

A qualitative exploration of resilience in pre-adolescent AIDS orphans living in a residential care facility

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Abstract

This article presents the findings of a study among a small group of South African AIDS orphans living in a residential care facility, Lebone Land. The research was conducted between June and September 2006. A qualitative, exploratory study consisting of in-depth, semi-structured interviews with eight children and seven key informants aimed to identify and investigate developmental assets operating in the children's lives to help them cope amid exposure to adversities. The findings indicate that the developmental assets that facilitate coping and foster resilience in these children relate to four main components: external stressors and challenges, external supports, inner strengths and interpersonal and problem-solving skills. Emerging key themes relate to the experience of illness, death, poverty and violence, as well as the important roles of morality, social values, resistance skills, religion and faith in assisting these children in defining their purpose in life. To this end, constructive use of time, commitment to learning, goal-setting, problem-solving ability and self-efficacy are fundamental in the children's attainment of their future projections. Therefore, qualities such as optimism, perseverance and hope seem to permeate the children's process of recovery. Strong networks of support, particularly friendships with other children, also seem to contribute to developing and sustaining resilience.

Keywords: resilience, HIV/AIDS affected children, pre-adolescence, residential care.

Résumé

Cet article présente les conclusions d'une étude réalisée au sein d'un petit groupe d'orphelins du Sida sud-africains vivant dans une institution, Lebone Land. L'étude a été conduite de juin à septembre 2006. Une étude qualitative préliminaire consistant en entretiens approfondis et semi-structurés avec huit enfants et sept informateurs clés a visé à identifier et à étudier les facteurs développementaux à l'action dans les vies des enfants afin de les aider à faire face aux difficultés auxquelles ils se trouvent confrontés. Les conclusions indiquent que les facteurs développementaux aidant à faire face aux difficultés et favorisant la résilience chez ces enfants sont associés à quatre composantes principales : les facteurs de stress et les défis externes, les soutiens externes, les forces intérieures et les compétences interpersonnelles et de résolution de problèmes. Les thèmes clés qui émergent se rapportent à l'expérience de la maladie, de la mort, de la pauvreté et de la violence, ainsi qu'aux rôles importants de la moralité, des valeurs sociales, des compétences de résistance, de la religion et de la foi pour aider ces enfants à trouver leur but dans la vie. A cette fin, une utilisation constructive du temps, un dévouement à l'apprentissage, la fixation d'objectifs, la capacité à résoudre des problèmes et l'auto-efficacité sont essentiels pour permettre à l'enfant de réaliser ses projets d'avenir. Par conséquent, des qualités telles que l'optimisme, la persévérance et l'espoir semblent imprégner le processus de rétablissement des enfants. De solides réseaux de soutien, en particulier les liens d'amitié avec d'autres enfants, semblent également contribuer au développement et au maintien de la résilience.

Mots clés: résilience, enfants affectés par le VIH/Sida, préadolescence, institutions.

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Introduction

Resilience is a key factor in children's ability to cope with and survive adversity (Grotberg, 2003). Promoting resilience is therefore critical as this may contribute to the prevention of negative outcomes for youths challenged by significant stressors such as those posed by the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) epidemic (Rolf & Johnson, 1999). However, these factors influencing the resilience of pre-adolescent AIDS orphans in South Africa remain unclear. This research is probably the first in South Africa to explore the concept of resilience as it manifests in pre-adolescent AIDS orphans in a residential care setting. Drawing from Bronfenbrenner's ecosystemic theoretical framework, the present study aims to add to the emergent body of literature on protective factors or resiliencies that may contribute to adaptive outcomes of children exposed to adversities due to HIV/AIDS-related orphanhood in South Africa. Knowledge of these factors is needed to inform prevention and intervention programmes aimed at fostering resilience in children affected by the epidemic.

The effects of HIV/AIDS devastate the lives of millions of children, and the anticipated extent of the mounting crisis is enormous (Cluver *et al.*, 2007; Mangoma *et al.*, 2008). The global number of children under the age of 15 years who have lost one or both parents to HIV/AIDS is expected to increase from approximately 14 million in 2004 to 25 million by 2010 (Gulaid, 2004; UNAIDS, UNICEF & USAID, 2004). It is foreseen that by 2020 40 million children will have lost their primary caregiver(s) to the disease (Interagency Coalition on AIDS and Development [ICAD], 2002). In South Africa, almost 6 million people were living with HIV at the end of 2007 (UNAIDS, 2008). In that year, an estimated 1.2 million South African children under the age of 18 had lost one or both parents due to AIDS, a figure that is projected to reach 5.7 million by 2015 (Bradshaw *et al.*, 2002; UNAIDS, 2006; 2008).

For children, the death of a parent due to AIDS is not a single misfortune. It usually involves a lengthy process of multiple stressors or adversities and changes occurring before, during and after the death. This process may include facing adversities such as parents' illness and death, consequent disintegration of the family structure, poverty, homelessness, relocation, trauma and major adjustments in placement in residential care, stigmatisation, societal discrimination, exploitation and abuse (Richter, 2004, Nyamukapa *et al.*, 2008).

Among these adversities, poverty is considered one of the most devastating risk factors for children. Almost all other risk factors (for example, neglect or poor care, violence and substance abuse) that make poor developmental outcomes more likely are found disproportionately among impoverished children (Schorr, 1988). Factors such as school failure, school-aged childbearing and violent crime have frequently been shown to correlate with poverty (Mastropieri & Scruggs, 2000; Schorr, 1988; Williams, 2002). Growing up in violent circumstances is often accompanied by a cluster of feelings, including depression, guilt, hopelessness, low self-esteem, and a sense of danger, or worries about injuries and death (Das Eiden, 1999; Greene *et al.*, 2002). Several studies (cf. Huntington & Bender, 1993; Jensen *et al.*, 1993; Prior *et al.*, 1999; Cluver *et al.*, 2009) indicate the co-existence of anxiety, depression,

post-traumatic stress or emotional problems on the one hand, and learning disabilities in children on the other. Rates of school drop-out, substance abuse and subsequent delinquency have also been found to be significantly higher in children with learning disabilities than in those without learning disabilities (Cameron & Dent, 2003; Morrison & Cosden, 1997). Therefore, the threat and potentially devastating impact of poverty not only encompass deprivation of resources, capabilities, choices, security and power necessary for the enjoyment of a satisfactory standard of living, but also extend across the physical, emotional and intellectual components of children's development. Consequently, many of their rights, such as the rights to survival, health and nutrition, education and protection from harm, are impeded (Bellamy, 2004; Felner, 2005; Monson *et al.*, 2006).

