4.2.1.2).

The children in the care facility seemed to perceive this volatile relationship between the participants and the management team, which apparently gave the children the power to make the lives of the participants more difficult by intensifying their behavioural misdemeanours. However, the participants were aware of this practice and understood that it undermined their authority at the care facility. The participants recognised that this was a concern for them and felt that they should be empowered by the care facility's management team:

Co3: What kind of support would you like to have from the Management? If I was Management now, I was sitting there, what would you say to me, what kind of support would you like to have from me as Management?

P3: We will say help us to discipline our children. To handle a situation like this, you must show us the way. If we can be a unit, these kids do not have power over us (FG, lines 1182–89).

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It is clear from this excerpt that the participants realised that they needed the managers' support as it could reduce their experienced stress and would allow them to provide better care for the children. However, a few participants found ways in which to control this aspect of their job. These participants generally appeared much happier than those who felt that they had less control over the children under their care:

> P7: Some of the mamas they do cry here. Some of them were even fired because of this children.
>
> Co1: But not you?
>
> P7: No, not me.

This may indicate an instance where a sense of control over the environment could result in the ability to thrive, or at least function effectively in adverse circumstances.

The participants revealed different ways of dealing with children who seemed to be giving them difficulties. Participant 6 mentioned that she would have a one-on-one conversation with whomever she was experiencing difficulty with and tried to sort the problem out:

> P6: Like when I'm angry with the kids or my colleague I try to go when we are alone … I try to approach her, so telling her this and this is not OK for me, and then could you try to do like this and then she agreed (II, lines 170–73).

By separating the person from a group, Participant 6 was able to regain some power when speaking to the individual. Furthermore, her tactful, gentle approach appeared to work well for both parties in restoring order. Participant 6 also made sure that the children knew that they were loved, even when they were being difficult:

> An: How do you feel if they tell you, "You don't love us"?
>
> P6: I say, "I love you" (II, lines 239–40).

Participant 8, in turn, made sure that the children did not take chances in misbehaving by being very strict with them and by setting clear, unmovable boundaries:

> P8: I don't do that. I just take the child [and] tell her don't do that. I'm here to look after you so you don't have to say like what you want [say whatever you like] to me. So I can say [that] these children, they don't do to me like they are doing to the other mamas. And even they can come they [are] scared of me because I don't give them that chance they can do [of doing] whatever they want (II, lines 319–24).

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4.2.2.3 Demonstrating resilience by planning for the future

While overall the participants expressed general unhappiness with their working conditions, three of them exhibited traits of resilience by planning for the future. In other words, they were attempting to create a better life for themselves in the future. Participant 4 mentioned that she was busy studying through the University of South Africa in order to change her career path:

> An: And what do you want to do with your degree when you are finished?
>
> P4: What can I say, I just want to see myself doing something because even if in my degree there is those courses that are including the kids, like I'm doing, like next week I will be writing psychology (II, lines 377–80).

Participants 6 and 8 were collaborating on establishing a crèche of their own. These participants displayed an attitude of believing that they could themselves influence their futures positively, demonstrating elements of resilience by creating hope for themselves and by taking some degree of control of their own futures:

> P6: P8 and I, we decided to, to make a crèche. To open a crèche for ourselves. So we are now looking for a place to make a crèche.
>
> An: OK, that's good. To do that and then you'll stop working here?
>
> P6: Yes, we decide now, we are planning to get the place, only the place (II, lines 117–23).

4.2.2.4 Discussion of findings for Theme 2

The above subthemes described different ways that participants in this study used to control certain aspects of their lives. Similarly, in another study, coping mechanisms identified in Kenyan caregivers included taking some time out for oneself and confronting problems head-on (Mutiso et al., 2011). Similar coping mechanisms were identified in the current study, in accordance with which participants would take time out to pray, cry, or calm down to compose themselves before continuing with their work. Participants also reported addressing difficult situations, such as managing children's behaviour directly, in order to remain in control and thus exhibiting a form of coping. This links with the fact that resilient individuals tend to resolve problems more effectively than non-resilient individuals (McMahon, 2007).

Fredriksen-Goldsen (2007) identified social support as an important factor in the resilience of caregivers. This is connected with the fact that resilient individuals seek pro-social elements in their environments to negate some of the stressors that they experienced (Kumpfer 2002).

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Furthermore, Kumpfer in turn identified the processes of dreaming and developing a sense of purpose in life as contributing to resilience. In the current study, participants were found to be planning for the future, with at least three of them actively working towards making their dreams a reality by studying or by planning a new career venture.

4.2.3 THEME 3: DEMONSTRATING RESILIENCE THROUGH BELIEF

The concept of demonstrating resilience through belief was a prominent subtheme in the data collected from the interviews with the participants. The importance of religion was discussed in the focus group interviews and all four participants who were interviewed individually also made mention of it. In the course of the data collection process, participants referred to their faith, a belief in a God-given gift to work with children, and the solace that they derived from praying. They spoke very strongly about their beliefs, indicating that a sense of faith might be central to their identities and resilience processes.

Table 4.5: Inclusion and exclusion criteria for Theme 3

Subtheme	Inclusion Criteria	Exclusion Criteria
3.1 Resilience through religion	References to the impact of religion and religious practices on the participants' working context	References to the concepts of hope and passion
3.2 God-given gift for working with children	References to the way in which participants choose and view their job	References to religious practices or coping mechanisms

4.2.3.1 Resilience through religion

Caretakers repeatedly mentioned their belief in God's grace carrying them through the day, especially in difficult situations. Participant 5 and Participant 3 specifically mentioned that their faith was a source of strength or resilience for them, giving them the power to complete their work:

> An: What makes you strong?
>
> P5: I'm just telling myself maybe God make me like that, mmm … because I never go to the hospital to admit they say I've got a lot of stress or what (II, lines 378–87).
>
> P3: When I'm at home I always pray to God. I say, "God, it is You who makes me to love the children, it is not by my grace, it's by your Grace; it's by Your power. Give me love and strength to work with them [the children]" (FG, lines 286–89).

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Participant 4 mentioned her conviction that she was only able to function at the workplace thanks to God's grace:

> P4: And sometimes I've told myself that I am not doing it because I'm clever enough, but it is God's grace. Truly speaking, it is God's grace because after a kid swears onto you and then you go back to her and loving, you know how difficult is it? It's really difficult but I just told myself that it's really God's grace to do all of those things to accommodate them [the children] (FG, lines 200–206).

It appeared as if the facility itself might have a religious approach as well, as was evident from the following research diary observation:

> On the side [of the room], in a raised corner stood a small wooden pulpit. Maybe this room is also used for religious gatherings?

Prayer was often mentioned as a way in which caregivers were able to regain strength and motivation throughout the day. As mentioned previously, prayer functioned as a coping mechanism (discussed in Section 4.2.2.1), and its presence was indicative of a far more profound sense of religiosity as reflected in the excerpts below. Participant 3 described how she was able to draw strength and understanding from prayer to help her care for the children better:

> P3: When the children upset me, I discipline them. I take the child and lock the child in the room. I'll put the child in the corner and after that, maybe when I arrive at home I just pray to God. I say, "God, to give me power and strength. Maybe this child, they need love and they are still young. God give me strength and power, give me love because they need unconditional love" (FG, lines 257–63).

Participant 4 spoke very frankly about the role that God's grace played in her work life. She admitted that she felt she could not cope with all aspects of her work without relying on God to provide her with strength:

> P4: If I look at that kid eish … hey, hey, hey, it's so difficult, and I can feel that this thing it almost develop a hatred—just imagine a person or a kid calling you a bitch, you know a bitch. Even now. And that's why I used to say, maybe you know it's God's grace to be in this house and managing some of the things; on my own I cannot (II, lines 218–24).

Participant 6, on the other hand, appeared to experience the calming influence of prayer, which allowed her to control her temper:

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P6: I always, I'm, uh, sometimes going to the toilet and praying. I used pray[er] when I'm stressed even if I'm at work. I go to the toilet and pray so that I can control my temper (II, lines 187–89).

4.2.3.2 God-given gift for working with children

From the beginning of the focus group interview, participants mentioned that they saw their job not merely as a job, but rather as a calling. They felt convinced that God had granted them a gift to work with children, which appeared to be a major motivating factor in their choice to work at the care facility and in keeping them intrinsically motivated to do their job well. Participant 4 explained that she was wired to help people:

An: You say it's a difficult place to work yet somehow you're able to work here?

P4: No it's, uh, uh, I'm unable really because ei…ah…ah…man. As I've said, it's God's grace because I have this thing of helping people. You know, I don't want to see a person who is suffering (II, lines 784–87).

Participant 1 mentioned that she enjoyed her job because of her love for children:

P1: It's because, if you love kids, that's why you come to work. There are so many work which we can do, but because you love kids, that is why we are here (FG, lines 55–57).

Participant 6 expressed similar sentiments:

P6: Yes, I enjoy working 'cause I like the kids.

Co1: So is that why you decided to come and work here?

P6: Yes (II, lines 14–16).

These comments seemed to indicate the presence of some form of internal motivation or conviction of a gift to care for and work with children.

4.2.3.3 Discussion of findings for Theme 3

The participants in the study appeared to have found strength and purpose through religion. In their view, their religiosity helps them to cope with difficult situations, gives them power and energy to deal with problems, and provides them with a purpose in life. According to Kumpfer (2002), resilient individuals tend to have a strong spiritual foundation, which provides a form of existential meaning.

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Furthermore, Kumpfer (2002) postulates that spirituality in itself is a good indicator of resilience, as it typically fosters a sense of belonging and community, direction or purpose in life and fellowship. While participants did not elaborate on their sense of fellowship or community, the strong evidence of a spiritual component in the lives of each of them indicated that these factors were present in their life attitudes.

Participants in this study found purpose in life by caring for children and they considered themselves to possess a gift or a passion for working with children. Their belief that these gifts should be put to good use was one of the main reasons for working in the care facility.

4.2.4 THEME 4: RESILIENCE BORN OUT OF THE IDENTITY OF CAREGIVER

This theme focuses on the roles that the participants play, both at work and at home. In the data, there appears to be an overlap between parental roles at home and the role as caregiver at the care facility. The extent of this overlap looms so large that it appears as if the caregiver role has become a central element in the identities of the participants.

Table 4.6: Inclusion and exclusion criteria for Theme 4

Subtheme	Inclusion Criteria	Exclusion Criteria
Responsibilities at home and at work	Any references to the participants' roles and responsibilities in or outside of the work context	References regarding participants' identity
Constructed caregiver identities	Any references to the way in which participants identified themselves	References to how others see the participants

4.2.4.1 Responsibilities at home and at work

Three participants explicitly mentioned their being the main breadwinners in their families and/or carers for an extended family at home. These participants did not see resigning from their jobs as a caregiver as an option, because of their responsibilities at work and at home. Resigning from their jobs would also be regarded as incongruent with the caregiver identity that the participants assumed. It appeared that their identities as caregivers contributed to their positive sense of self, which may be construed as an aspect of resilience construction. One aspect of this self-constructed identity was that they appeared to survive difficulties and challenges, because they believed that this was what responsible caregivers do.

The extract from the focus group interview below illustrates the way in which caregiving responsibilities encourage participants to remain resilient for their families' sake. Participant 4

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and Participant 8 discussed how the need to provide for their families left them no other option than to persevere through difficult circumstances, essentially forcing them to be resilient or strong:

> P4: Like, on my side, I've got five kids to put bread onto the table. And you know, if I'm just going to decide now that this is too much for me, I can't carry on living like this, what about those five kids? They need bread every day. What would happen about my life? Because you see now, it's difficult to find a new job. So you just come with this, ah, maybe today it will be better. On the other hand, you are thinking about the other people who are on my side, who are relying on me to put something on the table. So it's vice versa.
>
> Co2: So it's your personal responsibilities as well?
>
> P4: Yes, so you see I have needs, I have the kids, I have this and this and this to do. If I just decide now to leave the job, what am I going to do? How am I going to leave here without even if it's a cent? But you have at least, you know, how to manage it to support your family.
>
> P8: It's better to come to work when you're thinking that it's, you must come to work because you like the work. You are happy when you are coming to work. But when you are coming to work to say, you think about my children if I leave them, then even if you are working it's not you. You are not working alright. It's nice to come to work if you enjoy your work, I think I like my work, I'm happy with what I'm doing. Yes, sometimes we feel like that, like she said. I have children, what if I leave the job today, my children, what is going to happen to them? So it's no longer love, you just come.
>
> P4: It's perseverance (FG, lines 1126–53).

In this instance, the participants described how their responsibilities and their sense of responsibility protected them from giving up within the caregiving context. While facing risk factors on a daily basis, the roles that they fulfil at home and at work do not allow them to be non-resilient, but rather encourage them to forge ahread through difficult circumstances.

4.2.4.2 Constructed caregiver identities

Participants discussed the way they saw themselves. When asked directly about the way she saw herself at work, Participant 7 unhesitatingly described herself as fulfilling the role of a mother to the children at the care facility:

> Co1: How do you see yourself?
>
> P7: As the mother. The one who must show you the way to go, you see (II, lines 1208–10).

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Participant 8 spoke of her hopes and dreams for the children under her care in a way similar to that of a mother speaking of her own children:

> P8: For us as caregivers, we want to see these children growing in the right way. They must go to school, learn, being like any other children who are staying home. Not being like these children who are staying here. They must be like any other children. We want to see them growing up, go being somebody else. Sometimes when we will see them on the TV or what they will see, these children they are a Minister today, I was looking after that child. Then we feel happy for that (FG, lines 1224–32).

She also described how she was forced to be strong due to the absence of a husband, effectively making her the breadwinner and main caregiver at home as well:

> P8: What makes me strong is that you see like now I'm telling you that my children have graduated nè. I didn't have anyone to help me. I was on my own. I didn't have a husband or a … who … I was doing it alone. Any problem, which comes, I face it on my own (II, lines 201–205).

4.2.4.3 Discussion of findings for Theme 4

From the subthemes presented, the theme of caregiver identity runs strongly through the narrative of the participants. They identify themselves as mothers, the persons who care for others no matter how difficult the situation might be. It is their job to help these children become functioning adults, and they are clearly not about to give up on either the children at the care facility, or the children under their care at home.

