A NEEDS ASSESSMENT OF CAREGIVERS IN CHILDREN'S HOMES

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Dedicated to all caregivers working with ‘looked-after children’

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My Heavenly Father for bearing with me in these difficult three years.

I declare that “A NEEDS ASSESSMENT OF CAREGIVERS IN CHILDREN’S HOMES“ is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete reference.

Name: Elizabeth Greyvenstein Date: June 2010

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A NEEDS ASSESSMENT OF CAREGIVERS THAT CARE FOR CHILDREN IN A CHILDREN'S HOMES

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ABSTRACT

Caregivers in children's homes are the front-end workers who care for looked-after children daily. Looked-after children in children's homes constitute a particularly vulnerable group, who are known to reveal mental health problems, which complicate the care-giving role. In conjunction with the lack of training and support, caregivers experience great challenges. This research study explores and describes the training and holistic care-giving needs of caregivers, by applying qualitative needs assessment design, where the responses of 12caregivers are explored and described. Data from the literature and semi-structured interviews and questionnaires was categorised into themes. Overarching findings include altruistic needs, the need for support and to be valued, with the researcher making recommendations and providing a convincing argument for immediate therapeutic support for caregivers.

KEY TERMS

Caregiver, looked-after children, children's homes, Gestalt Therapy, Field Theory, Phenomenology, Dialogue, Qualitative, needs assessment, Play Therapy.

INDEX

CHAPTER ONE

INTRODUCTION AND RATIONALE FOR STUDY

1.1 INTRODUCTION

Caregivers in children's homes are the front-end workers, who care for looked-after children daily. They are the people who have to provide physical, emotional and social support in order to contribute to the well-being of looked-after children. In order to provide quality care and an environment that is protecting, development-enhancing and promotes growth and well-being, caregivers take on different roles daily.

Being a caregiver is a demanding and emotionally stressful occupation (Brannen, Mooney & Statham, 2009:119). The difficulty arises when unskilled caregivers are placed in a care-giving environment and are not trained or given support to be able to give quality care to children inundated with trauma symptoms (Rhodes, Orme & Buehler, 2001:86; Boyd-Webb, 2006:58). If caregivers were to receive training and support, feelings of preparedness and emotional well-being may be experienced. The writer pursues this research in the hope of providing a few small additions to the knowledge on care-giving in children's homes.

In this chapter, an overview of the research study will be given. The chapter is an orientation towards the rationale for the study and the problem that was under investigation. An introduction to the theoretical assumptions, which this research study is based on, will be explained. The research questions and the aim of this study follow with a brief overview of the research approach, design and methodology. Ethical aspects are included. Lastly, the operational definitions applicable to this research study are provided.

1.2 LITERATURE REVIEW AND RATIONALE

Statistics in South Africa confirm that there are currently in the region of 458000 children in foster and residential care facilities (South Africa, 2005:14) who have been exposed to trauma, to an extent that warranted statutory organisations removing them from their homes (South Africa, 2007-2008:14). The removal from parental homes and the placement into residential facilities could cause even more trauma to these vulnerable children (Boyd-Webb, 2006:84-85). Literature proves that children exposed to traumatic events, pose overwhelming clinical challenges to welfare workers and caregivers (Little, Akin-Little & Gutierrez, 2009; Boyd-Webb, 2009; Ko, Kassam-Adams, Wilson, Ford, Berkowitz & Wong, 2008; Litz, 2008; Briere, Kaltman & Green, 2008; Zeanah, Smyke, Settles, 2008; Springer, 2007; Clemmons, Walsh, DiLillo & Messman-Moore, 2007; Littleton, Horsley, John & Nelson, 2007; Perkins-Mangulabnan, & Flynn, 2007; Strand, Sarmiento & Pasquale, 2005; Little, Kohm & Thompson, 2005; Bass, Shields & Behrman, 2004; Evans, 2004; Champion, Shipman, Bonner, Hensley & Howe, 2003).

The Children's Act No. 38 of 2005, as amended does not refer to the term Children's Homes any more but embraces the new term "Child and Youth Care Centres" when referring to places of safety, industrial schools, reform schools and children's homes. However, for the purpose of this research document the term Children's Homes will be utilized as this is a unique population within the broader Child and Youth Care Centres. In terms of South African law, a residential setting for children in need, is referred to as a children's home and is defined as a facility where children who are in need of care are housed, making use of either a family structure type of household or a group hostel set-up (Meintjes, Moses, Berry & Mampane, 2007; Skelton, 2005:4; South Africa, 1997:66). Children residing in children's homes are referred to as "looked-after children", both in South Africa and abroad (Social care and health - Westminster, 2010; Department of Social Development, 2010; Office on Children's Rights South Africa, 2007; Guishard-Pine, McCall & Hamilton, 2007; South Africa, 2006). For the purpose of this research, the term looked-after children will be used. Adults, who are responsible for, live with and care for looked-after children daily, are referred to as caregivers (Social Development Portfolio Committee, 2007).

According to research reports, looked-after children often experience severe behavioural, emotional, and psychological difficulties due to a history of exposure to traumatic stress, which increases the level of difficulty of care (Strand, Spath & Bosco-Ruggiero, 2010; Halverson, 2009; McCrae, 2009; Anderson & Johansson, 2009; Sempik, Ward & Darker, 2009; Adnopoz, 2007; Guishard-Pine *et al*, 2007; Little *et al*, 2005; Stanley, Riordan & Alaszewski, 2005; Harden, 2004; Nicolas, Roberts & Wurr, 2003; Ferris-Manning & Zandstra, 2003; Hudson & Levvaseur, 2002; Annie Casey Foundation, 2002). Provision of specialised needs for looked-after children is thus apparent. However, a lack of provision for the specialised training of caregivers, regarding the needs of looked-after children, exists (Rhodes *et al*, 2001:86; Boyd-Webb, 2006:58), causing caregivers to become deprived and disheartened.

According to literature, failure to provide for the specialised needs of looked-after children could result in the intensification of trauma symptoms, as can be seen by the increase in attachment disorders, developmental difficulties and delays, poor interpersonal relationships, mental health problems, behavioural difficulties, poor academic achievement, anxiety, depression, dissociation, posttraumatic stress symptoms and sexual concerns (Anderson, 2009; McCrae, 2009; Little *et al*, 2009; Milanak & Berenbaum, 2009; Crosland, Ciagales, Dunlap, Neff, Clark, Giddings, & Blanco, 2008; Adnopoz, 2007; Linares ,Li, Shourt, Brody & Pettit, 2007; Chapman, Wall, Barth, & National Survey, 2004; Craven and Lee, 2006; Fisher, Burraston, & Pears, 2006; Harden, 2004; Evans, 2004).

The difficulty, as already indicated above, is that caregivers who are placed in a care-giving environment are not trained to identify and support children inundated with trauma symptoms (Rhode *et al*, 2001:86; Boyd-Webb, 2006:58). In addition, looked-after children experience placements as confusing, destabilising and damaging (Bass *et al*, 2004:25), since traumatic symptoms are often overlooked. The result is that the experience of trauma either continues or is exacerbated (Springer, 2007:1; Ko, Kassam-Adams *et al*, 2008:398; Fisher *et al*, 2006; Boyd-Webb, 2006:58-94). Caring for challenging children, who show problematic mental health, as well as learning and behavioural issues, complicates the care-giving role.

In conjunction with the lack of training and support, the caregivers experience great challenges.

The researcher, currently a student in Gestalt Therapy theory, and having been an intern in children's homes for the past year, has become aware of the frustrations that caregivers experience, such as the lack of information, guidance, structure and support that one needs to deal with the needs of looked-after children. From the literature it becomes evident that the focus is on the needs of foster guardians who care for children in their own homes (Brannen *et al*, 2009; Mitchell, Kuczynski, Tubbs & Ross, 2009; Brown, 2008; Davies & Write, 2008; McGreggor, Rodger, Cummings, Leschied, 2006; Dozier, 2005; Pithouse, Hill-Tout & Lowe, 2002; Hudson & Levasseur; 2002).). However, there is a lack of evidence in the assistance and support of caregivers' needs, regarding the training and care of looked-after children in children's homes. With this study, the researcher intended to explore what the training and holistic needs of caregivers in children's homes are, regarding the care of looked-after children.

1.3 PROBLEM STATEMENT AND FOCUS

Fouché and De Vos (2005:100) state that the formulation of the problem is the foundation of research and engages the reader towards the specific focus of the study. In this study, the research focused on the holistic needs of caregivers; their care of looked-after children.

In the literature, it is evident thatlooked-after children pose behavioural, emotional and psychological difficulties, due to their being exposed to multiple traumatic events. To that effect, the difficulty of providing care is increased (Strand *et al*, 2010; Child welfare South Africa, 2009; Halverson, 2009; McCrae, 2009; Anderson, 2009; Sempik, Ward & Darker, 2009; Adnopoz, 2007; Little *et al*, 2005; Stanley *et al* , 2005; Harden, 2004; Nicolas *et al*, 2003; Ferris-Manning & Zandstra, 2003; Hudson & Levvaseur, 2002; Annie Casey Foundation, 2002). The problem is that there is a lack of support and training available for caregivers to deal with traumatised children

in the welfare system (Crosland *et al*; 2008; Bisson & Cohen, 2006). The implication is that caregivers find it difficult to care for these children.

Limited literature exists, as far as the needs of caregivers, regarding training and care-giving in children's homes, are concerned. Exploring the needs and problems that caregivers face could provide a broader and more realistic understanding. This study is of a limited scope, but could serve as a pilot study for future research.

1.4 THEORETICAL FRAMEWORK, RESEARCH QUESTION, AIM AND OBJECTIVES

1.4.1 Theoretical framework

A theoretical paradigm consists of a worldview, a system of beliefs including epistemological, ontological and axiological aspects, together with practices and assumptions that are associated with that view; and could be understood as the ground from which a researcher investigates a phenomenon (Teddlie & Tashakkori, 2009:20; Mertens, 2003:139; Morgan, 2007:24). This research is grounded on constructivism (Boghossian, 2006; Kukla, 2000) and the theory of the school of Gestalt Therapy (Resnick & Resnick, 2010).

Gestalt Therapy as paradigm and worldview, implies that one holds true to three determining boundary markers, namely that of field theory, phenomenology and dialogue (Bowman & Nevis, 2005:5; Estrup, 2000; Resnick & Parlett, 1995:3), where Gestalt Therapy subscribes to constructivism (Wheeler, 1999:2). Epistemological, ontological and axiological aspects of the school of Gestalt Therapy were considered in this study(Van De Riet, Korb, & Gorrell, 1980; Perls, 1969; Perls 1973; Korb, 1975; Levitsky & Perls, 1970; Fletcher, 1966; Wertheimer, 1959; Kohler, 1925).

By focusing on constructivism and Gestalt Therapy principles, the research setting was the participants' natural environment, where field contexts of actual living were included (Field Theory). The researcher embraced the role of 'researcher as instrument', incorporating her experience (phenomenology) as participant to the

process and admitting that all observation was conditioned, to a certain degree, on the perceptual and judgemental processes of the observer (fixed gestalt/character/phenomenology). Empirical procedures were designed to describe and explore (dialogical/interviews) the experiences of the participants (phenomenological field). In this study, the qualitative approach was used, as it has epistemological roots in phenomenology and constructivism (Fouché & Delport, 2005:75; Teddlie & Tashakkori, 2009:4).

1.4.2 Research question

Research questions are used as a guide for investigations and the process of inquiry, and are concerned with some unknown aspects of a phenomenon of interest (Teddlie & Tashakkori, 2009:5; Fouché & Delport, 2005:106; Strydom, Fouché & Delport, 2005:278). For this study, the research questions were:

What are the holistic needs of caregivers, regarding the care-giving of looked-after children in children's homes?

Sub-question: What are the training needs of caregivers of looked-after children in children's homes?

1.4.3 Research aim

Fouché and Delport (2005:107) stated that the aim identifies the end result that needs to be achieved in a research project. The aim of this study was to explore and describe the needs of caregivers of looked-after children in children's homesas far as training and care-giving were concerned.

1.4.4 Objectives

Objectives are seen as steps taken and specific purposes that guide a study in achieving the desired goal (Fouché, 2005:107; Teddlie & Tashakkori, 2009:110;

Babbie & Mouton, 2004:79). Literature (Babbie & Mouton, 2001:79; Fouché & De Vos, 2005:106) proves that there are three common objectives in research; exploration, explanation and description. For the purpose of this study, the main objectives were that of exploration and description.

Exploratory research, together with descriptive research, aims to gain rich insights into the phenomenon (Teddlie & Tashakkori, 2009:6, 296; Fouché & Delport, 2005:74, 105-106; Babbie & Mouton, 2004:28). It portrays an image of the specific details of a situation, social setting or relationship (Fouché & De Vos, 2005:106) and, for this research, it gained insight into the needs of caregivers in the social setting of a children's home. The description and exploration of the needs of caregivers were achieved by conducting objectives.

Objectives that guided this study were:

a. To conduct a literature study on the theory of the school of Gestalt Therapy, looked-after children and caregivers in a children's home;

b. To undertake an in-depth empirical study, exploring the needs of caregivers of looked-after children in a children's home, regarding the holistic care-giving and specific training needs, making use of semi-structured, open-ended, one-on-one interviews and questionnaires (Greeff, 2005:286-313; Punch, 2005:169; Flick, 2009:149);

c. To analyse the qualitative data by means of heuristic inquiry (Brownell, 2008:57; Patton, 2002: 107; Gray, 2009:29; Stabile, 2009:234)in the Qualitative Data Analysis model of Miles and Huberman (Punch, 2005:197; Miles & Huberman, 1994:10);

d. To verify and describe the research findings;

e. To draw appropriate conclusions based on the research findings and make recommendations to the board of social workers, people managing children's

homes and government officials in control of the quality of care in children's homes.

1.5 RESEARCH APPROACH, DESIGN AND METHODOLOGY

1.5.1 Research approach

The research approach for this study was ideographic (Brownell, 2009:38), inductive (Lichtman, 2009:14; Flick, 2009:239; Patton, 2002:57) and a qualitative needs assessment was performed (Tutt & Rothery, 2009:155). Applied research with a descriptive (making detailed descriptions of the context and other aspects of the research setting) and exploratory (generating information about unknown aspects of a phenomenon) nature was used to gain rich insight into the phenomenon (Teddlie & Tashakkori, 2009:6, 296; Fouché & Delport, 2005:74, 105-106; Babbie & Mouton, 2004:28). The qualitative approach is interpretive and holistic and aims to understand meaning, experience and perception (Fouché & Delport, 2005:74; Patton, 2002:3). This research study aimed to understand the needs of caregivers and, for this reason, a qualitative approach best suited this study. Ideographic research focuses on the understanding of the individual as a unique and complex entity, leading to a descriptive and detailed presentation of findings (Brownell, 2009: 38). As this research focused on the understanding and description of the caregiver, it qualifies as an ideographic study. This study focused on the needs of caregivers in respect of necessities, lacks, wants, strategies and constraints of the population under study (West, 1994:3-5). In addition, the concern that caregivers of looked-after children in children's homes may not be receiving the support and training that they require to create an environment of quality care was addressed. As the study addresses a problem that needs a solution, it is of an applied nature. Applied research is generally a short study in which practical results are found, which addresses a specific concern or offers a solution to a problem (Neuman, 2003:22).

Inductive analysis involves the discovering of patterns, themes and categories in data.

1.5.2 Research design

In this research study a holistic, instrumental case study (Yin, 2008:4; Creswell & Maietta, 2002: 163; Punch, 2005:144; Teddlie &Tashakkori, 2009:25) design was used. An instrumental case study is an empirical inquiry that investigates a problem in its real-life context and occurs when cases are described in order to provide insight into a matter or phenomenon (Creswell & Maietta, 2002:163; Punch, 2005:144; Fouché, 2005:272). The researcher aimed to further understanding about a social problem (the lack of training and support for caregivers) of the population being studied (caregivers in children's homes) and concentrated on experiential knowledge of the case. Close attention was paid to the contexts (influence of its social, political, and other contexts), relying on phenomenological, heuristic descriptions (Gerring, 2007:20; Denzin & Lincoln, 2005:451; Fouché, 2005:272; Yin, 2003; Scholz & Tietje, 2002:9-10).

1.5.3 Sample

A universe refers to the totality of all elements, subjects, or members that possess a specified set of characteristics that define that universe (Wiersma & Jurs, 2008:490; Strydom & Delport, 2005:328). For the purpose of this study, the universe could be described as all caregivers who care for looked-after children in children's homes in Gauteng. The population (Strydom, 2005:193) sets boundaries on the universe and is the pool from which a sample is drawn and will be caregivers in a children's home in Pretoria. A sample is a part of the population which is considered for the study and comprises of elements of the population (Teddlie & Tashakkori, 2009:170; Strydom, 2005:193). In qualitative research, the purpose of the inquiry directs the sample size (Patton, 2002:244). In this study, 12caregivers made up the sample. Non-probability

purposive, sequential sampling was used. With this procedure, a relatively small number of units that could provide particularly valuable information related to the research question under examination and where the purpose of the research is to generate themes, are selected (Teddlie & Tashakkori, 2009:174; Strydom, 2005:202; Neuman 2003:213). The unit of analysis (Teddlie & Tashakkori, 2009:169) are caregivers of looked-after children in children's homes.

Selection criteria:

a) Subjects employed as caregivers of looked-after children in children's home.
b) Caregivers who have been providing care to children in children's homes for more than two years. This criterion was not used as there were a number of participants who had only been with the children's home for a few months, but also wanted to participate in the study.

1.5.4 Preparation for data collection

A literature review was conducted on the theory of Gestalt Therapy, looked-after children and caregivers in children's homes, to acquire a thorough and coherent comprehension of the nature and scope of the problem in this constructed field (Fouché & Delport, 2005: 123-124; Teddlie & Tashakkori, 2009:121-123). Consent was obtained from the board of social workers at a children's home, as well as the research participants. Themes for the semi-structured interview and questionnaire were considered.

1.6 DATA COLLECTION AND ANALYSIS

1.6.1 Data collection techniques

Greeff (2005:287) stated that interviewing is the main mode of data collection in qualitative research. For the purpose of this study, the researcher used an interview schedule, conducting semi-structured, one-on-one interviews making use of open-ended questions organised in areas of interest, allowing flexibility in scope and depth

(Barber & Brownell, 2008:55; Turner, 2008:29-55; Padgett, 2008:129; Greeff, 2005:292). For caregivers who wanted to participate, the interview schedule was given in the form of a questionnaire, which was completed in writing. This enabled the researcher to gather information regarding the training and care-giving needs of caregivers.

1.6.2 Managing data

The data obtained from the interviews was managed by organising the collected data into electronic audio files, which were easily retrievable from the researcher's computer. These files were converted into text, known as a transcription. These transcripts, together with the questionnaires, were reviewed many times to get a sense of information and to become familiar with the data. Thus, inductive and iterative techniques were applied until significant and recurring themes and connections occurred and were identified (Teddlie & Tashakkori, 2009:6; De Vos, 2005:337-338).

1.6.3 Qualitative Data Analysis (QDA)

Qualitative research data analysis involves categorising and contextualising strategies which result in themes and include the breaking down of narrative data into smaller units, making connections, rearranging units and producing categories to facilitate better understanding (Teddlie & Tashakkori, 2009:25; De Vos, 2005:335). This research made use of the model for QDA of Miles and Huberman (Punch, 2005:197; Miles & Huberman, 1994:10), which states that analysis consists of three current flows of activity: data reduction, data display and conclusion drawing/verification. In this model, the methodology of heuristic inquiry (Brownell, 2008:57; Patton, 2002:107; Gray, 2009:29; Stabile, 2009:234; Ryan & Bernhard, 2003)was applied where data was collected and organised, labelled and colour-coded according to key concepts. Transcriptions and questionnaires were reviewed using inductive and iterative techniques until significant and recurring themes and

connections occurred and were identified (Teddlie & Tashakkori, 2009:6; De Vos, 2005:337-338).

Sound quality inferences should capture the meaning of the phenomenon under consideration for study participants (Mertens, 2003:254; Teddlie & Tashakkori, 2009:295; Miles & Huberman, 1994:36). In this study, inference quality (credibility, transferability and trustworthiness) was measured and ensured by member-checking (Teddlie & Tashakkori, 2009:296), thick descriptions (Teddlie & Tashakkori, 2009:296) and a referential adequacy strategy (Teddlie & Tashakkori, 2009:296; Thyer, 2009:369; Eisner, 1998:110).

Trustworthiness (Creswell, 2005:189) of the study was improved by making use of data triangulation, which involves the use of a variety of data sources (Teddlie &Tashakkori, 2009:27; 75). A semi-structured questionnaire with the same questions as in the semi-structured interview schedule was given to all non-participating volunteer caregivers who wanted to participate. To ensure further trustworthiness, the researcher completed a reflexive journal that contained daily information about the investigator, regarding possible biases and methodological decisions (Teddlie & Tashakkori, 2009:297). Statistical data from the children's home, regarding the caregivers' and the researcher's experience in working at the children's home for two years, is included.

1.7 ETHICAL ASPECTS

Ethical standards ensure the well-being of the participants in a study, and are guidelines of behaviour governing the treatment of participants, and information gathered in the research (Teddlie & Tashakkori, 2009:188; De Vos, 2005:57). Different considerations are added in literature, regarding ethical concerns. According to Barber and Brownell (2008:52), the following aspects need to be considered in all research:

a. Efficiency, referring to professional effectiveness, familiarity with the field that is beginning to unfold and the current working hypotheses. The researcher

has been working at the children's home for the past two years, allowing for an in-depth knowledge of the field and the difficulties that caregivers experience.

b. Authenticity, referring to the knowledge of one's truest self, awareness of deeper motives and biases, the researcher's openness to their own experience. The researcher's reflective journal was used to consider biases and motives.
c. Alienation, referring to the trust developing between people, leading to the overlooking or dismissing of relevant data. In this study, analysed data was given to two caregivers to check the validity thereof, in order to see whether the relevant data had been overlooked.

Yontef and Bar-Yoseph (2008:197) added that it is important for a Gestalt Therapy researcher to consider:

a. The degree to which the co-researcher/participant experiences the researcher as truly understanding his or her immediate experience, thoughts, feelings, context, and life experience.
b. The extent to which the co-researcher/participant experiences the researcher as caring for and respecting him or her.
c. The extent to which the researcher is able to be present as a person to the participant is affected by the co-researcher/participant, and willingness for the co-researcher/participant to know this is relatively transparent and non-defensive, understands the co-researcher/participant's issues, and knows how to direct the phenomenological focusing and experimenting.
d. The degree to which the co-researcher/participant enters into the dialogue in such a way as to give up preconceptions, goals, support the cultivation of uncertainty, and allow something to emerge from the dialogic contact.

The above concerns of Yontef and Bar-Yoseph (2008:197) were considered as the researcher conducted this study from a dialogical stance, including the participants from within their own world and allowing them to make an impact on the researcher.

From the literature, it is evident that a number of ethical aspects are delineated (Chambliss & Schutt, 2009:48-72; Flick, 2009:35-45; Finlay & Evans, 2009:159-174;

Mertens & Ginsberg, 2008; Schutt, 2008:318-321; Crano & Brewer, 2002: 344-358; Fowler, 2002:147-153; Babbie, 2007:28; Rwomire, Nyamnjoh & Organisation for Social Science Research in Eastern and Southern Africa, 2007; World Health Organisation, 2007; Flick, 2006:45; APA, 2002; Kimmel, 1988: 106). Aspects that are included are: an obligation to society, an obligation to colleagues, an obligation to the release of findings, an obligation to a children's home, an obligation to participants, actions and the competence of the researcher.

These will be discussed briefly:

1.7.1 Obligation to society

If social research is to remain beneficial to society and the groups and individuals in it, then social researchers must conduct their work responsibly and in light of the moral and legal order of the society in which they practice. They have a responsibility to maintain high scientific standards in the methods employed in the collection and analysis of data and the impartial assessment and dissemination of findings (Chambliss & Schutt, 2009:48-72).

1.7.2 Obligation to colleagues

Social research depends on the maintenance of standards and of appropriate professional behaviour that is shared amongst the professional research community. Without compromising obligations to funders/employers, subjects or society at large, this requires methods, procedures and findings to be open to collegial review. It also requires concern for the safety and security of colleagues when conducting field research. This research will be available for review. All standards for qualitative studies were ensured.