Indicating further risk for these children is the fact that chances for maladaptive outcomes increase when adverse conditions are continuous and/or cumulative, and when there are few opportunities for support and hope (Richter, 2004). This may well be the case for AIDS orphans placed in residential care. Concern has been raised that responses to increasing numbers of AIDS orphans in need of support are resulting in a considerable increase of orphanages across sub-Saharan Africa and in South Africa, especially since 1999 (Meintjies *et al.*, 2007; Tolfree, 2003). This unease emanates from the view that residential care violates the principles of the UN Convention on the Rights of the Child and consequently impacts negatively on children's development. More than five decades of research shows that children in long-term residential care are at high risk for impaired cognitive, behavioural, emotional and social development (Browne, Hamilton-Giachrits, Johnson & Ostergren, 2006; Kaler & Freeman, 1994; MacLean, 2003, Van Ijzendoorn, Luijk & Juffer, 2008). These deficits can lead to overwhelming, enduring problems for children (e.g. peer rejection, school failure, delinquency and future unemployment) as they may fail to develop the ability to regulate their emotions and social behaviours. Moreover, for HIV/AIDS-affected children, overwhelming feelings of grief (anger, sadness, guilt and anxiety), loneliness, hopelessness, confusion and fear associated with HIV/AIDS may remain a part of their lives (Gerwartz & Gossart-Walker, 2000: 315; Richter, 2004: 23). It is furthermore argued that distress from orphanhood may be exacerbated due to financial difficulties associated with parental illness and death (Cluver *et al.*, 2009). Often, due to the structure and capacity of residential care institutions, children's (social and psychological) needs are unmet (Dunn *et al.*, 2003). If their need to express their reactions to grief and mourning are inhibited, extreme reactions such as complicated grief or prolonged emotional numbing, severe depression, anti-social behaviour, and physical illness may arise and further impede their development (Mallmann, 2003; Williams, 2002).

Furthermore, residential care facilities have been found to attract children from poverty-stricken environments, be costly, dislocate them from their extended family members and communities, render them more vulnerable to physical and sexual abuse, and promote stigma and discrimination (Meintjies *et al.*, 2007; Tolfree, 2003). Hence, the international welfare sector is united in advocating that residential care be used only as a temporary 'last resort' for children (Dunn *et al.* 2003; Meintjies *et al.*, 2007). This view is shared by the South African government and other key

players in the local child welfare sector. Presently, two important policy processes aim to limit, transform and regulate residential care for children: (1) international agencies are campaigning for international standards for 'children without parental care' and (2) in South Africa, the primary piece of children's legislation that includes provisions for residential care has been under review and replaced by a new Children's Act. Yet, these policy changes are occurring, or have occurred amidst limited systematic empirical evidence about the phenomenon of residential care for (HIV/AIDS-affected) children (Meintjies *et al.*, 2007).

Since problems associated with residential care are not readily solved, the realisation of positive developmental outcomes associated with resilience is crucial for HIV/AIDS-affected children. It may not only lead to survival, thriving and well-being, but also to academic achievement, independence and autonomy (Dass-Brailsford, 2005; Dugan & Coles, 1989; Greene, 2002; Luthar *et al.*, 2000; Mallmann, 2003; Sesma *et al.*, 2005; Walsh, 2003). Moreover, for pre-adolescents, this realisation is paramount as adolescence is a period of important developmental changes.

In addition to the biological events of puberty, enormous social, emotional and cognitive transitions take place during this period which may hold many difficulties and challenges for children (Cowie & Smith, 1988; Papalia & Olds, 1992). Similar to risk factors, protective factors or inner strengths tend to co-occur in a specific population, e.g. children in poverty, or within a certain period of development, e.g. adolescence. According to Werner (2005), 'the presence of a certain cluster of (interrelated) variables that buffer adversity at one point in time also makes it more likely that other protective mechanisms come into play at later stages of development'. As a result, the attainment, development and sustainment of resilience strengths and assets during pre-adolescence are paramount to facilitate and ensure positive development during adolescence (Steinberg & Belsky, 1991; Watkins, 2002).

While the importance of developmental (resilience) factors for disadvantaged youth under adverse conditions is widely recognised (cf. Dugan & Coles, 1989; Luthar *et al.*, 2000), research to identify factors that contribute to resilience among South African AIDS orphans in residential care settings is still lacking.

Resilience: a conceptual framework

Resilience theory describes resilience as a process marked by the interaction between the child and his or her environment (Glantz & Sloboda, 1999; Kaplan, 1999; Luthar *et al.*, 2000). This process involves 'a balancing of protective factors against risk factors, and the gradual accumulation of emotional strength as children respond successfully to challenges [stressors and adversities] in their families, schools and communities' (Ah Shene, 1999). Within an organised developmental framework, resilience can thus broadly be defined as the ability to successfully use external and internal resources to resolve developmental issues and life-tasks. The child shows the tendency to achieve 'wholeness not as a static state, but as a dynamic, flexible balance that permits recoil or regression and rebound or progress' (Murphy, cited in Kaplan, 1999).

In the current study, in order to provide a holistic conceptualisation of the term, *resilience* was investigated as a process consisting of various related processes and constructs, organised within a dynamic framework. This framework comprises four main categories considered as determinants of resilience (Grotberg, 1995; Kumpfer, 1999; Zimmerman & Arunkumar, 1994): (1) *external realities* that function as stressors and challenges and which initiate risk and resilience processes; (2) *external supports or support networks* that promote resilience; (3) *inner strengths* that develop over time and sustain children who are dealing with adversity, and (4) *interpersonal, problem-solving skills* that help the child to deal with the actual adversity. The last three categories refer to protective factors that help children to resist or ameliorate risk and increase their resilience.

Research strategy and methods

Due to the unique nature of community-based care initiatives and their impact on the resilience of AIDS orphans, a case study design was used to intimately familiarise the researcher with these children's lives, culture and environment. Thus, the strength of case study research, namely that it includes context as an essential part of what has to be studied, was utilised favourably (Yin, 2003). The case study design allowed also for multi-perspective analyses. This meant that the researcher not only considered the voices and perspectives of the eight children selected for the study, but also those of significant key informants, as well as the interaction between the children and key informants.

The research setting

Lebone Land, formerly Lebone House, a day-care facility for HIV/AIDS-infected and -affected children near Bloemfontein, was established in May 2000. Within a few months, Lebone House was registered as a 24-hour care facility. With increasing numbers of HIV/AIDS-infected and -affected children, the need for additional care and housing intensified. As a result, in July 2002, an international company funded the institution of Lebone Land.

Lebone Land is located on a 17-hectare plot in Bloemfontein, in close proximity to the neighbouring black township, Bergman Square. The facility is surrounded by other small-holdings and houses. The buildings on the premises have been renovated and are used presently for administrative and schooling purposes. The two renovated houses on the property are used as accommodation for employees and children. Maersk House accommodates pre-schoolers, while the older children stay in Rist House. The Lebone Education Centre was established in September 2002 as part of Lebone Land. It comprises four sections: (1) a crèche for infants aged up to 12 months; (2) two classes for toddlers, one class for children between the ages of one and two years, and the other for children between two and four years; (3) a Grade R class for children between five and six years; and (4) afternoon classes for children in Grades 1 - 5. The Education Centre is open to day scholars living in the community surrounding Lebone Land. Due to the extreme poverty of the surrounding community, attendance at all the institution's facilities is without charge.