By finding this purpose in their job and by fulfilling this meaningful role in the lives of the children in their care, the participants are able to give meaning to the adverse conditions under which they work. This phenomenon is especially strong if the individual finds this purpose by helping or caring for others (Kumpfer, 2002). Finding meaning in their work can clearly be identified in the participants in this study, especially when they started talking about their hopes for the children under their care. This overlaps with the findings of a study done by Ross et al. in 2003, which concluded that caregivers who held a belief that their role as caregiver was in some way meaningful, tended to be more resilient. Further correlation of such findings can be found in Edward and Warelow (2005), and McMahon (2007).

The hopeful future perspective that the participants in this study held for the children in their care was indicative of a positive undercurrent in their attitudes that can be highly conducive to resilience building. It appears as if the participants' burden is lightened by the knowledge that they are making a meaningful contribution to the lives of many children. In this instance, the

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process of hope and their identities as caregivers are combined to contribute to their resilience. Significantly, the phenomenon of caregivers' internal identity being combined with the interactional process between person and context fits in well with the paradigm first described in the Resilience Framework by Kumpfer (2002).

4.3 CONCLUSION

This chapter outlined the results of the study, which centred on four different themes that were each aimed at representing an aspect of the employment reality of the participants and explicating how such an aspect related to their perceptions and construction of resilience. The findings were also related to existing literature with the aim of highlighting certain similarities and differences between the findings and the theory.

In the next chapter, I discuss how these results link to the theoretical framework from a South African perspective. Furthermore, a potential conceptual framework for caregiver resilience in South Africa is introduced and discussed. The limitations of this study are also delineated, and recommendations for practice, training, and future research are suggested.

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CHAPTER 5
RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter includes a summary of Chapters 1 to 4. The underlying theoretical framework is also revisited and contextualised, and the research questions are answered. A discussion of the study's limitations, and recommendations for practice, training, and future research are presented in conclusion.

5.2 SUMMARY OF CHAPTERS 1 TO 4

CHAPTER 1

The study was introduced by providing an overview of the necessary background information and the rationale for the investigation. The significance of and the need for exploring the topic of caregiver resilience were outlined. The research questions that guided this study were introduced, and key concepts for the study were explained. Furthermore, the ethical concerns of the study were discussed.

CHAPTER 2

By exploring what other researchers have written in the field of adult and caregiver resilience, the literature that is relevant to the study was reviewed. The chapter included a section on the South African caregiving context and an in-depth discussion on the theoretical framework. A conceptual framework for caregiving, as set out by Fredriksen-Goldsen (2007), was also introduced.

CHAPTER 3

The methodological aspects of this study were discussed, which included the research process, from sampling to data collection, and finally to data analysis. Also included was a breakdown of the particulars of the participants of the study and an explanation of how the sampling process progressed. The qualitative approach that guided the study was discussed in addition to the constructivist paradigm that underlies the research methodology.

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CHAPTER 4

The results of the thematic data analysis were reported. Four main themes were identified, including a number of subthemes linked to each main theme. The results were linked to the literature reviewed in Chapter 2 and these findings were discussed in detail.

5.3 ADDRESSING THE RESEARCH QUESTIONS

Based on the results of this study, the research questions are answered in this section. The main research question is addressed first, after which two subquestions will be answered individually.

5.3.1 ADDRESSING THE MAIN RESEARCH QUESTION

"How do formal caregivers of orphaned and vulnerable children construct their own resilience?"

Based on the results of the study, this section attempts to address the main research question by relating the result to the theoretical framework while situating it in the caregiving context. The primary research question had to be explored in order to arrive at satisfactory explanations of caregivers' coping strategies and resilience building. Different factors and processes that contributed to resilience evinced by the participants were investigated, based on insights into the phenomenon of resilience fostered by Kumpfer's (2002) Resilience Framework and Fredriksen-Goldsen's (2007) Caregiving Resilience Model.

As a theoretical viewing lens aimed at answering the main research question, a conceptual framework was devised that would also allow for the organisation of the results into different relevant aspects (see Figure 5.1). Since the data analysis was conducted from an inductive approach, only themes that emerged from the data were incorporated into the model (bearing features borrowed from the Resilience Framework of Kumpfer (2002) and the Caregiving Resilience Model proposed by Fredriksen-Goldsen (2007)).

Kumpfer's Resilience Framework relies on six main constructs: stressors or challenges, the external environmental context, person-environment interactional processes, internal self-characteristics, resilience processes, and positive outcomes (see Section 2.3). Fredriksen-Goldsen's (2007) model originally included four primary factors, namely background characteristics, risk factors, protective factors, and caregiving outcomes (see Section 2.3). These factors have been adapted for the framework for the South African context investigated in the present study. In the proposed framework, the following four constructs were identified as contributing to the caregivers' resilience processes:

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i. Environmental factors

ii. Caregiver individual resilience characteristics

iii. Environmental-individual transactional process

iv. Resilience outcomes

Figure 5.1: Caregiving Resilience Model adapted for South African context

5.3.1.1 Environmental Risk Factors

The concept of environmental risk factors embodies two of Kumpfer's (2002) six main factors in the Resilience Framework, namely exposure to stressors, and risk factors present in the

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environmental context. It also draws on the concept of risk factors present in Fredriksen-Goldsen's Caregiving Resilience Model (2007).

In resilience literature there is a general consensus that exposure to risk or stressors serves as the catalyst for the resilience process. Without exposure to stressors, there is no difficulty to overcome or recover from. In this study, the participants mentioned a plethora of stressors in their working environment. The elements surrounding the participants' everyday work experience link with the second aspect of Kumpfer's Resilience Framework (2002), the environmental context. The working environment where this study took place was not conducive to the participants' job satisfaction, work happiness, or their organisational commitment. It can therefore be deduced that the work environment was not conducive to the participants' well-being and resilience. The work environment itself was certainly perceived to be more of a risk than a protective factor. To a certain degree, the concerns raised by the participants correspond to the stressors found by Mutiso et al. (2011) in their study of Kenyan caregivers (see Section 2.4.2 relating to stress experiences of caregivers, specifically Table 2.2). The results of the current study show that the main risk factors that participants were exposed to related to their environmental context. Within the proposed framework, the risk factors identified were a part of the participants' everyday working context.

In terms of environmental stressors, organisational leadership, and interpersonal demand factors, there are similarities between this study and the study on Kenyan participants (Mutiso et al., 2011). Organisational leadership and communication styles were some of the main concerns raised by the participants in this study, with a large number of negative comments and complaints directed towards the manager and management team of the residential care facility. The participants felt that they were being disregarded by management on whom they could not rely for support in difficult situations. Similarly, the participants experienced the interpersonal demands of having to accommodate the multiple needs of orphaned and vulnerable children as a stressor. This was exacerbated by the fact that the children appeared ungrateful and would at times lash out with hurtful comments that would make the participants feel as if their love and care for the children were being rejected. Nevertheless, the participants were often able to identify possible solutions to these environmental risk factors, especially those involving the facility's management team.

Furthermore, there appears to be an overlap between the factors relating to economic difficulties and those relating to family demands. The participants in the current study also felt economic pressures, specifically because they felt financially responsible for their families. While there

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were no reported cases of family problems, the participants mentioned that they were the main breadwinners and/or were domestically taking care of children that were not their own. The participants in this study did not elaborate on any of the environmental factors as discussed in Section 2.4.2 and as identified by Mutiso et al. (2011).

The participants faced difficult working conditions on a daily basis and some felt so discouraged at times that they were unable to cope with their situation. Furthermore, the participants felt economic pressure as breadwinners outside of the workplace while receiving a limited salary. Despite these difficulties, the participants returned to work to care for the orphaned and vulnerable children, indicating a sense of responsibility toward their occupation and their roles.

5.3.1.2 Caregiver Individual Resilience Characteristics

This concept in the proposed framework links with what Kumpfer (2002) identified as internal resiliency factors within the individual. Resiliency factors refer to those individual character traits that contribute to the individual's resilience. Resilience is seen as a development process and resiliency is generally accepted to refer to an internal trait (Earvolino-Ramirez, 2007; Fergus & Zimmerman, 2005; Ungar, 2005). Resiliency factors identified by Kumpfer (2002) include cognitive, emotional, physical, behavioural, and spiritual factors. The participants in this study displayed characteristics of behavioural and social competencies, as well as spiritual and motivational resiliency factors.

In terms of behavioural and social resiliency factors, the participants evinced behavioural coping mechanisms such as crying and distancing, and isolating themselves for a small period of time to gain control over their emotions. Furthermore, the participants mentioned the different ways in which they would regain control over the children in their care, indicating that they were able to confront problems head-on. These results are consistent with coping mechanisms found in the study by Mutiso et al. (2011) on Kenyan caregivers, who employed tactics such as confronting the source of a problem and taking a few minutes to compose themselves.

Participants also relied on each other for support. Researchers have identified the importance of a close and personal relationship with a caring adult as a protective factor in the development of children (Fergus & Zimmerman, 2005; Luthar et al., 2000). The participants in this study derived much support from positive relationships with their colleagues, indicating strength in their social competencies.

Furthermore, almost all the participants in this study mentioned that faith and religion played an important role in sustaining them through difficult times and in motivating them to live out their

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passion for working with children. The majority of the participants mentioned prayer as a coping mechanism, as it was seen as a source of strength and guidance. In terms of internal resiliency factors, the spiritual resiliency factor emerged as the most prominent.

Motivational resiliency factors also played a major role in this study. Participants identified themselves as caregivers or mothers, indicating that their jobs were an important part of their identity. As an extension of this caregiver identity, they felt strong and were convinced that they had to remain strong or resilient for the sake of the orphaned and vulnerable children under their care. The identities that they created for themselves therefore had to be resilient. If they did not see themselves as strong or resilient, this would probably be deemed incongruent with the caregiver identity that they created. Many participants mentioned that they had a passion for working with children, which indicated that they were more likely to be intrinsically motivated to do their job well. Typically, motivated people are intrinsically able to cope better with stressors in their working environment and are more likely to engage in proactive behaviour in the workplace (Youssef & Luthans, 2007).

Similarly, a case can also be made for some of the participants' exercising the process of dreaming and planning or even hoping. Instances of this process include planning for a better job or a better future by studying or by dreaming of opening a crèche. These participants live with hope for the future, which obviates some of the negative experiences of the present. Furthermore, the participants in this study also reported the forging of strong peer relationships and support to mitigate organisational stressors. This is an example of participants' seeking out the pro-social elements from their colleagues. The combination of these interactional processes between the participants and their environments helps to negate the constant exposure to stressors and a negative environment. In this manner, these processes appear to contribute to the participants' effective functioning and their individual and collective construction of resilience.

According to Fredriksen-Goldsen (2007), the background characteristics of the caregivers influence the way in which they negotiate stressors. As it is difficult to comment on factors such as gender in this discussion (since the participants were all female no comparison with male caregivers could be made), the individual caregiver characteristics discussed under this aspect are faith/spirituality, caregiving identity, sense of control, presence of coping mechanisms, and future directedness/hope. In this study, the degree to which these factors were present and were being utilised in participants' lives seemed to influence their ability to function effectively in their working environment. For example, having a sense of spirituality and faith as individual caregiver characteristics appeared to support resilience construction processes. Indications were

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that caregivers with a strong faith—often viewing their capacity for working with children in difficult circumstances as a gift from God—demonstrated the ability to find meaning in their work.

5.3.1.3 Person–environmental transactional process

According to Kumpfer (2002), resilient individuals, living in high-risk environments, either actively seek ways to find a better environment, or try to create one. In the current study, participants employed coping mechanisms that were solution-directed in that these participants were able to identify solutions to at least some of the risk factors. Kumpfer (2002) identifies the processes of selective perception, planning and dreaming, and identification and attachment with pro-social people, among other things, as ways to minimise risk. In this study, the caregivers sometimes chose to ignore negative comments or behaviours from the children. This is an example of selective perception exercised by the caregivers. Choosing to ignore negative events may lead to a more positive perception of the environment.

5.3.1.4 Resilience Outcomes

Once a stressor is experienced, the resilience process is set in motion. In this process, the stressors, environment, internal characteristics of the person, and interactional process between these factors come together in a level of reintegration (Kumpfer, 2002). In this study, it can be assumed that the participants typically reintegrated their construction of resilience processes on either a homeostatic or resilient level. This assumption is supported by the fact that participants were able not only to fulfil their daily employment roles and functions, but also to care for their own children outside of the work context.

The findings of this study would also be congruent with a compensatory model of resilience as identified by Fergus and Zimmerman (2005). In this case, the protective factors (faith, identity as caregiver, coping mechanisms) have a direct influence on the risk factors and reduce or negate the effect that the risk factors (environment) have on the individual. The participants appeared to be able to function adequately within a fairly negative environment because of the presence of protective factors. Through their reporting, caregivers could be observed relying on their internal resiliency traits (religious beliefs, caregiver identity, coping mechanisms) and external resources, such as support from fellow caregivers/participants, to achieve a homeostatic or resilient reintegration outcome of the resilience process.

In addition, this study illustrates the contextual nature of the resilience process. Protective factors, such as a participant's identity as a caregiver, may not actually be considered protective

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in contexts other than resilience-related ones. Similarly, the interactional processes between individual and environment are highly context specific. Some individuals may thrive under certain circumstances, while others may not. Therefore, participants who are able to negotiate hurdles in their current working environment successfully may not necessarily be able to function effectively in a different working environment. Conversely, a different group of individuals who are functioning effectively in their own environment may not be able to adapt to the working environment in which the current study's participants are able to function. Against this background, and in view of the analysis of their reporting, it can be concluded that the participants in this study were able to successfully negotiate the interactional process between their environment and their internal resiliency factors. It is the successful negotiation between these factors that allows the participants to function within their environment.

This study was unable to explore the effects of gender and ethnicity, as all participants in the study were women of African ethnicity. This study is therefore unable to comment on the relevance of these factors.