1.7.3 Obligation to the release of findings

This obligation focuses on the written report and findings. It includes aspects such as the avoidance of bias, plagiarism, the honest reporting of findings, reporting unexpected findings, not creating fictitious hypotheses that are misleading, reporting both positive and negative findings, reporting shortcomings and errors, reporting on constraints and not making changes to any data collected or observed. The findings of this study are being released as a Master's Degree dissertation as well as a report to the children's home. Biases were bracketed and findings were honestly reported without misleading the readers, by not making changes to any data collected or observed.

1.7.4 Obligation to a children's home

The relationship of the researchers with and commitments to the children's home was clear and balanced. The relationship and commitments did not compromise a commitment to morality, to the law and to the maintenance of standards commensurate with professional integrity. In this study, a report was given to the children's home regarding the findings in order for them to improve support to their caregivers.

1.7.5 Obligation to participants

This obligation entails protecting participants from harm. Social researchers must strive to protect subjects from undue harm, arising as a consequence of their participation in research such as unnecessary risks, or mental and physical discomfort that may be inherent in the research procedure. A copy of the informed consent that participants signed is included in Appendix A. The following matters, concerning the obligation to subjects, were considered in this study:

a. Informed consent

Informed consent refers to “all possible or adequate information on the goal of the investigation, the procedures that will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subjects of their legal representatives” (Williams, Tutty & Grinnel, 1995:30). This requires that participation of subjects should be voluntary and as fully informed as possible, with no group to be disadvantaged by routinely being excluded from consideration (Babbie, 2007:26). Before an individual became a participant of this research study, they were notified of: the aims, methods, anticipated benefits and potential hazards of the research; their right to abstain from participation in the research and their right to terminate their participation at any time. A letter of informed consent was given to all participants before the study commenced and can be viewed in appendix A.

b. Harm to participants

The researcher has an ethical obligation to protect participants from psychological and physical harm (Chambliss & Schutt, 2009:48-72; Flick, 2009:35-45; Finlay & Evans, 2009:159-174; Mertens & Ginsberg, 2008; Schutt, 2008:318-321; Crano &Brewer, 2002: 344-358; Fowler, 2002:147-153; Babbie, 2007:28). This includes putting participants in situations that are stressful and anxiety provoking. Informing participants of these risks and allowing them to withdraw from research is considered as a best option for ethical research. Identifying vulnerable respondents is also necessary when conducting research.

In this study, the possibility of psychological discomfort and the creation of frustration for the participants were a possibility owing to the inquiry into needs not being met, which could trigger unfinished business. This was considered and discussed with participants before entering this study.

During the course of the research investigation the researcher became aware of signs of depression and psychological difficulty being experienced by the participants. Within the paradigm of Gestalt Therapy, depression is considered as unsatisfied needs that are being retroflected. Perls, Hefferline and Goodman (1951)

stated: “when expression is overt, there normally is a release of pent up energy – for instance, the seeming lethargy of depression will if unblocked, be replaced by what is concealed and held in check: raging or the clonic movements of sobbing. “Gestalt Therapy argues that depression is a creative adjustment to the environment leading to the retroflection of difficult and unmet needs leading to a fixed pattern of behaviour (fixed gestalt) and thus limiting the spectrum of self-functions within contact with the environment. Considering the view of Gestalt Therapy regarding depression, it is necessary to tread carefully when working with depression. The removal of a fixed gestalt and exploration of the depressive symptoms without integration could lead to the mobilization of the client into the action phase of the contact cycle, which in the case of depression may lead to suicide.

In Gestalt Therapy clients acquire knowledge and awareness of how to accept support from their surroundings and how to create a system of self-support and if sufficiently developed an exploration into fixed gestalts commence. In this research study the researcher was careful not to enter into a therapeutic process (and thus exploring the process and configuration of the clients answers,) but stayed as close as possible to felt experience and to the open relational aspects of contact. The researcher created a supportive environment, ensuring confidentiality and availability should something trigger in-depth emotions. Participants with signs of depression and psychological difficulty were referred for treatment and discussions were consequently performed with the social worker in charge of their well-being.

Discussions with participants after the completion of the investigation indicated that no harm had been done. Participants agreed that although unmet needs were discovered and unfinished business triggered, it gave them an outlet where they could express desires, needs, distress and requests.

c. Deception of participants

Aspects such as the withholding of information, misrepresentation of the truth in order to get participants to participate, giving false hope for the outcome of the research, withholding information regarding the emotional impact of research on the participants and disguising the goal of the study, are deliberate deceptions of the researcher. Unintentional deception could also occur when an aspect in the

development of the research changes. In this study, participants were informed of all aspects and goals of the research study, thus preventing deception.

d. Anonymity and confidentiality

Anonymity, meaning "without a name" or "namelessness", refers to personal identity, or personally identifiable information that is not known. This is achieved when the identities of participants are confidential, or when the researcher does not know or use their names or any characteristics that might reasonably lead the researcher or anyone to discover their identities and where the data could not be linked to the participants. In this research, anonymity could only be limited to the questionnaire participants, as the researcher had to interview the sample participants. Confidentiality was however established in reporting the data where no identifiable information was used. All names were replaced by identification numbers which was meaningful only to the researcher.

e. Debriefing

Debriefing is a one-time, semi-structured conversation, an ethical procedure that occurs at the end of a study, whereby participants are given as much information as possible about the study (Crano & Brewer, 2002:346). Participants are given the option to discuss their experience of the study, to ensure that participants leave the experiment in the same emotional state that they had entered it.

Once this research was completed, a letter regarding the findings of the research was given to all participants who had filled out the questionnaire and a conversation was held with the interviewed participants. This granted them the opportunity to express their feelings regarding the study and participation, and to allow participants to express and finish unfinished business. Debriefing was done in a therapeutic setting, allowing for connection and expression of any unfinished business.

1.7.6 Actions and competence of the researcher

Action and competence in research consider aspects of skills and supervision where researchers must be able to be objective and to refrain from making judgements towards or regarding the participants. The researcher is a qualified Psychometrist, regularly conducting interviews with clients. The researcher is also enrolled in the Masters Degree in the Play Therapy Programme at Hugenote College in conjunction with the University Of South Africa, trained to give therapy to children. The researcher has clients who receive therapy weekly and she is working under supervision both in her therapeutic and research work. Accordingly, the researcher could be considered competent and adequately skilled to have undertaken this research.

1.8 OPERATIONAL DEFINITIONS

1.8.1 Children's homes

In this research children's homes are a care option for children "without parental care, a residence or home maintained for the reception, protection, care and bringing-up of more than six children apart from their parents, but does not include any school of industries or reform school." (Children's Act, No. 38 of 2005, as amended, s 150).It is considered to be a resource for the care and treatment of homeless, orphaned, psychologically traumatised, abused and socially maladjusted children, with the goal of providing an environment that is protecting, enhances development and promotes the growth and well-being of looked-after children.

The Children's Act No. 38 of 2005, as amended does not refer to the term Children's Homes any more but embraces the new term "Child and Youth Care Centres" when referring to places of safety, industrial schools, reform schools and children's homes. However, for the purpose of this research document the term Children's Homes will be utilized as this is a unique population within the broader Child and Youth Care Centres.

1.8.2 Looked-after children

In this study looked-after children refer to children in need of care and protection in terms of the Child Care Act (The Child Care Act, 2005, s 150) and who have been removed and placed in a children's home under the direct care of a caregiver.

1.8.3 Caregiver

In this research, the term "caregivers" refers to adults living in a children's home, who are responsible for a number of looked-after children. Caregivers are responsible for the care, protection and upbringing of these children.

1.8.4 Gestalt Therapy

Gestalt Therapy is a theoretical paradigm that consists of a worldview, a system of beliefs, including epistemological, ontological and axiological aspects, together with practices and assumptions that are associated with this view (Van De Riet, Korb, & Gorrell, 1980; Korb, 1975; Perls 1973; Levitsky & Perls, 1970; Perls, 1969; Fletcher, 1966; Wertheimer, 1959; Kohler, 1925). Gestalt Therapy subscribes to three boundary markers which include field theory, phenomenology and dialogue, and has been a movement away from deconstructive views of the world toward holistic models, away from linear cause-and-effect beliefs towards field theoretical paradigms and from an individualistic psychology toward a dialogical or relational perspective (Bowman & Nevis, 2005:5; Resnick & Parlett, 1995).

1.8.5 Needs

In this research 'needs' is considered to be an umbrella term, covering necessities, lacks, wants, strategies, challenges and constraints.

1.8.6 Needs assessment

A needs assessment refers to the process where the needs of caregivers of looked-after children in children's homes were studied, analysed and where analysis was provided to the Management of the children's home, social workers and government officials in control of quality care, to assist in the future planning for the caregivers' support and training.

1.8.7 Ontology

An ontological position defines the conceptualisation of reality and the nature of being human. This encompasses the nature of the social world, existence, reality and our being (Finlay & Evans, 2009:18; Rescher, 2003:166; Armstrong, Bacon, Campbell, & Reinhardt; 1993:45-60), which in turn identifies subjects of inquiry, matters worthy of attention and methods of demonstration (Brownell, Meara, &Polak, 2008:11).

1.8.8 Epistemology

Defined narrowly, epistemology is the study of knowledge and justified belief (Fumerton, 2006:4-5; Louise, 2004:1-17). As the study of knowledge, epistemology is concerned with the following questions: What are the necessary and sufficient conditions of knowledge? What are its sources? What is its structure, and what are its limits? What distinguishes true (adequate) knowledge from false (inadequate) knowledge? Does true knowledge exist?

1.8.9 Axiology

Axiology is the study of worth, quality and value where, in social settings, it is associated with man's relation to man, considering aspects of ethics, moral and value (McDonald, 2004: 56; Bahm, 1993:3-6; Van De Riet *et al,* 1980).

1.8.10 Field Theory

Field Theory is an integrating concept which strives to bring all parts of the field together; person and situation, self and others, organism and environment, individual and communal (Parlett, 1997:16). It assumes that all things are interconnected and that the organism and the environment co-regulate one another (Joyce & Sills, 2001:24).

1.8.11 Phenomenology

Phenomenology is the study of how the world appears and is experienced by organisms (Shultz, 2004). It draws attention to the fact that no perception is entirely objective (Brazier, 1992:1). Phenomenology studies the field as experienced by a person in a specific moment, and takes as its only data what is immediately and naively experienced at that moment (Yontef, 1993:239).

1.8.12 Dialogue

Dialogue is a special form of contact that becomes the ground for deepened awareness and self-realisation (Jacobs, 1989:1-25). The dialogical attitude allows for an attempt to stay with, stand beside and accept the otherness of the being who is present (Evans, 1981), allowing a kind of permissiveness and a safe environment (Yontef, 2008), provoking an openness and honest discussion and acceptance of the worldview of the other.

1.9 OUTLINE OF RESEARCH REPORT

1.9.1 Chapter One: Introduction and rationale for study

Chapter One serves as an introduction to this research study. A brief literature overview and rationale of the research was included. The outline of the research plan was included and referred to aspects of design, methodology and analysis. Main concepts were defined, followed by an explanation of the ethical aspects of this research. The chapter concluded with a brief overview of the research report.

1.9.2 Chapter Two: Looked-after children, children's homes and the caregiver

In this chapter, literature regarding looked-after children, caregivers and children's homes is discussed. The vulnerabilities and complications were discussed showing that trauma, abuse and neglect leave looked-after children with confirmed behavioural, emotional, psychological, scholastic and developmental difficulties. As children enter care in children's homes, the system and field are far from well-structured and little resources, together with organisational dysfunction, raise concerns about the outcomes for the children. In this disorganised environment, the caregiver is left dealing with difficult children day by day, with little or no support and training, in order to provide quality care. As the caring role is the focal point of all work done in children's homes, it is seen as an instrumental place where change might happen. It may be concluded that if the needs of caregivers could be fulfilled, outcomes for looked-after children might be changed, which could lead to satisfaction and fulfilment for both caregivers and looked-after children.

1.9.3 Chapter Three: Gestalt Therapy Theory

In this chapter a philosophical grounding was established in order to reach the point of data collection and interpretation. Philosophical considerations regarding the school of Gestalt Therapy concluded that field ontology, phenomenological epistemology and dialogical axiology are assumed where the researcher embraces the attitudes coherent with the philosophy. The needs of caregivers were reflected on, reviewing the self and the challenges that are being faced in contact.

1.9.4 Chapter Four: Empirical analysis and descriptions

This chapter described methodology, research design, data collection and findings comprehensively, explaining the context and purpose of the data collection. It includes descriptions of participants and the sampling plan, followed by the trustworthiness and rigour of the study. The chapter ends with the analysis, descriptions and understandings of data.

1.9.5 Chapter Five: Conclusion and recommendations

Chapter Five includes a summary, limitations, conclusions, recommendations and an evaluation of the significance of the study. Goals and objectives of this research were tested and final remarks were included.

1.10 CONCLUSION

Chapter One served as an introductory orientation to this study. The overall aim and objectives of this study was considered in the qualitative framework and rested on the philosophical grounding of the school of Gestalt Therapy. In Chapter Two, a comprehensive literature review will be given, discussing looked-after children, children’s homes and caregivers.

CHAPTER TWO

LOOKED-AFTER CHILDREN, CHILDREN'S HOMES AND THE CAREGIVER

"I have yet to see any problem, however complicated, which, when looked at in the right way, did not become still more complicated"

Poul Anderson (1968:59)

2.1 INTRODUCTION

In this chapter, literature, regarding looked-after children, children's homes and caregivers will be reviewed. The literature review will consider looked-after children and the difficulties they experience. Literature on children's homes will be discussed considering the goals and organisational functioning thereof, as well as positive and negative attributes. Lastly, the caregiver will be reviewed, considering the components of caring and their role in children's homes. The challenges, training and support needs of the carers will be reflected on, in order for the reader to gain an understanding of the reality of caring for difficult children.

2.2 LOOKED-AFTER CHILDREN

2.2.1 Definition

Different terms have been used to define children living in children's homes. Terms that are used in the literature are: looked-after children, children in need, foster children and care children (Social care and health - Westminster, 2010; Department of Social Development, 2010; Office on Children's Rights South Africa, 2007; Guishard-Pine, McCall & Hamilton, 2007; South Africa, 2006; Brennan, 2002). For the purpose of this study, the term 'looked-after children' (LAC) will be used. An abstract from the Child Care Act (The Child Care Act, 2005, s 150) follows, defining

children in need of care and protection, and is an important definition for this research.

*Child in need of care and protection (Child Care Act, 2005, s 150)*150.(1) A child is in need of care and protection if, the child

(a) has been abandoned or orphaned and is without any visible means of support;

(b) displays behaviour that cannot be controlled by the parent or care-giver;

(c) lives or works on the streets or begs for a living;

(d) is addicted to a dependence-producing substance and is without any support to

obtain treatment for such dependency;

(e) has been exploited or lives in circumstances that expose the child to exploitation; lives in or is exposed to circumstances which may seriously harm that child's physical, mental or social well-being;

(d) may be at risk if returned to the custody of the parent, guardian or care-giver of the child as there is reason to believe that he or she will live in or be exposed to circumstances, which may seriously harm the physical, mental or social well-being of the child;

(h) is in a state of physical or mental neglect; or

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

(2) A child found in the following circumstances may be a child in need of care and protection and must be referred for investigation by a designated social worker:

(a) a child who is a victim of child labour; and

(b) a child in a child-headed household.

(3) If, after investigation, a social worker finds that a child referred to in subsection (2)is not a child in need of care and protection, as contemplated in subsection (l), the

social worker must, where deemed necessary, take measures to assist the child, including counselling, mediation, prevention and early intervention services, family reconstruction and rehabilitation, behaviour modification, problem solving and referral to another suitably qualified person or organisation.

Statistics in South Africa confirm that there are currently in the region of 458000 children in foster care and residential care facilities (South Africa, 2005:14) who were exposed to trauma to an extent that warranted removal from their homes by statutory organisations (South Africa, 2007-2008:14). Children in need of care and protection can only be removed and placed into a children's home with a court order. The act on the Constitutional rights of children states that children have the following rights, which protect those who are being removed and placed into care:

a. Section 28(1)(b): The right to appropriate alternative care when removed from the family environment,
b. Section 28(1)(c): The right to basic nutrition, shelter, basic health care services and social services,
c. Section 28 (2)(d): The right to be protected from maltreatment, neglect abuse or degradation,
d. Section 28 (2): The child's best interests are of paramount importance in every matter concerning him or her.

Thus, when considering the definition of children in need of care and protection, together with their rights, it is seen that protection of this vulnerable population becomes important. An increased understanding regarding this population might increase the ability to care for and protect these children and will be discussed in the next section.

2.2.2 Understanding looked-after children

Looked-after children are children in need of care and protection and have been removed and placed in children's homes, which is one of the options available for alternative care. Children and youths, whether in their own homes or in children's homes, have the same basic life requirements for development, personal care, social

and intellectual stimulation and a sense of rootedness, as care is fundamental to each human life (Maier, 1991:27; Vestelen in Halvorsen, 2009:76; Daniel, Wassell & Gilligan, 1999).

Abraham Maslow's hierarchy of needs (1968) indicates that it is important to have basic needs met as this helps protect against psychosocial transitions in life. Psychosocial transitions can be considered as the losses and traumas of life, together with the demands placed on adaptation to new circumstances (Guishard-Pine, McCall & Hamilton; 2007:28-29). According to Guishard-Pine *et al* (2007:29), protective factors are those external and internal resources that limit our vulnerability to long-term psychological problems. Figure 2.2.2 illustrates children's mental health protective factors, which include: family, school, community, genetics and includes fulfilled needs, together with the care they receive. In most of looked-after children's lives, these are risk factors and do not add to their protection. Many other variables could be included in each hexagon. Each factor will have an effect on the child, but how these effects represent themselves, how powerful or weak their effect, will depend not only on the factor itself, but the unique child and how the other factors combine (Guishard-Pine *et al,* 2007:29).

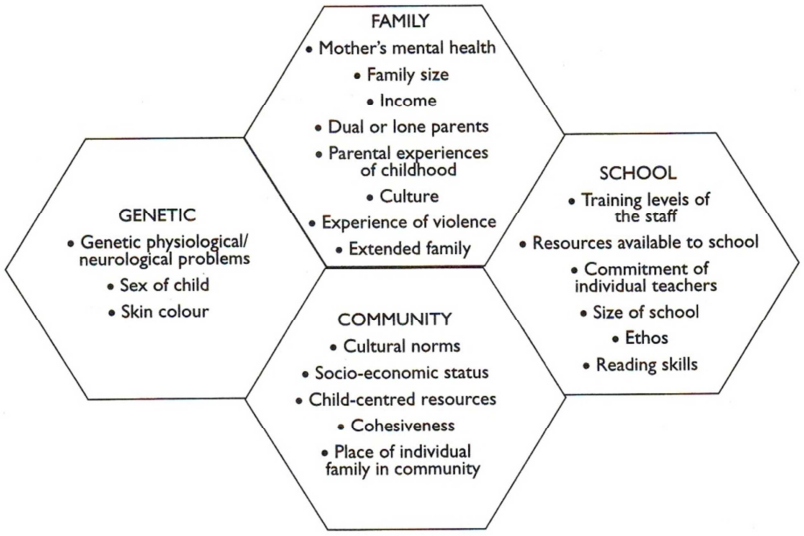


Figure 2.2.2 Interlinking systems/networks affecting the child's mental health: protective- and risk factors.

Literature on children entering care, confirms that most are traumatised or become traumatised following their introduction into a children's home (Maluccio, 2006:3). Thus, if looked-after children, who were declared children in need of care and protection, are removed due to a history of abuse, neglect or trauma (Teggart, 2006:153), it can be said that there has been sustained failure in meeting their basic needs and therefore compromising protective factors (Guishard-Pine *et al*, 2007:33). The background of trauma and disrupted attachment, combined with significant levels of disturbance, gives rise to high rates of mental health problems (Nicolas, Roberts & Wurr, 2003:78-83).

Trauma refers to emotional wounds that are caused by painful and frightening experiences. A traumatic event is one that threatens actual death or serious injury to an individual or to others, and in which the individual who is traumatised, experiences intense fear, helplessness, or horror. As a result of the terrifying experience, the person develops a variety of symptoms (Boyd Webb, 2006:14) as seen in Appendix B, (Symptoms of Trauma among children and adolescents during developmental stages, Cameron, Elkins & Guterman, 2006:56).

Literature abounds in evidence, regarding the symptoms that follow traumatic experiences (Littleton, Horsley, John & Nelson, 2007:985; Crenshaw & Hardy, 2006:189; Guishard-Pine *et al,* 2007:78; Solomon & Heide, 2005:51-60; Perry, Pollard, Blakley, & Vigilante, 2000,1995; Ko *et al*, 2008:397; Cameron *et al,* 2006:57; Briere, Kaltman & Green 2008:223; Lauterbach, 2001:5-18; Lieberman & Van Horn, 2004:117; Greenberg & Paivio, 1997). These traumatic experiences may be thought of primarily as pertaining to some of the DSM-IV-TR diagnostic criteria for PTSD and complex PTSD (Cameron *et al*, 2006:57; DeRosa & Pelcovitz, 2006:221), which are symptoms related to: the re-experiencing of traumatic events; the avoidance of stimuli and the numbing of responsiveness; increased arousal and difficulty with affect modulation and behavioural control; alterations in attention, consciousness, self-perception and in systems of meaning (APA, 2000).

There is a vast body of literature confirming severe behavioural, emotional, psychological, scholastic and developmental issues of looked-after children, due to a history of exposure to traumatic stress (White *et al*, 2009:38; McCrae, 2009:17-28; Halvorsen, 2009; Anderson, 2009; Sempik, Ward, & Darker, 2009; Boyd-Webb,

2009; Little *et al*, 2009; Ko *et al*, 2008; Litz, 2008; Briere *et al*, 2008; Zeanah *et al*, 2008; Springer, 2007; Milburn, Lynch, & Jackson, 2008:31-33; Rushton Minnis, 2008:493; Guishard-Pine, McCall, & Hamilton, 2007:77-91; Adnopoz, 2007; Clemmons *et al*, 2007; Littleton *et al,* 2007; Perkins-Mangulabnan, & Flynn, 2007; Perry, 2006:27-52; Strand *et al*, 2005; Little *et al*, 2005; Leslie, Gordon, Meneken *et al*, 2005; Stanley *et al*, 2005; Curtis, McMillan, Zima, Scott *et al,* 2005; Lieberman & Van Horn, 2004:112; Burns, Phillips, Wagner, Barth, Kolko, Campbell & Landsverk 2004; Evans, Scott, Schultz, 2004; Blower, Addo, Hodgson, Lamington, Towlson,2004:117; Bass *et al,* 2004:10; Mount *et al, 2004;* Meltzer, 2003; Schore, 2003; Champion, Shipman, Bonner, Hensley & Howe, 2003; Hudson & Levvaseur, 2002; Annie Casey Foundation, 2002; Nicole *et al*, 2000; Cooper, 2000:259; Stein *et al,* 1998) These symptoms and difficulties leave this population of children severely vulnerable and disadvantaged (Mekki, 2004:121; Farris-Manning & Zandstra, 2003).

According to Bowlby (1966:11), the essential key to mental health is that infants and young children experience a warm, intimate and continuous relationship with their mothers (or permanent mother-substitute) in which both find satisfaction and enjoyment, leading to a secure attachment. Most relationships of looked-after children were disrupted due to experiences such as abuse and neglect (Teggart, 2006:153), leaving the child more exposed to behavioural, emotional, psychological, scholastic and developmental difficulties (Milburn *et al*, 2008). Refer to Appendix C; on the common implications of child abuse. Attachment (between two individuals) involves a state of mutual dependence felt by individuals and provides a sense of rootedness. Genuine attachment experiences are vital for sound development and mental health (Maier, 1991:36). Abuse, neglect or punitive parenting is associated with insecure attachments, with the child displaying difficulties in dealing with changes, withdrawal and aggression, failure at school, loss of significant relationships, a poor self-esteem, inadequately developed intellectual,-interpersonal and emotional skills, and possibly extreme watchfulness (Guishard-Pine *et al*, 2007:44; McWey, 2000; Teggart, 2006:153). Whereas secure attachment is associated with trust, emotional regulation, self-reliance, relational intimacy, interpersonal competence, language and cognitive competence, self-confidence, Prior and Glaser (2006:174-176; 192-217) listed studies indicating that insecure attachments lead to hostile and antisocial behaviour, aggression, negative affect,

anger, scape-goating of peers, hesitance about engaging, anxiety disorders, oppositional defiant disorders and dissociation.