At the time the study was conducted, there were 78 learners attending the school. The school has six employees. Additionally, there are nine house staff, a varying number of approximately

14 employed staff at the Lebone Agriculture/Skills Centre, and 192 full-time and part-time volunteers from all walks of life. Many volunteers work at Lebone Land as part of Lebone's income generating, poverty alleviation and skills development programmes. The volunteers are involved in cultivating the land, gardening, building, making nappies and beds for the children, handcrafts, washing clothes and child care. A study room, a small library and a computer centre have been donated to the school.

Information gathering: Interviews with AIDS orphans and key informant

Primary data were obtained by means of 24 in-depth, semi-structured interviews with eight children. The following criteria were applied during the sampling process to adhere to the purpose of the study, to reduce variation among participants, and to ensure that the findings of the study represent a meaningful population: children, both male and female, at the inception of adolescence (9 - 13 years old), and those who had lost at least one parent to HIV/AIDS.

There was one initial interview with each child to build rapport, and then one after each stage, exploring their drawings for further information. The sampling was aimed at gaining insight about the resilience of this particular group of children, rather than empirical generalisation from the sample to the population. Participants selected for this study were considered as separate cases. The rationale for this approach was that cases are 'information rich' and illuminative, and may offer useful manifestations of these children's resilience (Patton, 2002). No documents could be obtained stating that the children's parents had in fact died because of AIDS; therefore, the researcher had to rely on the information provided by the staff working at the facility. A biographical questionnaire was used to gather information from staff regarding the children's names, ages, sexes, dates of birth and grade levels at school. Questions regarding the children's places of residence during school holidays, spoken languages, numbers of living primary caregivers, (probable) causes of parents' death, and the numbers of siblings and their ages were included too. The eight children had been orphaned for an average of three years.

Research tools from the CCATH (Child-centred approaches to HIV/AIDS) Project (Healthlink Worldwide & CCATH partners, 2004) were used, incorporating drawing to assist and structure the data collection process. Factors that enable the children to cope with and overcome AIDS-related adversities, as well as the actual adversities pertaining to each child, were identified and explored. The children were interviewed either in the playroom, boardroom or one of the classrooms at Lebone at their convenience, during the afternoon after school.

Data collection was divided into three stages. As the establishment and maintenance of rapport are critical for the disclosure of information, the first stage – *Communication mapping* – focused on building rapport with the child. This entailed showing genuine interest, accepting the child and building trust (Gladding, 2000). The children were asked to draw a picture of themselves. Drawings of people with whom they live or people who are important to them were then added to this picture. Lines were drawn between themselves and the other people in the picture. They were allowed

to draw a maximum of three lines for each person, depending on the importance of that person in their lives. The researcher then asked the child about the meaning of the drawing.

The second stage – *River of life* – aimed at exploring the child's life history and adversities to which the child had been exposed. Children were asked to draw a river of their life, starting from their birth and projecting five years into the future. An upward arching line depicted the flow of the river during good times in the child's life, and a downward arching line depicted the flow of the river during bad times. Small pictures and/or labels were added to the line drawing, explaining the events that influenced the flow of the river.

The final stage – *Happy and sad* – was directed towards facilitating closure of the whole process. Positive aspects of the children's environment that needed to be distinguished and strengthened and the negative aspects that needed to be addressed were investigated. Children drew and labelled two pictures: one of what makes a child of their age and gender happy, and another of what makes him/her sad.

Activities were structured in such a way that the children could draw without being interrupted as they found it difficult to answer questions and draw simultaneously. When necessary, the research tools were adapted to facilitate data gathering, and sessions were extended to ensure that children were emotionally stable after the disclosure of disruptive feelings and experiences. After every consecutive stage, the data obtained were reviewed, areas that called for (further) investigation were identified and, when necessary, additional research questions were formulated and the research schedules adapted accordingly.

Information obtained during these sessions (i.e. the three stages mentioned above) provided the researcher with a database from which to work and to add on. The data obtained were reviewed and interview schedules for each of the key informants were compiled. Individual semi-structured interviews were conducted with seven key informants (i.e. a social worker, three teachers, two caregivers and a pastor) chosen for their involvement in the education and care of the children. The interviews with the social worker, caregivers and pastor were held at Lebone, while the teachers were interviewed at the children's school. Interviews consisted of collecting complementary data regarding the children's behaviour, prior residence and family characteristics, as well as future prospects, were collected during these interviews. All interviews were audiotaped and transcribed verbatim. The entire data collection took place between 4 July and 18 September 2006.

Ethical considerations

Measures adapted from the ethical considerations discussed by Neuman (2006) and those listed by Patton (2002) and Varkevisser *et al.* (2003) were taken during the research procedures to ensure that the respondents did not suffer physical or emotional harm. A sample from the research population was drawn, permission was obtained from the administrator of Lebone Land for conducting the study at the facility and for accessing records containing personal data, informed consent was obtained from each respondent prior

to the study or interviews, and good relationships with the children were established. Informal meetings with staff were scheduled to discuss the study, possible considerations regarding the children, time frames, sampling and participation. A meeting was arranged to introduce both the researcher and the assistant researcher to the children in the sample group, to explain the purpose and nature of the study to them, and to obtain permission from each of the research participants for inclusion in the study.

Confidentiality of the children's identity and the data obtained was also ensured. The researcher gained adequate information about the culture of informants via informal interviews with doctors, teachers, nurses and caregivers at various health, day-care and educational facilities to ensure that their culture was respected during the data collection process. The presence and involvement of other qualified people (i.e. a teacher, psychologist and other caregivers) was arranged at various stages of the data collection process, especially when sensitive issues were being dealt with, as accountability and transparency are central to the achievement of ethical practice.

Prior to conducting the research involving the children, three employees of the facility were trained to assist with the fieldwork. Their assistance mainly entailed interpreting/translating and helping with any problems that might have arisen during the research process. In anticipation of direct and indirect consequences of the information-gathering process and to protect the children, as far as possible, from developing attachments to outsiders following the activity, the researcher selected responsible fieldworkers who would remain in the research area after the research activities had concluded. These fieldworkers were given the opportunity to learn from the research activities which empowered them to assume a supportive role with regard to the children, if necessary.

Information analysis and interpretation

The analysis of the collected information was based on the constant comparative method (Glaser, 1965) as it directed attention towards finding patterns and commonalities within the respondents' experiences (Patton, 2002). It is appropriate also for creating knowledge that is more generally descriptive or interpretive, such as coping with the effects of HIV/AIDS or the experiences and resilience of HIV/AIDS-affected children. Application of this method entailed: (1) categorising the information for each case according to the four components of the analytical framework explained previously; (2) an inductive analysis or 'open coding' of the collected information whereby codes were clustered according to commonalities to establish critical themes and subcategories (Wilson Scott, 2004); (3) comparative, cross-analysis of identified subcategories and themes to establish consistency; (4) employment of simple counting procedures, known as 'descriptive counting' to add more meaning and value to the information obtained (Steyn, 2001); and (5) interpretation of all the data (De Vos *et al.*, 2005; Patton, 2002).

Results

The following section(s) is limited to the most prevalent risk and protective factors pertaining to the children in the research group. Factors that concern three or more of the eight children are discussed.