In the adapted framework, the individual caregiver characteristics, the risk factors, and the protective factors all contribute to outcomes of the resilience process as described by Kumpfer (2002). While most participants functioned effectively in the work environment, other outcomes were also possible, such as ineffective functioning or, conversely, even thriving in the work environment.

The proposed caregiver resilience framework adapted for a South African context is still highly derivative at this stage. It is clearly adapted from the caregiver resilience framework by Fredriksen-Goldsen (2007), with influences from Kumpfer's Resilience Framework (2002), and acknowledgement should be given to these two authors.

5.3.1.5 Discussion of Main Research Question

One of the first things that emerged from this study was that the participants interpreted the concept of resilience as synonymous with being strong. Participants equated being *resilient* with *being strong* or with *coping* in adverse working conditions. This concept of *being strong* applied at work as well as at home, indicating that being strong applied to multiple contexts as part of the participants' identities.

Furthermore, participants described their strength as stemming from a number of factors and processes relating to who they were, as well as how they interacted with the environment. Participants identified themselves as being strong if they were able to fulfil their roles as

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caregivers at work and at home. While their work environment could be considered a stressor, the participants were still able to describe themselves as being strong as long as they were able to care for the children at the care facility. Caring for the children allowed them to fulfil their caregiver identity and contributed to their conception of being strong, especially if they were able to fulfil their roles in their difficult working environment. This ability to fulfil their functions despite adversity created the impression on the part of the participants that they were capable and dependable people. It can consequently be concluded that these positive impressions of themselves may be assimilated into their self-image, potentially boosting their self-esteem.

Participants also identified specific factors that contributed to their strength and coping abilities. These included practical actions or mechanisms that they utilised to cope with pressures at work. Participants discussed various coping mechanisms that they employed to regain control over themselves in stressful situations. These mechanisms ranged from crying in a toilet cubicle to venting their emotions, or to taking time out and saying a quick prayer in order to ask for patience or guidance. It can be assumed that such practical coping mechanisms allow participants to remain in control of themselves and to manage difficult situations more effectively.

Three of the participants constructed their own resilience by envisioning a future perspective and by considering ways in which they could improve and shape their futures in a positive manner. Two of them were planning to open a crèche together, while another was studying through the University of South Africa. The process of planning allowed the participants to take active steps in improving their lives. The inference may be drawn that such proactiveness forms part of a process whereby these three participants are empowering themselves through taking control over their futures.

Participants empowered themselves not only by envisioning and planning for improved prospects, but also by managing the seemingly difficult children in their care who, as reported, often insulted them and hurt their feelings. Participants also described situations in which they had difficulty in managing the children's behaviour. Such problems being exacerbated by the management team's unsupportive stance, participants had to empower themselves by devising their own ways of managing unacceptable behaviour of the children in their care. By overcoming difficult situations, participants could empower themselves motivationally and take control of difficult situations. Participants were also able to play an empowering role to each other. Participants found their colleagues to be a source of support and advice, which in turn allowed them to empower their colleagues in a positive cycle of reciprocity.

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Furthermore, religion was also discussed as an important aspect in the construction of the participants' resilience. Participants felt driven and motivated to work with children and many described it as a calling from God. Religion and prayer were also mentioned as contributing to the participants' coping mechanisms.

Lastly, participants described themselves as mothers or caregivers. These constructs seemed to be central in their identities. As an aspect of the caregiver identity, participants expected themselves to be resilient for the children in their care, both at work and at home. It appears as if the constructed caregiver identity reminds the participants of their responsibilities at work and at home, while also being a motivational factor for them to persevere in their work.

5.3.2 ADDRESSING SUBQUESTION 1

> "What are the factors that contribute to the resilience of caregivers of orphaned and vulnerable children?"

Based on the results of this study, a number of internal factors and transactional processes that seem to contribute to the resilience of the caregivers can be identified. These factors and processes that could help the participants ameliorate risk were discussed in relation to the theoretical framework and were adapted to the South African context in Section 5.3.1.

Within the working environment, the participants found it helpful to discuss the concerns that they had with supportive colleagues. Participants reported that this practice was very helpful, especially when set against the background of a management team that they viewed as having disempowered them. While the management team did not support formal meetings between the participants or between management and the participants, the informal conversations and support between colleagues did help the participants to function better at work.

When considering internal factors that could contribute to the resilience of the participants, five different factors can be identified. Firstly, the participants narrated and identified themselves as being caregivers and mothers. Embedded in the idea of being a caregiver is a certain level of strength or resilience. Three participants reported that they were the sole breadwinners and/or had to care for an extended family at home. When faced with this responsibility, participants appeared to see no other option than coping and functioning at work. However, the identity of caregiver extends beyond this. It means that the participants have an inherent passion to care for children.

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Secondly, participants also discussed minor actions or mechanisms that they employed for coping. The different coping mechanisms that they described ranged from taking a moment to compose themselves to venting emotions before dealing with a difficult situation. Such coping mechanisms helped participants to remain in control of themselves and the situations they were faced with.

The third factor that participants mentioned was that the children in their care often appeared difficult to control and discipline. For the majority of the participants, this appeared to be a serious problem. However, as caregivers they utilised different techniques to regain control over the children under their care. Generally, they that felt that they knew how to manage the children well and also reported feeling less stressed. This may indicate that the ability to regain control over difficult children could be considered a factor that contributes to their functioning, and therefore, their resilience.

The last factor that can be identified as contributing to the participants' resilience was that of a future-directedness, or hope of a better future. Three participants mentioned concrete plans for the future and/or for bettering themselves. It seems that the caregivers who knew that they had plans for the future used this knowledge as a way of maintaining their strength in their present situation.

Each factor contributes to the resilience of the participants. However, these factors are not static but interact with each other, synergistically adding to the potential positive effects they could have.

5.3.3 ADDRESSING SUBQUESTION 2

"What motivates caregivers to care for orphaned and vulnerable children?"

This question is aimed at exploring what it is that drives or motivates the participants to do the job that they do. Three factors mentioned in Section 5.5.2 relate to this: their constructed identity as caregivers, their roles as bread-winners, and their conviction that their ability to work with children is a gift from God.

Firstly, the participants identified themselves not merely as caregivers but also as mothers to the children under their care at work. This identity of caregiver apparently provides the participants with an internal sense of worth and strength. Embedded in the role of caregiver lies responsibility. The participants feel responsible for the children under their care and not doing

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their jobs properly would be incongruent with their caregiver identity. Therefore, participants may feel as if they have no other option than to function within their work environment.

Secondly, fulfilling the role of breadwinner at home puts some pressure on the participants, but it also serves as a motivating factor. The participants do not have the option of quitting or becoming overwhelmed as their family at home relies on them for care and financial support. Combined with the identity formation of caregiver, the breadwinning responsibility nullifies the option to stop functioning at work.

Lastly, the participants experienced their ability to work with and care for children as a gift from God or even a calling. Viewing abilities as a gift from God, and a job as a calling, may be indicative of strong internal motivation to do a good job and to serve God with perceived talents. Combined with religiosity, this seems to make for a strong motivating factor in caring for children.

It would appear then that the participants are motivated by a combination of extrinsic and intrinsic factors. Extrinsically, the pressure of being the main breadwinner does not leave the participants with the option of giving up. Intrinsically, the participants are motivated and driven by their identities as caregivers and by experiencing their job as a calling or gift from God.

5.4 SILENCES AND CONTRADICTIONS IN THE STUDY

Owing to the highly individual and contextualised nature of this study, it stands to reason that there may be certain silences and gaps in the findings. Asking participants for their personal perceptions of resilience will yield exactly that: personal perceptions. The data collected for this study are therefore not grounded in existing theory, but rather based on the personal opinions of the participants.

The fairly homogeneous nature of the sample made it unfeasible to deliver any comment on gender differences with regard to resilience. Several authors have alluded to the fact that culture may also play a role in the construction of resilience (Kumpfer, 2002; Mutiso et al., 2011). However, in this study no particular reference was made to the role of culture or cultural expectations regarding resilience.

Further silences identified in this study related to the impact of the political climate on caregivers, as identified by Mutiso et al. (2011). Participants in this study did not refer to the political climate once in the data. In the study by Kuo and Operario (2011), more than one-third of participants met, or almost met, the criteria for clinically significant depression. While

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participants in this study complained about stress and potential tension headaches, no-one discussed the topic of depression.

The only contradiction repeatedly mentioned in this study was the ambivalence of the participants towards the children in their care. Although the participants had a passion for working with children, they found the way that the children often treated them hurtful and experienced it as contributing to their stress in the work environment.

5.5 ADDRESSING THE WORKING ASSUMPTIONS

Given the results and findings from this study, it would be prudent to reconsider the working assumptions on which the study was based. This section evaluates whether the following working assumptions hold up against the results and findings of the study:

i. Caregivers working with orphaned and vulnerable children are resilient.

ii. Caregivers working with orphaned and vulnerable children face adverse and challenging conditions in their work on a regular basis.

iii. Caregivers working with orphaned and vulnerable children are able to directly or indirectly indicate factors that might contribute to their resilience.

iv. Resilient caregivers are able to provide better care for the orphaned and vulnerable children in a residential care facility.

Participants in this study indicated that they worked in an adverse and challenging environment, while also considering themselves to be strong and dependable. Furthermore, participants were able to identify factors that contributed to their resilience. Many of these factors were clearly identified (such as factors surrounding faith), while others (such as having a future perspective) were indicated in a more indirect manner. Lastly, while it was not measured, participants who described themselves as more resilient also felt that they were more capable of caring for the children under their supervision.

5.6 POSSIBLE CONTRIBUTIONS

The findings of this study contribute to the canon of literature on the subject of resilience, in that the study entailed an endeavour towards reducing the deficiencies that currently exist in literature on resilience in formal caregivers. Furthermore, the study may serve as a foundation for similar exploratory investigations in the field. Caregivers themselves may find this study useful in terms of helping them to identify possible factors that could contribute to their resilience construction.

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Most importantly, in South Africa, this study adds to the essential knowledge needed towards better training of caregivers by incorporating and developing factors that contribute to caregiver self-empowerment. This study and the conceptual framework derived from it may serve as a foundation for further research into the phenomenon of caregiver resilience.

5.7 THE RESEARCHER'S REFLECTIONS

The purpose of qualitative research is to gain the participants' perspective on the issue at hand. The participants had the opportunity to express their subjective realities in discussions that took place as focus group discussions and individual interviews (Henning et al., 2011). In this case, the issue at hand was their resilience. Essentially, I had to attempt to enter the participants' life world in order to get a subjective glimpse into the way that they experience their work and their resilience.

I found that the participants were initially hesitant to share their feelings with us (co-researchers and me), especially at the start of the focus group interview. This may have been related to our being new faces at the care facility, but, as we would later realise, the participants were also afraid that what they said would get back to the care facility's management.

As the focus group interview progressed, the participants opened up and became more at ease. Once we reiterated that the information they shared was confidential, the participants became more willing to discuss a large number of complaints in a frank manner. At the time, I gained the impression that the participants had a tremendous need to be heard and to discuss their difficulties. It felt as if the focus group interview had moved from a data collection method to a counselling session for the participants. However, we did receive valuable information and it seemed that trust was established. By the time one of the co-researchers and I conducted the individual interviews, the participants spoke freely. They appeared much more at ease than at the beginning of the sessions and allowed us to share in their life worlds. Initially I felt doubtful of their limited understanding of the resilience concept and their penchant for discussing stressful situations more than their resilience responses to them. However, they did provide more information on resilience than I initially thought they would. A great deal of information on resilience eventually emerged from their discussions of factors that caused them stress.

The participants allowed us to enter their life worlds with them—worlds filled with love, stress, strength, and perseverance. This unstinting sharing would allow me the opportunity to experience their resilience, even if they were unable to express it in the way they would perhaps have preferred to.

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5.8 LIMITATIONS OF THE STUDY

Every study or research component has its strengths and limitations. Limitations to this study arose as a result of the research design employed, the data collection methodologies applied, and the context within which the study was conducted.

With regard to the research design, one of the major criticisms levelled against the case study method is that it focuses on a single case or instance. This severely limits its generalisability, but, as Nieuwenhuis (2007b) states, "this is not the purpose of the case study method" (p. 76). Other possible limitations of the case study method include the fact that case studies may be biased and subjective as they are prone to observer bias and difficult to verify (Nisbet & Watt, as cited in Cohen et al., 2007).

The data collection methods utilised in the study entailed their own difficulties, since focus group information gathering means that the sample size is typically small and consequently does not lend itself readily to generalisation of findings. Another limitation was the difficulty to convene all participants at the same time and place (Nieuwenhuis, 2007b). A potential limitation of a focus group discussion relates to the role of the moderator, as the skill of the moderator largely determines the quality of the discussion. A further limitation was the secondary role of observations as a data collection technique. This, in conjunction with limited time in the field, meant that the researcher had to rely heavily on self-report data from the participants.

Limitations regarding the context of the study included time and language constraints. Language was a barrier in the sense that English was not the mother tongue of any of the participants. This difficulty was not insurmountable, however, since the caregivers were able to express themselves fairly well in English, and, when the need arose, the services of an interpreter were used. Time was also a limiting factor since this study formed part of a master's course in Educational Psychology, which restricted the time frame for research. Constraints in the availability of participants also played a role.

Finally, resilience was a difficult topic to discuss. I gained the impression that the participants struggled to comprehend the concept fully. They seemed to understand it better in terms of "strength" or "coping". While these are indeed aspects of resilience, they do not entirely capture the essence of the concept. My data collection was done in tandem with a co-researcher whose study focused on stress and stress experiences of participants, and it appeared that the participants were far more at ease discussing stressful events or factors than dealing with perceptions of resilience.

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5.9 RECOMMENDATIONS

Based on the results of this study, the following recommendations are made in such a way that they can relate to training, practice, and future research.