Considering the fact that looked-after children have a history of exposure to traumatic experiences, where their primary relationships were disrupted, leading to attachment difficulties, it could be assumed that looked-after children face complex challenges. These challenges include: separation from their parents or caregivers (Chapman *et al,* 2004:295; Teggart, 2006:153), facing different kinds of losses (Guishard-Pine *et al*, 2007:80), arriving at children's homes where everything is different (Wheal, 1995:13), adjusting to a new family system and living situations (Guishard-Pine *et al*; 2007:80), facing the psychological challenge of adjusting and coping with the range of traumatic events that led to their entry in the welfare system, and competing loyalties between the biological family/caregiver and new connections (Chapmen *et al,*2004:294). Thus, the importance of addressing mental health concerns becomes apparent as the psychological impact of these challenges is likely to continue to affect the children's behaviour, thoughts and feelings (Guishard-Pine *et al,* 2007:3, 78).

2.2.3 Assessment and treatment of looked-after children

As indicated above, looked-after children often reveal severe behavioural, emotional, and psychological difficulties due to a history of exposure to traumatic stress and pose overwhelming challenges to both welfare workers and caregivers. The importance of addressing the needs of looked-after children is well known, and failure to provide for their specialised needs could result in the intensification of trauma symptoms.

In order to begin treatment of these symptoms and difficulties, assessment becomes a necessity. An assessment is a set of procedures that usually involves a variety of activities intended to gain reliable information that can be used in making recommendations on the best way to proceed (Guishard-Pine *et al*, 2007:122; mount, Lister & Bennum, 2004). Studies conducted in the United States of America (USA) show that in less than half of the cases where children were removed,

comprehensive physical, mental health and developmental examinations of all children were required (Leslie, Hurlburt, Landsverk, Rolls, Wood & Kelleher, 2005; Leslie, Hurlburt, Landsverk, Barth & Slymen, 2004). However, no generally accepted, evidence-based model exists for assessing these children (Rushton & Minnis, 2008:493). Although studies suggest models of assessment (Goodman, Ford, Corbin & Meltzer, 2004; Bonnet & Welbury, 2004; Mekki, 2004:119; Boyd Webb, 2006:15;Cameron, Elkins & Guterman, 2006:61; Strand *et al*, 2005:55-78; Perry, Conrad, Dobson, Schick & Ryan, 2000), these are rare and evidence suggests that difficulties are commonly overlooked (Evans, 2004; Horowitz, Bell, Trybulski *et al*, 2001; Horwitz, Owens,, & Simms, 2000).

Mental health service waiting lists and limited resources for on-going psychotherapeutic work prevent or delay the appropriate assessment and treatment of these difficulties (Barber, Delfabbro, & Cooper, 2001:785-790). Blower *et al* (2004:127) stated that the main gap in the current service provision is in delivering effective interventions to children whose mental health problems have already been well identified, but which are persistent, disabling and difficult to manage. As mental health services are not a requirement for looked-after children on removal to alternative care, it is not widely available, which leaves these children vulnerable and exposed in the care of their new caregivers

2.3 CHILDREN'S HOMES

2.3.1 Definition: National context

Children's homes are referred to as group homes, residential care facilities, family-structured group homes, orphanages, places of care, or children's homes. For the purpose of this study, the term children's homes will be used.

The international child welfare sector considers children's homes as a care option for children 'without parental care'. This term, according to International Social Service and UNICEF (2004), encompasses all children living without their parents, for whatever reason or circumstances. In terms of the South African law, a residential

setting for children in need is referred to as a children's home, and is defined as a facility where children who are in need of care are housed, making use of either a family structure type of household or a group hostel set-up (Meintjes *et al*, 2007; Skeleton, 2005:4; South Africa, 1997:66). In terms of section 1 of the Child Care Act, 1983 (Act No 74 of 1983), a children's home is any residence or home maintained for the reception, protection, care and upbringing of more than six children apart from their parents, but does not include any school of industries or reform school. It is considered to be a resource for the care and treatment of homeless, psychologically traumatised, abused and socially maladjusted children (Epprecht, Matlakala, Moremi, Muller, Nieuwoudt, Raganya, Rich & Timm, 2001).

Children's homes in South Africa are governed by a clear, regulatory framework, which is discussed in detail in chapter 5 of the Child Care Act, 1983 (Act No 74 of 1983) and its associated regulations, together with the Minimum Standards for Child and Youth Care Draft Policy (1998). Although the South African government instructed the implementation of this policy, it was never formally completed and only released in draft form. In order to operate legally, these children's homes must be registered with the Department of Social Development, abiding to specifications as seen in Appendix D (Service Specifications, 2010/2011, for children's homes/child and youth care centres).

Children's homes in South Africa were declared as an 'essential service' (Government Gazette, 27104) of "which the interruption would endanger the life and personal safety of the whole or part of the population" (Labour Relations Act; 1995 (Act No 66 of 1995)).This indicates that children's homes are seen as a basic service provision, where staff are not allowed to strike or stay away from work, as this could harm the children in care.

Official data about South African children's homes is imprecise and consolidated statistics, regarding the number of children's homes, is not available. Although the law states that all children's homes must be registered, there are a number of facilities that are not complying with standards and cannot be supported and monitored by the State (Meintjes, Moses, Berry & Mampane, 2007). Pillay *(*2003) provided a table, indicating the number of registered children's homes countrywide, which date back to 2003.

Table 2.3.1 Registered children's homes in South Africa, 2003 (Pillay, 2003)

Provinces and numbers of children's homes	
Gauteng	53
The North West	4
Mpumalanga	4
Limpopo	8
The Free State	14
KwaZulu-Natal	48
The Western Cape	40
The Eastern Cape	24
The Northern Cape	9
Total	204

In a government research project, a quality assurance study for children's homes in all provinces was completed to see whether children's homes were sufficiently adhering to quality standards (Government, 2010; Appendix E). This study indicated that most children's homes did not provide quality administration and care.

Children's homes in South Africa form an important aspect of protection and service to vulnerable children, and are encouraged and motivated to provide quality care by ascribing laws and policies for their management. In order to understand what quality care involves; it is necessary identifying the goals and functions of children's homes. This will be discussed in the next section, following an introduction to the literature, regarding the organisational frameworks of children's homes.

2.3.2 Goals and functions of children's homes

When considering the goals and functions of children's homes, it is important to reflect on the reasons for the existence of these institutions. The Child Care Act, 1983 (Act No 74 of 1983) states that children's homes exist for the reception, care and upbringing of children in need, which indicates that children's homes are primarily there for the children in their care and should be the focus of resources. In terms of the Act on the Constitutional rights of Children, together with the purpose of existence of children's homes, it can be said that children's homes should, as their first and fundamental goal, ensure the protection, development and well-being of looked-after children in their care.

According to literature, some goals include:

a. providing care, protection and control (Rushton & Minnis, 2008);
b. enhancing health and development (Aldgate, J. 2006:17);
c. providing more than just the basics, and measurably improving the quality of life (McSherry & Larkin, 2006:135);
d. building on children's strengths, helping them overcome problems and leaving them in a better condition than when they entered (Terpstra, 1999:1);
e. creating a positive environment, promoting a capacity for mastery and a sense of integrity (Fulcher & Ainsworth, 2006; Simmerman & Cohler, 2000);
f. fulfilling the need to provide warmth, and encouraging the acquisition of valuable skills (Sinclair, 2005);
g. fulfilling the need to provide a child with a safe environment (Nunno, Holden & Leidy, 2003; McSherry & Larkin, 2006:135);
h. providing effective preparation for independence, given the accumulated evidence, which suggests that children's homes could often leave young adults ill-equipped for independent living (Pinkerton, 2002; Pinkerton & McCrea, 1999; McSherry & Larkin 2006:135).

Gelles (1999:60) mentioned that looked-after children's needs focus on safety, protection from harm, permanence and stability.

It seems that both the literature and the government agree that the goals of children's homes should focus on looked-after children, providing an environment that is protecting, enhances development and promotes growth and well-being. According to Weiner (1991:91), children in group care often face largely nonresponsive, depersonalising environments. In order to provide such an environment to looked-after children, it becomes necessary to consider the context, which could create this culture of care. The following section will focus on organisational information, in order to provide an understanding of the way in which children's homes function.

2.3.3 Organisational considerations

Children's homes are set in a wider field where different institutions have an impact on its organisation. Knowledge of organisations and how they function is important (Friedmann, 1991:239), as 'the interconnectedness of a set of elements that is coherently organised in a way that achieves something' (Meadows, 2008:11) is explained. For the purpose of this research, the, 'something' refers to the goals of children's homes, in other words, protection, development and the well-being of looked-after children, where the set of elements could be described as:

a. the justice system;
b. the welfare system;
c. the health system;
d. the education system;
e. the biological family system;
f. the system of the children's home;
g. the different family systems in the children's homes.

Thus, in order for the children's homes to provide an environment that is protecting, development-enhancing, promotes growth and well-being, all systems need to be aligned with the primary goal. Literature describes this alignment as 'the corporate parent', where systems join up and collaborate to provide looked-after children with the possibility of well-being (Guishard-Pine *et al*, 2007:109; also refer to Appendix F:

The corporate parent: professional subsystems as a protective shield; Guishard-Pine *et al*, 2007:110). It is not in the scope of this study to investigate the whole field and how their interconnections function to create a culture ascribing to these goals, but to focus on the context of children's homes. Thus, considering the holistic field of children's homes, different aspects play a role in the construction of the environment, which includes the model of care, the board of the children's home that is responsible for the management, the board of social workers, the caregivers and looked-after children, all influencing each other.

Literature considers two different models of children's homes: traditional models of group child care (TGCC) and family centred group child care (FCGC); (Ainsworth, 1997; Epprecht *et al*, 2001; Meintjes *et al*, 2007; Skelton, 2005:4; South Africa, 1997:66) The focus of this study is on family centred group child care which, according to literature (Devine, 2004), enhances a sense of belonging and safety for looked-after children. Thus, if protection, development and the well-being of looked-after children are considered to be the goal of children's homes, family centred group care seems to enhance these goals and could be regarded as in the child's best interests.

Organisational options that could possibly provide an environment that enhances the goals of children's homes is available in the literature (Ackoff, Addison & Bibb, 2007; Harden, 2004:31; Watson, 2003; Anglin, 2002; Whitaker, Archer & Hicks, 1998; Davison, 1995:50,128; Argyris, 1990), and addresses matters such as developmentally sensitive policies, practices designed to promote the well-being of the children; frameworks of appropriate routines and behavioural boundaries, focusing on the social, physical, emotional and intellectual needs of the children; appropriate documents and guidelines providing a sufficient quantity of information to enable the provision of quality care, quality of staff employed in the establishment and the creation of professionally skilled, knowledgeable, empowered and appropriately supported staff; consistency, guidelines and standards for congruency across processes and operations.

In children's homes that make use of the family centred group child care, a dynamic environment is provided where looked-after children may experience family life. Franshel and Shinn (1978:496) stated that "we can think of no greater influence on

the well-being of children while they are in care, than those who directly minister to their needs." The caregiver is fundamental in the children's home and could contribute greatly to building an environment that provides protection, development and the well-being of looked-after children. Literature proves that the caregiver is the focal point of all work done in children's homes (Guishard-Pine *et al*, 2007:35; Chapmen *et al,* 2004:295; Davison, 1995:60; Maier, 1991:28) Organisational functioning in children's homes is an important aspect to consider as it influences the culture of the home. The ways of running and resourcing children's homes could enhance their quality and, in this manner, contribute to the continuing debate about their purpose and potential. If children's homes are considered to be providing environments that protect, enhances development, promotes growth and well-being, these goals should be considered on all levels of the system. According to the researcher, management, social workers, caregivers and all related aspects should be designed to focus on this goal in order to establish a stable framework providing congruence across processes and operations throughout the organisation.

2.3.4 Positive and negative attributes of children's homes

Children's homes suffered from a collapse of confidence (Iwaniec, 2006:4) and heavy criticisms contributed to the different reasons for the reduction thereof. A critique against children's homes is that there was no consensus on the theoretical base on how to raise children in institutions; neither a coherent philosophy on how to run homes. In addition, running costs are high, the recruitment of and constant replacement of well-trained, skilful and experienced staff is difficult, the abuse of children by the child-care workers and malpractice in behaviour management, resulted in the vulnerability to this scandal (Iwaniec, 2006:4; Rushton and Minnis, 2008:490; Sinclair & Gibbs, 1998; Gibbs & Sinclair, 1999). This led to a conclusion that children's homes are ineffective or at worst, positively harmful, and a swing to a family resulted in the best ideology. This has made children's homes a disfavoured option and has led to the rapid decline of children's homes in many countries (Rushton and Minnis, 2008:490).

An overwhelming amount of research raises concerns about looked-after children in children's homes (Brannen, Mooney, & Statham; 2009; International HIV/AIDS Alliance & Family Health International, 2006; Johnson, Browne, Hamilton-Giachritsis; 2006:34-60; Teggart, 2006:147; Teggart, 2006:154; UNICEF, 2006a; Sinclair, 2005; International Social Service & UNICEF, 2004a; UNAIDS, UNICEF, & USAID, 2004; UNICEF & UNAIDS, 2004; Williamson, 2004; International Save the Children Alliance, 2003; McCrery, 2003; Rushton & Minnis, 2002:487; Meltzer, 2003; Scholte & van der Ploeg, 2000; Hobbs, Hobbs & Wynnes, 1999; McCann, & Pearlman, 1999). When considering the above, it is clear that the experiences of children's homes can be associated with a range of detrimental effects on the protection, development, growth and well-being of looked-after children. Literature on the role classification and support of caregivers was not found, and the researcher assumes that this could also have contributed to the failure of children's homes. There is, however, a body of research that indicates positive outcomes for looked-after children (McSherry & Larkin, 2006:136; Little *et al*, 2005:202; Richardson & Lelliot, 2003; McKenzie; 1999:103-126; Bronfenbrenner, 1979).

Bearing in mind that both positive and negative implications were found in the research, it is not clear whether the institution itself is under question or whether entry factors of looked-after children are the cause of unfavourable outcomes. Bronfenbrenner (1979) argued that children brought up in a high-quality care-giving environment are on a positive developmental path that has the potential to produce long-term positive outcomes. This, together with the research on the impact of the caregiver (Franshel & Shinn, 1978:496; Anglin, 2002; Devine, 2004; Smith, McKay & Chakrabarti, 2004; Little *et al,* 2004), forms a basis for developing environments that are protecting, enhances development promotes growth and well-being indicating that children's homes could have positive effects on looked-after children.

2.4 CAREGIVERS

2.4.1 Understanding caregivers and the components of caring

As seen in previous discussions, looked-after children pose overwhelming challenges to caregivers, which indicate that caregivers ought to be especially careful when considering their own needs and protective factors. Figure 2.4.1 below indicates possible protective factors that caregivers must take into account. These factors, together with Maslow's (1968) needs being met, enable caregivers to provide high-quality caring environments for looked-after children.

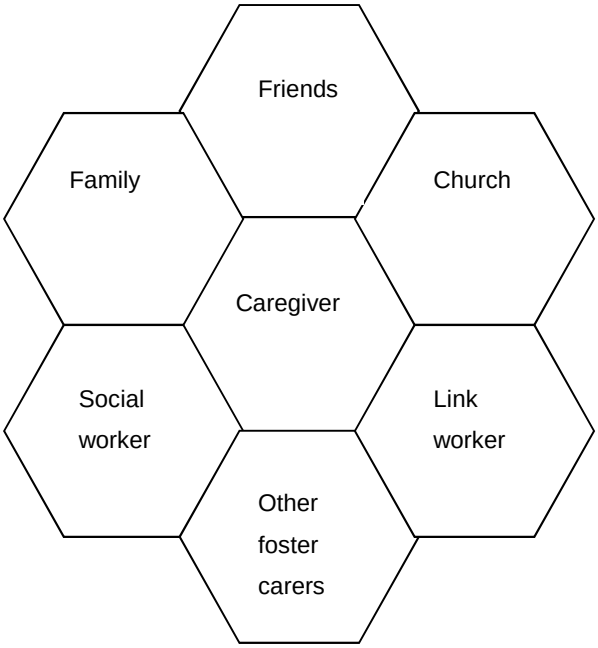


Figure 2.4.1 The caregiver's protective shield (Adapted from Guishard-Pie, McCall & Hamilton; 2007:36).

Caregivers in children's homes are the front-end workers caring for looked-after children daily. They are the people who have to provide physical, emotional and social factors that contribute to the well-being of looked-after children. In family based children's homes, caregivers are placed with a group of children in a house, where they function as a unit that could be described as a family. Research suggests that relationships between youths and caregivers are among the most beneficial

aspects of the children's home experience (Devine, 2004; Smith, McKay & Chakrabarti, 2004; in Little *et al* 2004:203; Anglin, 2002; Whittaker, 2004:17; Franshel & Shinn, 1978: 496), where true effectiveness and success depends on the quality and efficacy of the relationship between caregivers and looked-after children. Caregivers are in daily, direct, intimate contact with distressed children and youths, ministering directly to their needs, indicating that they may become the parent substitute for attachment. In previous discussions it was seen that children need a relationship that is caring and protecting, in order to establish an attachment. The person a child attaches to is known as an attachment figure. Howes (2008: 317-332) describes qualities of carers, who qualify for attachment figures, as:

a. The provision of physical and emotional care
b. Providing continuity or consistency in a child's life
c. Emotionally investing in the child

Hence, if caregivers are able to provide trusting relationships and are consistent and nurturing, it might lead to a number of positive developmental outcomes. Moreover, research suggests that positive and consistent caregiving has the potential to compensate for factors that have a deleterious impact on children (Harden, 2004:33; Bowlby, 1969/1982: 376-377; Ainsworth, 1989; Prior & Glaser, 2006:57; Weiner, 1991:88).

Research indicates that the role of the caregiver has a great influence in determining organisation or disorganisation of attachment security (Prior & Glaser, 2006:41). In childhood, both attachment and caregiving are predicated on the child's need for safety, protection and sense of security (Prior & Glaser, 2006:59). Care, provided in a context devoid of the emotions associated with affectional bonds such as joy, emotional commitment or love, may be termed instrumental care and may be found in some alternative caregiving arrangements. Love without protection leaves the child vulnerable to physical and psychological harm, whilst instrumental caregiving leaves the child vulnerable to feeling unloved and unworthy (Prior & Glaser, 2006:59-60). As seen in previous discussions, looked-after children struggle with attachment difficulties and trauma symptoms. The caregiver might be affected by the intensity of these symptoms which could cause psychological burnout and exhaustion. Tracy and Johnson (2006:119) drew up a table indicating the potential effects of trauma

symptoms on parenting (Appendix G). As caregivers could be regarded as substitute parents, potential effects that influence parents may also have an impact on caregivers (Morgan, Robinson & Aldridge, 2002).

2.4.2 The role and qualities of caregivers

Research suggests that caring is the focal point of all work done in a children's home (Davison, 1995:60), as caregivers form the central person for caring and attachment formation. They are the major norm conductors for group life, and are the legitimate representative of the norms of the larger context (Maier, 1991:28).

In order to provide quality care and an environment that is protecting, enhances development and promotes growth and well-being, caregivers assume different roles, exhibiting different qualities. Literature on the roles and qualities of caregivers considers aspects, such as, building relationships, setting norms, maintaining a link with society, managing, nurturing, understanding each child's needs, being emotionally available, teaching cultural and moral systems, being authoritarian, having a basic parenting capacity, ensuring safety, emotional warmth, stimulation, guidance, stability, practising sound professional practice, empowering children and sensitivity, as some of the most important aspects of the caregiving role (Clarke Stewart & Allhusen, 2005:127-132; Mekki, 2004:119; Chapmen *et al,* 2004:295; Paratz, 2000:37; Tronto, 1993; Maier, 1991:55-69; Barnes, 1993:128).

The factors mentioned above indicate the tremendous pressure caregivers have to face daily. In addition, expectations for sound professional practice and being a substitute parent may increase the pressure and stress caregivers live under. Some additional challenges will be mentioned briefly.

2.4.3 Challenges of caregivers

Being a caregiver is a demanding and emotionally stressful occupation (Brannen, Mooney & Statham; 2009:119). Given problematic backgrounds of looked-after

children, the caregivers in children's homes are confronted with numerous problems in caring for and managing the children (Rushton & Minnis, 2008:490), which are divided into three categories, namely challenges, as far as the children are concerned, challenges concerning personal health, as well as managerial and organisational challenges.

Literature on the challenges regarding looked-after children include aspects of behavioural, emotional, social, cultural, religious and developmental difficulties causing uncertainties and complicated relationships, where children may want to be cared for, but reject the care at the same time, (yielding a push-and-pull), making care work more complex (Rushton & Minnis, 2008:490; Guishard-Pine *et al*, 2007:41; Sinclair *et al,* 2005; Bass *et al*, 2004:11; Wheal, 1995:60,95; Maier, 1991:28). These difficulties are sources of significant burdens for caregivers and may lead to and be the cause of health difficulties.

Challenges regarding the personal health of caregivers include both physical and emotional aspects. The work of McCann and Pearlman (1990) and Saakvitne and Pearlman (1996) on vicarious traumatisation and compassion fatigue (Figley, 1995; 2002), indicates risks to caregivers involved in treating and caring for traumatised children. The emotional impact of working with looked-after children has the potential to inhibit sound care practices (Emmanuel, 2002) and could lead to burnout, depression and other psychological and physiological difficulties (Larkin, 2006:47; Kwok & Wong, 2000; Teggart & Menary, 2005; McCarthy, Janeway & Geddes, 2003; Lewis, 2000; Goodman, 1999). Stress in the areas, mentioned above, has been known to be associated with increased child-directed hostility, negatively expressed emotion, coercive parent-child interaction styles, and lack of warmth and availability, and child maltreatment (Larkin, 2006; Calam, Bolton, Barrowclough & Roberts, 2002; Rodgers, 2002).

In conjunction with challenges concerning looked-after children and personal health, caregivers are being employed, and therefore managed by children's homes. There is, however, a gap between the principles and guidelines offered by management and the daily practice of caring for children. A lack of consensus in children's homes as to what the critical ingredients of care and treatment should be, together with the differences in theoretical frameworks, traditions and approaches, lack of support and

training, complicates the role of the caregiver (Andersson & Johnsson, 2008:117; Whittaker, 2004; Hudson & Levasseur, 2002:853; Annie Casey Foundation, 2002; Rhodes *et al*, 2001).

The aspects and challenges of caregiving, mentioned above, need to receive attention and consideration as it could lead to caregivers feeling overwhelmed and unsupported. Challenges could be successfully addressed by training, supervision and support and will be discussed briefly.

2.4.4 Training and support

The caregiver in children's homes may be the best target for providing training, support and mental health consultation, because they are likely to have the greatest influence in helping the young person to develop self-understanding and prospects for change (Wilson, Petrie, & Sinclair, 2003; Rushton and Minnis, 2008:494). Even though research (Wilcox, 2008:417; Rhodes *et al,* 2001:110) indicates that training for caregivers increases confidence and positive interactions, there is still a lack of training available for caregivers (Rushton & Minnis, 2008:494; Teggart, 2006:159; Burns *et al*, 2004; Hills & Child, 2000; Davison, 1995:71; Golding, 2004). Literature (Clarke-Steward & Allhusen, 2005:1333-137; Peters & Madle, 1999), confirms that the most efficient caregivers are those who are more educated, trained and experienced.

Considering the challenges caregivers have to face, specialised knowledge and skills are required to prevent and manage challenges (Nunno *et al*, *2003)*. Different concepts for training have been proposed in literature (Greenwald, Maguin, Smyth, Greenwald, Johnston & Weiss; 2008:1-11; Rushton & Minnis, 2008:494; Ko *et al*, 2008:396; Wilcox, 2008:417; Guishard-Pine *et al,c2007*:83; Clarke-Steward& Allhusen, 2005:133; Wilson, Petrie, & Sinclair, 2003; Rhodes *et al*, 2001:110) and include aspects such as, caregiving demands, trauma-informed perspectives and behaviour management and development. The lack of competence of caregivers might present a danger to looked-after children, who are subjected to inappropriate responses and thus receiving a less than appropriate level of care and control (Davison, 1995:72). Few studies focus on the assistance and support of caregivers

in children's homes (Crosland *et al*, 2008:410), leaving caregivers unsupported and untrained in dealing with the challenges they face.