External realities: stressors and challenges

Every child in the research group had been exposed to at least eight or more adversities (stressors) correlating with the adversities listed by various authors (cf. Dent & Cameron, 2003; Grotberg, 2003; Winslow, Sandler & Wolnick, 2005), the major life events or episodic, traumatic events measured by the *Life Events Checklist* (Work *et al.*, 1990), and the stressors measured by the *Sources of Stress Inventory* (Chandler, 1981). As suggested by Naglieri & LeBuffe (2005), daily hassles, for example, poor quality child care and teasing were included to gain a complete picture of exposure to risk and adversity. Significant themes relating to the adversities or external realities that emerged from the responses of the children and/or key informants linked to three contexts, namely their family, their community or neighbourhood, and their school.

Family

The most prominent theme pertaining to the children's families was the illness, death and loss of primary caregivers (N=8). The children's initial responses to these adversities essentially included feelings of bereavement such as sadness (N=8, e.g. '[When I realised that my mother had passed away] *I felt sad*'); crying (N=6, e.g. '*I sat outside the house for the whole day and cried*'); hurt (N=1, e.g. '*My heart felt sore when my father died*'); and recalling fond memories of those they had lost (N=4, e.g. '[When I heard that my mother had died] *I felt sad and thought of the time she held a party for me*'). Generally, their responses not only captured their feelings or emotions, behaviours and thoughts, but also indirectly revealed their coping strategies. These strategies mainly involve taking on a variety of adult responsibilities, such as looking after siblings or other younger children, caring for ill and dying parents and doing household chores, dropping out of school, taking responsibility for the household livelihood, and turning to fellow youths, family members and other adults, such as teachers and staff members from Lebone for comfort and support concerning personal and private matters. Additional present responses that seemed to relate to adversities linked to the children's families, included bedwetting, nightmares, withdrawal and aggression.

Noteworthy is that six children had experienced poor care. Anti-social values (violence or conflict that on occasion resulted in death) of family members (N=5, e.g. '*My uncle grabbed me, pushed me down, and used an electric cord to beat me on my back and on the back of my legs ... it was not fine, because I had colour, colours*'), the funerals of loved ones (N=5), and separation from siblings (N=5), were common stressors experienced in this group. Seven of the children had been exposed to at least one or more of these stressors. In addition to these stressors, significant adversities indicated by the information provided by the key informants, included extreme poverty (N=4) and neglect (N=4). It appears that the children were not neglected by their primary caregivers only, but that neglect was common among children who were cared for by foster parents. Although family members provided children with connections in the community at large, visits to them (the family members) were often painful for the children. Reportedly, these family members often exploited, abused and neglected children. For example, '[Lebo's eldest brother] *always collected grant money to take care of Lebo, but used the money to buy alcohol and cigarettes for himself instead*'. '[Kagiso and his sister] *complained that they had no food and were not bathed. On one*

occasion, she [their aunt] left the children with people who lived on a plot where they were not looked after. She did not return to collect them either'. Other prevalent adversities concerning the children's families include being separated from a parent (N=3) and the loss of family members other than primary caregivers, such as a sister or extended family members (N=3).

Community/neighbourhood

For the interviewed children, actual violence relating to their neighbourhoods or communities involved witnessing or hearing about, and being aware of random violence in their communities (rape, suicide or other violent crimes), and witnessing and experiencing incidents of violence among peers and other children. A sense of danger and worries about injuries were noticed among the children in the research group (e.g. 'When I was home alone, I became scared, because I thought that 'tsotsis' [thugs] might come and hurt me'). In addition, feelings of sadness, anger, and being afraid and upset were communicated (e.g. 'When I think of the people fighting in the street, I become sad in my heart').

All the children had been relocated to a residential care facility (Lebone) and five of them had relocated to extended family members also before they were accommodated at Lebone. Additional information provided by the key informants suggests that older children who lived happily with their families found adaptation to Lebone more challenging. Adaptation was further compromised by the fact that it was a time-consuming process to get to know each child and learning how to take care of him/her. Reportedly, some of the caregivers maltreated, that is, screamed and shouted at the children and found it taxing having to deal with children's grief.

Further challenges associated with children's communities or neighbourhoods mentioned by the key informants include a lack of support from community members to families whose members suffered from HIV/AIDS, the 'culture of silence' surrounding HIV/AIDS, and HIV/AIDS-related stigma and abuse. Providing assistance to those families where the HIV status of parents was kept secret is challenging. Challenges concerning the children's future include having to cope with the transition back into the community. One key informant stated that, unless Lebone raises funds for these children to further their education, they would have to be employed at an early age. This in itself may pose difficulties, considering the high rate of unemployment in South Africa.

School

Six children in the research group experienced learning difficulties and four mentioned explicitly that they were teased at school. Although previous studies highlight gender differences on the subject of learning difficulties experienced by children (Mather & Ofiesh, 2005; Werner, 2005), no definite differentiation could be made regarding the group of children selected for this study. Two of the key informants mentioned that the children from Lebone are perceived differently by other children at school. This may point to stigmatisation of and discrimination against Lebone children among other learners at the school.

Despite the fact that exposure to the afore-mentioned adversities may render children vulnerable to a number of risks, none of the

children in the research group appeared to have been involved in criminal activity, sexual exploitation or substance abuse.

External supports or support networks

For the children in the research group, growth-fostering relationships predominantly included those established with friends (N=8), caregivers from Lebone (N=8), professionals in the community (e.g. a teacher, psychologist, nurse) (N=5) and, to a lesser extent, relationships with the babies in the house at Lebone (N=3), and at a metaphysical level, with God (N=3).

The most significant environments or contexts offering support to the children in the research group seemed to reside in the mesosystem, namely Lebone (N=8) and the school (N=5). Field observations revealed that both environments seem to establish high expectations for all of their learners (children) and aspire to provide them with the care and support needed to achieve their goals. Protective factors related to the children's school, which had been identified from the key informants' responses, included the absence of sexual activity, stigmatisation and discrimination among learners at school. However, as indicated previously, on the subject of stigmatisation and discrimination, two of the key informants reported the opposite (i.e. that the children from Lebone were perceived differently by the other learners at school).

Further to the key informant interviews, community involvement at Lebone, as well as Lebone itself, provide training and support to the children. This contributes to a sense of pride, enabling the children to deal with adversities, such as being teased at school. Ceremonies held by the church and at school assist in instilling morals and good values in the children. As suggested, these qualities in the children also seem to be cultivated by most of the staff members from Lebone Land. According to the views of the key informants, Lebone could play a key role regarding the children's future education and successful adaptation during young adulthood.