5.9.1 RECOMMENDATIONS FOR TRAINING

- Caregivers could benefit from training in issues relating to the management of children's behaviour. Participants had many concerns about how to manage children's difficult behaviour.
- Training that explores effective emotional coping techniques can benefit caregivers. Being under constant stress can have a negative impact on the emotional well-being of caregivers, and learning to obviate this may reduce the perceived stress that they experience.
- Caregivers should be provided with a certain degree of training in managing and caring for orphaned and vulnerable children. While seeing one's job as a calling or a gift is certainly positive, this alone does not prepare caregivers enough to work effectively and with resilience.
- Caregivers could benefit from annual workshops on emotional awareness and how to cope in the workplace.

5.9.2 RECOMMENDATION FOR PRACTICE

- Caregivers should have access to an open forum where they can discuss their difficulties with the facility's management team in order to encourage open communication between management and the caregivers.
- Open, honest communication should be encouraged as it has the potential for greatly easing the pressures of what is already a strenuous and taxing job for caregivers.
- Workshops for managerial staff may also be considered.

5.9.3 RECOMMENDATIONS FOR FUTURE RESEARCH

- A need exists for stronger utilisation of informal observations or participant observation as a data collection method in order to attempt to record resilient behaviour in participants.
- Owing to a dearth of appropriate literature, it is imperative that more research should be done on the topic of adult resilience and more specifically caregiver resilience.
- With regard to future research, exploratory investigations could be undertaken into the functioning of other care facilities and resilience building by their caregivers. The

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Caregiving Resilience Model that was adapted for a South African context needs to be expanded upon and investigated further, and adult and caregiver resilience should be investigated in more detail.

5.10 CONCLUSION

This study was aimed at contributing to the field of resilience research, especially in the area of caregivers' resilience in South Africa. The findings suggest the need for an integrated and comprehensive framework that will outline caregiver resilience, pertinently with due consideration of the South African context of caring for orphaned and vulnerable children. The roles of culture, socio-economic circumstances, and HIV and AIDS should be taken into account, together with more localised, context-specific findings from different care facilities and institutions.

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APPENDICES

Appendix A: Ethical Clearance Certificate

Appendix B: Participant Letters of Informed Consent

Appendix C: Sample of Focus Group Transcription

Appendix D: Sample of Individual Interviews

Appendix E: Extracts from Research Diary

Appendix F: Thematic Analysis: Grouping Themes

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Appendix A: Ethical Clearance Certificate

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Faculty of Education

RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE	CLEARANCE NUMBER : UP 10/03/01
DEGREE AND PROJECT	M.Ed Perceptions of resilience by caregivers of children in a residential care facility
INVESTIGATOR(S)	Andreas Baron
DEPARTMENT	Educational Psychology
DATE CONSIDERED	21 August 2013
DECISION OF THE COMMITTEE	APPROVED

Please note:
For Masters applications, ethical clearance is valid for 2 years
For PhD applications, ethical clearnace is valid for 3 years.

CHAIRPERSON OF ETHICS COMMITTEE	Prof Liesel Ebersöhn
DATE	21 August 2013
CC	Jeannie Beukes Liesel Ebersöhn Dr MR Mampane Prof K Mohangi

This ethical clearance certificate is issued subject to the following conditions:

1. A signed personal declaration of responsibility
2. If the research question changes significantly so as to alter the nature of the study, a new application for ethical clearance must be submitted
3. It remains the students' responsibility to ensure that all the necessary forms for informed consent are kept for future queries.

Please quote the clearance number in all enquiries.

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Appendix B: Participant Letters of Informed Consent

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Letter of Informed Consent: Participant

Faculty of Education

Department of Educational Psychology

February 2010

Dear participant

Arising from the findings of my PhD study entitled: *Finding roses amongst thorns: How institutionalized children negotiate pathways to well-being while affected by HIV&AIDS*, I found a need to examine the emotional responses of adults who care for children with a view to enhancing their emotional awareness.

I would therefore like to invite you to participate in a study that looks at caregiver's emotional response while working with and caring for children who are living with HIV&AIDS. Your participation in this research project is voluntary and confidential. It is proposed that in the first stage of the study, you would be completing a questionnaire (test) that explores your emotional intelligence. Thereafter, you will be required to form part of a focus group, the members of whom will be interviewed individually and collectively. During the second stage of the study, you will be invited to assist in the planning and actively participating in a group discussion that is aimed at emotional awareness and enhancing the emotional responses of the participants. Participation in a workshop aimed at stress management is also expected. During this research process, the primary researcher will be assisted by research field-workers (also known as research assistants) who will co-facilitate the focus groups and the group discussions. These research field workers will be students. It is possible that the field workers will utilize part of the information gained to embark on their own individual projects under the supervision of Dr Mohangi. The students are: Ms Chereen Pretorius, Mr Andreas Baron and Mrs Lolo Mosia.

Should you declare yourself to be willing to participate in this study, confidentiality will been assured. The data that emerges from this study will be shared with you to ensure the trustworthiness. Furthermore, the information gained from this study will be

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published in the form of journal articles and/or conference presentations. You may decide to withdraw at any stage should you wish not to continue with your participation. If you are willing to participate in this study, please sign this letter as a declaration of your consent ie. That you participate in this project willingly and that you understand that you may withdraw from the project at any stage. Signing this form also means that you give permission for all interviews and activities to be recorded by means photographs and digital voice recordings. Should you have any enquiries, please feel free to contact me.

Yours sincerely

____

Dr Kesh Mohangi
Tel: 012 420 5506
kesh.mohangi@up.ac.za

Consent to participate in the research project

I, ____, agree to participate in the research project as outlined in the letter and as explained to be verbally. I am aware that I may withdraw from the study at any stage. I am also aware that my identity will be restricted to only the members of the focus group, the researcher and the research field workers. In all other instances, my identity will remain anonymous. I agree to maintain confidentially will regard to the information shared and identity of other group members during focus group discussions as well as during the workshop.

I also agree to the research field workers (students) utilizing a part of the data from this study to explore their own individual projects under the supervision and guidance of Dr Mohangi. I will contact Dr Kesh Mohangi should I have other queries.

____

Participant's name (please print)

______________________________ ____________________

Participant's signature Date

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Letter of Permission: Institution

Faculty of Education
Department of Educational Psychology

February 2010

Dear Sir/ Madam

<u>Re: Permission to conduct research</u>

I am a lecturer at the Department of Educational Psychology at the University of Pretoria. Arising from the findings of my PhD study entitled: *Finding roses amongst thorns: How institutionalized children negotiate pathways to well-being while affected by HIV&AIDS*, I found a need to examine the caregiver's emotional responses to children with a view to enhancing their emotional awareness.

Thus, I would like to invite your institution to participate in this longitudinal research project that is ultimately aimed at enhancing caregiver emotional awareness and responses with the intention that the caregivers themselves as well as orphan and vulnerable children who are in the care of the institution, could benefit.

Your institution's participation in this research project is entirely voluntary and the name of the institution will remain confidential. It is proposed that the study will proceed in different stages: the first stage will be the administration of a psychometric questionnaire (test) that explores the participants' emotional intelligence. Secondly, the participants will be invited to participate in a focus group interviews (individually and collectively); the next stage will be in the form

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of a participatory intervention that will be aimed at exploring and developing emotional awareness as well as enhancing the emotional responses and stress management of the caregivers. In addition, further focus groups are envisaged with the participants in order to reflect on their care-giving experience. During this research process, the primary researcher will be assisted by research field workers (also referred to as research assistants) who will co-facilitate the focus groups and the workshop. These research field workers will be students. It is possible that the field workers will utilize part of the data gained to embark on their own individual projects under the supervision of Dr Mohangi.

Should you declare your institution to be willing to participate in this study, confidentiality and anonymity will be guaranteed. I therefore, request your permission to conduct this research study at your institution during the first and second terms of 2010.

I trust that my request will meet with a favourable response.

Yours faithfully,

____

Dr Kesh Mohangi
Department of Educational Psychology
University of Pretoria
Tel: 012 420 5506
Email: kesh.mohangi@up.ac.za

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Faculty of Education

Department of Educational Psychology

Declaration of responsibility: Research Assistant

Title of research project: A COHORT STUDY ON THE PSYCHOSOCIAL AND EMOTIONAL AWARENESS OF ADULTS WHO CARE FOR CHILDREN IN AN INSTITUTION

I, ____, in my capacity as research assistant to the above mentioned research project, do hereby declare that I am cognizance of the goals of the Research Ethics Committee in the Faculty of Education.

I subscribe to the principles of *privacy*, meaning that the confidentiality and anonymity of human respondents and the information they provide shall remain protected at all times; *safety in participation*, that all participants should not be placed at risk at any time and *trust*, which implies that participants will not be respondent to any acts of deception or betrayal in the research process.

________________________	___________________________	________
Research Assistant (Name)	Research Assistant (signature)	date
________________________	___________________________	________
Researcher (Name)	Researcher (signature)	date

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Appendix C: Sample of Focus Group Transcription

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Transcription: Focus Group Discussion

3 September 2010

Note: Underlined comments are transcribed from Northern Sotho

Co1	1 5 10 15 20 25 30	*Good morning again ladies, welcome. Thank you very much for making time again today to meet with us. I hope you are excited about this project like we are. Are you? Do you remember the last time we did the few questionnaires? Do you remember that? Okay. So today we have those questionnaires here and we'll go through it with you, but based on your responses in those questionnaires, we are going to talk to you. The students are just going to talk to you about what you do here as care workers. Therefore we have chosen only you because you work directly with the children. Alright? So we want to know about what it is you do with the children, how do you manage. When you have stress in your lives what do you do about it? Who helps you, who supports you. So it is a very open discussion, right, so we want you to relax, be comfortable and speak openly because this is confidential information. It means that we are not going to say your names according to who said what. So what you see here is a recorder, the students are just recording our conversation. They are making a recording of it for their purposes, for what they are doing for research. Right? The purpose is that we want to understand what challenges you are experiencing, what is hard for you, what is good for you in the job that you do, so we can help you further. That's the main reason for this. Okay. When I say it is confidential I mean that the information you give us we are going to use the information at the University to help people in similar positions like you. However we do not put your name down in whatever we write. Okay So we will just say participant 1 or participant 2, we won't say it's* [P2] *or* [P7] *or whatever you said. That is confidentiality. Okay everyone?* *I just want to mention that if there is anything that is being*	

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		said that you don't understand, I am here to translate. If	
		anybody says a word that you do not understand, or anything,	
Co3		*or you feel that you will be able to express yourself better in*	
	35	*another language you are welcome.*	
		Okay, so you are welcome to speak whatever you are	
		comfortable with speaking. And please free to talk, no one's	
		going to judge you, no one is here to criticise you, no one's	
		going to say that you are right or you're wrong. We just want	
Co1	40	*to hear each of your views, okay? So when my students ask*	
		questions, anyone, you just feel free to talk like you're having	
		a conversation and a discussion. There's no right and wrong	
		answers.	
		[Co2], *you want to start with one or two of your questions?*	
	45	*One of the questions I want to ask you is what do you enjoy*	
		about your work, the work that you do with the children, the	
		work at the centre? What is it that makes it enjoyable? Why	
		do you come to work every morning?	
		Perhaps let's take a step backwards.	
Co2	50	It's because, if you love kids, that's why you come to work.	
		There are so many work which we can do but because you	
		love kids that is why we are here.	
		She says because she loves kids. Anyone else? What do you	
Co1		*think ...? What makes you get up every morning and come to*	
P1	55	*work?*	
		For the kids.	
		For the kids. What is it about the children that you love? Do	
Co1		*you like to take care of them? Do you like to play with them?*	
		Yes, I like to take care of them.	
	60	*I am going to go back to* [Co3's]... *yes, you can ask.*	
P2		*What did you do before you decided to become caregivers,*	
Co1		*before you decided to come and work with the children?*	
		Me, I was staying at home and I did love the children. The	
		neighbours brought their children to our house, especially the	
P2	65	grandmothers. The pensioners did go to get money for	

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Co1 Co3 P3	 70	pensioners, and they did ask me, especially during the school holidays because I love the children. I love playing with them. Sometimes we play games, you see I love children. It was like a day care but I did not know whether I was going to be a caregiver or what. It was I was born like that. My sister went to school and at that time she had three children, and I was looking after them. I was going to school but looking after their children. It was two girls and one boy. I was loving them and sometimes I would put water in a big bowl and we	
	75	were playing games like that, like swimming. Every day in the morning I made their lunches and put them there. And after that, my mom's employer she was coming to my mom's home. She said that I love the children and after that when I finished my matric, she asked me if I wanted to work with the	
	80	children and what not. I said to her I wanted to work with the children. Before that I had a job as a domestic worker, they had the children there, I went there to work. I worked there for a year. And after that she took me to the college, my mom's employer, to do a course for Educare. And after that,	
	85	when I was at school I was doing the practicals. Weekends, Saturdays I must go and work with them and I started working like that. *And when did you start working here?* Now it is three years. Before I came here, I was working in	
	90	Hazelwood, also as a caregiver. *Anyone else?* *That is wonderful, so you have a long track record of working with children.* Yes.	
	95	*Lots of experience.* Yes. At that time I was19 years.	
Co3 P3		*You were 19 when you started?* Yes, not when I started to work, when I started to work with the children. When they started to take the children to my	

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Co3	100	mom's house.	
Co1		*Yes.*	
		Yes, I was 19 years and looking after my sister's children.	
P3		*You have a lot of experience and you've got a qualification*	
Co1		*also.*	
P3	105	Yes, I've got a qualification, Educare.	
Co1		*Alright.*	
P3		I have a youth group, aged 8 to 11. Every Saturday they don't	
		go to the streets, they come and gather at my place and form	
		dance clubs. My aim is to see these children being gaining	
Co1	110	skills. I am not at their stage of development, but I grew the	
P3		same way as them. Whenever I start thinking about being	
		away from them, I feel pain. Even when I don't feel like	
Co1		coming in to work, I just develop this painful feeling that I	
		must go and see these children. I started working here in	
P3	115	1999. The group that I have started in last year.	
Co1		I started working with kids in 2004. I was working for an	
P2		organisation called Children Home (word unclear). I started	
		to work with kids there because sometimes we do home	
		visits, you find out there is a need at home, so we just	
	120	organised a group of kids so that we keep them busy after	
		school. Some of them we were talking to them, sort of	
		counselling. I can say that I'm a good counsellor, but I don't	
		have a profession in counselling. Because there is a lot of kids	
		that I have helped, even today, they have made my life better.	
	125	I am somebody because of you. So I started to love the job	
		even though I was not on that track. Because of the	
P4		challenges that I used to get when I go to the house, you will	
		find that they are all with the granny, the granny will shout at	
		them, they don't have space for these kids. So for me to them	
	130	I was like a mentor for them, the mother at the same time.	
		Even when they come to the centre even when they won't	
		find me it's like they have something they've lost. So I started	
		working with these kids from 2002. Now I've realised that	