Since support in general is perceived as encouraging, it may well be likely to enhance psychological well-being, feelings of control and a good self-esteem, whereas the absence of support may contribute to factors such as loneliness, depression and despair (Larkin, 2006:53; Ceballo & McLoyd, 2002; Crouch, 2002; Weinman, Write &Johnson, 1995). Different kinds of support are established in literature where intrinsic supports include open communication and rapport; being participants in decision-making; being valued for their opinions and knowledge. Extrinsic support includes adequate training (Herczog *et al*, 2001; Orme and Buehler, 2001; Rhodes *et al*, 2001; Tracy, MacGregor, Rodger, Cummings & Leschied; 2006:354; Rhodes *et al*, 2003; Ferris-Manning and Zandstra, 2003; Hudson & Levasseur, 2002; Sanchirico *et al,* 1998).

If caregivers were to receive training and support, feelings of preparedness may be experienced. The problem, as already indicated above, is that caregivers who are placed in a care-giving environment are not trained to identify and support children inundated by trauma symptoms (Rhode *et al*, 2001:86; Boyd-Webb, 2006:58). In addition, looked-after children experience placements as confusing, destabilising and damaging (Bass *et al*, 2004:25) since traumatic symptoms are often overlooked. The result is that the experience of trauma either continues or is exacerbated (Springer, 2007:1; Ko, Kassam-Adams *et al*, 2008:398; Fisher *et al,* 2006; Boyd-Webb, 2006:58-94). Caring for challenging children who show problematic mental health, as well as learning and behavioural issues, complicates the care-giving role. In conjunction with the lack of training and support great challenges are experienced by the caregivers.

2.5 CONCLUSION

It is all too easy to underestimate the needs and vulnerability of children once they become looked after by the welfare system. In this chapter, vulnerabilities and complications were discussed showing that trauma, abuse and neglect leave looked-

after children with confirmed behavioural, emotional, psychological, scholastic and developmental difficulties. As children enter care in children's homes, the system and field are far from well-structured and little resources, together with organisational dysfunction, raise concerns about the outcomes for the children. In this disorganised environment, the caregiver is left dealing with difficult children day by day, with little or no support and training to provide quality care. As the caring role is the focal point of all work done in children's homes, it is seen as an instrumental place where change might happen. It may be concluded that if the needs of caregivers could be fulfilled, outcomes for looked-after children might be changed, which could lead to satisfaction and fulfilment for both caregivers and looked-after children.

In the following chapter the philosophical foundation of the school of Gestalt Therapy will be explained where the researcher attempts to integrate all aspects of this research study with that of Gestalt Therapy.

CHAPTER THREE

GESTALT THERAPY THEORY

There is nothing as good as a practical theory

Kurt Lewin (1951:169)

3.1 INTRODUCTION

The purpose of this research is discovering, observing and exploring the needs of caregivers in the larger field configuration of children's homes and looked-after children. It is necessary to take the philosophical and theoretical framework of this research into account as it explains the position from which the study was executed, analysed and interpreted.

A theoretical paradigm consists of a worldview, a system of beliefs including epistemological, ontological and axiological aspects, together with practices and assumptions that are associated with that view, and could be understood as the ground from which a researcher investigates a phenomenon (Teddlie & Tashakkori, 2009:20; Morgan, 2007:24; Mertens, 2003:139). This research is grounded on constructivism (Boghossian, 2006; Kukla, 2000) and the theory of the school of Gestalt Therapy (Resnick & Resnick, 2010). This research is written in an interpretivistic tradition, exploring multiple meanings and interpretations (Finlay & Evans, 2009:18) and adopting a critical realist position, seeking to capture the way in which the caregiver experienced the phenomenon (needs) (Finlay & Evan, 2009:20; Brownell, Meara & Polak; 2008:1; Fleming-Crocker, 2008:126; Kant, 1958).

The purpose of this chapter is to provide a thorough overview of the philosophical grounding of Gestalt Therapy and will be discussed according to its three boundary markers, which include field theory, phenomenology and dialogue, and their relation to ontology, axiology and epistemology of this school. A Gestalt Therapy research

paradigm will also be discussed in this chapter considering the focus of inquiry, the research setting, the role of the researcher, and the methodology of this school.

In this chapter, the researcher attempts to synthesise this research design and methodology and the needs of caregivers with the main principles of Gestalt Therapy.

3.2 THEORETICAL AND PHILOSOPHICAL UNDERPINNINGS OF THE SCHOOL OF GESTALT THERAPY

Gestalt Therapy has three boundary markers, which include field theory (including holism), phenomenology and dialogue (Resnick & Parlett, 1995). Gestalt Therapy is a “holistic, process-oriented, dialogical, phenomenological, existential, and field theoretical approach to human change with the centrality of contact, awareness, personal responsiveness and responsibility” (Kirchner, 2000). Literature (Ginger, 2007:5; Oaklander, 1994:143) explains that Gestalt Therapy is concerned with a unifying vision of the human being, integrating all aspects of the total organism (the person), including senses, feelings, thought, social relationships, spirituality, emotions and intellect. Gestalt Therapy is based on beliefs that organisms have all the resources they need for living, and that they are responsible for their own choices and avoidances (Ginger, 2007:5). Organisms are perceived as having the ability to be in satisfying contact with others and the environment, leading to rewarding and creative lives (Joyce & Sills, 2001:7).

The word Gestalt is a German word, which is translated to “shape, form or figure” where “gestalten” suggests giving shape or significant structure, resulting in the “Gestalt” which is a complete figure or configuration with meaning (Ginger, 2007:1; Latner, 2002:19; Simkin, 1976:225). This configuration, which is a patterning where parts are integrated into a whole, is believed to be a basic function of the human organism experience, leading to subjective reality where the world is organised according to perceptions; and where no absolute reality exists (Perls1951:ix). Gestalt Therapy aims for organisms to discover, explore and experience their own shape, pattern and wholeness, aiming for the integration of all disparate parts (Ginger,

2007:1; Clarkson, 2004:1). When discovering their own shape, pattern and wholeness “people can let themselves become totally what they already are, and what they potentially can become. This fullness of experience can then be available to them both in the course of their life and in the experience of a single moment” (Clarkson, 2004:1). The goal of Gestalt Therapy is to facilitate self-healing (Lampert, 2003:9) by creating awareness and insight into a person’s meaning-making process (Yontef & Simkin, 1989:323). In this study, caregivers were motivated to explore, discover and experience their own needs, which facilitated awareness of their needs, in order to find satisfying contact with themselves and their experiences, allowing them to take responsibility for their needs.

To understand Gestalt Therapy as a theoretical school and in this research paradigm, epistemological, ontological and axiological aspects of the school will be explored (Van De Riet, Korb, & Gorrell, 1980; Korb, 1975; Perls 1973; Hussler, 1970; Levitsky & Perls, 1970; Perls, 1969; Fletcher, 1966; Wertheimer, 1959; Kohler, 1925). Ontology, epistemology and axiology are important aspects of any paradigm and implicate the questions being asked and the way research is conducted and interpreted. Gestalt Therapy philosophy is a movement -

a. away from deconstructive views of the world toward holistic models,
b. away from linear cause-and-effect beliefs toward field theoretical paradigms’
c. away from an individualistic psychology toward a dialogical or relational perspective (Bowman & Nevis, 2005:5).

It is in the phenomenological, holistic field theoretical paradigm and the dialogical perspective that the philosophical foundation of Gestalt Therapy is grounded.

When considering a philosophical foundation for any theoretical school, three aspects are contemplated and include:

a. Ontology: What is real? What is life? What is the world? What is being human? (Heidegger, 1988:1)
b. Epistemology: What is truth? How do we know what we know? (Fumerton, 2006:6)
c. *Axiology: What is good? What is right? What is wrong? What is ethical? (*Bahm, 1993:3)

Ontology, epistemology and axiology will be considered in this chapter, and points to the position the researcher assumes on how research was conducted, what the research results indicated, the ethical standards for this study and the values and attitudes that were supposed. Appendix H (Comparing various paradigms; Meara, 2010) and Appendix I (Positivist, Interpretivist, Critical Realist assumptions; Meara, 2010) are comparisons of different philosophical interpretations and is added to facilitate an understanding of the ontological, epistemological and axiological position of Gestalt Therapy. According to Mistler (2010), Gestalt Therapy subscribes to field ontology and phenomenological epistemology, where axiology maintains that what is 'good' is what works at the moment that a dialogical stance is assumed.

3.2.1 ONTOLOGICAL CONSIDERATIONS

An ontological position defines the conceptualisation of reality and the nature of being human (Heidegger, 1988:1). Ontology encompasses the nature of the social world, existence, reality and the individual being (Finlay & Evans, 2009:18; Rescher, 2003:166; Armstrong, Bacon, Campbell, & Reinhardt; 1993:45-60), which in turn identifies subjects of inquiry, issues worthy of attention and methods of demonstration (Brownell, Meara, &Polak, 2008:11).Hence, ontology refers to both environment and the human being, which in Gestalt Therapy is referred to as the organism environment field. A table indicating the differences between traditional western ontology and Gestalt Therapy ontology, as assembled from literature, follows (Brownell *et al,* 2008; Van De Riet, Korb and Gorrell; 1980).

Table 3.2.1 Comparative Ontologies

Traditional Western Ontology	**Gestalt Therapy Ontology**
Dualism: Humankind, the world, life itself can be defined by creating lists of characteristics, traits, or objects, each of which is separate and distinct from each of the others.	*Holism*: Organisms, the world, and life itself should be perceived as undivided, and as greater than the sum of their descriptions.
The nature of reality is that the world is	*The nature of reality is* of life and the

constant and absolute.	world is regarded in terms of an on-going, constantly changing process – field theoretical orientation.
Nature of being human: Different schools have different views.	*Nature of being human:* - Each individual exists in an environmental field with which he or she must engage. - People are collections of processes. - Existentialism. - Existence is primary in the experience of humankind. - Maintains that it is the contact between the person and his or her environment that defines the person's identity. - Humankind created the world in which they live through their own perceptions and psychological processes and through this created order, structure, meaning, or relationships.
The individual and the environment stand apart from each other.	Both the individual and the environment, together with their interactions, must be affirmed, studied, and described together.

In the above table it is seen that traditional western ontology has a basic assumption that humankind, the world and life itself can be defined by creating lists of characteristics, traits, or objects, each of which is separate and distinct from each of the others, thus subscribing to dualism. Gestalt Therapy assumes that the nature of reality, of life, humankind, and the world, is regarded in terms of an on-going, constantly changing process, where all things are inextricably linked and part of a network of interactions and thus subscribing to holism and a field theoretical

orientation (Parlett, 1991:70; Van De Riet, Korb, & Gorrell, 1980). The environment and being human is considered a totality where "meaning derives from looking at the total situation, the totality of co-existing facts" (Parlett, 1991:70). This totality (holism) includes all aspects of the environment and the organism, and is referred to as field theory.

3.2.1.1 Holism and Field Theory

Holism refers to the concept that the whole is greater or different from the sum of its parts (Ginger, 2007:2). Field theory is an integrating concept which strives to bring all parts of the field together – “person and situation, self and others, organism and environment, individual and communal” (Parlett, 1997:16). It assumes that all things are interconnected and that the organism and the environment co-regulate one another (Joyce & Sills, 2001:24). Change of the organism takes place as a result of interactions at the boundary of the organism/environment field. Everything affects everything else, as the field is viewed as a unit (Fleming-Crocker, 2008:129; Nabozny & Carlson 2001:1; Parlett, 1997:16; Parlett, 19991:68; Perls *et al*, 1951). Accordingly, when considering existence, Gestalt Therapy ultimately aims to understand everything as a whole, an integrational part of the organism/environmental field. Perls (1973) stated that: “No individual is self-sufficient; the individual can exist only in an environmental field. The individual is inevitably, at every moment, a part of some field. His behaviour is a function of the total field, which includes both him and his environment. The nature of the relationship between him and his environment determines the human being's behaviour. The environment does not create the individual nor does the individual create the environment. Each is what it is, each has its own particular character, because of its relationship to the other and the whole...the environment and the organism stand in a relationship of mutuality to one another” (1973:15-17).In considering the above statement, it is seen that the organism needs to be in contact with his or her environment.

This research study focuses on the needs of caregivers that care for looked-after children in children’s homes. In Chapter Two, the field of this study was considered

and it was concluded that different systems form and are a part of the total field of caregivers. These systems (the justice system' the welfare system, the health system, the education system, the biological family system, the system of the children's home, the different family systems in the children's home) includes all systems that affect all other systems, as the field is viewed as a unit.

As Gestalt Therapy ultimately aims to understand everything as a whole and as an integral part of the organism/environmental field, it becomes necessary to understand how these systems work together. It is not in the scope of the research study to do so and the focus will only be on a small part of the total field. The individuals/caregivers are inevitably, at every moment, a part of some field and their immediate field in their own home systems will be explored and considered in the larger field of the children's home. The caregivers' needs are considered a function of the field and created by personal as well as organisational functions.

In Gestalt Therapy needs can only be satisfied in contact with the environment or the self of the organisms/individuals. This aspect of Gestalt Therapy will be reflected on in the following section.

3.2.1.2 Contact in the field

Central to the Gestalt Therapy perspective is a focus on the interaction of organisms and the environment where an individual exists in an environmental field with which he or she must engage (into which he or she must "aggress," according to Perls (1969) in order to live). "He must ***engage*** with the objects of his world in order to survive physically; he must have food, clothing, and shelter, or the resources for providing them; and he must ***engage*** with persons in his environment in order to survive psychologically" (Van De Riet, Korb, & Gorrell, 1980). Therefore, the organism is both an autonomous individual person and an environmentally oriented person who needs other persons and other social institutions. In Gestalt Therapy the ***engagement*** which Van De Riet, Korb and Gorrell (1980) refer to, is entitled contact. Contact is a responsive meeting with the other (environmental and internal others,

alienated aspects, blocked feelings, thoughts, and memories, whatever are not integrated and therefore experience as other), leading to a new configuration of both environment and organism (Woldt, 2008). Accordingly, responsive meetings or contact occur as a survival mechanism of the person to solve problems and satisfy needs.

Gestalt Therapy theory holds that people are inherently self-regulating and motivated to solve their own problems and satisfy their needs. Organisms are born with a sense of social and psychological balance and every move he or she makes on the social or psychological level is a movement in the direction of finding balance, of establishing equilibrium between personal needs and problems and the demands of society. Difficulties arise not from the desire to reject such equilibrium, but from misguided movements aimed towards finding and maintaining it. Thus, the satisfaction of needs is considered the movement of organisms in order to obtain balance and will be the focus of the next section.

3.2.1.3 Needs and the satisfaction of needs

Organisms have needs which are referred to as contact needs. The needs could be psychological – felt when the psychological equilibrium is disturbed, or physiological – felt when the physiological equilibrium is disturbed. The more intensely these needs are felt to be essential to continued life, the more closely organisms identify themselves with the need and the more intensely they will direct their activities towards satisfying the need. In healthy organisms, many needs are present at any one time and are organised into a hierarchy of importance, as a natural process (Barlow, 2010). In Gestalt Therapy the satisfaction of needs are considered a process where figures (needs) emerge from a background.

Perls (1973:9, Perls *et al,* 1951), discussed the connection between needs and figure-ground differentiation, and introduced the concept of needs into the "psycho-therapeutic" figure-ground concept (needs arise and the Gestalt recedes when the need is satisfied). The dominant need will become the foreground figure (Foreground – the need which presses most sharply for satisfaction). For individuals to satisfy

their needs (and close the gestalt/forming a whole) they must be able to sense (be aware of) what is needed, must be able to manipulate themselves and the environment, as needs could only be satisfied through the interaction of organisms and the environment. In order to satisfy a need, the organism searches its environment for the desired object and when the object is found, acts to assimilate it. When the needed object has been assimilated, the Gestalt is closed, and a state of equilibrium is reached. The formerly dominant need recedes from awareness (becomes ground), and the energy thus freed, is directed towards the next most dominant need. Organisms are thus self-regulatory or homeostatic (Smuts, 1926; Lewin, 1935; Goldstein, 1939; Latner, 1973; Perls, 1973, Barlow, 2010). In this way, organisms are regarded as being "born with the capacity to cope with life" (Simkin, 1976:17). Thus, a hierarchy of needs are indicated where organisms focus all attention on the figural (highest order) need.

In Maslow's hierarchy of needs, the survival level is considered to be the "active organising force of meaningful wholes, which relates to physical, emotional, mental or social survival" (Perls 1973:3). When considering other levels of needs, as in Maslow's community needs and self-actualising or altruistic needs, Perls notes these as a need to "grow"(1973:7). The need for safety and security is dominant in the presence of threats to any of the survival needs— such as food, clothing, shelter, and touch, in the physical sphere or care and validation in the mental/emotional/social sphere. However, when safety and security are assured, the need for novelty, experimentation, discovery and altruistic (which are the need to consider others in need) needs emerges (Mistler, 2010 b). To conclude, imaginative curiosity takes over when the individual feels safe and secure, when there is no need to fear for survival in any context—physical, mental, emotional, or social.

Gestalt Therapy holds that every experience and satisfaction of needs has a cycle that has a beginning, a following-through, and an end (Ginger, 2007:29) and is referred to as the contact cycle, cycle of awareness, contact-withdrawal cycle (Clarkson, 2004:34; Ginger, 2007:30) and will be discussed in the section on the contact cycle.

In this research study the needs of caregivers were explored and contemplated making use of a qualitative needs assessment. As seen in the discussion above,

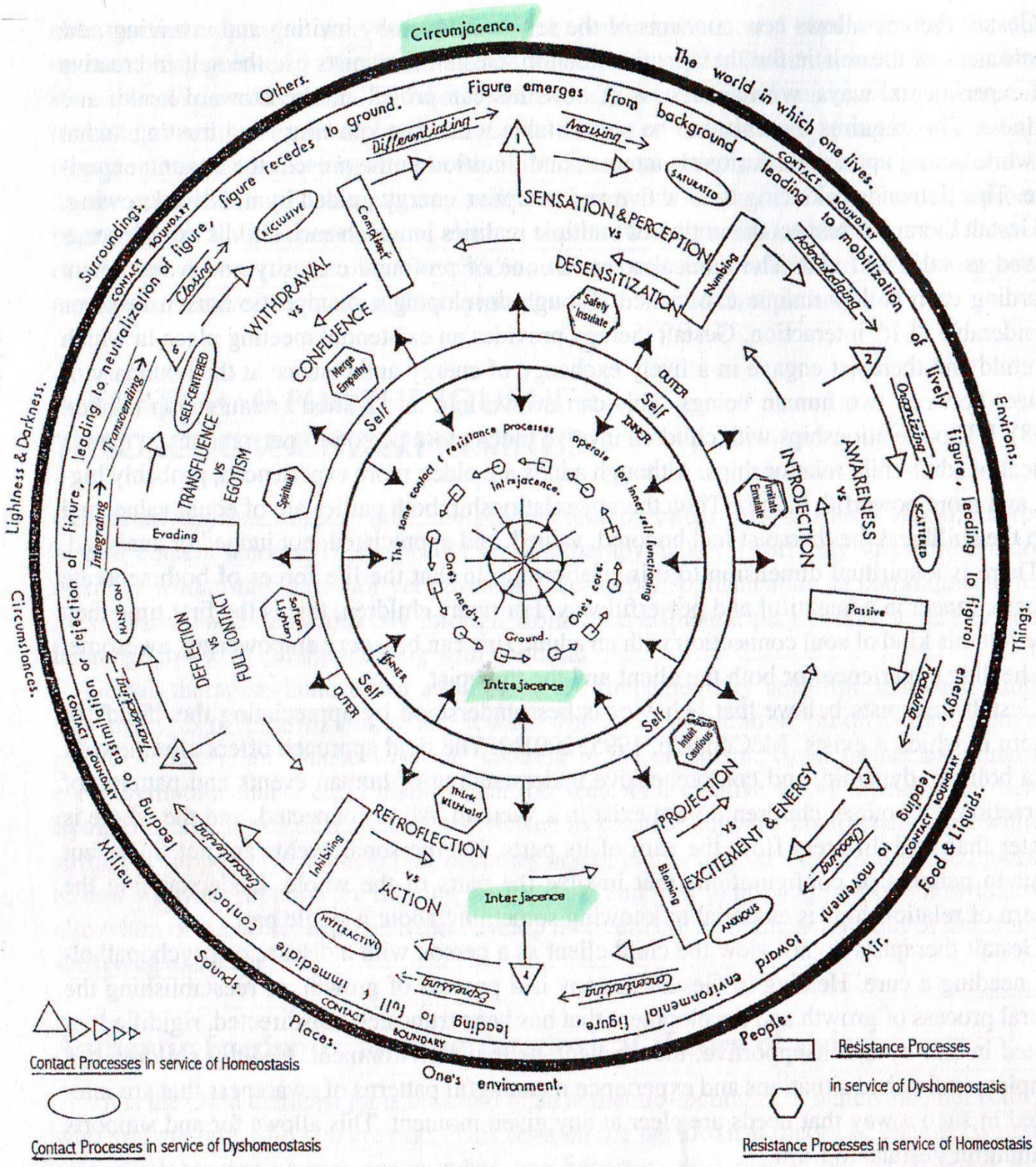
needs arise as a physiological need or a psychological need in what is referred to as the figure-ground concept where the awareness of needs (sensing a need) is an important aspect when defining that need. In this study the researcher considered whether the caregivers were aware of their needs and if they were able to progress towards satisfaction of their needs. In this research study Maslow's hierarchy of needs was considered when interviewing participants and the figure-ground process of caregivers emerging needs was reflected on. The need for safety and survival lies at the bottom of Maslow's hierarchy of needs and satisfaction of higher order needs is dependent on satisfaction of the need for safety and security. In this study the question regarding the satisfaction of caregivers need for safety and security was explored as well as higher order needs of experimentation, discovery (where training can be included).

In the above discussion, it was seen that organisms have needs which are referred to as contact needs. In the following section, the process of contact will be reflected on.

3.2.1.4 The contact cycle

In Gestalt Therapy, contact is considered to occur through different stages as is indicated in Appendix J. A diagram (The gestalt homeostasis cycle; Woldt, 2005:160) of the contact process of organisms follows. A discussion will ensue this diagram.

The gestalt homeostasis cycle (Woldt, 2005:160)



Organisms are considered to be situated in the circumjacence, having an intrajacence, which, in contact, creates the interjacence (Appendix K) Circumjacence, intrajacence and interjacence together create the field (Bloom, 2010; Philippson, 2010; Brownell, 2010). According to Woldt (2008), the circumjacence refers to everything that surrounds organisms, including the world, people, environs, things, food and liquids, air, places, systems, sounds, milieu, circumstances, lightness and darkness. The intrajacence represent the self which includes the core, ground, needs, persona and that which guide them on their journey through life. The interjacence is considered to be the place where organisms are in contact with that which is in them (interjacence) and that which surrounds them (circumjacence).

This awareness cycle is a way of tracking the formation, interruption and completion of emerging figures (Joyce & Sills, 2001:33). Gestalt Therapy considers experiences as being on a continuum in which our contact with people and the environment begins with some level of awareness that is contingent on our senses. In Appendix L, a comprehensive overview of the contact processes is delineated. Woldt (2008) describes the healthy contact process as follows:

a. Using sensate and perceptual data, a figure emerges from the ground *(all figures have a background)*; after which
b. The “what” that is being experienced is then figural *(the figure becomes the “what” of our experience)*; leading to
c. Some level of mobilisation of energy and the figure becomes lively;
d. Not only is the figure *(the “what”)* energised, but we may also have an added awareness of our process of being excited *(the “how” of experience)*;
e. Our excitement leads to movement toward *(if interested or attracted)* or away from *(if turned off or fearful)* the figure; which in turn leads to action.
f. Action takes us into full contact with or away from the figure;
g. Interaction between the self and the figure is a de-structuring process that makes the environmental object assimilable, or, if not amenable, rejected;
h. If the figure is assimilable and accepted, the de-structuring of it leads to neutralisation of the figure; if rejected it is also neutralised.
i. This allows the figure to recede to ground and for withdrawal from contact with that figure.

j. In the healthiest of worlds, this allows for the possibility of experiencing a fertile void – openness to new experiences, fresh figures to form, being unencumbered by “unfinished business.”

The above description regarding the contact cycle reveals what contact should look like when it is healthy. However, “There are a number of ways that we learn to maintain our sense of security, defend our egos, maintain equilibrium, and cope with whatever comes our way in life. Our survival is partially contingent on learning to interrupt contact when it does not feel safe or right for our system of boundaries” (Woldt, 2008).