Inner strengths

Both the children's and key informants' responses relating to inner strengths were grouped according to 21 associated subcategories (inner strengths), 16 of which were based on the individual spiritual, cognitive, social, as well as behavioural, physical and emotional or affective competencies or resilience traits discussed by Brooks & Goldstein (2003), Kumpfer (1999), McConnell (1974) and Wright & Masten (2005), and the internal assets listed by the Search Institute's Framework of Developmental Assets (Scales & Roehlkepartain, 2003, Sesma *et al.*, 2005). Five additional inner strengths (i.e. assertiveness, authority, obedience, accountability and dedication) were newly identified, although these were not common amongst this group of children. Significant inner strengths identified from the responses of the children and/or key informants include morality, social values and resistance skills (N=8), optimism and positive identity (N=8), achievement motivation (N=8), emotional management (N=7), trust (N=7), religion and faith (N=4), and humour (N=3).

Just more than half of the responses (N=24/43) associated with morality, social values and resistance skills concern the boys in the research group, whereas the two subsequent subcategories,

optimism and positive identity, as well as religion and faith, contain more responses (N=17/24) from the girls. Important responses associated with morality, social values and resistance skills include stances against violent behaviour (such as fighting with and beating others) (N=6, e.g. *'It's not right to beat children when they've done something wrong'*) and avoiding early involvement in serious relationships with the opposite sex (N=5). To these can be added: caring for others (N=3, e.g. *'When my [the caregiver's] feet are sore, Lebo always rubs them with cream,'* and *'Poelo ... and two of her friends planned to take care of me when I'm old'*), expressing clear judgement (N=3, e.g. *'He hurt my little sister ... that man did something very wrong'*), being responsible (N=3, e.g. *'She [Poelo] fed her father, washed him, and tried to do anything she could for him. It was very difficult for her, but she handled it boldly, maturely,'* and *'Bophelo took care of the younger children in the house'*), being well-mannered (N=3), and valuing love (N=3, e.g. *'I love my grandmother, because she also loves me'*).

All the children in the research group exhibited optimism and positive identity in that they displayed a positive view of their future and a happy disposition. They showed achievement motivation considering that they were motivated to do well in school. Seven of the children displayed trust. The same children showed emotional management by way of their ability to recognise feelings and control undesirable feelings.

Significant responses associated with spiritual characteristics included finding healing and comfort in faith and religion (N=4). For example, *'When they [my family members] died, I cried, and thought of the cross. I went to church and this 'made my river flow up' [made me feel better] again'*; *'When 'my river flows up' [things are going well in my life and I am happy], it is because God made my heart feel good'*; and *'When I go to heaven one day, I will see my father again'*.

Three children employed humour to access external resources (e.g. *'Poelo likes making jokes with me. She will often poke fun at my grey hair, hit [thump] me playfully and run, or swing me around and dance with me'*). Yet, humour never seemed to be used to make fun of others or put others down. Instead, it often seemed to provide the children with a sense of hope (e.g. *'Sometimes he [Bophelo] will ask me and one of the ladies who works in the kitchen to help him find someone that he could marry ... he often jokes about this with me'*). Humour assisted them in forming or strengthening supportive relationships, especially with the caregivers from Lebone Land.

Interpersonal and problem-solving skills

Eight subcategories relating to interpersonal and problem-solving skills were identified from the responses of the children and/or key informants. Six of these subcategories corresponded with resilience factors cited by other authors (Benard, 1991; 2004; Grotberg; 2003; Millgram & Palti; 1993; Scales & Roehlkepartain, 2003; Riley, 2002; Sesma *et al.*, 2005; Vanderpol, 2002). These include constructive use of time (N=8); goal-setting, purpose in life and commitment to learning (N=8); problem-solving ability, self-efficacy and personal power (N=8); open communication (N=8); perseverance (N=4); and hope (N=1). Except for the last one, these are the most important interpersonal and problem-solving skills employed by the children in the research group.

For the children in the research group, constructive use of time predominantly involved playing (N=8), taking part in other creative activities, such as writing, drawing, dancing or singing, and doing sports (N=5). A caregiver related that *'playing house'* is a game often played by the children, particularly over the weekends: *'Lebo's favourite game is 'playing house.' She collects some of the children inside a steel pipe structure, which stands next to the house at Lebone. Some children would sit, and others would lie on pieces of mat that she places on the ground. I [the caregiver] would often give them pots and pans and food to play with. Lebo often pretends to be the mother of the household. She feeds the children, sends them to school or crèche, and instructs them to go to church. They also pray together before they eat. The older children join in the game. The household does not have a husband, only a mother and children. Even the older boys, like Bophelo, are considered children. The boys are always instructed to rake the yard and to go to school'*. Three children enjoy working, and three of the boys in the group watch television as a constructive use of time. These activities seem to reflect their interests and are mostly regarded as enjoyable by the children.

The responses associated with goal-setting, purpose in life and commitment to learning mainly involved caring for and helping others (N=8, e.g. *'I'm going to study hard to become a nurse. I want to help sick people who have colds and flu ...'*). All the children in the research group exhibited problem-solving ability, self-efficacy and personal power, given their belief in their ability to exercise control over their future and over threatening situations. For the sake of clarification, it is important to note that these qualities are related to specific incidents. Although children may display self-efficacy or problem-solving in certain situations or areas of their lives, they may not necessarily exhibit these qualities in other areas or contexts pertaining to their lives. Nevertheless, these qualities are crucial indicators of resilience that may develop and broaden in scope as children mature. All the children in the research group employ open communication as a means of dealing with problems and receiving support or help (e.g. *'Dikeledi is a quiet girl who's not afraid to ask [people at Lebone] for help if she needs something, is unhappy or feels sick'*). Four of them also showed perseverance when faced with difficulties or failure.

Discussion and conclusion

Research indicates that exposure to four or more adversities in childhood is associated with four- to twelve-fold increase in risk for alcoholism, drug abuse, depression and alcohol abuse in adulthood. Exposure to eight or more adversities increases the risk of negative mental outcomes by 5.7 times (Winslow *et al.*, 2005; Nyamukapa *et al.*, 2008; Kumakech *et al.*, 2009). Thus, the results of the empirical investigation indicated that all the children in the research group are at risk for poor developmental outcomes which may compromise their development and future success. Although the adversities (threats) or stressors and the situational protective factors identified from the children's responses are grouped and located within different areas (i.e. within the individual, the family and those experienced outside the family or within community organisational domains), these factors interrelate and interact and their effects permeate different systems, aspects and time frames of the children's lives. For instance, poverty may cause poor care and neglect of children,

affect their access to health care, lead to learning disabilities, cause dysfunction within the family environment and give way to violence within the children's communities and families. Similarly, although inherent protective factors are for the most part listed separately, many of these strengths are interrelated. Achievement motivation and self-efficacy may lead to a positive view of oneself and one's future. Collectively, these three inner strengths may also lead to problem-solving and goal-setting.

Although this study does not provide evidence for the level of stress and depression experienced by the children in the research group, several indicators of trauma or anxiety, emotional problems and possible depression (such as bedwetting, nightmares, withdrawal, difficulty concentrating, unpleasant memories, times of great sadness and aggression) were recorded which may link with learning disabilities in these children. Considering the duration of the children's responses to their external realities, these responses are not necessarily classified as extreme reactions requiring specialised help. They may relate to adversities, such as death and loss of loved ones, and may indicate that the grief process has not been dealt with adequately.