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	135 140 145 150	I've got this thing of working with kids because even at church I am a Sunday school teacher, I play games with them, then it is nice. I love kids. But the challenges, yo, these kids have challenges. More especially the teenagers. You know I just told myself no, no, I won't work with kids because some of them, more especially these ones who are vulnerable, you have stress, you must learn to listen to them. Some of them, even if you want to listen to them they are so difficult in a way that you can't handle them. So that is the challenge I have with the kids. Otherwise I have space for kids, I can listen. Even though now I am harsh but to my surprise I just saw kids love me. Even when I am at home, before I wake up. Kokokoko, we want to see [P4], you see maybe I have this thing of kids and I am harsh. If I say I am going to beat you, I am going to beat you. I have this thing of kids so I started working with kids. *You say you are harsh. Tell us more about that. Why do you say you're harsh?*	
Co1 P4	 155 160 165	No, if I am angry, I'm angry. You know sometimes like these kids who are difficult, who do not want to listen. Serious, let me tell you. Even at home I have five kids, my brother's kids they know that if I say I don't want this, I don't want it. So at work, sometimes, they have this tendency of doing it because like they know that I don't have the authority to beat them or whatever. So that is the challenge that I have, because sometimes it is difficult working with kids. More especially, some of them they do not appreciate things, instead of appreciating, they will tell you a lot of hard words. Like "you are not my Mom". Then you end up saying if I am not your mom I don't think I will sacrifice my time to be with you. Sometimes it is hurting because you are doing your best for them but some of them they don't see. But what I like is some of them they see, because they will come to you and say they saw that you have this thing. So I saw I have the potential to	

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		work with kids. There are challenges, but challenges...I don't know how to explain it. Any work has its own challenges.	
	170	*But what helps you cope,* [P4]*? What makes you, despite what the children say to you sometimes, but you still go back and you still love the children. What's giving you that strength to continue?*	
	175	It is so difficult. I think maybe we need something like debriefing. You just go into your room, cry and after that I tell myself no I am going back there. There is nothing that you can do, more especially if it's for your life. You think I am going to benefit something for my kids anyway. You just cry and thereafter you dry your tears and you go back to	
	180	them. And sometimes it's not easy because sometimes you'll have that feeling that you know these kids the way is so difficult. I feel like I will hate them, but you will never. And sometimes I've told myself that I am not doing it because I'm clever enough, but it is God's grace. Truly speaking it is	
	185	God's grace because after a kid swears onto you and then you	
Co1		go back to her and loving, you know how difficult is it? It's really difficult but I just told myself that it's really God's grace to do all of those things to accommodate them, to give	
	190	them what they need, to do everything for them each and	
P4		every day. I don't say no, yesterday you've done this. But when it comes to punishment I don't want to lie, I punish. If I say I am going to do this, I am going to do it and I don't change. And even my daughter knows that. When it comes to	
	195	punishment, if I say I am going to beat you, I will do that because if I will say I am going to punish you and then I change, then she will have this tendency to say aaah, she used to say that. You know what I've learnt is, my daughter used to stay with my mother. Then one day she did something and	
	200	I said to her, I am going to beat you. She kept quiet. The next thing she does it again and then I beat her. After she cried she said to me you know Mommy, Granny used to say I am going	

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		to beat you, I am going to beat you, but she never beat me.	
		Why don't you beat me every day! So I just learnt that OK, if	
	205	you say I am going to beat you, and then you don't, she will	
		continually do the very same thing which is wrong and I	
		don't like it.	
		And here at the home, how do you handle these upsetting,	
		how do you deal with it what do you do when these kids have	
	210	*upset you?*	
		As I've said, I just go into my room and I cry, and I've got	
		this small heart, I cry easily.	
		Because you can't beat them?	
		No, not because I can't beat them. You know even my	
	215	daughter if I beat her I'll beat her crying. She will tell you	
		that my mother, she'll beat me but she will be helping me to	
		cry again [inaudible]. Because I'm doing that. I am beating	
		her because, I don't like to beat her but she pushed me to do	
		that. So you do your job you just go into your room and you	
	220	cry, you satisfy yourself that you let all out, do whatever is	
		needed for that day.	
		So that helps you to release some of the stress you're feeling	
		so you use that as one of your coping means. You isolate	
		yourself and you cry and you give off your emotion and then	
	225	*you're OK. What other methods do people use to help them*	
Co3		*cope? I am sure everyone's facing challenges with the*	
		children, not so? So how do you individually cope? I know	
		some people cope by prayer, by getting strength in God, but	
P4		*different people have different ways of helping them cope, you*	
	230	*know. You might have family that helps you, your own*	
Co3		*children, how else? P5, you're smiling. Tell us how?*	
P4		I just go home and talk to my children and say, hey, you	
		know at work maybe *** or *** just hurt me so just talk to	
		my family, it helps me.	
	235	*So that helps you, that gives you support?*	
		Yes.	

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		Anyone else?	
		When the children upset me, I discipline them. I take the	
		child and lock the child in the room. I'll put the child in the	
Co1	240	corner and after that, maybe when I arrive at home I just pray	
		to God. I say God, to give me power and strength. Maybe this	
		child, they need love and they are still young. God give me	
		strength and power, give me love because they need	
		unconditional love. And I also learn when I'm at home if I	
	245	tell them to do this they have to do that and I keep on telling	
		that. When I punish that child or discipline the child I keep on	
		telling the child not to do this not to do this. And I'm glad	
		because the children, when I punish them, after five minutes	
		or ten minutes they come to me and say I'm sorry. Our own	
	250	children are not the same as the children we are helping here.	
P5		Our own children just come to us and say I'm sorry to do this	
		and this, because we punish them. Maybe I'll say do you	
		know what, tomorrow you are not going to play or that. Even	
Co1		those children, I was looking after them. Some of them have	
P5	255	got children, sometimes they bring their children to me.	
Co1		When I go home they bring their children to my house at	
P3		home and say this is the agreement, this is what, and I'm also	
		telling them to respect their mothers. Because our children	
		have got their own rights. Here when they upset me, I	
	260	discipline them, putting them in the corner, saying you are not	
		going to play, you are going to sit here unless you will tell me	
		you are sorry. Or if they fight, they make me angry, I say you	
		go to that one and say sorry to him or her no playing.	
		When I'm at home I always pray to God. I say God, it is You	
	265	who makes me to love the children, it is not by my grace, it's	
		by your Grace, it's by Your power. Give me love and strength	
		to work with them.	
		I notice that behaviour is a big challenge, getting them...the	
		behaviour problems, the challenges affect you a great deal.	
	270	*Do you get any kind of support in that kind of training? Do*	

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		you get help, people helping you how to control the children's	
		behaviour?	
		Yes.	
		How, through what means do you get that training?	
	275	*Didn't* [Manager] *help you?*	
		No!	
		For me I got training on how to work with the children's	
		behaviour, but here we did not get the training.	
		One hour's training?	
	280	Yes.	
		Has anyone else had background training to work with	
		children?	
		When the child behaves strange, you just ignore the	
		behaviour, not the child, you ignore that behaviour, you	
	285	groom that child, meaning that unwanted behaviour.	
P3		*Where did you learn skills with regard to working with*	
		children?	
		Somewhere in town, the course it was BQCC.	
		BQCC?	
Co1	290	Yes. Basic Qualification in Child Care.	
		Basic qualification. OK. You completed that course?	
		Yes.	
		Did you do it on your own or were you taken by your	
		previous employer?	
All	295	The *** employers took us there.	
Co1		*Who else has done that course?*	
		[Murmur] *No one*	
All		*OK. Did you find that course very helpful for working here?*	
P6		Yes.	
	300	*Is it? Did it teach you some ways to cope with difficult*	
Co1		*situations?*	
P1		Yes, it helps, but these **** kids, they know that we can't	
Co1		beat them. Then they say you are not going to beat us. So	
		they behave strange hoping that you are not going to do	

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P6	305	anything to them. So even if you can ignore that behaviour, that strange behaviour, you have got no use to do that because they cannot listen to you.	
Co1			
P6	310		
Co1			
P6			
Co3			
P6			
Co1	315		
All			
Co1			
All			
An	320		
P6			
An			
P6	325		
	330		

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Appendix D: Sample of Individual Interviews

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Transcription: Individual Interview 1, Participant 4

16 May 2011

Note: Underlined comments are transcribed from Northern Sotho

Co2	1.	The confidentiality, no one is going to know your	
	2.	name, things that you tell us are kept between us as	
	3.	well. When we type it out the names are deleted from	
	4.	the transcription that goes into the study. Your	
	5.	anonymity is kept confidential.	
P4	6.	Okay.	
Co2	7.	Okay. We just have a few questions that we want	
	8.	to ask you and discuss with you based on the	
	9.	workshop and all those things we did with you at	
	10.	****. Um, so firstly what is your role at	
	11.	****?	
P4	12.	I'm a uh house mother	
Co2	13.	House mother?	
P4	14.	Ja	
Co2	15.	What does that entail?	
P4	16.	Meaning it's like housewife, you know	
	17.	housewife? Ja doing everything, attending to the	
	18.	kids. Make sure that they have food. Make sure	
	19.	they are clean. Make sure they are going for	
	20.	checkups. Whatever else is going on in the house.	
An	21.	Checkups meaning medical checkups?	
P4	22.	Ja, ja, medical checkups. Make sure they go to	
	23.	church all the stuff that a housewife must do.	
Co2	24.	Do you have people that support you here? How	
	25.	Many people work at **** that support you?	
P4	26.	Like for example?	
Co2	27.	Are there other people, caregivers? How many	
	28.	Other caregivers	
P4	29.	I don't have a caregiver, I'm with [P8] who is	
	30.	Helping me with the domestic work.	
Co2	31.	Okay so it is just the two of you that work here?	

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P4	32.	Ja, and then we have a gardener who is sorting
	33.	Everything out, out there.
An	34.	And after how many kids do you have to look
P4	35.	Eight
An	36.	Eight...?
P4	37.	Four boys...
An	38.	And it's just you and [P8]?
P4	39.	Ja, but maybe [P8] she works if I'm on, I'm off
	40.	She Will be there for maybe Friday, Saturday,
	41.	Sunday then she get offs and then it's me thirteen
	42.	Days on duty no off.
Co2	43.	Sjoe, and then you say there are four boys, four
	44.	Girls?
P4	45.	Four boys, four girls. It's teenagers, you know
	46.	Teenagers.
An	47.	Oh
P4	48.	It's very difficult.
Co2	49.	At what age do they start?
P4	50.	The last born is eleven years and the oldest one is
	51.	sixteen.
Co2	52.	Sjoe, okay. So it must be very stressful?
P4	53.	"sigh" more than that because I was thinking of
	54.	Quitting.
An	55.	Really?
P4	56.	Ja, really really! Even now if I can have something
	57.	Somewhere I'm quitting I can't work like this.
Co2	58.	Why do you feel you need to quit?
P4	59.	I'm unable.
Co2	60.	In what way?
P4	61.	You know these kids, the problem it's like they
	62.	Don't appreciate that the first thing ne and then they
	63.	have like this thing of saying like you're not my mother
	64.	You can't tell me this and that. So it's very difficult.
	65.	It's really, really difficult. Sometimes I feel like I can

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	66.	Cry. Last time I was just talking to the social worker
	67.	Saying you know I feel like I just go out of this
	68.	Premise and run away, run nonstop. Sometimes
	69.	I'll just feel like I'll climb the mountain and be there
	70.	And shout! So it's not easy.
An	71.	And how long have you been here?
	72.	Since 2008, October
An	73.	So that's already a good three years or so.
P4	74.	Ja...
An	75.	Almost three years
P4	76.	Ja, it's almost three years but we are not at the
	77.	Same page you see. I think maybe with your own
	78.	Kids you can manage because it's your own kid
	79.	You can do whatever you want.
Co2	80.	Ja...
P4	81.	With your own kid but with these ones you cannot.
	82.	You can't, you can't, you can't.
Co2	83.	Do you get any support from outside, that helps
	84.	You with training or...
P4	85.	So far we don't have any, any, any training.
	86.	Nothing. Even at debriefing session we don't
	87.	Have. It's for my own baby to go see what can I do
	88.	If I have stress I must just make sure it doesn't
	89.	affect me to an extent that I can't do anything.
	90.	But now I think I've got some tactics on how to deal
	91.	with. I've got some tactics on how to deal with.
	92.	Sometimes I just ignore because sometimes I just
	93.	Can't, can't. You know talking and talking on it's
	94.	Self is a stress. I can't say to you take that trunk.
	95.	Even if you can go to their rooms, they just wake
	96.	Up. You know it's a mess. Each and every day I
	97.	Teach them when you wake up after you've bathed
	98.	Everything, take, pick up everything on the floor
	99.	They will leave their underwears, trouser, just go

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	100.	Out of the trouser and leave it the way it was, bath
	101.	Towels, everything they will just leave it there and
	102.	And when we ask them they say no **** is
	103.	Paying you so... and then even when you are
	104.	Telling them it's not for my own benefit, it's for your
	105.	Own benefit.
Co2	106.	Ja
P4	107.	Cause even if you are a grown up you'll behave
	108.	Like the way you behave now because you must
	109.	Start treating yourself like a old person now you
	110.	can't Wait until you are twenty one then say you'll
	111.	Teach yourself to pick up things. You know what
	112.	I've realised even if they were telling me that uh
	113.	I'm getting paid for this, there's a kid at home she,
	114.	He's four years old, after bathing, he is four years
	115.	He knows that he must take everything but with
	116.	This ones it's very very very difficult because they
	117.	Have this like of saying you are getting paid. You
	118.	Must do whatever.
Co2	119.	Ja
P4	120.	So it's difficult.
An	121.	You mentioned a talk to the social workers?
P4	122.	No, she will talk to them, try to explain real life
	123.	Even myself I try to explain real life to them. But ja
	124.	After that back to square one.
An	125.	Ja, so you have the social worker that comes in?
P4	126.	Ja, every Monday even today she will be here.
An	127.	Is it, okay.
Int3	128.	And does she offer any support?
P4	129.	Ja she, she offer but one hour I think it's, it's not
	130.	Enough especially because sometimes we have
	131.	Issues and they have this tendency of fighting with
	132.	Old people these kids. So now I just "uh ah" hands
	133.	Off, I can't, I can't really I can't.