3.2.1.5 Interruptions to contact

Interruptions to contact include desensitising, introjecting, projecting, retroflecting, proflecting; deflecting, egotising, confluence and avoiding. These are considered to be resistances that interrupt contact. Appendix M consists of resistance processes as delineated from Woldt (2008).

Thus, healthy contact leads to satisfaction of needs where the interruption of contact leads to dissatisfaction. For organisms to experience healthy contact, support from both the environment and self-support is necessary. Support for contact will be reflected on in the following section.

3.2.1.6 Support for contact

A main concept in Gestalt Therapy is the concept of self- and environmental support (L. Perls, 1992 a & b). Support is considered a “necessary basis of all healthy functioning and the ground that enables satisfying contact” (Joyce & Sills, 2001:83). The following table indicated different kinds of support.

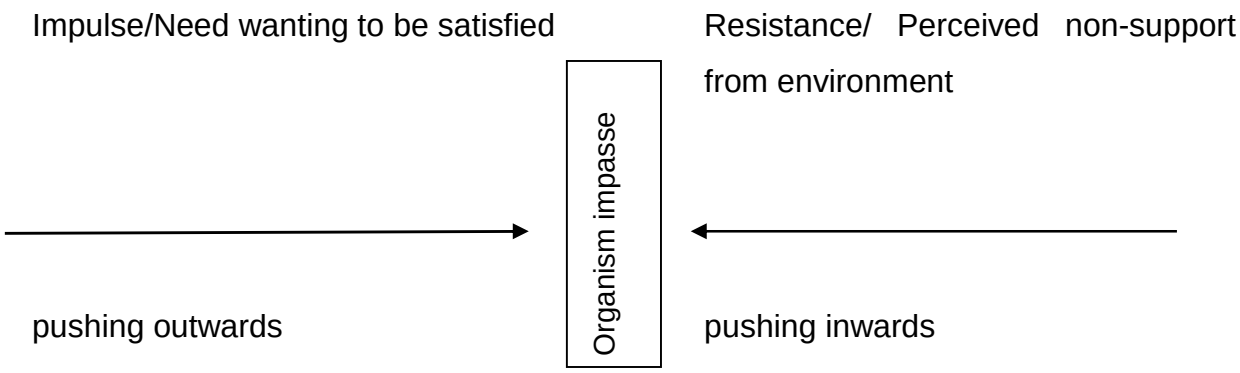
Table 3.2.1.6 Kinds of support (Joyce & Sills, 2001:83)

Self-supports	***Environmental supports***
Sound physical health	A healthy physical environment
Supportive body posture and breathing	Adequate resources, such as, food and shelter
Effective coping strategies and creative adjustments	Intimate relationships
Relationship with nature	Loving family and friends
Strong sense of identity	Validation from others
Realistic beliefs about the self and the world	Religious or social networks
Spiritual practice	Fulfilling employment
	Enjoyable leisure activities

“Healthy support is a position of interdependence where the person is self-supported but also able to recognize when he also needs environmental support. The issue is not whether the person is self-supported or needing environmental support, but rather, how he choice-fully uses both of these two positions; how he can co-operate with his environment or community for mutual support, balancing his own needs with consideration of the needs of others” (Joyce & Sills, 2001:84). An organismically self-regulating person takes responsibility for what is done for the self, what others do for the self, and what the self does for others.

An *impasse* is a situation in which external support is not forthcoming and the person believes he or she cannot support himself or herself (Yontef, 1993|). An impasse is owing, in large part, to the person's strength being divided between impulse and resistance (Yontef, 1993). This impulse, together with the resistance, allows the organism to get ‘stuck’ as one force is pushing out and one force is pushing in. In Gestalt Therapy theory, it is considered a necessity for organisms to learn to fully use internal and external senses in order to be both self-responsible and self-supportive. The following diagram indicates the process of Organismic impasse.

Diagram 3.2.1.6 Organismic Impasse



Perls *et al* (1951) stated the following in connection with support: “The fact is that we mature all the time that our development, and this is the essence of growth, is from complete environmental support to a possible complete self-support. But, the child still needs a lot of support. He needs to be carried, he needs to be fed, as he gets older, he needs financial support, he has to be given emotional support, encouragement, and so on. Now the essence of the neurosis is that, the neurotic, instead of developing his own self-support puts all his energy into manipulating the environment for support. For instance, a neurotic person cannot appreciate himself, so he tears himself to pieces to get the world to appreciate him. He has not enough self-esteem, emotional self-support.” The person exchanges with the environment, but the basic support for regulation of one’s existence is by the self. When the individual does not know this, external support becomes a replacement for self-support rather than a source of nourishment for the self (Yontef, 1993).

Support is considered the necessary basis of all healthy functioning and the ground that enables satisfying contact. In this study, support structures of caregivers will be considered and an exploration into the perceived self- and environmental supports as seen in table 3.2.1.6 will be considered, together with the possibility of caregivers beings stuck in an impasse.

3.2.1.7 Conclusion

To summarise, when contemplating ontology, the nature of reality and the nature of being human are explored and a position is assumed on both aspects. Regarding the nature of reality, Gestalt Therapy embraces the assumption of a process existence, stating that all “things” (environment and person) are in process. A field perspective is adopted with the main characteristics of change, flow, interconnectedness and holism. On the subject of the nature of being, Gestalt Therapy states that people are collections of processes, on-going and changing physiological, emotional, intellectual, psychological, and spiritual, where processes constitute the existence of each human being. The Gestalt approach similarly maintains that there is constant contact between the person and his or her environment. Organisms are considered self-regulating, constantly satisfying needs in a desire to maintain equilibrium, needing sufficient support for the contact and satisfaction of needs to take place.

3.2.2 EPISTEMOLOGICAL CONSIDERATIONS

Epistemology is the study of knowledge and justified belief (Fumerton, 2006:4-5; Louise, 2004:1-17). As the study of knowledge, epistemology is concerned with the following questions: What are the necessary and sufficient conditions of knowledge? What are its sources? What is the structure of knowledge, and what are its limits? What distinguishes true (adequate) knowledge from false (inadequate) knowledge? Does true knowledge exist? (Fumerton, 2006:4-5; Louise, 2004:1-17).

According to Van De Riet, Korb and Gorrell (1980) Western epistemology agrees that knowledge is presumed to maintain the structure of existence and is seen as an existing apart of man’s awareness being available for understanding and analysis, is witnessed in cause-and-effect and has an inherit meaning. However, the school of Gestalt Therapy challenges the assumption that knowledge exists apart from the organism’s awareness. A table indicating the differences between traditional western

epistemology and Gestalt Therapy epistemology, as assembled from literature, follows (Bloom, 2010 b; Brownell, 2010; Van De Riet, Korb and Gorrell; 1980).

Table 3.2.2 Comparative epistemologies

Traditional western epistemology	Gestalt Therapy epistemology
Absolute and true knowledge exists.	Absolute and true knowledge is a myth.
Knowledge exists apart from man's awareness.	Knowledge is a part of man's awareness.
Verbalisation and communication of an experience is the true experience.	Verbal communication is a lie and is only a report of experience.
Absolute meaning exists	Meaning is subjective.
Knowing "why" is the intelligence of the organism – cause and effect.	Knowing "how" is the intelligence of the organism.
Organismic knowing is constituted by the intellect.	Organismic knowing is integrative and includes the awareness of bodily sensations. A person knows what he knows as he is aware of his own experience.

In the above table, it is evident that western epistemology has a basic assumption that knowledge exists apart from the organism's awareness and that cause-and-effect applies to knowledge seeking. Gestalt Therapy's epistemological position assumes that knowledge is a part of the organism's awareness and that meaning is subjectively created as the organism goes through life. A phenomenological stance is taken (Van De Riet, Korb & Gorrell, 1980) concluding that knowledge (what is known) is the derived product of "sensory input, structural formation and inner experience" (Van De Riet, Korb & Gorrell, 1980). Husserl (1970) stated that organisms know/gain knowledge as they create meaning and in this statement lies

the epistemology of Gestalt Therapy. The subjective world of organisms' experience is the major component of life and the source of knowledge.

How organisms know, is also an epistemological matter that requires attention. For the Gestalt therapist, organisms know what they know as they are aware of their experiences. Their awareness becomes the basis for choices and actions. In Gestalt therapy, organismic knowing is not merely constituted by the intellect, which searches for meanings and for causes. According to western epistemology, intellectual knowing assumes that knowing can be approached analytically, broken into its component parts, and organised categorically. Knowledge, however, in the sense of Gestalt Therapy, organismic knowing occurs integratively and not analytically. Organisms grow, mature, increase, and become more whole as they integrate (accept and assimilate) parts of themselves and perceptions of their world.

Accordingly, the school of Gestalt Therapy holds that knowledge is situated in each organism, where they possess their own truth - what is true for the organism is considered the truth. The above concept is referred to in Gestalt Therapy Theory as phenomenology and will be briefly reviewed in the following section.

3.2.2.1 Phenomenology

Phenomenology is the study of "how" the world appears and is experienced by organisms (Shultz, 2004) and draws attention to the fact that perception is not entirely objective (Brazier, 1992:1). Yontef (1993:239) maintains that phenomenology studies the field as experienced by the person at a moment and takes as its only data what is immediately and naively experienced at a moment. Spinelli (2007:20) elaborates that: "The focus is on the events, occurrences, happenings as one experience them, with a minimum regard for the external, physical reality." Phenomenology states that the self is linked to the perceptions of immediate experiences. In other words, what is real is not as important as what is perceived or felt in a situation. In this regard, Yontef (2007) adds that within

phenomenological thought, reality and perception are interactional co-constructions; they are a relationship between the perceiver and the perceived" (2007:16-17).

In Gestalt Therapy theory on phenomenology, organisms are viewed as possessing their own unique truth; what is true for the individual is considered the truth. According to Bloom (2010 b), experience integrates all dimensions of human functioning, which is one of the bedrock aspects of Gestalt Therapy's non-dualistic philosophy. "What we see is what we get" (Bloom, 2010 b). Consequently, Gestalt Therapy believes that absolute and certain knowledge does not exist and meaning is created by each organism as it experience life. Perls (1972, 64-65) maintains that: "A meaning does not exist. A meaning is a creative process, a performance in the here and now. This act of creation can be habitual and so quick that we cannot trace it, or it can require hours of discussion. In every case a meaning is created by relating a figure, the foreground, to the background against which the figure appears."

In this study, the researcher focused on the phenomenologically created reality of the caregivers, their felt experiences, events, occurrences, happenings as caregivers experience them, with a minimum regard for the external, physical reality in which they live. The meaning caregivers create, regarding their needs, was the focus of this research. Gestalt Therapy holds that organisms create their own meaning as they are aware in the here-and-now.

3.2.2.2 Meaning created and awareness in the here-and-now

In phenomenological thought, meaning is considered a product of the interaction between figure and ground (Resnick & Parlett, 1995). Organisms experience a figure where it is 'measured' against the ground (previous contacts and whole) and meaning emerges. In Gestalt Therapy, the creation of meaning with awareness in the here-and-now is an important concept.

The process of awareness is described by Woldt (2008) as follows. "This is the function or process of experiencing and identifying the thoughts, feelings and behaviours associated with the sensory data, where we cognitively identify what is

happening inside and in-between our self and our environment and having sufficient description or understanding of that process to create enough meaning to either move towards or away from the possibility of further contact. Awareness typically involves aspects of our total self – our emotional, physical, and cognitive and *(sometimes)* spiritual processes. Awareness is both a process *(what we are experiencing to move toward a goal or to contact the object of our attention)* and an outcome *(experiencing the result of our contact or goal attainment).*" The act of awareness is always here-and-now, although the content of awareness may be distant. The act of remembering is now; what is remembered is not now. Awareness implies the taking of responsibility for the sensations being perceived, feelings and thoughts that emerged and the direction of action regarding conscious choices (Yontef, 1993:12).

Accordingly, Gestalt Therapy emphasises the here-and-now and is sensitive to how it includes residues of the past, seen in body posture, habits, and beliefs. Awareness takes place *now*. Prior events may be the object of present awareness, but the awareness process (e.g., remembering) *is now*. *"Now* I can contact the world around me, or *now* I can contact memories or expectations. Not knowing the present, not remembering, or not anticipating are all disturbances. The present is an ever-moving transition between the past and future. "Now" refers to *this moment* and experiences of the past few minutes, days, years or decades that are of present importance are dealt with" (Yontef, 1993).

Full awareness is the process of being in vigilant contact with the most important events in the individual/environment field with full sensorimotor, emotional, cognitive and energetic support. Aware contact creates new, meaningful wholes and thus is in itself an integration of a problem. Joyce and Sills (2001:30-33) maintain that awareness is holistic and consists of an inner, middle and outer level. Perls referred to these levels as zones of awareness. Being able to move between these levels of awareness is considered to be healthy where being stuck in one of them indicates dysfunction (Joyce & Sills, 2001:30-31). A table, indicating the different zones of awareness, follows.

Table 3.2.2.2 Zones of awareness (Joyce & Sills, 2001:30-33)

Inner zone	The inner Zone of awareness refers to the internal world of the organism.
Outer zone	This is the awareness of contact with the outside world. This includes all our behaviour, our speech and action. It includes how we use what are call contact functions (seeing, hearing, speaking, tasting, touching, smelling and moving) which are all the ways that we receive or make contact with the world. Paying attention to our contact functions. In order for us to be aware of our choices and to make changes in the way we behave, perhaps to get different responses from other people, we have to become aware of what we are doing and its effect on others and ourselves. We need to become skilled at noticing what is going on around us.
Middle zone	The middle zone consists of our thinking, memories, fantasies and anticipations. It includes all the ways in which we make sense of both our internal stimuli and external stimuli. It acts as a mediator or negotiator between the inner and outer. One of its major functions it to organise our experiences in order to come to some sort cognitive and emotional understanding. Another is to predict, plan, imagine, create and make choices. It is the middle zone that includes beliefs and memories. It is also the main cause of our problems and distress; it holds our self-limiting beliefs, our fixed ways of understanding the world, and our tendency to fill the present with thoughts about the past or the future.

In this study, the caregivers were assisted to explore and find their own meaning in their field which was facilitated by the researcher's phenomenological attitude and enquiry. Gestalt Therapy supports the concept that each person is an expert in their own experience and creates meaning that is true for them. Caregivers will create

meanings as a result of the interaction between their backgrounds and their figure, and will be explored in this study.

3.2.2.3 Conclusion

When contemplating epistemology a position on truth and the basis of knowledge and justified belief, together with how an individual gets to know something, are assumed (Van De Riet, Korb, & Gorrell, 1980). Gestalt Therapy embraces the assumption of a phenomenologically created meaning and knowledge where organisms possess their own truth. The subjective world of experience is considered as a major component of life and the source of personal knowledge. The self is created in contact and through contact the organism learns and starts to 'know'.

3.2.3 AXIOLOGICAL CONSIDERATIONS

Axiology is the study of worth, quality and value. In social settings, axiology is associated with an individual's relation to another individual. Axiology considers aspects of ethics, morals, value and good (McDonald, 2004: 56; Bahm, 1993:3-6; Van De Riet *et al,* 1980), and seeks to answers questions such as: What is right or wrong? What is good? What is of value? What is worthy? What is ethical?

3.2.3.1 What is right and wrong?

In Gestalt Therapy, there is no right and wrong built into any question. Van De Riet *et al*(1980) stated that: "There are rights and wrongs, but they are aspects of the stance and choices of an individual or of a society in particular situations; their rightness or wrongness is a factor of attitudes and values vis à vis the issues: they emerge in the process of interaction of the person with the environment or of the societal environment with the person. Gestalt Therapy does assume that there are

"good" things for each individual, that each individual has values and a valuing process. Gestalt Therapy also assumes that there are social "goods" and values. These values have their origins in the self, in the culture, and in aspects of the social environment. The individual, however, in the Gestalt system is assumed to be responsible for increasing awareness of his value system and, based on his awareness and attention, his choices."

In this research study, the researcher aimed to honour Gestalt Therapy theory by allowing caregivers to include their own rights and wrongs regarding the choices and experiences, as Gestalt Therapy assume that right or wrong exists only for the individual and society at a given time.

3.2.3.2 Gestalt Therapy and responsibility

Self-responsibility is an important concept in Gestalt Therapy and implies that organisms be responsible for choices they had made (Yontef, 1993; Clarkson, 2004; Mackewn, 1997; Woldt, 2005; Wheeler, 1996). The researcher will consider personal responsibility for this work, together with an exploration of the amount of self-responsibility taken up by caregivers.

3.2.3.3 What is ethical?

In Gestalt Therapy, a situational ethical stance is assumed which considers axiological aspects as bounded by the existential moment where right and wrong in any event or for any person is based on the situation and choice of the person (Mistler, 2010; Fletcher, 1966; Naranjo, 1970). Each person makes choices based on personal awareness, abilities, knowledge, values, and beliefs. Ethical aspects that are important to the researcher were discussed in Chapter One and will guide this study.

3.2.3.4 What is of value and what is good?

Perls, Hefferline and Goodman (1951:335) wrote: “Man does not strive to be good; the good is what it is human to strive for.” In Gestalt Therapy “good” things are not considered as certain actions, but embrace certain values and attitudes. Naranjo (1970) proposes three values which include: the valuing of what is actually present in time and space, and real rather than a symbol of a reality; the valuing of personal awareness and the affirmation of personal experience and the valuing of personal responsibility, which constitutes wholeness (Van De Riet *et al,* 1980). These three values are accepted in Gestalt Therapy if self-selected, based on personal awareness and choice. Joyce and Sills (2001:195) indicate that there are certain value bases in Gestalt Therapy. A table indicating values (left) that are embraced by Gestalt Therapy follows (Joyce and Sills; 2001:195).

Table 3.2.3.4 Values that are embraced by Gestalt Therapy

Autonomy	Over	Dependence
Life	Over	Death
Cohesion	Over	Fragmentation
Integrity	Over	Randomness
Community	Over	Isolation
Honesty	Over	Manipulation
Joy	Over	Despair
Truth	Over	Deceit

More “good attitudes” that Gestalt Therapy incorporates is the dialogical attitude described by Gestalt Therapy literature (Andersson, 2008; Daniels, 2008; Schulz, 2004; Yontef, 2002; Purcell-Lee, 1999; Jacobs, 1989) and a discussion follows.

3.2.3.5 Dialogue

Dialogue is a special form of contact that becomes the ground for deepened awareness and self-realisation (Jacobs, 1989:1-25). The dialogical attitude allows for an attempt to stay with, stand beside and accept the otherness of the being who is present (Evans, 1981), allowing a kind of permissiveness and a safe environment (Yontef, 2008), provoking an openness and honest discussion and acceptance of the worldview of the other. Principles of this dialogical attitude include (Jacobs, 1989:10; Yontef, 2002:24-25)

a. Confirmation and inclusion, implying no judgment, analysing or interpreting.
b. Authentic presence, implying the complete bringing of oneself to the interaction with authenticity, transparency and humility, allowing the other and the self to be flawed and recognising it as part of existence.
c. A commitment to what emerges in the situation, thus not aiming for any direction, but allowing the contact to bring forth any facet of experience, opinion or feeling.

The dialogical stance of the school of Gestalt Therapy was embraced by the researcher, focussing on confirmation, presence and a commitment to whatever emerged.

3.2.3.6 Conclusion

When contemplating axiology, a position on right and wrong, ethical standards, what is of value and what is considered as good, is taken. With regard to right and wrong, Gestalt Therapy embraces the assumption that the organisms/individual persons subscribe morals and values for themselves. Pertaining to ethical standards, Gestalt Therapy embraces a situational ethical stance. In connection with what is good and of value, Gestalt Therapy implies that there are attitudes and not actions that could be regarded as good and of value, which incorporates the dialogical attitudes.

3.3 THE FIELD OF GESTALT THERAPY RESEARCH

In the above discussions, the following has become clear, when bearing in mind the approach and methodology of research in the tradition of Gestalt Therapy, it is necessary to honour its field, phenomenological and dialogical nature as this forms the structure in which research takes place. Field theory, phenomenology and dialogue influences the methodology, design, interpretation, together with the relationship and attitude a Gestalt Therapy researcher enters with into the field when conducting the research.

According to Barber and Brownell (2008:37), Gestalt Therapy researchers are well on the way to conducting qualitative inquiry as research addresses the subjects under investigation in its embedded field (2008:37). A table follows, indicating various aspects of the qualitative research tradition, which will then be discussed according to the research paradigm of Gestalt Therapy.

Table 3.3 The qualitative research tradition (Barber & Brownell, 2008:38-40)

Criterion	**Qualitative Research**
Research culture	Constructivist worldviews; relativistic, interpretational (Hermeneutical) viewpoints on ontology; reality is socially constructed and known through lived experience in which researcher and subject mutually influence one another
Focus of inquiry	Rich and complex exploration of the experience of a small number of individuals; it is an idiographic approach
Research setting	Participants' natural worlds and everyday lives, the field settings, environmental, and social contexts of their actual lives
Role of researcher	The researcher embraces the role of researcher as instrument, incorporating his or her experience as participant to the process and admitting that all observation is conditioned to some degree on the perceptual and judgmental processes of the observer; Participants' primary contact would then be with research assistants who, ideally,

	would be naive to the researcher's hypotheses.
Emic distinction	Emic: Constructs of behaviours unique to an individual; social-cultural context that is not generalizable
Methodology	Empirical procedures designed to describe and interpret experience in context-specific settings involving psychological events, experiences, and phenomena

In this section the researcher attempted to synthesise the research paradigm used in this study with the main principles of Gestalt Therapy. This section will focus on the research paradigm's focus of inquiry, the research setting, the research relationship, the phenomenological method of inquiry and a methodology of Gestalt Therapy research.

3.3.1 Focus of inquiry

Gestalt Therapy is concerned with the direct perception of how a person senses, thinks, feels and imaginatively projects information to constellate the world (Baber & Brownell, 2008:37). The focus is on the social world of subjective meanings, aiming to offer rich, textured descriptions of emotions, thoughts, or dialogue in order to highlight personal experience or taken-for-granted social practices (Finlay & Evans, 2009:5). In Gestalt Therapy research, the aim is to discover new awareness, to find out more about another individual or a specific phenomenon. In this study, the direct perception of the caregivers will be explored and described aiming for new understanding and awareness regarding their needs and will be investigated and described by given textured descriptions of emotions, thoughts and dialogue in order to highlight their experience in children's homes.

3.3.2 Research setting

Gestalt Therapy research takes place in natural, real-life settings and attempts to capture the experiences of the persons in context (Finlay & Evans, 2009:5). This study will be conducted in the natural setting of caregivers in children's homes and interviews will be conducted in their environment of care-giving of looked-after children.

3.3.3 The research relationship and role of the researcher

The research relationship could be characterised as a dialogical process to which both researcher and co-researcher (participant) contributes. As discussed above, the dialogical attitude of inclusion, presence and a commitment to whatever emerges out of contact, are important aspects of the research relationship. It is notable that the research relationship shares similar processes as the therapeutic relationship; therefore the same attitude is adopted in Gestalt Therapy research.

In Gestalt Therapy, researchers use themselves as research tools where they become, together with the participant, central figures which influence the collection, selection and interpretation of data (Finlay & Evans, 2009:6). According to the dialogical nature of Gestalt Therapy, the researcher expects to be affected-by the dialogical attitude of inclusion, where the researcher starts from a relatively unknowing position, characterised by curiosity and interest. According to Finlay and Evans, the dialogical process "is the unwilled willingness to meet what is utterly strange in what is most familiar, the aim is to see through fresh eyes, to understand through embracing new modes of being"(Finlay & Evans, 2009:95; Finlay, 2008:29), The dialogical attitude encompasses a vulnerable meeting and disinterested interest involving humility and respect toward the figure/phenomenon of inquiry (Dahlberg *et al,* 2008:98). In the field that the researcher and participant co-create through dialogue, results are formed where outcomes are seen as a co-creation, a joint product. Gestalt Therapy research does not involve a participant talking to a passive, distanced researcher, who receives information, but involves a constantly

developing, negotiated, “dynamic co-created relational process to which both researcher and co-researcher contribute” (Finlay & Evans, 2009:9).