Nevertheless, although most of the children in the research group seemed to exhibit symptoms of trauma and emotional disturbance, they are getting on with their lives, going to school, making friends, and apparently building constructive lives as they adapt to life at Lebone. Therefore, the children's responses to environmental adversity, or the subsequent effects thereof, portray a more accurate picture of their resilience than the attainment of developmental outcomes, absence of problems or risk factors, such as depression or learning difficulties alone. This viewpoint correlates with the definition of resilience formulated for this study in that resilience does not prohibit recoil and regression. Given this perspective and the clear indications of rebound or progress among the children in the research group specifically reported by key informants, their lives appear to be a testimony to the astonishing human capacity for resilience.

Personal factors underlying those identified from the children's responses and thought to contribute to their ability to adapt to their circumstances include curiosity, compassion, gratefulness, the capability of invoking good internalised self-images and being in touch with the effects, the ability to draw support from others and to set clear goals, resourcefulness and a fighting spirit. Caring and helping, specifically among this group of children and also towards other children from Lebone, seem to strengthen the cohesiveness of the whole group (i.e. all the children at Lebone) and contribute to a sense of family or a kind of tribal belonging, respect and responsibility.

Interpersonal and problem-solving skills, such as caring and helping, have frequently been correlated with optimism (Williams, 2002). Evidently, this correlation applies to the children in the research group and relates to their view of the future. Optimism may also be a particularly valuable personality factor for those in the group who commented on violence. Previous research indicates that this quality promotes positive adjustment in children who are exposed to violence in their homes and communities, and may lead to improved self-efficacy and self-esteem functioning in

adolescence (Williams, 2002). These qualities are thought to play a critical role in sustaining and fostering resilience, in particular among this group of children.

Significant situational protective factors appear to be the fact that both the school and Lebone are faith-based institutions that advocate spiritual teaching. As faith-based institutions, these environments provide or host services (religious ceremonies) that are usually rendered by the church. In this way, with reference to Bronfenbrenner's ecological model (Cowie & Smith, 1988; Greene, 2002), the church does not function independently as part of the exosystem, but becomes an integral part of the mesosystem. For the children in the research group the impact of religion in their lives may be protective as religious beliefs wield further development of resilience by offering ways in which children can give meaning to their pain and suffering (Grotberg, 2003). Furthermore, spiritual teachings advocate resilience strengths, such as compassion and forgiveness (Walsh, 2003), deepen and expand children's values and perspectives, and allow children to view adversity as an opportunity for personal growth and development. An organised spiritual community lays the foundation for self-acceptance and tolerance of others as it provides a context for hope, reassurance and comprehension of that which is beyond the child's (current) understanding. With regard to the children's school specifically, high expectations of teachers and the learners themselves suffice to guarantee success for many disadvantaged children (Constantine *et al.*, 1999), particularly if other forms of support, as mentioned previously, are available.

Moreover, spirituality may be considered a key factor in fostering resilience in these children as it encompasses existing and shared inner strengths, as well as interpersonal and problem-solving skills, such as hope and morality. Morality, social values and resistance skills denote beliefs concerning what is right and wrong. A belief in one's own competence and skills, that things can change for the better, that there is hope for the future, and that one can control the direction of one's life, represents optimism, positive identity and faith. Religion may be understood as the external expression of a child's faith or inner system of beliefs, which includes ethical codes and various forms of worship (Greene & Conrad, 2002). These culminate in the children's belief systems, and may inform and provide guidance regarding other aspects of their lives. As children build on and develop these inner developmental and asset-related traits, they may construct a strong internal locus of control which seems fundamental to transcending risk in their lives. Hence, these children's beliefs and convictions can be powerful healing tools.

Subsequently, the children's capacity to transcend the risk of oppressive environments can, generally speaking, be attributed to the culturally-unique protective factors of this group (i.e. the children and staff at Lebone), for instance, positive social orientation, including peer friendships, regard for others and servitude. Common experiences among the children in the research group, such as the illness and death of their parents, are perhaps also protective to the extent that they seem to promote group cohesiveness which incorporates factors such as empathy, understanding and other forms of support, and seem to bring about a sense of connectedness and, perhaps, family.

The clearest implication of this investigation is that it is important to invest in efforts to promote healthy relationships and social and emotional development in HIV/AIDS-affected children. Failure to do so may be costly to both children and to society.

With adequate support, children can be extremely resilient to stressors. Teachers and adult caregivers play a key role in rendering this support. They may not only fill basic needs, but also further needs such as expanding the worldview of children, provoking a sense of understanding and direction, and creating environments in which children can feel valued as significant contributors. They may create opportunities to develop (individual) strengths, acknowledge the existence of children and their rights, some of which include the right to identity, participation in decisions affecting their lives, education, and appropriate alternative care.

In order to help the children in Lebone, and similar institutions overcome barriers to a successful transition to adulthood, intervention and prevention programmes should not only display individual level characteristics (thus, focus or build on strengths that are characteristic of a specific child), but also incorporate group activities that focus on shared experiences such as the death of primary caregivers. In addition, programmes should draw on existing growth, fostering relationships as far as possible, provide one-on-one attention, be developmentally appropriate, and empower youth.

Limitations of the research and the results

A number of limitations became evident during the course of this study. These are recorded here as potential guidelines to future researchers in this particular field.

Firstly, as the number of children who participated in the study is limited, the findings and results cannot be generalised to a larger population of pre-adolescents, but should be viewed as specific tendencies only. Secondly, the significance of the identified subcategories applies only to the information as communicated and recorded during the empirical investigation. Further investigation may reveal additional subcategories, perhaps of similar significance, or alter the significance of existing categories. Thirdly, the identified resilience strengths cannot be viewed as definite but merely as indicators of resilience. This study was unable to provide explicit answers concerning positive long-term outcomes for the children in the research group. Fourthly, the language proficiency of the children necessitated the use of an interpreter/translator which, to a degree limited the extent of direct contact between the researcher and the children. As a result, emotion and spontaneity were often lost between the researcher, the child and the interpreter. Furthermore, the interpreter's presence may have influenced the children's responses. Further research on resilience in AIDS-orphaned, would surely benefit from a researcher capable of the mother-tongue of the respondents in order to capture the richness of the data especially regarding the emotional experiences of these unfortunate children.

References

Ah Shene, D. (1999). Resiliency: A vision of hope. *Developments*, 18(7). Edmonton: AADAC (Alberta Alcohol and Drug Abuse Commission). An Agency of the Government of Alberta. Retrieved on September 1, 2005 from <http://corp.aadac.com/copyright/>.