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Co2	134.	Does the social worker support you in anyway?
P4	135.	Ja, she perfectly 100 percent, 100 percent she is
	136.	Trying 100 percent.
Co2	137.	In what kind of, does she give you advice or how
	138.	Does she...
P4	139.	Ja, because most of the time we will sit here
	140.	Discussing, most of the time she can't even go
	141.	To the kids because we can sit down and discuss
	142.	You know I have this problem and this and this
	143.	And this and we discuss. No I wonder if you can
	144.	Do this and then she will advise me and then
	145.	Some of things I will tell her no I decided to do this
	146.	But she will tell me if you benefit from that thing
	147.	Then you can do it but if I can see I cannot then
	148.	I contact her again and tell her no I can't do this.
An	149.	And you find those sessions helpful?
P4	150.	No, I even develop my own tactics to deal with
	151.	These things.
Co2 & An	152.	What sort of tactics do you have?
P4	153.	Like ah maybe I've used the wrong word to say
	154.	Tactics. You know ah I don't know how can I
	155.	Explain it. Like if there something I really see that
	156.	I'm this person I can't pretend, there something
	157.	That hurt me I, I can't pretend and I'll just tell you
	158.	The truth this one I'm not going to do it and I'm not
	159.	Going to do it. So when I say tactics I was trying to
	160.	Say I've got my own to deal with the things some
	161.	Of the things are difficult and I've come to such an
	162.	Extent that I've just told myself that I'm going to do
	163.	That whatever that suit me because these kids are
	164.	Very very difficult. They don't understand, even
	165.	This morning I had a very, very you know that one
	166.	Comment and I didn't write it about because I just
	167.	Ignore it, this is too much.

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Co2	168.	Can you tell us what happened?	
P4	169.	They don't understand even if you come to them	
	170.	You know go pick that thing that you've put there	
	171.	Then already she had this thing the attitude on	
	172.	How to answer you, you see. When I come to you	
	173.	Politely may you please or even if I say go and pick	
	174.	That thing that you've put there, there is no need	
	175.	That you can shout he or she can shout. But they	
	176.	Have this thing of, I think it's a tendency or a habit	
	177.	On to them. Even if you talk to them nicely they	
	178.	Don't understand they don't see, they don't	
	179.	Differentiate being politely and I don't know.	
Co2	180.	And how does it make you feel when they speak	
	181.	To you that way?	
P4	182.	Sometimes I just keep quiet, let me just, what can	
	183.	I say. There is nothing that I can do, cause like I	
	184.	Have said this is not my own kids. There is no way	
	185.	even my kid at home I can punish her my kid	
	186.	I can punish her, but with this one I am trying,	
	187.	I am trying to punish them most of the time I will	
	188.	Take away from them their pocket money but	
	189.	They used to it they know if I can just do this she	
	190.	Will just gonna take my pocket money for week	
	191.	And the next week life goes on, that's the way	
	192.	And there is no way I can punish them, there is no	
	193.	Way.	
Co2	194.	And you've had no training on sort of disciplining	
	195.	Them or that **** has given you support in how	
	196.	To handle those situations?	
	197.	I've never had any training, that's why I said I have	
	198.	My own way to it.	

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Transcription: Individual Interview 2, Participant 8

16 May 2011

Note: Underlined comments are transcribed from Northern Sotho

Co2	1.	We going to use the recorder, but when type out the things	
	2.	In our studies we don't use any names, so no one will know	
	3.	Who you are. [P8] what is your role at ****?	
P8	4.	I'm a helper and I'm also relieving on weekends for [P4] as a	
	5.	House mother.	
Co2	6.	As a helper what does your job consist of?	
P8	7.	Cleaning, laundry things	
An	8.	And relieving over weekends?	
P8	9.	Just maybe medication and cooking, look after children.	
Co2	10.	What do you enjoy about your work?	
P8	11.	I like work with kids, but now teenagers they have got a lot	
	12.	Of things on their mind, you can't control them anymore	
Co2	13.	When you say you can't control them anymore what do you	
	14.	Mean?	
P8	15.	If you talk to them nicely they you know just talk to you the	
	16.	Way they like and they don't respect us because we are not	
	17.	Their Parents or what	
Co2	18.	Is there anything else that you enjoy about your work?	
P8	19.	I don't know what to say about that.	
Co2	20.	Would it be easier for you to tell us what you don't enjoy	
	21.	About your work?	
P8	22.	I'm not enjoying it because these children don't respect us	
	23.	Anymore. Sometimes we must shout at them you see, it's not	
	24.	Nice.	
Co2	25.	Is there anything else about your work that you don't enjoy?	
P8	26.	Ja, eish you know if you got problems you don't enjoy	
	27.	Anymore you just work because there is no work anywhere.	
Co2	28.	Can you identify anything in your work environment that	
	29.	Causes you stress?	
P8	30.	It's these children give us stress because they don't listen if	
	31.	You say you don't come late at home maybe at five o'clock	
	32.	On Fridays they came late, we get worried about them. If you	
	33.	Ask them where were you? Ah with friends. So become	
	34.	Scared where's the children at this time.	

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Co2	35.	And what else causes you stress?	
P8	36.	Boys are coming here now a days to look for girls	
An	37.	Okay so you worried about them	
P8	38.	If you refuse some time, they mustn't go out they come	
	39.	Aggressive to you and you see all these things.	
Co2	40.	And do you feel that you get enough support?	
P8	41.	I don't feel that get enough support. If you talk to the social	
	42.	Worker the children do this and that, they talk to the children	
	43.	But you don't get to that point where you can say you can	
	44.	Maintain them.	
Co2	45.	Do you feel not getting enough support causes you to	
	46.	Experience stress as well?	
P8	47.	Ja, ja we not get enough support	
Co2	48.	Do you feel like you have any control over your work	
	49.	Environment, the things that cause you stress?	
P8	50.	Sometimes I can control myself, say ei it's not my own	
	51.	Children and I must just stay like that work with them	
Co2	52.	How do you approach it then, what do you do to cope with the	
	53.	Stress?	
P8	54.	You know sometimes it is tough to talk with them because if	
	55.	You talk to them nicely they shout at you, you see that's the	
	56.	Problem. In the morning they want to wake up on weekends	
	57.	Maybe we say they must wake up maybe 8:30 until 9:00.	
	58.	They want to sleep until late you see?	
Co2	59.	And how do you yourself cope when you are stressed, what	
	60.	Do you do?	
P8	61.	Sometimes I'm just going outside, maybe to the gate, look	
	62.	Cars.	
Co2	63.	How do you know when you feeling stressed?	
P8	64.	You feel no, I'm not the same level	
Co2	65.	What do you mean the same level?	
P8	66.	You become, eish I don't know how to explain it	
Co2	67.	Tense?	
P8	68.	Mmm others are not the same, others they behave good,	
	69.	Others they don't behave good. They not the same.	
Co2	70.	How do you behave when you stressed?	
P8	71.	I'm talking maybe alone, eish I must take things easy I must	
	72.	Used to it because I work with these children.	

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Co2	73.	So you cope by going out, taking a walk and coming back?	
P8	74.	If, if I'm going out, they inside there is a lot of trouble, become	
	75.	Fighting do funny things. They see maybe I'm going out,	
	76.	Jumping the sofa, doing things you don't want they must do.	
Co2	77.	You can't really leave, just go...	
P8	78.	Ja, maybe just a minute and come back, not a long time.	
	79.	Because they eight some go to study, others go to their room	
	80.	Maybe here watching TV you see they do funny things.	
Co2	81.	So you don't really feel there is a place you can go for a	
	82.	Couple of minutes just to de-stress or find some quiet time?	
P8	83.	No, not able to work like that.	
An	84.	Do you have your own room here or do you go home?	
P8	85.	If I'm in I stay this room, so even if you here during the day	
An	86.	You can't just go for five minutes and quickly quiet yourself	
	87.	Down?	
P8	88.	I go maybe outside, because maybe if I'm inside the house	
	89.	The other one will shout mama come and see he do this to	
	90.	Me, ai wola, wola, wola you see	
Co2	91.	How do you deal then with situations that upset you?	
P8	92.	Upsetting problems, it's just waiting for [P4] when my	
	93.	Colleague can come at work maybe on Sunday then I say	
	94.	You know today he was doing this, this, and I don't like it the	
	95.	Way he act. Even you do the punishment they don't do it	
	96.	Sometimes.	
Co2	97.	So you deal with it by talking to [P4] about it?	
P8	98.	mmm...	
Co2	99.	Things that you are struggling with, worried about?	
P8	100.	Ah ah ah, even you talk to the manager or social worker	
	101.	They say same, I will make a day to come talk with the	
	102.	Children, but they take a long time to come	
Co2	103.	How do you know when you feeling stressed?	
P8	104.	If you feel stress, you can feel inside you today I'm not	
	105.	Feeling well, maybe headache or a pain somewhere, feel	
	106.	Dizzy, tiredness, you feel like sleeping. Be alone.	
Co2	107.	So that's how you experience it?	
P8	108.	Ja	
Co2	109.	What do you do when you have those feelings?	
P8	110.	I feel nervous, I just talking to myself alone	

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Co2	111.	How do you cope with that? What do you do? To get over it?	
P8	112.	I'm just coping but I don't know how, but I'm just coping	
An	113.	How do you manage to make those feelings of stress go	
	114.	Away?	
P8	115.	Eish, maybe I talk to someone close to me, maybe when I'm	
	116.	Going home. With my daughter, say you know today maybe	
	117.	He do this I don't like the way he do unto me.	
An	118.	Where do you live? Do you live close by?	
P8	119.	At Mamelodi	
An	120.	So you go home everyday	
P8	121.	Ah	
An	122.	And do you find that, that helps?	
P8	123.	It helps a lot.	
Co2	124.	Do you get a lot of support from your family?	
P8	125.	Ja, too much	
Co2	126.	Too much?	
An	127.	Support is good.	
Co2	128.	Did you find doing the journal helpful at all for managing	
	129.	Or identifying things that cause you stress and how you	
	130.	handle them?	
P8	131.	I think this journal maybe can help us a lot but sometimes if	
	132.	you Write, expressing yourself, this is not right for me eish. I	
	133.	Feel so, I don't know I don't like it to write down	
Co2	134.	To write it down	
P8	135.	Uh	
Co2	136.	So how did you approach the task of doing the journal? What	
	137.	Did you do?	
P8	138.	I just write, just a few, just a program a small manyane that	
	139.	Was stressing me. It's not about the children it's just about	
	140.	My husband	
Co2	141.	Ok, alright so you identified not only stressors at work but	
	142.	Also things at home	
P8	143.	Ja, especially at home and at work.	
Co2	144.	Do you think that when you're stressed at home and you	
	145.	Come to work and something happens that you can identify	
	146.	That I'm not upset with what happened at **** but	
	147.	Actually with what happened at home	
P8	148.	Ja, if I got stress at home, usually I don't take my stress out	

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	149.	At work	
Co2	150.	So what do you do then?	
An	151.	Ja, how are you able to	
Co2	152.	Leave at home and not bring it to work	
An	153.	Ja.	
P8	154.	The way do things for myself is just keep quiet and do my job	
	155.	I feel, and like talk too much uh ah rather stay still and don't	
	156.	Talk for the whole day.	
Co2	157.	So...	
P8	158.	Maybe after two or three days then when I say hey I must	
	159.	Talk to someone like maybe my colleague then I discuss it	
	160.	But not same day same time, I will take days	
Co2	161.	Ok	
P8	162.	Ja.	
An	163.	So does that give you time to...	
P8	164.	I'm thinking first if I'm talking to someone. Maybe [P4] ask	
	165.	Why you so quiet today, I say uh ah no problem I just feel like	
	166.	I don't wanna talk, or I'm not feeling well	
Co2	167.	How do you think you act towards other people when you're	
	168.	Feeling overwhelmed or stressed?	
P8	169.	Actually myself I don't, I'm not a person that has anger. I can't	
	170.	Shout to other people, just everyone must see I'm stressed or	
	171.	mmm..., ja...,	
Co2	172.	Ok, so the strategy you then use when you're feeling	
	173.	Overwhelmed about something you said is to just stand	
	174.	Outside for a couple of minutes, what else do you do?	
P8	175.	Usually when I come back I'm drinking a lot of water mmm,	
	176.	Mmm	
An	177.	Would you say that if you are working here there is a lot of	
	178.	Stress or just a little bit?	
P8	179.	It's a little bit stress because it's only children, and I can	
	180.	Sometimes deal with children. Let's say it's just children, it's	
	181.	Not a lot of stress just a little bit	
Co2	182.	Ok, so you're not as stressed working here? Or do you	
	183.	Experience a lot of stress working here?	
P8	184.	Not much, not so much.	
Co2	185.	What does cause you stress though?	
P8	186.	If they don't listen to me if I talk to them, they make me upset,	

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	187.	They make me feel like they don't respect me.	
Co2	188.	Is there any other part of job that causes you, like for example	
	189.	Having to take care of them and doing the cleaning and so on	
P8	190.	When I'm coming to leave and it's the way I get stress, mmm	
An	191.	Over the weekend	
P8	192.	Over the weekend, during the week I got no stress with them	
Co2	193.	So only when you have to stay here permanently?	
P8	194.	Ja,	
Co2	195.	Why is that, why do feel more stressed when you have to	
	196.	Stay here permanently?	
P8	197.	You know, if you talk to them they don't listen unto you ne,	
	198.	They do funny things. If you say maybe watch TV after	
	199.	Supper go wash dishes, they do funny things. Ja I'm not	
	200.	Gonna wash dishes blah blah blah, they complaining. others	
	201.	They fight each other, they shout in the house, you see things	
	202.	Like that. They use vulgar words	
Co2	203.	Ok	
P8	204.	Come late from school, especially girls after they came	
	205.	Maybe around five after that the boys come also after them.	
Co2	206.	And how do you cope with feeling that way? With the stress	
	207.	That you have? Or how do you cope working here? What	
	208.	skills have you developed? Coping skills?	
P8	209.	I develop a lot of skills with working with children, the work	
	210.	Here is a challenge, too much challenge.	