The presence of the researcher becomes an important aspect of the meeting and is considered to be “the essence of work with another person” (Gendlin, 1996:297). In research, presence is considered an authentic, energised, active, direct and self-aware expression of researchers (Finlay & Evans, 2009:93) where they are focused on both themselves and the co-researcher/participant (Finlay & Evans, 2009:108). According to Zinker and Nevis (1994:385) “Presence is the ground against which the figure of another self or selves can flourish and stand out fully”. Thus, the presence of the researcher calls forth, and “perhaps even gives permission, for the presence of the participant to come forth, and then there is usually a mutually reciprocal dynamic where each impacts further upon the other” (Finlay & Evans, 2009:113). Presence is not a technique or tool to be used to manipulate the other. It is rather ‘a way of being with, without doing to’ (Zinker & Nevis, 1994:385-386), which requires authenticity, transparency and humility (Yontef, 2002:15). It involves the researcher being in contact with the situation holistically (physically, emotionally, mentally) in order to be able to respond to what is arising in both themselves and co-researchers/participants allowing the researcher to be ready to respond to whatever emerges in the meeting. The presence of the researcher creates a frame that will hold and contain unfolding and emerging awareness (Finlay & Evans, 2009:113).

In this study, the researcher will embrace the dialogical attitude being present to the participant and committing to whatever emerges in the meeting. The interviews will be conducted with awareness and allowed to spontaneously develop.

3.3.4 The phenomenological method and ideographic approach of inquiry

In the above discussions, phenomenology was considered to be one of the boundary markers of Gestalt Therapy. Four main components of a phenomenological attitude and method in research exist (Burley & Bloom, 2008), namely:

a. *The Bracketing* of the researchers' beliefs, assumptions and judgements that are temporarily suspended in order to see the phenomenon or situation 'as if for the first time;
b. *The Description* of the phenomenon, which is simply described in terms of what is immediately obvious to the senses, what is noticed and perceived, and the current experience of the researcher
c. *Horisontalism*, pertaining to all aspects of the phenomenon that are given potentially equal importance
d. *Active curiosity* where the researcher needs to be interested in how situations arise, how the participant makes sense of them, how this fits with that and what it means in the larger field. A stance of active curiosity from the researcher leads to the asking of a lot of questions.

In this research study, interviews were conducted making use of the phenomenological method of inquiry. The researcher bracketed her beliefs and assumptions as much as possible and described the phenomenon to the participant, as regarded by the researcher. All aspects of the phenomenon were considered to be important and through active curiosity, the researcher will investigate whatever emerges.

An ideographic research approach focuses on the understanding of organisms as unique and complex entities leading to a descriptive and detailed presentation of findings (Barber & Brownell, 2009: 57). In this research, the ideographic approach was adopted by focussing on caregivers' detailed descriptions of their needs and presenting that finding in a descriptive manner.

3.3.5 Methodology

In Gestalt Therapy there, a right way of doing research does not exist. However, in literature, a framework is suggested (Barber & Brownell, 2008:41- 53; Scheinberg, Johansson, Stevens, & Conway-Hicks; 2008:299) and will be discussed briefly.

Six phases are proposed in the tradition of Perls, Hefferline and Goodman's (1951) explanation of the phases of contact by Barber and Brownell:

a. Pre-Contact: Surfacing Interest and motivation
b. Orientation: Building Trust and Surfacing a Researchable Question
c. Identification: Refining a Focus and Methodology
d. Exploration: Entering the Research Field and Building Experiential Knowledge
e. Resolution: Evaluating outcomes and communicating results
f. Post Contact: Writing Up and critiquing the Results

A table incorporating Gestalt Therapy's cycle of experience as a model for a research approach according to Scheinberg, Johansson, Stevens and Conway-Hicks (2008:299) follows.

Table 3.3.5: Stages of Gestalt Therapy Research (Scheinberg, Johansson, Stevens, & Conway-Hicks, 2008:299)

Stages of research	**Stages in the Gestalt cycle of experience**
Introduction	Sensation
Theory and literature review Research questions	Awareness
Research design, structure Method, sample and data collection	Mobilising energy

Definition planning and limitations	
Data collection	Action
Ethics, reliability and validity	Contact
Method of analysis and strategy Research findings	Evaluation and reflection
Research results, Discussion Contributions	Integration and standardisation
Final conclusions	Closure

Yontef (1993) discussed four different time zones that are considered in Gestalt Therapy, which are described according to research by Finlay and Evans (2009:35).

a. In the *Here and Now,* researchers investigate the self-environment field at the particular moment of the research encounter holistically
b. In the *There and Now,* researchers are concerned about understanding an organism/co-researcher/participant's life outside the research setting
c. In the *Here and Then,* researchers examine what has happened in the research exploration over time (a few moments ago or in preceding interviews)
d. In the *There and Then*, an organism/co-researcher/participant's history – the background from which meaning emerges – is an ever-present horizon (In research, an understanding of so-called past issues is sometimes essential in order to understand what is going on in the here and now. However, there is no such thing as the past. There is history, but the past is always present in the background and may become figural in the here and now.

Thus, no definite structure is given to the process of Gestalt Therapy's research and is an on-going discussion between leaders in the field (Brownell, 2010).

3.3.6 Conclusion

In this section, the researcher attempted to synthesise the research design of this study and methodology with the main principles of Gestalt Therapy Research. The qualitative aspects of this study agree with Gestalt Therapy as well as the mode of interviewing, the role of the researcher the methodology as well as the research setting and focus of inquiry.

3.4. CONCLUSION

This chapter was divided into two sections. Section one attempted to synthesise Gestalt Therapy principles with the focus of this research – the needs of caregivers. Ontological aspects that were considered in this chapter included field and holism, contact in the field, needs and the satisfaction of needs, the contact cycle and interruptions thereof and support for contact. The caregivers' field, needs, contact and supports were contemplated in the Gestalt Therapy ontological considerations. Epistemological aspects of the school of Gestalt Therapy included phenomenology, awareness and the here and now and the creation of knowledge/the self was reflected on in this chapter. Meaning created by caregivers and their felt experience of phenomenology was discussed. Axiological aspects included reflections of right and wrong, ethical, value and dialogical attitudes. Axiology was considered in this research study and especially regarding the attitude that the researcher embraces in the Gestalt Therapy paradigm. In the second part of this chapter, the researcher attempted to synthesise the current research study's focus, setting and methods used with that of a Gestalt Therapy research paradigm.

In the following chapter, the focus will be on empirical processes, where methodology is explained, data analysed and findings discussed in detail.

CHAPTER FOUR

EMPIRICAL ANALYSIS AND DESCRIPTIONS

When two people meet a new reality emerges

Symington (1986:30)

4.1 INTRODUCTION

The aim of this study was to explore and describe the needs of caregivers of looked-after children in children's homes on the subject of training and care-giving. In the literature review a thorough analysis of how the field of this study is configured was reflected on and formed the basis for the empirical study. The study was undertaken in the qualitative paradigm, making use of a needs assessment, using applied research with a descriptive and exploratory nature to gain rich insight into the phenomenon (the needs of caregivers). As the qualitative approach is interpretive and holistic and aims to understand meaning, experience and perception, this research approach suited this study best.

In this chapter, the data collection procedures are described comprehensively, clearly explaining the context and purpose. A description is given of participants, the research design, the sampling plan as well as the data collection procedures and the steps that were followed in order to complete data collection. The research focus is on the empirical process that is followed in order to evaluate and analyse the results by means of heuristic inquiry in the Qualitative Data Analysis (QDA) model of Miles and Huberman (1994), and is suitable for the research method followed for this study.

The use of a qualitative strategy is, according to Patton (2001:190), a combination of empirical data, personal involvement and observation of the researcher in the research process and analysis of the data and will be the point of departure for this chapter.

4.2 THE RESEARCH PROCESS FROM A QUALITATIVE APPROACH

According to Leedy (1993:), the research process can be described as being circular in configuration, where it begins with a problem, and ends with the solution to that problem. Babbie and Mouton (2001:72) refer to four elements that are considered standard in all forms of empirical research and include: the research problem, the research design, the empirical evidence and the conclusions. For this research study, the researcher made use of the qualitative approach in order to explore and describe perceived needs of caregivers. A table that indicates the systematic steps taken to complete this research study follows.

Table 4.2 The qualitative research process (Fouché & Delport, 2005:79).

<table>
<tr><th>Phase One: Selection of a researchable topic</th><th>Phase Two: Formal formulations</th><th>Phase Three: Planning</th><th>Phase Four: Implementation</th><th>Phase Five: Interpretation and presentation</th></tr>
<tr><td rowspan="3">Identify a researchable problem/ question</td><td>Assess suitability of the research approach</td><td>Select a paradigm and consider the place of a literature review</td><td rowspan="2">Consider applicability of elements of a pilot study</td><td rowspan="2">Process and analyse data and verify results. Select additional criteria for judging adequacy</td></tr>
<tr><td>Formulate the problem/questions/hypothesis</td><td>Select a research strategy or strategies</td></tr>
<tr><td>Draft the research proposal</td><td>Select method(s) of information collection and analysis</td><td rowspan="2">Collect materials, record, and undertake literature study</td><td rowspan="2">Plan narratives and write the report</td></tr>
<tr><td></td><td>Frame and develop the sample</td></tr>
</table>

The selection of a researchable topic as well as the formal formulations was reviewed in Chapter One. Accordingly, the research process as indicated in Table 4.2, is described from Phase Three.

4.3 PHASE THREE: PLANNING

4.3.1 Research approach

The research approach for this study was ideographic (Brownell, 2009:38), inductive (Lichtman, 2009:14; Flick, 2009:239; Patton, 2002:57) and a qualitative needs assessment was performed (Tutt & Rothery, 2009:155; Kaufman & English, 1979:32; Richards, 1990:1-2). This study is regarded as applied research with a descriptive (making detailed descriptions of the context and other aspects of the research setting) and exploratory (generating information about unknown aspects of a phenomenon) nature to gain rich insight into the phenomenon (Teddlie & Tashakkori, 2009:6, 296; Fouché & Delport, 2005:74, 105-106; Babbie & Mouton, 2004:28). The theoretical assumptions of the school of Gestalt Therapy underpin this study.

The qualitative approach is interpretive and holistic and aims to understand meaning, experience and perception (Fouché & Delport, 2005:74; Patton, 2002:3). The purpose and process of qualitative research is that of discovering, avoiding the making of predictions and declarations where researchers keep themselves open to the unfolding of data encountered (Finlay & Evans, 2009:5).This research study aims to understand the needs of caregivers and a qualitative approach would therefore best suit this study.

Ideographic research focuses on the understanding of the individual as a unique and complex entity leading to a descriptive and detailed presentation of findings (Brownell, 2009: 38). As this research focused on understanding- and description of the caregiver, this study qualifies as ideographic.

West (1994:3-5) notes that the term “needs” is often seen as an umbrella term, covering necessities, lacks, wants, strategies and constraints. This study focused on

the perceived needs of caregivers and hoped to address the concern that caregivers of looked-after children in children's homes may not be receiving the support and training that they require to create an environment of quality care.

This study is of an applied nature, as applied research generally entails a short study in which practical results are used to address or offer solutions to specific concerns (Neuman, 2003:22). Inductive analysis involves the discovering of patterns, themes and categories in data and was the method of analysis in this study.

Thus, this study is an applied, descriptive, exploratory and ideographic qualitative needs assessment, making use of inductive analysis, set on the philosophical ground of the school of Gestalt Therapy.

4.3.2 Research design

For this research study, a holistic, instrumental case study (Yin, 2008:4; Creswell & Maietta, 2002: 163; Punch, 2005:144; Teddlie &Tashakkori, 2009:25) design was used. An instrumental case study is an empirical inquiry that investigates a problem in its real-life context and occurs when cases are described in order to provide insight into a matter or phenomenon (Creswell & Maietta, 2002:163; Punch, 2005:144; Fouché, 2005:272). Case studies include an in-depth review of settings (the venue and site of the study), actors (who is involved, their origins and behaviours), events (what and when it happens), and processes (the roles and relationships that define a situation) where data emerges through an array of participant interviews, documents and questionnaires (Barber & Brownell, 2008:55).

The researcher aimed to further understand a social problem and the population being studied, and concentrated on experiential knowledge of the case, while paying close attention to the contexts (influence of its social, political, and other contexts), relying on phenomenological, heuristic descriptions (Gerring, 2007:20; Denzin & Lincoln, 2005:451; Fouché, 2005:272; Yin, 2003; Scholz & Tietje, 2002:9-10). Heuristic inquiry is a research process designed for the exploration and interpretation of experience, which uses the self of the researcher (Brownell, 2008:57; Patton,

2002:107; Gray, 2009:29; Stabile, 2009:234; Ryan & Bernhard, 2003). In this study, the researcher attempted to explore the experiences of caregivers, regarding their day to day care-giving and training needs.

4.3.3 Data collection procedure

4.3.3.1 Context and purpose of the data collection

The purpose of the data collection was to explore and describe the perceived training and care-giving needs of caregivers of looked-after children in a children's home. The aim was to provide information with regards to the management of children's homes, social workers and government officials responsible for ensuring quality care. This information might enable role players to form a helping partnership with caregivers for the improvement of the rendering of services, assistance and support, and enable training possibilities. In addition, knowledge collected might provide caregivers with the assurance and reassurance of the extent of competency and so aid in reducing and managing stressful working environments.

In this study, caregivers were motivated to explore, discover and experience their own needs, which facilitated awareness thereof, leading towards a notion to find satisfying contact in their field. This information provided caregivers with the experience of being competent and empowered, allowing the stressful environment to be more manageable.

4.3.3.2 Data collection techniques

The researcher used data triangulation, which included literature, interviews, questionnaires, official documents, the researcher's experience and field notes for data collection:

- *Literature*

Hofstee (2006:137) indicated that literature is considered as primary sources for data collection. In this study the researcher conducted a literature review on two separate occasions. Firstly, a thorough literature review was done in order to draw up the semi-structured open-ended interview schedule. Secondly, a literature review was done in order to control findings of this study.

- *Interviews*

Greeff (2005:287) stated that interviewing is the main mode of data collection in qualitative research. For the purpose of this study, the researcher used an interview schedule, conducting semi-structured, one-on-one interviews making use of open-ended questions organised in areas of interest allowing flexibility in scope and depth (Barber & Brownell, 2008:55; Turner, 2008:29-55; Padgett, 2008:129; Greeff, 2005:292). The areas of interest focused on organisational functioning, challenges, support, training, personal aspects regarding the experience of giving care, day by day caregiving and emotional well-being that was discovered in the literature review.

Interviews were guided by the Gestalt Therapy framework. In a qualitative research interview the participant is not passively reporting facts or opinions, but is better seen as an encounter where the person is actively engaged in exploring the meaning of events or experiences that have been significant for them (McLeod, 1999:125). The phenomenological field of the participant (the needs of caregivers) was explored in the wider field (children's homes). The researcher allowed the interview to progress with some fluidity, allowing the Gestalt Therapy dialogical relationship to form the ground of the interview.

After consent had been given, interviews were scheduled and conducted in the home where the caregivers reside. An interview schedule (Appendix N) was used as a guideline (Greeff, 2002:302) to ensure uniformity and repeatability of this study.

The duration of the interviews was between 40 and 80 minutes. Interviews were video recorded and transcribed, and the accurate field- and reflective notes that were made on each session were used in conjunction with the written questionnaires in the data analysis process.

- *Questionnaires*

Participants who could not attend the interviews, owing to the limited scope of this study, completed semi-structured, open ended questionnaires, with the same questions as in the interview, in order to allow them to give voice to and elaborate on their needs as well.

- *Official documents: Statistical data documents*

According to Strydom and Delport (2005:317), official documents can be used in the collection of qualitative data. Official documents are compiled and maintained on a continuous basis by organisations and are formal and structured (Bailey, 1994:294). In this study, the researcher made use of statistical documents regarding the age of caregivers, the number of and age of looked-after children in each of the caregivers' homes and the years each caregiver was employed at the children's home.

- *Observation*

Observation is a method used to record conditions within the field when conducting research (Walliman, 2005:287). In this research endeavour, the researcher made use of observation by considering aspects within the contact with the participant. Different aspects were observed within the interview and include the following:

- Appearance and self-care (to include stature, weight, clothing, grooming, cosmetic use, posture, motor activity)
- Sensorium (attention span, concentration, orientation, recall and memory)
- Relating and contact (eye contact, facial expression, attitude toward examiner, manner of making and breaking contact)

- Affect and mood
- Thought and language (speech flow, thought content, preoccupations, organization)
- Executive functions (reality testing, insight, decision making, abstraction, judgment)
- Stress (stressors, coping ability, skill deficits, supports)
- Social functioning

The above-mentioned aspects are included in a mental status evaluation when conduction psychological evaluations (Zukerman, 2000:42-43) and was considered and explored when the research was conducted.

- *Field notes*

Greeff (2002:298) maintains that field notes help researchers to remember and explore the process of the interview and is a written account of the things the researcher hears, sees, experiences and thinks about in the course of interviewing. In this study, the researcher's field notes were employed in the data analysis.

- *Member Checking*

This is when data, analytic categories, interpretations and conclusions are tested with members of those groups from whom the data was originally obtained. This can be done both formally and informally as opportunities for member checks may arise during the normal course of observation and conversation. Typically, member checking is viewed as a technique for establishing to the validity of an account.

According to the Qualitative research guidelines project (Cohen, 2006) the positive aspects of member checking include the following:

- Provides an opportunity to understand and assess what the participant intended to do through his or her actions

- Gives participants opportunity to correct errors and challenge what are perceived as wrong interpretations
- Provides the opportunity to volunteer additional information which may be stimulated by the playing back process
- Gets respondent on the record with his or her reports
- Provides an opportunity to summarize preliminary findings
- Provides respondents the opportunity to assess adequacy of data and preliminary results as well as to confirm particular aspects of the data

Lincoln and Guba (1985:315) consider member checking as vital in the establishment of the credibility of qualitative data. “In a member check, researchers provide feedback to study participants about emerging interpretations, and obtain participants’ realities; participants should be given an opportunity to react to them” (Polit & Tatano Beck, 2008:254).

In this research study member checking was done after analysis of data during which all themes, categories and subcategories were given to the participants in printed version and were discussed in face–to-face meetings. Two participants did not want to discuss the research any further while the other participants considered the analysed data themes, categories and subcategories as relevant and accurate.

4.3.4 Sampling plan

In chapter one the sampling plan was described together with the universe and pool from which this study was conducted. For this study 12 caregivers at the children’s home made up the sample. Six caregivers were selected for interviewing, using non-probability purposive, sequential sampling. Non-probability purposive sequential sampling is the sampling procedure defined as selecting a relatively small number of units that could provide particularly valuable information related to the research question under examination, and where the purpose of the research is to generate

themes (Teddlie & Tashakkori, 2009:174; Strydom, 2005:202; Neuman 2003:213). Six additional caregivers, who requested to participate in the study, received identical questionnaires that were used for the semi-structured interviews, and were motivated to explore and expand their views in writing, as much as possible.

Selection criteria included

a. Subjects employed as caregivers of looked-after children in a children's home
b. Caregivers providing care to children in children's homes for more than two years. This criterion was not used as there were a number of participants that had only been with the children's home for a few months, but also wanted to participate in the study.

4.3.5 Participants and respondents

For the purpose of confidentiality, research participant names are not mentioned. Participants interviewed and who filled out the questionnaires, were all caregivers of looked-after children in a children's home in Pretoria, South Africa. The ages of the children in their care ranged from 8 to 18 years old. All participants employed at the children's home live with these children daily and have no other income. More details on the participants are discussed later on, where the data is analysed.

4.4 PHASE FOUR: IMPLEMENTATION

The implementation phase, according to Table 4.2, consists of the consideration of a pilot study and the collection of materials, records and the literature study. The researcher concluded that a pilot study was not necessary as the experience of the researcher in the children's home indicated that the questions were accurate. The researcher adopted the dialogical and phenomenological stance of Gestalt Therapy

and maintains that questions will change as the caregivers tell their story. After the semi-structured interview schedule was compiled, interviews were conducted and field notes were made. The questionnaires were given to participants and statistical documents from the children's home were retrieved.

4.5 PHASE FIVE: INTERPRETATION AND PRESENTATION

Phase Five, in accordance with Table 4.2, consists of the process and analysis of data and verification of results. It includes planning of the narratives and writing of the report. See Appendix O for the signed agreement between the researcher and the children's home. Appendix P consists of the different homes and times caregivers was available for interviewing. In Appendix Q transcripts of all interviews can be reviewed and in Appendix R all analysed questionnaire answers can be checked and validated. In Appendix S the process of data interpretation can be examined.

4.5.1 Data analysis

With qualitative analysis, the focus is on unpacking both explicit and hidden meanings through iteratively examining the data. Engaging in analysis involves researchers dwelling with their data, examining it and then progressively deepening their understanding as meanings come to light (Finlay & Evans, 2009:145). Thematic analysis is a method for analysing and describing important patterns in data (Finlay & Evans, 2009:149). Braun and Clarke (2006) provide a step-by-step guide to typical phases, including the:

a. Familiarisation of the data
b. Generation of initial codes
c. Search for themes
d. Reviewing of themes
e. Definition and naming of themes

f. Production of the report

Creswell (2003:191) states that case study research involves the detailed description of participants, followed by the analysis of the data themes. In this section, the researcher will present the participants' data followed by the exploration and description of the categories and subcategories of the interviews and questionnaires. The researcher recorded and transcribed the interviews, and used the technique of interpretive analysis to investigate the needs suggested by the content of the interviews and questionnaires. The hermeneutic phenomenological process sets the stage for the interpretive analysis, which requires that the description of the data be transparent, rich and complete (Terre Blanche *et al*, 2006; Gummeson, 2003).

4.5.2 Analysis Techniques: QDA of Miles and Huberman (1994)

Qualitative research data analysis involves categorical and contextualising strategies, which result in themes and include breaking down narrative data into smaller units, making connections, rearranging units and producing categories to facilitate better understanding (Teddlie & Tashakkori, 2009:25; De Vos, 2005:335). This research made use of the model for QDA of Miles and Huberman (Punch, 2005:197; Miles & Huberman, 1994:10). Miles and Huberman (1994:10), the authors, state that analysis consists of three current flows of activity: data reduction, data display and conclusion drawing/verification.

4.5.2.1 Data reduction

The data obtained from the interviews was managed by organising the collected data into electronic audio files, which were easily retrievable from the researcher's computer. These files were converted into text, known as a transcription. These transcripts, together with the completed questionnaires, were reviewed many times in order to obtain a sense of information and to become familiar with the data. Thus, inductive and iterative techniques were used until significant and recurring themes

and connections occurred and were identified (Teddlie & Tashakkori, 2009:6; De Vos, 2005:337-338). The generation of categories, themes and patterns in the data was the most difficult phase. An analytic process was used to make comparisons, look for categories and identify themes, ideas and belief patterns (De Vos, 2005:337).

4.5.2.2 Data display

The demographic data obtained from the interviews and questionnaires will be discussed in more detail. This information is useful as it helps to establish a profile of respondents and participants that could be used in further studies.

a. Basic demographic information

Age	**F**	**%**
18-24 years		
25-34 years	1	8.3 %
35-49 years	2	16.6 %
50-59 years	9	75%
60 years +		
Total	**12**	**100%**

The majority of participants and respondents, 75% (9 out of 12), were distributed between the ages of 50 to 59. This table might indicate that caregivers enter this occupation when they are older. When considering developmental psychology, and specific Milton Erikson's psycho-social developmental stages (Appendix T, Bukato & Daehler, 1998:23), caregivers in this study are classified as being in the stage of generativity versus stagnation. "Generativity is a wide concept that includes productivity, creativity and the passing on of culture. People, who acquire

generativity and care, concern themselves with enriching their own and other people's lives. This can be done in a variety of ways, for instance, by educating children, by producing meaningful work, of by creating cultural products. Generativity presupposes faith in the meaningfulness of life, in the value of the human, race, and in the future of humankind." (Louw, Van Ede & Louw; 1998:54). The researcher concludes that the ages of caregivers in this study indicates that they have entered the phase of generativity successfully. Most important developmental tasks and changes during middle adulthood will be briefly named:

- To adjust to physical changes
- To redefine one's self-concept and identity
- To reassess one's values and philosophy of life
- To develop generativity
- To find renewed job satisfaction
- To become a mentor for younger colleagues
- To prepare for eventual retirement
- To expand social activities as a preparation for retirement
- To become more involved in the community and civic affairs
- To act as mediator and bridge between generations
- To act as a conserving force and moral watchdog in the community

b. Gender

Gender	**F**	**%**
Female	11	91.6 %
Male	1	8.3 %
Total	**12**	**100%**

In this study, only one male participated, while the rest of the population were females. This might be an indication that the role of caring is considered a female occupation.

c. Educational qualification

Highest qualification	**F**	**%**
Grade 9	1	8.333 %
Senior certificate	10	83,33 %
Diploma		
Degree	1	8.333 %
Honours Degree		
Masters Degree		
Doctoral Degree		
Total	**12**	**100%**

The majority of this sample, 83, 33% (10 out of 12), indicated having obtained a senior certificate or grade 12, whereas only 8% of participants were graduated. It is noted that the one caregiver who indicated having a degree was also the most positive caregiver in this sample.

d. Number of years as caregiver in this children's home

e.