- Bellamy, C. (2004). *The state of the world's children 2005: Childhood under threat*. New York: The United Nations Children's Fund (UNICEF).
- Benard, B. (1991). Prevention should emphasize protective factors. *Western Center News*, 4(4): 11-13.
- Bradshaw, D., Johnson, L., Schneider, H., Bourne, D. & Dorrington, R. (2002). Orphans of the HIV/AIDS Epidemic: The time to act is now (Policy Brief). MRC Policy Brief 2002; 2: 1-4. Retrieved on October 15, 2009 from <http://www.mrc.ac.za/policybriefs/2policy2002.pdf>.
- Brooks, R.B. & Goldstein, S. (2003). *Nurturing resilience in our children: Answers to the most important parenting questions*. Chicago: Contemporary Books.
- Browne, K.D., Hamilton-Giachritsis, C.E., Johnson, R. and Ostergren, M. (2006). Overuse of institutional care for children in Europe. *British Medical Journal*, 332: 485-487.
- Chandler, L.A. (1981). The source of stress inventory. *Psychology in the Schools*, 18(2): 164-168.
- Clandinin, D. & Connelly, F. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass Publishers.
- Cluver, L., Gardner, F. & Operario, D. (2007). Psychological distress amongst AIDS orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry*, 47(8): 755-763.
- Cluver, L., Gardner, F. & Operario, D. (2009). Poverty and psychological health among AIDS-orphaned children in Cape Town, South Africa. *AIDS Care*, 21(6):732-741
- Constantine, N., Benard, B. & Diaz, M. (1999). Measuring protective factors and resilience traits in youth: The healthy kids resilience assessment. (A paper presented at the Annual Meeting of the Society for Prevention Research, held in New Orleans, LA, during June). Retrieved on September 26, 2005 from <http://crahd.phu.org/papers/HKRA-99.pdf>.
- Cowie, H. & Smith, K.P. (1988). *Understanding children's development*. New York: Basil Blackwell Ltd.
- Das Eiden, R. (1999). Exposure to violence and behaviour problems during early childhood. *Journal of Interpersonal Violence*, 14(12): 1299-1313.
- Dass-Brailsford, P. (2005). An exploration in resiliency: Academic achievement among disadvantaged Black youth in South Africa. *South African Journal of Psychology*, 35(3): 571-594.
- Dent, R.J. & Cameron, R.J.S. (2003). Developing resilience in children who are in public care: The educational psychology perspective. *Educational Psychology in Practice*, 19(1): 3-19.
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delpoit, C.S.L. (2005). *Research at grass roots: For the social sciences and human service professions*. Pretoria: Van Schaik Publishers.
- Dugan, M.D. & Coles, M.D. (1989). *The child in our times: Studies in the development of resiliency*. New York: Brunner/Mazel Inc.
- Dunn, A., Jareg, A. & Webb, D.W. (2003). *A last resort: The growing concern about children in residential care*. London: Save the Children UK.
- Felner, R.D. (2005). Poverty in childhood and adolescence: A transactional-ecological approach to understanding and enhancing resilience in contexts of disadvantage and developmental risk, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 125-147. New York: Kluwer Academic/Plenum Publishers.
- Gladding, S.T. (2000). *Counseling: A comprehensive profession*. New Jersey: Prentice Hall.
- Glantz, M.D. & Sloboda, Z. (1999). Analysis and reconceptualization of resilience, in Glantz, M.D. & Johnson, J.L. *Resilience and development: Positive life adaptations*. New York: Kluwer Academic/Plenum Publishers, 109-126.
- Glaser, B.G. (1965). *Social problems*. San Francisco: University of California Press.
- Gerwartz, A. & Gossart-Walker, S. (2000). Home-based treatment for children and families affected by HIV and AIDS. *Child and Adolescent Psychiatric Clinics of North America*, 9(2):313-320.
- Goldstein, S. & Brooks, B.R. (2005). Why study resilience?, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 3-17. New York: Kluwer Academic/Plenum Publishers.
- Greene, R.R. (2002). Human behaviour theory: A resilience orientation, in Greene, R.R. *Resiliency: An integrated approach to practice, policy and research*, pp. 1-27. Washington: NASW Press.
- Greene, R.R. & Conrad, A.P. (2002). Basic assumptions and terms, in Greene, R.R. *Resiliency: An integrated approach to practice, policy and research*, pp. 28-62. Washington: NASW Press.
- Greene, R.R., Taylor, N.J., Evans, M.L. & Smith, A.L. (2002). Raising children in an oppressive environment: Voices of resilient adults, in Greene, R.R. *Resiliency: An integrated approach to practice, policy and research*, pp. 241-264. Washington: NASW Press.
- Grotberg, E. (1995). A guide to promoting resilience in children: Strengthening the human spirit. From the *Early Childhood Development: Practice and Reflections series*. The Hague: The Bernard van Leer Foundation.
- Grotberg, E.H. (2003). *Resilience for today: Gaining strength from adversity*. Westport: Greenwood Publishing Group Inc.