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Transcription: Individual Interview 3, Participant 7

16 May 2011

Note: Underlined comments are transcribed from Northern Sotho

Co2	1.	Okay, so you don't have the book here, it's ok. Did you find it	
	2.	It useful doing the stress journal?	
PAR	3.	Yes, yes it was useful, very much useful.	
Co2	4.	Ok and how did you approach it, what did you do in the book?	
	5.	Did you write? Did you do pictures? What did you do?	
PAR	6.	I didn't put any pictures I was just writing.	
Co2	7.	And how often did you write in the book?	
P7	8.	Not for too long because I'm having eye problems so I can't	
	9.	See properly. I didn't do many of the things but I just writing.	
Co2	10.	Okay and what sort of things did you write about? Can you	
	11.	Remember?	
P7	12.	Mmm yes I was just writing many things, sometimes these	
	13.	Children they upset you ja then you just do how you feeling	
	14.	When they do that and how can you handle it when they are	
	15.	Doing like this how, what can I do things like that	
Co2	16.	Alright. What is your role at ****?	
P7	17.	At ****?	
Co2	18.	Yes, what do you do? What is your job description?	
P7	19.	I'm a caregiver, I'm a senior caregiver	
Co2	20.	So what does that mean what do you do, what are your	
	21.	Responsibilities?	
P7	22.	What I do is to I can say what I first do when I come in the	
	23.	Morning I feed them, I bath them, feed them breakfast,	
	24.	Feeding them, those who are going to school I have to look	
	25.	That they clean, those who can't dress themselves I dress	
	26.	Them I'm giving them food mmm	
Co2	27.	Okay	
P7	28.	Mmm looking that everything is nice and clean when they are	
	29.	Going to school. Those who are here we look are they clean	
	30.	Because they also go to preschool to mama mina so we have	
	31.	To prepare everything for them and then eight o' clock we	
	32.	Take them to mama mina. And then if maybe it's at night	
	33.	When they come from school we must teach them homework	
	34.	Those that didn't finish their homework and sometimes we	

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	35.	Read bible stories to them, mmm.
Co2	36.	Okay. How long have you been working at ****?
P7	37.	Thirteen years
Co2	38.	Thirteen years? Wow
An	39.	That is a very long time. And do you enjoy it
P7	40.	Yes I do, I do enjoy
An	41.	What do you enjoy
P7	42.	I enjoy mmm what can is say like I'm a mother, I have
	43.	Children and these also are children, I treat them like my own
	44.	Children. When there is a problem I have to solve it I don't
	45.	Have to go to mama [Manager] everytime say look what this child
	46.	Did is doing. I'm the mother if the children doing these things
	47.	Not right I have to call her, sit down, talk to her nicely mmm
Co2	48.	Okay. What do you see is the positive things about your job?
P7	49.	Mmm, like what can I say
An	50.	Anything that's good about your job
P7	51.	What is good to my job is that mmm me on my side I don't
	52.	Like being upset to my job I like my job. I'm always here and I
	53.	Always want to talk to children in a nice way I don't make
	54.	Noise when I'm with the children. And I want when I'm
	55.	Working I want to do my job perfectly I don't want to leave
	56.	Something behind. When I'm doing my job I want to see that
	57.	I've done it right.
Co2	58.	Yes
P7	59.	Mmm
An	60.	How do you know if you have done your job good? Or if you
	61.	Have done your job perfectly
P7	62.	I can say I know that because when I'm on duty nobody
	63.	Complains, nobody complains about my work they always
	64.	Say if you are here you are doing your work perfectly so I
	65.	Know that I'm doing it alright.
An	66.	And how do you feel then?
P7	67.	I feel alright
An	68.	If you know that you've done a good job
P7	69.	Ja, mmm . I feel alright, since I've been working here when
	70.	I'm working I make sure that I must do my job alright and I
	71.	See even people can tell me if you are here the work is
	72.	Perfect, so I know that I'm doing my job alright mmm.

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Co2	73.	And do they tell you that often?
P7	74.	Yes they do
Co2	75.	Who tells you? Your co-workers and [Manager]
P7	76.	Mmm even [Manager], [Nurse] even those maybe volunteers who
	77.	Come to volunteer here. Many of the times when the
	78.	Volunteer comes here I'm the first one to teach them what
	79.	They do because they send them to me. They say if you want
	80.	To work go to Miriam and then you will right. Some of the
	81.	Volunteers they tell me that oh somebody tell, told us that if
	82.	You want to work with somebody who can teach you the way
	83.	Then you must go to Miriam
Co2	84.	That's fantastic
P7	85.	Ja,
An	86.	That's good
Co2	87.	And what is it that you don't enjoy about your work? What
	88.	Makes you unhappy in your work environment?
P7	89.	Mmm like now you see these children now they are growing
	90.	But I can't say that it is a big problem that I can say I don't
	91.	Want, the children like older children these days they don't
	92.	Understand. If you tell them to this they don't want, they want
	93.	It on their way, and they don't want. So but that is not a big
	94.	Problem otherwise the problem that I'm having is the money
	95.	I'm getting here.
Co2	96.	Okay
P7	97.	It's not alright for me or for the years I've worked here and for
	98.	The work I'm doing, they said I'm working alright but the
	99.	Money they are giving me is not alright
Co2	100.	And does that cause a factor of stress for you?
P7	101.	Ja,
Co2	102.	In what way?
P7	103.	It does because at end of the month I have to get my salary
	104.	And there are many things I want do that salary is not going
	105.	Anywhere. It's not helping me with anything.
Co2	106.	Are there other things within your work environment that
	107.	Make you unhappy?
P7	108.	Mmm, others no
Co2	109.	Nothing?
P7	110.	Nothing

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Co2	111.	Do you feel you get enough support?	
P7	112.	Ja, the support is there like let me say like these days when	
	113.	[Nurse] she's here then, she be making the medicine for the	
	114.	Children, since she came here I think the things are alright	
	115.	Than before	
Co2	116.	Okay	
P7	117.	Ja, before it was not alright.	
An	118.	When did [Nurse] start coming here?	
P7	119.	[Nurse] I can say maybe now six months, but I can't really	
	120.	Remember exactly but it's not	
An	121.	It's recently?	
P7	122.	Ja	

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Transcription: Individual Interview 4, Participant 6

16 May 2011

Note: Underlined comments are transcribed from Northern Sotho

Co2	1.	Can you tell us what is your roll at ****? What is your job	
	2.	Here?	
PAR	3.	I'm a care worker	
Co2	4.	So what do you have to do?	
PAR	5.	I have to take care of the kids. Bathing them, feeding them	
	6.	And cooking for them during the weekends or the holidays.	
	7.	Taking them to the hospital if there is someone who is sick.	
Co2	8.	And how long have you been working at ****?	
P6	9.	1999	
Co2	10.	Sjoe, so it's quite a long time now. Twelve years.	
An	11.	Almost just as long as [P8]	
P6	12.	Yes	
Co2	13.	And do you enjoy working at ****?	
P6	14.	Yes I enjoy working cause I like the kids	
Co2	15.	So is that why you decided to come and work here?	
P6	16.	Yes	
Co2	17.	Because of the children	
P6	18.	Yes	
Co2	19.	Are there other things that you enjoy about your work?	
P6	20.	I enjoy about with my colleagues, I think it's okay with them.	
Co2	21.	So do you have a lot of friends here that you work with? Have	
	22.	You made good friends with the people that work here?	
P6	23.	Yes, I do communicate with them and they also do the same	
Co2	24.	And are there things that you don't enjoy about your work?	
P6	25.	Like the money we earn is not enough, we earn	
	26.	Approximately two point seven. It's not enough for me to take	
	27.	Care of my kids, because my kids now are grown up.	
Co2	28.	So does that then cause stress for you...	
P6	29.	Yeah	
Co2	30.	To think about you not earning enough to take care of them	
P6	31.	Mmm	
Co2	32.	And are there other things within your work environment that	
	33.	Make you happy?	
P6	34.	They sometimes take us out for the outing and then again	

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	35.	They throw a party for us during the Christmas they do	
Co2	36.	That's nice so you enjoy that?	
P6	37.	Yes	
Co2	38.	So that makes it quite pleasant, something to look forward to	
P6	39.	Ei, yes. And then they used to take us to the trainings like we	
	40.	Trained in town BQCC we've done it.	
Co2	41.	And do they still, do you have any training now? Do they still	
	42.	Give you training? Or any courses that they offer you on	
	43.	Helping you to do things here?	
P6	44.	Now it has stopped, there is no course anymore	
Co2	45.	Would it be something that you would like them to help with,	
	46.	Giving you guidance and giving you courses and things in	
	47.	Order to support you in what you have to do?	
P6	48.	Sorry?	
Co2	49.	Would you like to go on courses? And have people come to	
	50.	Talk to you and give you help and guidance and way to help	
P6	51.	Yes	
Co2	52.	You with your job?	
P6	53.	Yes	
An	54.	Did the courses help a lot? The ones that you did attend?	
P6	55.	Yes it helped a lot because, now we can avoid the stress	
	56.	Working with the stress and stress with these kids and then	
	57.	We know how to handle those who are, who misbehave. Yes	
An	58.	Okay	
Co2	59.	So you say the salary is one thing that you don't like about	
	60.	Working here, are there other things that make it difficult to	
	61.	Work here or that make it unpleasant for you to work here or	
	62.	That you don't like?	
P6	63.	Mmm	
Co2	64.	What causes you stress here at work?	
P6	65.	Maybe let's say I've got something to say, to talk to them, say	
	66.	If the child make a mistake and if we can shout they say it's	
	67.	Abuse. They are going to write a warning for, you see. That	
	68.	Makes me to stress, we can't talk them loudly, we can't.	
	69.	Maybe we can say hey then they say you are naming them.	
An	70.	And then management doesn't back you up? They give you a	
	71.	Warning or	
P6	72.	Yes	

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An	73.	Okay, and they also do they tell you how to um	
Co2	74.	Discipline	
An	75.	How to discipline? Do they tell you the correct ways or do	
	76.	They just	
P6	77.	They just we've got the courses, we must handle them	
	78.	According to the course. But when you can shout at them	
	79.	They say you are abusing the children.	
An	80.	So the managements not	
Co2	81.	Supporting you	
P6	82.	She's not	
An	83.	And is management involved a lot with the day to day working	
	84.	With children?	
P6	85.	Yes she is	
An	86.	Is it?	
P6	87.	Mmm	
An	88.	Okay	
Co2	89.	So she sees what's happening	
P6	90.	Or sometimes the kids used to go to the office and tell her	
	91.	What's going on.	
Co2	92.	Okay. And can you think of anything else that causes you	
	93.	Stress working here?	
P6	94.	I think uh that is it cause the colleagues, my colleague uh are	
	95.	Well to me	
Co2	96.	So you feel that you get a lot of support from the people that	
	97.	You work with?	
P6	98.	Yes	
Co2	99.	You help each other	
P6	100.	Ja we help each other, like [P8] we are	
Co2	101.	Close	
P6	102.	Ja we are close to each other	
An	103.	Is that something that gives you strength to work here	
P6	104.	Yes because uh [P8] and myself we are getting the same	
	105.	Salary and then everything we are talking. We say but this	
	106.	Salary is not enough for us and then we discuss about it.	
An	107.	And does it help you to talk about it?	
P6	108.	Yes if we can talk it out I think it's going to relieve the stress	
An	109.	Ja because how does that make you feel if your salary is so	
	110.	Small? How does that make you feel?	