Number of years as caregiver	**F**	**%**
0-1 year	4	33.3 %
2-4 years	6	50%
4-8 years		
8-10 years		

More than 10 years	2	16.7 %
Total	**12**	**100%**

In this study the majority of participants, 50% (six out of 12) indicated that they had been working at this Children's Home between two and four years. Do not start with an percentage16.7% (two out of 12) participants had been working for more than ten years, while 33.3% (4 out of 12) indicated that they had been working for less than one year at this children's home.

f. Previous training as a caregiver

Training as caregiver	**F**	**%**
None	8	66.6%
Onecourse attended	4	33.4 %
More than one course attended		
Diploma		
Certificate		
Total	**12**	**100%**

The majority of the sample, 66.6% (8 out of 12), indicated that they had no previous training with regards to the task of care-giving. Only 33.4% (4 out of 12) indicated that they had attended one course on care-giving, which dealt with the disciplining of looked-after children.

g. Participants in interviews

Participant	Number of children in house	Gender	Number of years as a caregiver	Previous training
A	12	F	3	None
B	11	F	2	None
C	13	F	14	One course
D	13	F	3	None
E	12	F	3	None
F	13	F	1	One course

h. Respondents of questionnaires

Participant	Number of children	Gender	Number of years as a caregiver	Previous training
G	12	F	20	One course
H	11	F	1	None
I	12	F	1	None
J	13	F	3	None
K	13	F	1	None
L	12	M	4	One course

4.5.2.3 Conclusion drawing and verification of data analysis

The conclusions and verification of the data analysis phase will follow in the next section of this chapter and is considered a part of phase 5 of the research process.

4.6 THEMES, CATEGORIES AND SUBCATEGORIES

In this section, descriptive data is presented in order to facilitate an understanding of the phenomenon under investigation, elaborating and summarising the responses given by caregivers, who participated in this study. The phenomenological descriptions and explanations given by caregivers will be included, which will lead to an in-depth exploration of caregivers' needs.

A table (and discussion thereof) follows that indicates the different themes, with their related categories that were explored during the interviews and in the questionnaires. Themes that were identified in the literature, which also came to the fore in the study during the semi-structured interviews and in the questionnaires are the following: organisational functioning, challenges, support, training, experience as a caregiver, day-by-day care-giving and emotional well-being.

Table 4.6 Themes and categories from data analysis

Theme	**Category**	**Subcategory**	**Delineations**
Organisational functioning	The need for support	ASSISTANCE	Less administration Open communication Availability of management Marketing Disciplinary procedures Vacation leave
		EMOTIONAL	
		ACKNOWLEDGMENT	Be a part of decisions Caregivers' interests
	The need to be valued		To be treated equally
Challenges	Altruistic needs	TO MAKE A DIFFERENCE	

	The need to be valued The need for support	RESPECT ASSISTANCE RESOURCES EMOTIONAL	From children From Management Rest Less working hours Physical resources
Support	The need to be valued The need for support	ACKNOWLEDGEMENT RESOURCES ASSISTANCE EMOTIONAL	To be heard/voice To be understood With difficult children Therapy for children Time for self Therapeutic

			Social networks Other caregivers
Training	The need for support	ASSISTANCE EMOTIONAL	No time for self No time for training
Experience as a caregiver	The need for support Altruistic needs The need to be valued	EMOTIONAL ASSISTANCE RESOURCES TO MAKE A DIFFERENCE GIVING RESPECT	 With difficult children With therapy for children Time for self Physical

Emotional well-being	The need for support	EMOTIONAL	Vicarious traumatisation Therapeutic Trauma

4.6.1 Themes

Themes were identified and recognized in literature from which the interview and questionnaire were developed. During the interviews the following themes were explored and investigated from where subcategories evolved.

4.6.1.1 Organisational functioning

In Chapter Two, the organisational functioning of children's homes was discussed. According to the literature study it was seen that the role of a children's home is to provide an environment that is protective, enhances development and promotes growth and the well-being of looked-after children (Rushton & Minnis, 2008; Aldgate, J. 2006:17; McSherry & Larkin, 2006:135; Terpstra, 1999:1; Simmerman & Cohler, 2000; Sinclair, 2005; Nunno *et al*, 2003; McSherry & Larkin, 2006:135; Pinkerton, 2002; Pinkerton & McCrea, 1999). Owing to the fact that caregivers spend most of their time with looked-after children daily, the goals of children's homes regarding the provision of an environment that is protective, enhances development and promotes growth and the well-being falls to the caregivers. The researcher maintains that the responsibilities of caregivers is exhausting and places tremendous pressure on caregivers.

From the literature it also becomes clear that a gap exists between principles and policies that are set for the organisational functioning and the actual day-to-day life of caregivers (Andersson & Johnsson, 2008:117; Whittaker, 2004; Hudson & Levasseur, 2002:853; Annie Casey Foundation, 2002; Rhodes *et al*, 2001). In the interviews and in the questionnaires this aspect of the organisational functioning was explored.

Children's homes are set in a wider field and include the justice, welfare, health, education, biological and care-giving family system and the system of the children's home. If these systems collaborate to provide looked-after children with the possibility of well-being, aligning to a designated goal (Guishard-Pine, McCall

&Hamilton; 2007:109; also refer to Appendix F: The corporate parent: professional subsystems as a protective shield; Guishard-Pine, McCall & Hamilton; 2007:110), the demands on caregivers will be alleviated, according to the researcher. It is however, difficult for systems to collaborate (Friedman, 1991:239) and thus the demands on caregivers increase.

Organisational functioning was explored during the interviews and in the questionnaires. The main categories that evolved were firstly the need for support, and secondly the need to be valued. Subcategories that evolved from the main themes were: assistance and acknowledgment; and will be discussed in the section that explores caregivers' needs. Below are statements from participants indicating subcategories of:

Assistance: "*I need a lot of assistance with all the admin and management of this place*" (Participant F)

Emotional support: If they could help me emotionally with this management thing that would be great" (Participant D)

Acknowledgment: "*They do not use our knowledge I want them to acknowledge m."* (Participant J; 1)

4.6.1.2 Challenges

In the literature review, different challenges that caregivers face were considered. Some of the challenges included caregivers taking the role of attachment figures, who provide constant physical and emotional care (Harden, 2004:33; Bowlby, 1969/1982: 376-377; Ainsworth, 1989; Prior & Glaser, 2006:57; Weiner, 1991:88). Caregiver challenges include the emotional difficulties and trauma the children display (Rushton and Minnis, 2008:490; Guishard-Pine, McCall & Hamilton, 2007:41; Sinclair *et al,* 2005; Bass *et al*, 2004:11; Wheal, 1995:60,95; Maier, 1991:28), the management of daily routines and tasks (Andersson & Johnsson, 2008:117;

Whittaker, 2004; Hudson & Levasseur, 2002:853), and difficulties relating to emotional and physical health (Larkin, 2006:47; Calam *et al*, 2002; Rodgers, 1998; Kwok & Wong, 2000; Teggart & Menary, 2005; McCarthy *et al,* 2003; Lewis, 2000; Goodman, 1999; McCann and Pearlman,1990; Saakvitne and Pearlman,1996; Figley, 1995; 2002).

The main challenges that caregivers face daily that came to the fore in the investigation, were those leading to the emergence of altruistic needs, the need for support and the need to be valued. Subcategories that evolved from the main themes were to make a difference, to gain respect, assistance, resources and emotional support and will be discussed in the next section

To make a difference (Participant H; 2): *"I want to make a difference"*

To gain respect (Participant J): "*They (referring to management) should listen to the caregivers more and respect them."*

Assistance (Participant E): "*I need help with all this admin and with the children's discipline."*

Resources (Participant A): "*They need to help me with the practical day to day things."*

Emotional Support (Participant K*): "I am so alone in here and I need someone to help me."*

4.6.1.3 Support

Caregivers are the front-end workers (Anglin, 2004; Devine, 2004; Smith, McKay & Chakrabarti, 2004) providing physical, emotional and social factors that enhance the well-being of looked-after children daily. Caring for challenging children who show problematic mental health, as well as learning and behavioural issues was reflected on in the literature reviews and indicated that the care-giving role was complicated.

In literature, few studies focus on assistance and the support of caregivers in children's homes (Crosland *et al*, 2008:410).

Literature regarding support as discussed in Chapter Two indicated that caregivers need to consider a protective shield as a support structure (Guishard-Pie, McCall & Hamilton; 2007:36). In the literature review, the protective factors for caregivers were reflected on and it was seen that social workers, management and other caregivers of the children's home were considered as helping factors that protect caregivers form burnout and exhaustion (Guishard-Pie, McCall & Hamilton; 2007:36). The literature review indicated that support enhances psychological well-being, feelings of control and a sound self-esteem whereas the absence of support may contribute to factors such as loneliness, depression and despair (Larkin, 2006:53; Ceballo & McLoyd, 2002; Crouch, 2002; Weinman, Write &Johnson, 1995). The felt experience of support of caregivers was explored in the interviews and questionnaires and will be discussed in the next section.

Different kinds of support was established in the literature; intrinsic support includes open communication and rapport; role satisfaction; participation in decision-making; being valued for opinions and knowledge. Extrinsic support involves adequate training (Herczog *et al*, 2001; Orme & Buehler, 2001; Rhodes *et al*, 2001; Tracy, MacGregor, Rodger, Cummings & Leschied; 2006:354; Rhodes *et al*., 2003; Ferris-Manning & Zandstra, 2003; Hudson & Levasseur, 2002; Sanchirico *et al*, 1998). In the data collection and analysis, intrinsic and extrinsic support for caregivers was explored.

In Chapter Three, the main concepts in Gestalt Therapy were reviewed. An important concept used in Gestalt Therapy is self- and environmental support (L. Perls, 1976, 1978). Support is considered a "necessary basis of all healthy functioning and the ground that enables satisfying contact" (Joyce & Sills, 2001:83). Hence, if caregivers are to come into contact with their needs and find satisfying contact with their colleagues and management, support is of utmost importance. Self-support includes sound physical health, supportive body posture and breathing, effective coping strategies and creative adjustments, relationship with nature, strong sense of identity, realistic beliefs about the self and the world and spiritual practice (Joyce & Sills, 2001:83). Environmental support include a healthy physical

environment, adequate resources, such as food, shelter, intimate relationships, loving family and friends, validation from others, religious or social network, fulfilling employment and enjoyable leisure activities (Joyce & Sills, 2001:83).

In the interviews and questionnaires, self- and environmental support was explored. The main categories that evolved from the exploration of support were the need to be valued and the need for support. Subcategories emerging from the main categories include acknowledgement, resources, assistance and emotional support and will be discussed in the following section. Subcategories were denoted from the following assertions.

Acknowledgment (Participant D):*"Can they not see that I do so much? They never acknowledge what I sit in."*

Resources (Participant G; 3): "*physical, spiritual, emotional help"*

Assistance (Participant I; 4): "*When a warning was given and the problem is still there we need assistance from them to proceed with the disciplining these difficult children."*

Emotional support (Participant K): *"There is no place to talk. We need such help from them."*

4.6.1.4 Training

In the literature, it comes to the fore that the training of caregivers is both necessary and of great value (Wilson *et al*, 2003; Rushton & Minnis, 2008:494; Wilcox, 2008:417; Rhodes *et al*, 2001:110).Training increases confidence, positive interaction, efficiency and the quality of care (Rushton & Minnis, 2008:494; Teggart, 2006:159; Burns *et al*, 2004; Hills & Child, 2000; Davison, 1995:71; Golding, 2004). According to the researcher, which can also be obtained from the literature (Nunno *et al*, *2003;* Wilson *et al*, 2003; Rushton and Minnis, 2008:494) the challenges caregivers face, are an indication of the specialised knowledge and skills required to prevent and manage the difficulties of day-to-day living. A trauma-informed system is

considered a need in all children's homes (Ko *et al*, 2008). Illiteracy together with a lack of competence presents a danger to looked-after children, according to the researcher. Literature supports the focus on the training of caregivers (Wilcox, 2008:417; Rhodes *et al,* 2001:110).

It is remarkable that, in the investigation, a surprisingly low number of participants stated a need for training. During the exploration of the training theme, the researcher searched for further information regarding the low need for training and discovered that due to limited emotional support, together with the lack of assistance and burnout, the caregivers could not imagine where and how they would fit training into their schedule. Even though caregivers felt that training is very important and is imperative for their work they just did not have emotional time resources to include this need. Being a caregiver is a demanding and emotionally stressful occupation (Brannen *et al*; 2009:11) leading to difficult challenges to overcome, depleting caregivers of emotional resources. According to statements from caregivers, the researcher believes that if they were given enough emotional support and assistance, training needs would emerge.

In the investigation of the theme of training, the need for support emerged with the subcategories of assistance and emotional support. The following reports from the participants identified these categories.

Need for support (Participant C): "I *am too tired to do training* "

Assistance (Participant E): "I need help with all this admin and with the children's discipline."

Emotional support (Participant B): *"I am actually just too tired and cannot do any training"*

The need for support, together with the sub-categories, will be discussed in the section regarding needs.

4.6.1.5 Experience as caregiver

A theme that arose in the literature was that of the experience of being a caregiver and was considered in job motivations and satisfaction. Work motivation, also described as a set of internal and external forces that arouse or initiate work- related behaviour and determine its direction, intensity, form, and duration (Ambrose and Kulik, 1999). McGregor *et al* (2006:352) explained that “Intrinsic motivation has been defined as tasks that are performed for the pleasure they yield and due to forces that are inherent in the person, such as values. In contrast, extrinsic motivation refers to environmental or situational expectations and rewards (Baron, 1998).”Intrinsic job attributes are highly related to job satisfaction and retention rates” (Ambrose & Kulik, 1999).What motivates caregivers was explored, which will be considered in the section that explores and describes the needs of caregivers.

Societal influences such as religious affiliation and the feeling of an obligation to care for others is another form of motivators found in studies (Gillis-Arnold, Crase, Stockdale & Shelley, 1998). Some caregivers in this study were also in children’s homes themselves, and therefore identify closely with looked-after children. This is confirmed in studies regarding foster caregivers (Baum, Crase & Crase 2001; Redding, Fried & Britner, 2000).

Another intrinsic motivator is altruism. Some individuals feel blessed for what they have in life and have a desire to ‘give back’ to the community (Denby Rindfleisch & Bean, 1999; Testa & Rolock, 1999). Other altruistic motivators include wanting to help children, providing children with a stable environment, and caring out of a love for children (Barth, 2001; Buehler, Cox & Cuddeback, 2003). In Chapter Three, Maslow’s hierarchy was considered and it was concluded that when safety and security is assured, the need for novelty, experimentation, discovery and altruistic (which is the need to consider others in need) needs emerges (Mistler, 2010 b, Maslow, 1963). From the interviews and answers to the questionnaires, altruistic motivations emerged and will be reflected on in the next section. Results from this

study showed that the most frequent motivations for being caregivers were intrinsic, altruistic motivators of wanting to make a difference in children's lives.

A motivator that is of an extrinsic nature is monetary. Some studies report that people are fostering as a means of an income (Isomaki, 2002; Redding *et al*., 2000). The researcher believes that caregivers in children's homes also respond to monetary motivators. This was included in the interviews and questionnaires. Results showed that caregivers in this sample reported not doing the work as a means of income, but did indicate a feeling of receiving too little payment.

Research regarding foster parents indicated that when receiving adequate preparation and training, timely crisis intervention, and a sense of being valued and respected by the agency, they are more likely to continue to foster (Hudson and Levasseur, 2002). The researcher believes this to be true for caregivers in children's homes as well and therefore investigated and explored motivations for the continuation of care-giving as an occupation. To sum up, job motivation and altruistic motivations were explored indicating the need for support, altruistic needs and the need to be valued.

Definitions on looked-after children in the literature indicate that they are children inundated and exposed to trauma to such an extent that warranted removal from their homes (South Africa, 2007-2008: 14). Literature indicated and confirmed that severe behavioural, emotional, psychological, scholastic and developmental issues of looked-after children, due to a history of exposure to traumatic stress, exists (White *et al*, 2009:38; McCrae, 2009:17-28; Halvorsen, 2009; Anderson, 2009; Sempik *et al*, 2009; Boyd-Webb, 2009; Little *et al*, 2009; Ko *et al*, 2008; Litz, 2008; Briere, Kaltman & Green, 2008; Zeanah *et al*, 2008). The literature on looked-after children's difficulties complicates the caregiving and specialised role considered necessary (Guishard-Pine *et al,* 2007:3, 78). The needs of caregivers with regards to specialised care for looked-after children will be discussed in the following section.

Looked-after children have the right to appropriate alternative care, basic nutrition and shelter, health care and social services. In addition, they have the right to be protected from maltreatment, neglect, abuse or degradation. Their best interests are of paramount importance in every matter (Act on constitutional rights of children,

section 28). It is noted that there are no documents that indicate the rights of caregivers in children's homes in South Africa. The rights of looked-after children and those of caregivers have implications for their daily needs and were investigated in this study and will be reflected on in the next section.

From the literature, organisational options that could provide an environment that enhances the goals of children's homes were contemplated (Harden, 2004:31; Watson, 2003; Anglin, 2002; Whitaker *et al,* 1998; Davison, 1995:50,128) and addressed matters such as policies; routines and behavioural boundaries, appropriate documentation and guidelines providing a sufficient quantity of information as to enable the provision of quality care of staff employed in the establishment; consistency, guidelines and standards, in order for congruency across processes and operations. The daily organisational functioning and needs were investigated in the questions and the findings will be explicated under the "needs" heading. What additionally came to the fore was that caregivers indicated not being protected under the labour law in South Africa which has implications on their daily activities and working hours. The researcher explored this statement and found it to be true owing to the fact that children's homes were declared an essential service. The lack of being protected by the law is a major concern for the researcher and should be considered by the welfare system and government.

Day-to-day care-giving needs were explored indicating a category of the need for support emerging, together with altruistic needs and the need to be valued. Sub-categories included the lack of resources and emotional support, the need for respect and to make a difference. Indications toward the above-mentioned categories and subcategories follow.

Need for support (Participant L):"*It's an overwhelming job and I need some support."*

Need for respect (Participant L): *"These children are disrespectful and impolite."*

Need to make a difference (Participant A): "*And you know, I want to make a difference in these children's life and in society."*

Emotional Support (Participant G): *“Emotional release is needed – just to have an ear to listen to me.”*

4.6.1.6 Emotional well-being

The researcher believes that caregivers can be seen as parental substitution as physical and emotional care, continuity and consistency, thus emotional investment is provided (Howes, 2008:317-332). Tracy and Johnson, (2006:11) mentioned that there are typical observed responses to trauma and typical effects trauma has on parenting roles and capacities. Some effects are on the cognitive, affective, behavioural and physiological domains (Tracy & Johnson, 2006:119; also refer to Appendix G). This theme was included in the data collection.

From the literature, it was established that caregivers were exposed to trauma daily (Nicolas, Roberts & Wurr, 2003:78-83). Living with distressed traumatised looked-after children, ministering directly to their needs, cause trauma symptoms for caregivers and is termed vicarious traumatisation or compassion fatigue (McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996; Figley, 1995; 2002). Evidence regarding the symptoms following traumatic experiences were indicated in chapter two (Littleton, Horsley, John & Nelson, 2007:985; Crenshaw & Hardy, 2006:189; Guishard-Pine, McCall & Hamilton; 2007:78; Solomon & Heide, 2005:51-60; Perry, Pollard, Blakley, & Vigilante, 2000,1995; Ko *et al*, 2008:397; Cameron, Elkins & Guterman; 2006:57; Briere *et al*, 2008:223; Lauterbach, 2001:5-18; Lieberman & Van Horn, 2004:117; Greenberg & Paivio, 1997). These traumatic experiences may be thought of primarily as pertaining to some of the DSM-IV-TR diagnostic criteria for PTSD and complex PTSD (Cameron, Elkins & Guterman; 2006:57; De Rosa & Pelcovitz, 2006:221), which are symptoms related to: re-experiencing of traumatic events; avoidance of stimuli and numbing of responsiveness; increased arousal and difficulty with affect modulation and behavioural control; alterations in attention, consciousness, self-perception and in systems of meaning (APA, 2000). In this study, the diagnostic criteria of PTSD and complex PTSD were taken into account and explored.

In Chapter Two, it was seen that the emotional impact of working with looked-after children has a potential to inhibit sound care practices (Emmanuel, 2002) and could lead to burnout, depression and other psychological and physiological difficulties (Larkin, 2006:47; Kwok & Wong, 2000; Teggart & Menary, 2005; McCarthy *et al,* 2003; Lewis, 2000; Goodman, 1999). Stress on physiological and psychological areas has been known to be associated with increased child-directed hostility, negatively expressed emotion, coercive parent-child interaction styles, lack of warmth and availability, and child maltreatment (Larkin, 2006; Calam *et al*, 2002; Rodgers, 1998). Psychological and physiological well-being and challenges were considered and will be commented on in the following section.

When conducting the interviews, the researcher became aware of the depressive state of caregivers and consequently studied literature on depression. According to research, approximately 16% of the general population experience depression at some point in their lives (Kessler *et al*., 2003). Studies have demonstrated that depression and depressive symptoms in primary caregivers affect child cognitive and socio-emotional development adversely (Belsky, 1984, 1996, 1999; Cicchetti, Rogosh, & Toth, 1998; Duggal, Carlson, Sroufe, & Egeland, 2001; Essex, Klein, Miech, & Smider, 2001; Hipwell, Goossens, Melhuish, & Kumar, 2000; Kurstjens & Wolke, 2001; Radke-Yarrow & Klimes-Dougan, 2002; Ramchandani, Stein, Evans, & O'Connor, 2005; Shiner & Marmorstein, 1998). Depressive symptoms that were considered as themes for the study were: a depressed mood for most of the day and nearly every day; diminished interest or pleasure in all or most activities; significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy nearly every day and feelings of worthlessness or excessive or inappropriate guilt almost every day (APA, 2005:335).

A major concern is that of the strong need for support that was displayed during the investigation. The main category regarding needs that evolved from the exploration of emotional well-being was that of the need for support as indicated by the following statements.

(Participant G): "*Burn out is an emotional, spiritual and physical tiredness and I feel like that now."*

(Participant K): “Somewhere to *let my tears out without being judged.”*

(Participant H): *“Therapy, a place to talk.”*

(Participant J): *“Medical aid for therapy.”*

(Participant B): *“I work hard here and do not feel cared for of loved. I need to recuperate emotionally. I feel worthless and guilty about that and I can’t sleep. I am very irritated and sometimes feel hostile towards everything. Even when I am off I do not rest here I need to go away for a while.”*

(Participant C): “*More counsellors – somewhere that you can let go.”*

The above statements indicated towards the subcategory of emotional support and will be described in the following section.

4.6.2 Needs

Needs are theoretical constructs and not easy to extract (Lederer, 1980; Heller, 1980; Galtung, 1980), because it cannot be observed in a direct, physical way. Bay (1980), Masini (1980) and Maslow (1968) maintained that the satisfaction of needs is a requirement for safety, well-being and growth of human beings. The satisfaction of needs is also a requirement for survival and development in societies.

Chapter Two and Three indicated that needs are satisfied in a hierarchical order (Maslow, 1968). The need for safety and security is dominant in the physical sphere, where care and validation are dominant in the mental/emotional/social sphere (Galtung, 1990; Maslow, 1968). However, when safety and security are assured, the need for novelty, experimentation, discovery and altruistic (which are the need to consider others in need) needs emerges (Mistler, 2010 b; Perls, 1973; Maslow, 1968). Imaginative curiosity takes over when the individual feels safe and secure, when there is no need to fear for survival in any context—physical, mental, emotional, or social. In data collection and analysis of this study, the felt experiences of caregivers regarding safety and security were explored and will be commented on in the conclusion of this section.