- Gulaid, A.L. (2004). The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS. Retrieved October 18, 2005 from <http://synkronweb.aidsalliance.org/graphics/OVC/documents/0000292e.pdf>.
- Health link Worldwide & CCATH partners (ACET Uganda, KANCO, NACWOLA, Child-to-Child Uganda and Child-to-Child Trust UK). (2004). Final evaluation of the project on child-centered approaches to HIV and AIDS report. Retrieved March 29, 2006 from http://www.healthlink.org.uk/PDFs/ccath_ev.pdf.
- Huntington, D.D. & Bender, M.N. (1993). Adolescents with learning disabilities at risk? Emotional well-being, depression, suicide. *Journal of Learning Disabilities*, 26(3): 159-166.
- Interagency Coalition on AIDS and Development (ICAD). (2002). Best practices for care of AIDS orphans. Retrieved June 30, 2006 from http://www.icad-cisd.com/pdf/publications/e_orphans_web.pdf.
- Jensen, P.S., Shervette, R.E., Xenakis, S.N. & Richters, J. (1993). Anxiety and depressive disorders in attention deficit disorder with hyperactivity: new findings. *American Journal of Psychiatry*, 150: 1203-1209.
- Kaler, S.R., Freeman, B.J. (1994). Analysis of environmental deprivation: Cognitive and social development in Romanian orphans. *Journal of Child Psychology and Psychiatry*, 35: 769-781.
- Kaplan, H.B. (1999). Toward an understanding of resilience, in Glantz, M.D. & Johnson, J.L. *Resilience and development: Positive life adaptations*, pp. 17-83. New York: Kluwer Academic/Plenum Publishers.
- Kumakech, E., Cantor-Graae, E., Maling, S. & Bajunirwe, F. (2009). Peer-group support intervention improves the psychosocial well-being of AIDS orphans: Cluster randomized trial. *Social Science & Medicine*, 68: 1038-1043.
- Kumpfer, K.L. (1999). Factors and processes contributing to resilience: The resilience framework, in Glantz, M.D. & Johnson, J.L. *Resilience and development: Positive life adaptations*, pp. 179-224. New York: Kluwer Academic/Plenum Publishers.
- Luthar, S.S., Chichetti, D. & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71, 543-562.
- MacLean, K. (2003). The impact of institutionalization on child development. *Development and Psychopathology*, 15: 853-884.
- Mallmann, S. (2003). Building resilience in children affected by HIV/AIDS. Namibia: Longman Namibia Inc.
- Mangoma, J. & Chimbari, M. & Dhlo, E. (2008). An enumeration of orphans and analysis of the problems and wishes of orphans: The case of Kariba, Zimbabwe. *Journal of Social Aspects of HIV/AIDS*, 5(3): 120-128.
- Mastropieri, A.M. & Scruggs, E.T. (2000). *The inclusive classroom: Strategies for effective instruction*. New Jersey: Merrill Publishers.
- Mather, N. & Ofiesh, N. (2005). Resilience and the child with learning disabilities, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 239-256. New York: Kluwer Academic/and Plenum.
- McConnell, J.V. (1974). *Understanding human behavior: An introduction to psychology*. New York: Holt, Rinehart and Winston Inc.
- Meintjies, H., Moses, S., Berry, L. & Mampane, R. (2007). Home truths: The phenomenon of residential care for children in a time of AIDS. Cape Town: Children's Institute, University of Cape Town & Centre for the Study of AIDS, University of Pretoria.
- Milgram, A.N. & Palti, G. (1993). Psychosocial characteristics of resilient children. *Journal of Research in Personality*, 27: 207-221.
- Morrison, G.M. & Cosden, M.A. (1997). Risk, resilience, and adjustment of individuals with learning disabilities. *Learning Disability Quarterly*, 20: 43-60.
- Monson, J., Hall, K., Smith, C. & Shung-King, M. (2006). *South African Child Gauge*. Cape Town: Children's Institute, University of Cape Town.
- Naglieri, J.A. & LeBuffe, P.A. (2005). Measuring Resilience in Children: From theory to practice, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 107-121. New York: Kluwer Academic/Plenum Publishers.
- Neuman, W.L. (2006). *Social research methods: Qualitative and quantitative approaches*. Boston: Pearson Education, Inc.
- Nyamukapa, C.A., Gregson, S., Lopman, B., Saito, S., Mohasch, R., Jukes, M.C.H. (2008). HIV-associated orphanhood and children's psychosocial distress: Theoretical framework tested with data from Zimbabwe. *American Journal of Public Health*, 98(4): 133-141.
- Papalia, D.E. & Olds, S.W. (1992). *Human development*. New York: McGraw-Hill Inc.
- Patton, M.Q. (2002). *Qualitative research & evaluation methods*. London: Sage Publications Ltd.
- Prior, M., Smart, D., Sonson, A. & Oberklaid, F. (1999). Relationships between learning difficulties and psychological problems in pre-adolescent children from a longitudinal sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(4): 429-436.
- Richter, L. (2004). The impact of HIV/AIDS on the development of children. In: *A generation at risk? HIV/AIDS, vulnerable children and security in South Africa* edited by Robyn Pharoah. ISS Monograph Series, no. 109. (December). Pretoria: Institute for Security Studies.
- Riley, G.J. (2002). Physical health, in Greene, R.R. *Resiliency: An integrated approach to practice, policy and research*, pp. 171-194. Washington: NASW Press.
- Rolf, J.E. & Johnson, J.L. (1999). Opening doors to resilience intervention for prevention research, in Glantz, M.D. & Johnson, J.L. *Resilience and development: Positive life adaptations*. New York: Kluwer Academic/Plenum Publishers, 229-249.
- Scales, P.C. & Roehlkepartain, C.E. (2003). Boosting student achievement: New research on the power of developmental assets. *Search Institute Insights & Evidence*, 1(1): 1-10.
- Sesma, A., Mannes, M. & Scales, C.P. (2005). Positive adaptation, resilience, and the developmental asset framework, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 281-96. New York: Kluwer Academic/Plenum Publishers.
- Schorr, L.B. (1988). *Within our reach: Breaking the cycle of disadvantage*. New York: Doubleday.
- Steinberg, L. & Belsky, J. (1991). *Infancy, childhood, and adolescence: Development in context*. New York: McGraw-Hill Inc.
- Steyn, F. (2001). The role of criminology in the training of probation officers specialising in the Free State. Unpublished MSocSc thesis. Bloemfontein: University of the Free State.
- Tolfree, D.K. (2003). *Community based care for separated children*. Stockholm: Save the Children Sweden.
- UNAIDS. (2006). *2006 Report on the Global AIDS pandemic*. Geneva: UNAIDS.
- UNAIDS. (2008). *2008 Report on the Global AIDS pandemic*. Geneva: UNAIDS.
- UNAIDS (The Joint United Nations Programme on HIV/AIDS), UNICEF (The United Nations Children's Fund & USAID (The United States Agency for International Development). (2004). *Children on the brink: A joint report of new orphan estimates and a framework for action*. New York: IVT Associates/The Population, Health and Nutrition Information Project for the USAID, UNAIDS and UNICEF.
- Vanderpol, M. (2002). Resilience: A missing link in our understanding of survival. *Harvard Review of Psychiatry*, 10(5): 302-306.
- Van Ijzendoorn, M.H., Luijk, M.P.C.M. & Juffer, F. (2008). IQ of Children Growing Up in Children's Homes: A Meta-Analysis on IQ Delays in Orphanages. *Merrill-Palmer Quarterly*, 54(3): 341-366.
- Varkevisser, C.M., Pathmanathan, I. & Brownlee, A. (2003). *Designing and conducting health systems research projects. Volume I: Proposal development and fieldwork*. Amsterdam: KIT Publishers.
- Walsh, F. (2003). Family resilience: Strengths forged through adversity, in F. Walsh (Ed.), *Normal family processes* (3rd ed.), pp. 399-423. New York: Guilford Press.
- Watkins, M.L. (2002). Listening to girls: A study in resilience, in Greene, R.R. *Resiliency: An integrated approach to practice, policy and research*, pp. 115-131. Washington: NASW Press.
- Werner, E.E. (2005). What can we learn about resilience from large-scale longitudinal studies?, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 91-105. New York: Kluwer Academic/Plenum Publishers.
- Williams, N.R. (2002). Surviving violence: Resilience in action at the micro level, in Greene, R.R. *Resiliency: An integrated approach to practice, policy and research*, pp. 195-215. Washington: NASW Press.
- Wilson Scott, K. (2004). Relating categories in grounded theory analysis: Using a conditional relational guide and reflexive coding matrix. *The Qualitative Report*, 9(1): 113-126.
- Winslow, B.E., Sandler, I.N. & Wolnick, A.S. (2005). Building resilience in all children: A public health approach, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 337-356. New York: Kluwer Academic/Plenum Publishers.
- Work, W.C., Cowen, E.L., Parker, G.R. & Wyman, P.A. (1990). Stress resilient children in an urban setting. *Journal of Primary Prevention*, 11(1):3-17.
- Wright, M.O. & Masten, A.S. (2005). Resilience processes in development: Fostering positive adaptation in the context of adversity, in Goldstein, S. & Brooks, R.B. *Handbook of resilience in children*, pp. 17-37. New York: Kluwer Academic/Plenum Publishers.
- Yin, R.K. (2003). *Case study research: Design and methods*. London: Sage Publications Ltd.
- Zimmerman, M.A. & Arunkumar, R. (1994). Resiliency research: Implications for schools and policy. *Social policy report: Society for research in child development*, 8(4): 1-17.