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P6	111.	I feel to my kids, I feel like I'm helpless because the other I've
	112.	Got two twins, the other one is a soldier and then the girl is a
	113.	Nurse and then they earning more salary than mine so it's
	114.	That thing it hurts me
An	115.	And then if you talk to [P8] about it how does it make you
	116.	Feel
P6	117.	[P8] and I we decided to, to make a crèche. To open a
	118.	Crèche for ourselves. So we are now looking for a place to
	119.	Make a crèche.
An	120.	Okay, that's good. To do that and then you'll stop working
	121.	Here?
P6	122.	Yes, we decide now, we are planning to get the place, only
	123.	The place
An	124.	But in a crèche you're still going to be working with children
	125.	Right?
P6	126.	Mmm
An	127.	And working with children you, do you enjoy working with
	128.	Children?
P6	129.	Ja, I enjoy it working with the kids but I'll be the boss there
Co2	130.	Okay, so you won't have to answer to somebody else. You
	131.	Can be the one in charge. What do you uh, we spoke a lot
	132.	About stress at the workshop and so on, what do you
	133.	Understand by stress? What is stress?
P6	134.	Mmm stress is something that touched you inside then
	135.	Maybe you don't have the clue or the uh guess the answer for
	136.	That thing. I start to stress, maybe I can't press myself to tell
	137.	You something, it's deep inside myself so
Co2	138.	You stress about it
An	139.	And if you are stressed what gives you the strength to come
	140.	And work or to wake up in the morning and come to work?
P6	141.	Stress like at home?
An	142.	Ja, no if you do feel stressed. If you do feel stressed what
	143.	Make you strong so that you can work?
P6	144.	Okay if I'm at home and then I'm stressed, I'm always take
	145.	The milk, the fresh milk and drink it. Like uh last week when I
	146.	Was sleeping at one am I feel like my finger is going inside
	147.	And then I, feel like something is shaking then I phoned
	148.	Somebody who is working in here, it's my friend and then I

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	149.	Tell, I told her I feel like my finger is going inside and then she
	150.	Said drink the vinegar and the cold water mixed it and drink it.
	151.	And then after drinking those I feel liked relieved.
Co2	152.	Better, okay
P6	153.	Mmm
Co2	154.	How does it show when you're stressed? How do you know
	155.	When you're stressed? How does it feel in your body and in
	156.	Your heart and your emotions, how do you feel?
P6	157.	When I'm stressed, maybe I don't know what stressed me
	158.	And then I feel dizzy, like I can cry or something is hurt me
	159.	And I decided to stay alone for a while. And then after a while
	160.	I relieved. But I always crying, when I feel like that I cried.
Co2	161.	You cry. Do you feel you can control the things that cause
	162.	You stress, or the things in your work environment that upset
	163.	You?
P6	164.	Some I can control them but like the money the wage I can't
	165.	Because it's like something going continuously and then we
	166.	Can't come across it.
Co2	167.	And what do you feel you can control?
P6	168.	What I feel I can control?
Co2	169.	Mmm
P6	170.	Like when I'm angry with the kids or my colleague I try to go
	171.	When we are alone I try to approach her so telling her this
	172.	And this is not ok for me, and then could you try to do like
	173.	This and then she agreed.
Co2	174.	And how do you think it affects your work with the children
	175.	When you're upset or when you're stressed about
	176.	Something?
P6	177.	With the children?
Co2	178.	Ja, does it affect the way you work then with children?
P6	179.	Not as much.
Co2	180.	You don't think so?
P6	181.	Mmm, even myself I don't like somebody, maybe I've done a
	182.	Mistake to you then I don't like you to come when to come to
	183.	Me when I am with the kids. Just call me aside and tell me, I
	184.	Like that. But if you can shout uh before the children I feel like
	185.	I feel like stressed and then being helpless.
Co2	186.	How do you cope with those feelings?

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P6	187.	I always, I'm uh sometimes going to the toilet and praying. I	
	188.	Used pray when I'm stressed even if I'm at work, I go to the	
	189.	Toilet and pray so that I can control my temper.	
An	190.	That's very good ja.	
Co2	191.	Is there something you wanted to ask?	
An	192.	There was something I wanted to ask if I can just remember	
	193.	It.	
Co2	194.	Okay I'll give you a minute. You were here when we did the	
	195.	Workshop on the stress and we did the different breathing	
	196.	And the stress balls and things. Did any of the techniques	
	197.	That we showed you help you? Did you find what we did and	
	198.	The workshop helpful?	
P6	199.	Yes I did.	
Co2	200.	In what way?	
P6	201.	To try and, to control my temper. Like uh when I'm angry at	
	202.	Home I try to, I always used to shout my little boy but after	
	203.	Shouting him I tried to regret my selves and saying that why	
	204.	Can I shout at this boy and then I'm calling her, him and say	
	205.	Sorry.	

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Appendix E: Extracts from Research Diary

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04-06-2010: Meeting and administration of the BarOn EQ-i™. Ethical Concerns discussed.
Present: Dr Kesh, Mrs Finestone, Chereen, Andreas, Lolo
16 participants – 1 staff member (nurse) declined – 17 in total
Caregivers, cleaners, assistants

Right, today was Day 1. The beginning for my practical research journey. Today we visited the research site, which was very neat and clean. First impressions indicated that the site was well maintained but on a tight budget. Therefore, no major luxuries could be seen, but everything was quite neat, if not a bit old and worn-out. The manager seemed friendly enough, welcoming us to the site, and showing us to a large room in which there were some chairs packed out and a table or two. On the side, in a raised corner stood a small wooden pulpit. Maybe this room is also used for religious gatherings?

Dr Kesh and Mrs Finestone took the lead, introducing us all to the 17 persons present in the room. Some of the participants are already familiar with Dr Kesh, as they formed part of some of her previous research at this site. Dr Kesh discusses the reason for wanting to do the BarOn EQ-i™, and also discusses ethical concerns – confidentiality, anonymity, freedom to refuse participation, etc. One staff member, a nurse, excuses herself, and declines to participate. My goodness. Lost one participant already on day 1. What if more participants decide to decline? Will there be enough left? My worries appear to be unfounded as the rest of the staff members seem willing to participate. Mrs Finestone discusses the procedure for answering the BarOn EQ-i™ by using a concrete method to explain how a 5-point Likert-scale works. Most of the participants seem to understand, but language is clearly a barrier, and may prove to be an obstacle later on in my own data collection phase. Luckily, Lolo is also present, and she is able to act as a translator should it be necessary. She will probably also be present in all future interactions, which is good.

Today my role was to walk around and see if any of the participants needed assistance in completing the BarOn EQ-i™. Many had questions regarding the specific meanings of words, once again indicating that language as a barrier is a concern. Today I fulfilled the role of research assistant. Next time I will have to negotiate two roles: research assistant in Dr Kesh's larger study, and researcher.

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03-09-2010: Feedback on BarOn EQ-i™ and focus group interview.

Present: Dr Kesh, Chereen, Andreas, Lolo (acting as translator)

7 participants – all caregivers

Day one as an active researcher. Today I spent very little time on my role as research assistant, and instead focused more on my role as researcher. It was an interesting experience. Not being a small cog in someone else's research programme, but instead being an important part of my own research project. Today we did a focus group discussion with 7 of the participants, based on their roles as caregivers at the facility. This being only the second focus group ever I have participated in as a researcher I was somewhat nervous. I hoped that I would be able to ask the correct questions, be understood correctly, and would receive meaningful answers that were applicable to the topic under discussion. Naturally I had done my homework, and had come prepared with notes, voice recorder, and some ideas of questions I would like to cover over the course of the focus group. Dr Kesh would start the focus group off as she is a more experienced researcher than Chereen, Lolo, or me. Once the focus group was up and running, Dr Kesh would start to give the participants individual feedback on the BarOn EQ-i™.

At first Dr Kesh set all the participants at ease, and explained the process to them. Then Chereen fired off the first question. No response. I imagined the awkward sound of crickets playing in my head. No pressure then. Dr Kesh stepped in and facilitated the question, which turned out to be unnecessary as one of the participants had started to answer Chereen. Great! Things were starting up. I let the participants warm up a little to the process before pitching my first question. Luckily it was fairly well received and the participants seemed to respond well to me. Some participants did seem to be a lot more verbal than others, with one or two of the quieter participants sometimes needing some probing to get them involved in the discussion again. A lot of the focus group was centred around stress, and experiences of stress in the workplace (Chereen and Lolo's topics for their respective studies). I found that I had a hard time getting enough information on my topic, as I also did not want to interfere too much with Chereen and Lolo and their data collection. However, my topic falls roughly along the same continuum as theirs, and is rather complimentary to theirs, so it did not work out too bad.

At times, it appeared as if three or four participants were carrying the group. Questions arose in my mind and I began to wonder if the other participants were interested in the process at all, or whether language was indeed a bigger barrier than previously thought. Of course it may have been possible that some participants were less comfortable in sharing their opinions, perhaps out of a fear of being judged or dismissed, or possibly out of fear that their words would reach

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management, which, from the discussion did not sound like they were very supportive of the caretakers. It appears as if many of the caregivers feel ambivalent towards their workplace and the children in their care. Many have proclaimed their intense love for working with children, yet they also expressed a lot of negativity toward the same children. It appears as if their love for working with children is what drove them to take a job at the care facility. However, much more time during the focus group interview was spent on complaining about the children's behaviour than on their original motivation for working.

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16-05-2011: Individual interviews

Present: Chereen, Andreas

Today was the day of reckoning. Chereen and I decided on the participants for the individual interviews, based on the focus group discussion. We noted that four of the participants were relatively well-versed in English, and openly discussed their opinions during the discussion. The reason these participants were selected was due to the fact that we did not have a translator at our disposal due to fact that our colleague fell pregnant.

Chereen contacted the participants telephonically, asking them if they would mind if we came to see them for follow-up individual interviews. All four participants agreed, and a date and time was set. I prepared open-ended questions that I wanted to pose to the participants in order to gain more information for my study. I would soon discover during our interviews that these questions merely served as a very rough guideline, and that language and educational barriers would cause us to have to rephrase questions as the interview progressed. Participants seemed to answer questions more easily if these questions were accompanied by concrete examples and elaborations of what was meant by the question. This may have an impact on my data analysis, as a lot of the information provided was very basic and concrete. I found myself frustrated by the process because the answers that they provided were not the same as the answers I would have expected. I continuously had to bring participants back to the topic at hand, as I found that their answers would wander off, and their train of thought digressed from the question posed. Hence the interviews took significantly longer, and were more physically draining than expected.

It appeared as if the participants were a lot more at ease with us today than they were during the focus group discussion. This may be due to the fact that we were familiar to them by now, or perhaps due to the fact that speaking to us on an individual basis may be less daunting than speaking your mind in a group of colleagues. Trust may also have played a role here, seeing as how none of the confidential information from the focus group had been divulged to management, of whom they had quite a few negative comments previously.

It became apparent as it did during the focus group discussion that the caregivers began the interview by sketching a picture of a satisfactory working environment, but by the end of the interview this picture turned to grey.

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To me as researcher, these interviews were useful for collecting data for my study. However, I could not help but feel that these caregivers are working under such stressful conditions that they inadvertently treated these interviews as an opportunity to air some grievances and to get a lot of negativity off their chests. However, I do feel that the information gained today was meaningful to my study.

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Appendix F: Thematic Analysis: Grouping Themes

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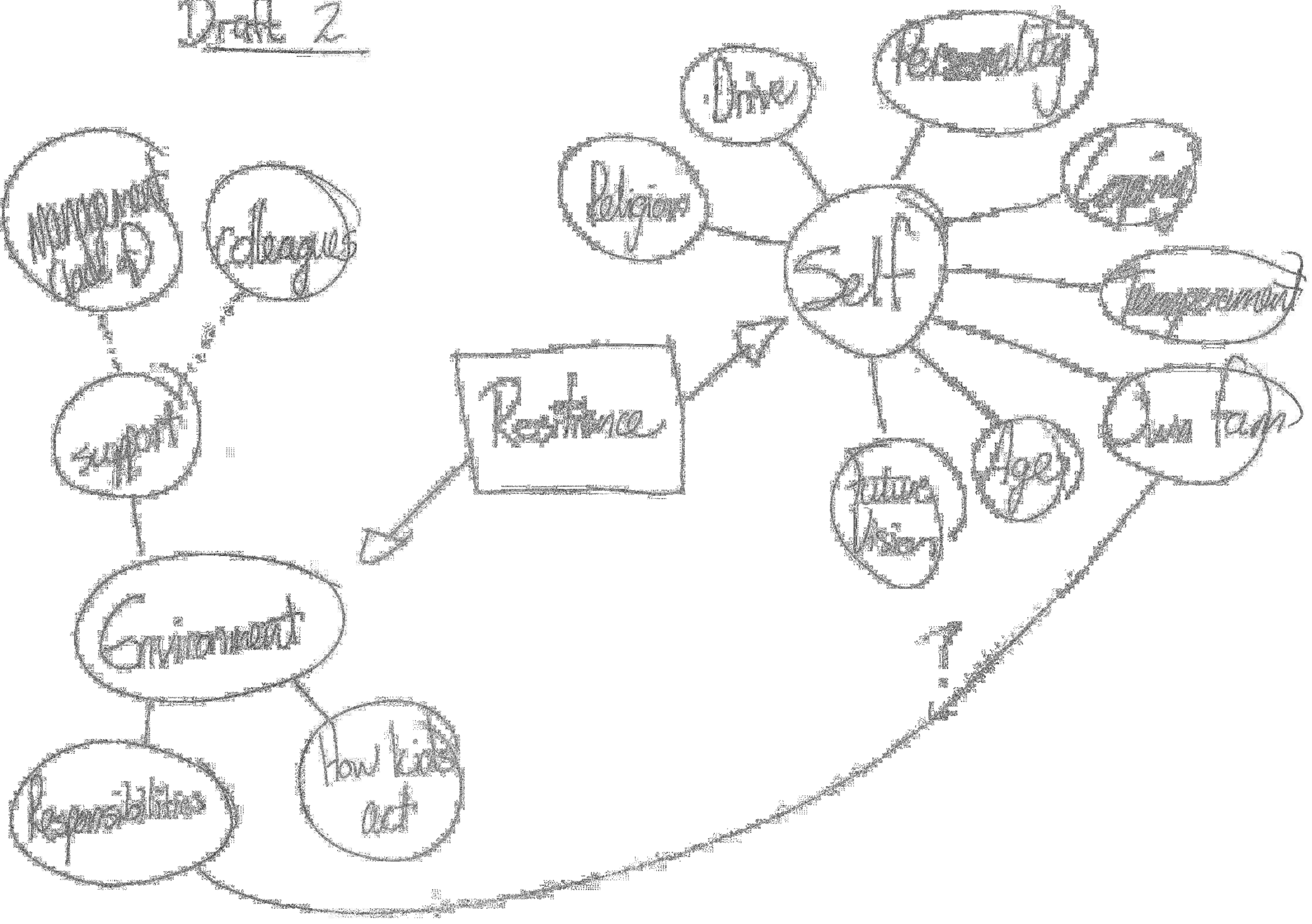

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Draft 4

1. Responsibilities vs power at work
   - → how kids treat workers
   - → support from management
   - → working conditions
   - → age of children

2. Drive to work with children vs disillusionment
   - → love of children (care for)
   - → working with colleagues
   - → working with children

3. Care for own children vs care for OVC

4. Self-image
   - → love children
   - → strong
   - → breadwinner at home
   - → own future perspective

5. Stressors

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Draft 6

→ Resilience as surviving multiple stressors
- → rejection
- → management
- → conditions at work
- → conditions at home

→ Resilience as control
- → coping
- → power
- → children
- → future

→ Resilience as belief
- → God's grace
- → Prayer

→ Resilience as passion
- → at work
- → at home

→ Resilience as part of sense of responsibility
- → extended family
- → bread-winner
- → caring at work

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