In conjunction with the prior experience the researcher gained at caregiving homes, for the data collected in the study, interviews, questionnaires, statistical documents, as well as reflective field notes were used. The aim of the discussion of the section that follows is to present descriptive data from the data analysis to broaden the understanding of the needs that caregivers experience. The needs that will be discussed are the need for support, altruistic needs and the need to be valued. A table indicating the need categories, subcategories and delineations that emerged during the data analysis, follows.

Table 4.6.2 Data analysis categories, subcategories and delineations

NEEDS CATEGORY	SUBCATEGORIES	DELINEATIONS
THE NEED FOR SUPPORT	The need for assistance	Regarding children's discipline and therapy
		Regarding administration
		Regarding marketing
		Regarding availability
		Regarding working hours
	The need for resources	Regarding physical resources
	Emotional needs	Therapeutic needs
		The need for social networks
		The need for collegial bond
		The need to recover from trauma and vicarious traumatisation
ALTRUISTIC NEEDS	The need to make a difference	in life and in the children's lives
	The need to give	love, care, belonging
THE NEED TO BE VALUED	The need to be respected	by children, by management
	The need to be acknowledged	by inclusion in decisions
		by recognition of interests
		by equal treatment
		by being listened to

4.6.2.1 The need for support: Assistance, resources and emotional

While working at the children's home alongside the caregivers, the researcher became aware of the intense need for support, specifically the need towards emotional support and assistance in managing the home with adequate resources. This need was expressed by all the participants (12 out of 12) and pertained to the following:

> *"This is a system for children and not for the caregiver. I feel very lonely and unsupported in this place"* (Participant E)
>
> *"They (referring to management) are very good for the children, but very hard on the caregivers, there is no place for me and nobody looks out for me."*(Participant F)
>
> *"They (referring to the management) do not make my life easy and nobody supports me."*(Participant L)

It was evident that the Child Care Act, 1983 (Act No 74 of 1983) states that children's homes exist for the reception, care and bringing-up of children in need. This indicates that children's homes are primarily there for the children in their care and should be the focus of all resources. The goal of children's homes, as indicated by literature (Rushton & Minnis, 2008; Aldgate, J. 2006:17; McSherry & Larkin, 2006:135; Terpstra, 1999:1; Simmerman & Cohler, 2000; Sinclair, 2005; Nunno *et al*, 2003; Pinkerton, 2002; Pinkerton & McCrea, 1999; McSherry & Larkin 2006:135; Gelles, 1999:60), agrees with a focus on the children in care, leaving out an important aspect of the environment, namely caregivers. In the above statements from caregivers, the Child Care Act, 1983 (Act No 74 of 1983) and the literature seems to have achieved the goal of requiring a focus on looked-after children. Caregivers in children's homes felt neglected, where all attention was focused and resources directed to looked-after children leaving caregivers feeling unsupported and unwelcomed.

The strong reactions and feelings reflected by caregivers, both in interviews and questionnaires, indicated to the researcher that this was an important aspect in the

investigation. The investigation and data analysis led to subcategories of assistance, resources and emotional support and will be discussed in the following section.

a. Assistance

From interviews and questionnaires, the subcategory of assistance emerged and includes aspects of assistance with children, regarding discipline and therapy, administration, marketing, availability of management, working hours and with regards to vacation leave. Should caregivers receive assistance in the identified matters, a greater feeling of support could be experienced, that could contribute to protective factors (Guishard-Pie, McCall & Hamilton; 2007:36) for caregivers as identified in the literature and indicated in Chapter Two.

Daily managerial tasks and administration, together with the challenges produced by looked-after children, creates a stressful environment in which caregivers have to function and produce quality of care, as suggested in Chapter Two (Rushton and Minnis, 2008:490; Guishard-Pine, McCall & Hamilton, 2007:41; Sinclair *et al,* 2005; Bass *et al*, 2004:11; Wheal, 1995:60,95; Maier, 1991:28; Andersson & Johnsson, 2008:117; Whittaker, 2004; Hudson & Levasseur, 2002:853). As indicated by caregivers, pressure from social workers and management to perform in excellence, together with long working hours, further increases the demanding and challenging atmosphere.

> *"There are enough policies for the whole Africa."*(Participant A)
>
> *"These policies just don't work in the real world."*(Participant B)
>
> *"There is a tremendous amount of administration."*(Participant B)
>
> *"There are a lot of meetings, and enough time to raise concerns."* (Participant C)

It was indicated that the amount of administration including weekly reports did not correlate with the amount of time available in working hours. Working hours are from one o'clock in the afternoon until all children are in bed at about 10 pm. The "off duty

time" from 8 am is spent on administration, marketing of homes and daily routine tasks.

> *"I am on duty 24/7. I am exhausted."*(Participant H page 2, Participant I p 3)
>
> *"I never go off duty. I get the feeling that they do not want me to rest because there is always more to do."*(Participant B)
>
> *"I am supposed to rest in the mornings but there is just too much to do."* (Participant C)
>
> *"Could somebody assist with the marketing of the house? I am not a saleslady"* (Participant C)

These statements clearly indicate the frustration and exhaustion the caregivers experience and necessitate attention towards administration, the marketing of homes and working hours of caregivers.

In literature, training is considered an extrinsic support (Herczog *et al*., 2001; Orme and Buehler, 2001;Rhodes *et al*, 2001; Tracy, MacGregor, Rodger, Cummings & Leschied; 2006:354; Rhodes *et al*., 2003; Farris-Manning and Zandstra, 2003; Hudson and Levasseur, 2002; Sanchirico *et al*., 1998; Sanchirico *et al*., 1998) increasing confidence, positive interactions, efficiency and quality of care (Rushton & Minnis, 2008:494; Teggart, 2006:159; Burns *et al*, 2004; Hills & Child, 2000; Davison, 1995:71; Golding, 2004). According to the researcher and literature (Nunno *et al*, 2003; Wilson, Petrie, & Sinclair, 2003; Rushton and Minnis, 2008:494) training is necessary and illiteracy together with a lack of competence presents a danger to looked-after children, according to the researcher. Literature supports the focus on training of caregivers (Wilcox, 2008:417; Rhodes *et al*, 2001:110). Although a need for training does exist, the mentioned circumstances cause for this need to be shifted into the background. The children's homes' focus on looked-after children further reduces the possibility and availability of training resources.

With regard to the availability of management, caregivers stated that:

> *"If they were only available when I need them"* (Participant L)

The absence of management was experienced by the researcher as well. During important decision-making periods, both social workers and management were not available, however this was owing to court proceedings that consume a great deal of time from both social workers and management, leaving caregivers unsupported and without assistance. In literature, open communication and rapport is considered an extrinsic support (Herczog *et al*., 2001; Orme and Buehler, 2001; Rhodes *et al*, 2001; Tracy, MacGregor, Rodger, Cummings & Leschied; 2006:354; Rhodes *et al*., 2003; Farris-Manning and Zandstra, 2003; Hudson and Levasseur, 2002; Sanchirico *et al*., 1998; Sanchirico *et al*., 1998) and could be considered an aspect of intervention in the support of caregivers.

Another need that came to the fore in the investigation was a need for assistance with children's therapy and discipline. As can be seen in the literature, (South Africa, 2007-2008:14; Teggart, 2006:153; Nicolas, Roberts & Wurr, 2003:78-83; White *et al*, 2009:38; McCrae, 2009:17-28; Halvorsen, 2009; Anderson, 2009; Sempik, Ward, & Darker, 2009; Boyd-Webb, 2009; Little, Akin-Little Gutierrez, 2009; Ko, Kassam-Adams, Wilson, Ford, Berkowitz & Wong, 2008; Litz, 2008; Briere, Kaltman & Green, 2008; Zeanah, Smyke, Settles, 2008) these children have confirmed behavioural, social and emotional difficulties. Symptoms and difficulties leave this population of children severely vulnerable and disadvantaged (Mekki, 2004:121; Farris-Manning & Zandstra, 2003). This increases the difficulty of caring for the children and therapeutic resources for looked-after children becomes an important factor to reflect on. Caregivers indicated that long waiting lists and the shortage of psychological aid increase the challenges.

> *"The children become crazy and there is nobody to see them and help them."*(Participant K p 2)

> *"Their problems just keep piling up, and nobody can see them to help them."*(Participant C)

> *"If they (referring to looked-after children) do not go for therapy they just keep getting worse until I cannot control them anymore."*(Participant G p 3)

Caregivers indicated that, together with the little assistance they receive as far as the psychological needs of the children are concerned; the discipline procedures are not consistent. Social workers differ in opinions and consistent punishment and discipline is not available.

b. Resources

From the interviews conducted and in the written questionnaires, all caregivers indicated a need for support with regard to resources. Statements that point to this need included:

> *"If I just didn't have to worry about the food, clothes and medicine of the children, then I would be o.k."*(Participant E)
>
> *"I wish I could give them more."*(Participant J p 3)
>
> *"I need a lot of things in my home."*(Participant D)
>
> *"There are things that I cannot live without but since I do not have them, what should I do?"*(Participant F)

Tangible needs include mainly finances, computers, the internet, medicine, a library, household equipment, a car, more meat and vegetables and clothes. Each caregiver receives an amount of R5000, 00 per month to run a house with thirteen children in it, which must cover all expenses of the household. In the experience of the caregiver, from the experience of raising her own family, this seems to be unrealistic. Caregivers have to market their own houses and search for donators. The researcher observed the various homes and it became apparent that those caregivers who had the ability to "sell" their houses had more furnished houses, due to donations, whereas others had not, leading to frustrations and contention amongst caregivers. Although caregivers indicated a need for more resources, they did indicate that should there be an emergency, social workers and management are ready to help looked-after children.

c. Emotional

Emotional support was the most significant theme throughout this study. The need for emotional support was a theme that occurred continuously, a clear indication of the urgency and importance of the need. Throughout the interviews with the participants the researcher was constantly aware of the tiredness amongst caregivers and the number of times exhaustion was referred to.

> *"I do not feel that I can manage the home, I am too tired"*(Participant D)
>
> *"There is no emotional support for me."*(Participant K; 3)
>
> *I feel burned out."*(Participant G; 7)
>
> *"Everything is just too much to bear."*(Participant E, Participant J; 2)

In the system and field of this particular children's home, a culture has been established where caregivers are afraid to show their pain and emotional suffering clearly seen by descriptions and expressions such as the following:

> *"I cannot talk about my pain with management of the social worker as they will think I am not strong enough."*(Participant I; 4)
>
> *"I have to wear a mask as they (referring to management and social workers) should not see my tiredness."*(Participant F)
>
> *"I have to bury my pain very deep inside."*(Participant H; 2)
>
> *"If you talk about your pain and suffering they think you have failed and might replace you."*(Participant B)
>
> *"It would be so nice to have a place to let go of the tears without feeling judged."*(Participant K; 5)

Strong emotional words were used throughout interviews and included suffering, pain, agony and hurt. These words are an indication of the level of emotional distress caregivers experience daily. However their difficulties and expression thereof does not seem to be tolerated or supported.

“I have nowhere to go with my pain.”(Participant D)

The reader is referred to Appendix G, (Trauma Symptoms and Potential Effects on parenting, Tracy & Johnson, 2006:117), where different domains of people’s lives that are influenced by the exposure to trauma can be seen. Domains that are affected include cognitive, affective, behavioural, and physiological. In the interviews with the caregivers and the analyses of the questionnaires, the researcher probed and investigated the presence of difficulties in all of the mentioned domains and concluded that ten out of the 12 participants were affected in all domains. Two caregivers were affected in affective, behavioural and physiological domain. Statements that indicated the presence of difficulties includes the following.

“Sometimes I do not know where I am and do not know what time it is.” (Cognitive domain)(Participant E)

“I sometimes dream of the children’s difficulties” (Cognitive domain)(Participant F)

“I feel so low and cry all the time.” (Affective domain)(Participant D)

“I cannot keep these children safe all the time and it drives me insane.” (Affective domain)(Participant A)

“I feel hopeless and sad.” (Affective domain)(Participant H; 1)

“I cannot cry anymore and I do not care what they do anymore.” (Affective domain)(Participant L)

“I feel so alone.” (Affective domain)(Participant I; 8)

“I just feel like I am running around the whole time without completing anything.” (Behavioural domain)(Participant B)

“I sometimes react in the strangest ways toward these children” (Physiological domain)(Participant L)

The above statements are indications of the intense need for emotional support. In the literature review, it was established that caregivers are exposed to trauma daily (Nicolas, Roberts & Wurr, 2003:78-83). Living with distressed, traumatised looked-

after children, ministering directly to their needs, causes trauma symptoms for caregivers, which in the literature refers to the work of McCann and Pearlman (1990) and Saakvitne and Pearlman (1996) on vicarious traumatisation and compassion fatigue (Figley, 1995; 2002). Vicarious traumatisation and compassion fatigue indicates the risks to caregivers involved in treating and caring for traumatised children. The emotional impact of working with looked-after children has a potential to inhibit sound care practices (Emmanuel, 2002). Caregivers in this study are definitely presenting symptoms of vicarious traumatisation and compassion fatigue as indicated by above statements and literature reveals that it could lead to burnout, depression and other psychological and physiological difficulties (Larkin, 2006:47; Kwok & Wong, 2000; Teggart & Menary, 2005; McCarthy *et al,* 2003; Lewis, 2000; Goodman, 1999).

There is a need for therapeutic assistance and a place where caregivers could visit their own trauma. Trauma could lead to preoccupation, withdrawal, a lack of presence, and a lack of focused attention while attempting to care, leading to an environment of instrumental care (Prior & Glaser, 2006:59-60). The literature review considered instrumental care (Prior & Glaser, 2006:59-60) as arrangements without joy, emotions commitment or love, leaving already vulnerable children feeling unloved and unworthy. In this study, most caregivers indicated that the tremendous burden they feel is absorbing their joy and emotional commitment to the children.

> *"I simply cannot be there and listen to them; we just go through the daily routines."*(Participant L)

Most caregivers in this study indicated a feeling of being burned out, being depressed, being fatigued, having diminished interest, having Hypersomnia and feeling unworthy. Stress in the areas, mentioned above, has been known to be associated with increased child-directed hostility, negatively expressed emotion, coercive parent-child interaction styles, alack of warmth, availability, and child maltreatment (Larkin, 2006; Calam *et al*, 2002; Rodgers, 1998).

In Chapter Two it was seen that traumatic experiences may be thought of primarily as pertaining to some of the DSM-IV-TR diagnostic criteria for PTSD and complex PTSD (Cameron, Elkins & Guterman; 2006:57; DeRosa & Pelcovitz, 2006:221),

which are symptoms related to: re-experiencing of traumatic events; avoidance of stimuli and numbing of responsiveness; increased arousal and difficulty with affect modulation and behavioural control; alterations in attention, consciousness, self-perception and in systems of meaning (APA, 2000). The researcher is not a clinical psychologist and cannot make any diagnosis with regards to the trauma symptoms of caregivers. However, all symptoms relating to PTSD and complex PTSD were indicated by caregivers and the researcher asserts that further investigation and therapeutic diagnosis should be considered.

In the literature research, studies have demonstrated that depression and depressive symptoms in primary caregivers affect child cognitive and socio-emotional development adversely (Belsky, 1984, 1996, 1999; Cicchetti, Rogosh, & Toth, 1998; Duggal, Carlson, Sroufe, & Egeland, 2001; Essex, Klein, Miech, & Smider, 2001; Hipwell, Goossens, Melhuish, & Kumar, 2000; Kurstjens & Wolke, 2001; Radke-Yarrow & Klimes-Dougan, 2002; Ramchandani, Stein, Evans, & O'Connor, 2005; Shiner & Marmorstein, 1998). Depressive symptoms included in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2005:335) follows: a depressed mood most of the day and nearly every day; a diminished interest or pleasure in all or most activities; significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy nearly every day and feelings of worthlessness or excessive or inappropriate guilt nearly every day. In the interviews and through data analysis of the written questionnaires, the researcher became aware of the depressed emotions being displayed and being written by caregivers. Again, as the researcher is not a clinical psychologist, no diagnosis could be made.

Together with the emotional condition caregivers seem to be in, other protective factors are also neglected. According to Guishard-Pine *et al* (2007:29), protective factors are those external and internal resources that limit our vulnerability to long-term psychological problems. Figure 2.4.1 in Chapter Two, indicated possible protective factors that caregivers must take into account (Guishard-Pie, McCall & Hamilton; 2007:36). Social networks and collegial bonds are considered necessary factors to protect and enhance well-being. Caregivers expressed a need for collegial support and social network. However, in this children's home environment, few social

networks and collegial bonds are encouraged. Time constraints and the emotional condition of caregivers do not enhance the ability to form these bonds and support.

Emotional support is considered by the researcher as the main need of caregivers and it is recommended that therapeutic assistance, social networks and collegial connections be the focus of intervention.

4.6.2.2 Altruistic needs

Altruism refers to the quality a person possesses regarding the unselfish concerns for the welfare of others and the devotion to the interests of others (Palmer, 2009:1-18). Caregivers in this study indicated that this need drives them from day to day and motivates them to "*get up in the morning* (Participant B)*."* The **need to make a difference**(Participant G; 5)in the lives of looked-after children and the **need to give** *love, acceptance, support, recognition, affection, warmth and care* was the main encouragement and motivator for caregivers. Altruistic needs allow caregivers to feel valued and appreciated, increasing their self-esteem.

In the literature review, work motivation has been defined as a set of internal and external forces that arouse or initiate work-related behaviour and determine its direction, intensity, form, and duration (Ambrose and Kulik, 1999). MacGregor *et al*(2006:352) explained that "intrinsic motivation has been defined as tasks that are performed for the pleasure they yield and due to forces that are inherent in the person, such as values (Baron, 1998)." Intrinsic job attributes are highly related to job satisfaction and retention rates (Ambrose & Kulik, 1999). Motivations of caregivers indicated that intrinsic factors are very strong and especially the intrinsic motivator altruism. Caregivers indicated that they have a desire to 'give back' to the community as is confirmed in the literature (Denby *et al*., 1999; Testa & Rolock, 1999). For the purpose of this study, altruistic motivators included wanting to help children, providing children with a stable environment, and caring out of a love of children, which was established in literature as well (Barth, 2001; Buehler *et al*., 2003). Owing to the pressure to perform and time pressure, altruistic needs of caregivers are fading and as no support is made available to them, the feeling of

‘unselfish concerns for the welfare of others and the devotion to the interests of others’ is depleted.

4.6.2.3 The need to be valued

Different kinds of support are established in literature where intrinsic supports include being valued for opinions and knowledge (Herczog *et al*., 2001; Orme & Buehler, 2001; Rhodes *et al*, 2001; Tracy, MacGregor, Rodger, Cummings & Leschied; 2006:354; Rhodes *et al*., 2003; Ferris-Manning & Zandstra, 2003; Hudson and Levasseur, 2002; Sanchirico *et al*., 1998; Sanchirico *et al*., 1998). Caregivers indicated a strong need to feel valued. The exploration of this need indicated that caregivers need to be respected and acknowledged.

“I sometimes feel nobody sees me. I want them to value me.”(Participant K; 2)

“I would like to be valued” (Participant J p 1)

a. To be respected

“These children are disrespectful and impolite.”(Participant L)

“I want to be accepted and respected and want to be treated fair.”(Participant E and Participant A)

In the analyses of interviews and questionnaires, the need for respect emerged. In the experience of the researchers’ work with some of the looked-after children, this need also emerged. Children in this environment have a history of abuse and neglect leading to difficulties in behavioural issues and in turn, a display of disrespect. The need to be respected surfaced for 9 out of 12 participants.

b. To be acknowledged

"The system is only focussing on the children."(Participant C)

"Everything that is considered in this place revolves around the children."(Participant D)

In these statements, it is seen that caregivers felt that the system is only catering for the needs of looked-after children. The children's home in this study fails to provide caregivers with the feeling of being equal partners. Descriptions of how interests and needs were considered irrelevant were described by most caregivers as an important aspect of their experience in the children's home and they were constantly reminded of "the children's needs" as being the most important. Caregivers felt that they were not acknowledged in decisions and felt that as they had the most contact with the child, should be involved in the decisions being made. The experience of caregivers regarded the system as focusing on the children, and that they were not acknowledged in decision-making, led to the emergence of the need for acknowledgement. The following aspects are included in the need for acknowledgement through:

a. Inclusion in decision-making;
b. Recognition of caregiver interests;
c. Equal treatment of caregivers;
d. By listening to and allowing caregivers to have a voice.

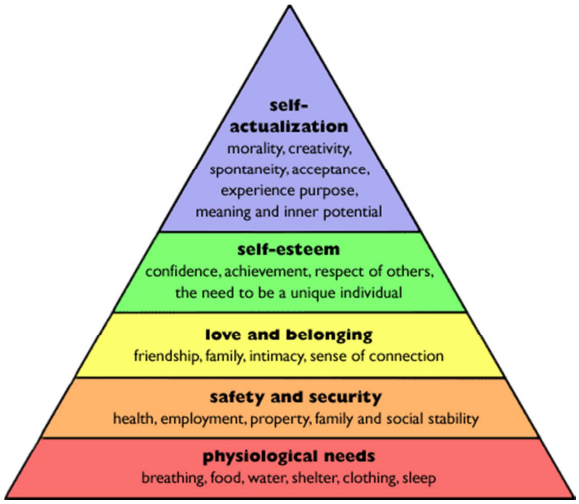
4.6.3 Conclusion

Perls (1973:17) stated that: "No individual is self-sufficient; the individual can exist only in an environmental field. The individual is inevitably, at every moment, a part of some field." The question to ask is: "What is considered to be appropriate and pertinent action in a hostile field?"

When considering the circumjacence (Woldt, 2005:160) of caregivers, hostility, intolerance, conflict, resistance, disagreement and unfriendliness seem to be in the order of the day. An environment filled with constant disruptions without support indicates difficulties and challenges, regarding contact in the field. Contact is considered a **responsive meeting** with the other (environmental and internal others, alienated aspects, blocked feelings, thoughts, and memories, whatever are not integrated and therefore experience as other), leading to a new configuration of both environment and organism (Woldt, 2008). However, in this study, it became clear that caregivers are discouraged to make contact with both environmental others (social workers, management, colleagues, and other social networks) and internal others (needs that are not integrated and perceived as caregivers own). A 'responsive meeting' would encourage differences and 'voices' to be heard, but social workers and management of this children's home seems not to support a 'responsive meeting' which led to difficulties for caregivers. Caregivers indicated their discouragement of a 'responsive meeting' with their own needs, not allowing needs to be satisfied or to surface, owing to the fear of being viewed as "emotionally not able to cope."

According to psychologist Abraham Maslow, people are motivated by their needs. The base of Maslow's pyramid as seen in Figure 4.9 contains our most basic biological needs, while safety, love, and self-esteem form the next three levels, respectively. The top of the pyramid is the desire for self-actualisation, or self-fulfilment. Maslow stated that without meeting basic needs at the bottom, those more evolved cannot be obtained. Thus self-actualisation, according to Maslow's model, is what all people ultimately strive toward; it is the purpose of life. Needs are satisfied according to an order. Although this results in selfish behaviour when operating at lower levels (competition for food and water), those who have overcome the basic struggle to survive behave differently as they draw strength from loving relationships and begin to seek higher goals such as a sense of belonging and a purpose in their lives.

Figure 4.6.3 Maslow's hierarchy of needs



When considering the needs of caregivers, it is seen that according to Figure 4.6.3 physiological need (the need for support of resources); safety and security (the need for support through assistance); love and belonging (the need for emotional support); self-esteem (the need to be valued) and self-actualisation (altruistic needs) were all aspects/needs considered by caregivers. The top order need in Maslow's hierarchy is that of self-actualisation, indicating the need to develop one's potential. Training needs were a background need for caregivers and could indicate that some of the bottom order needs are not satisfied.

Previous chapters indicated that the satisfaction of higher order needs is dependent on the satisfaction of the need for safety and security. However, when safety and security are assured, the need for novelty, experimentation, and discovery emerges (Mistler, 2010 b). To conclude, imaginative curiosity takes over when the individual feels safe and secure, when there is no need to fear for survival in any context—physical, mental, emotional, or social. In this study, the question, regarding the satisfaction of caregivers' need for safety and security, was explored. Imaginative curiosity, which include learning/training, was a background need indicating that caregivers might fear for survival in physical, mental, emotional or social aspects. In this study, the researcher believes that the fear for mental, emotional and social aspects was indicated.

Gestalt Therapy holds that every experience and satisfaction of needs has a cycle that has a beginning, a following through, and an end (Ginger, 2007:29) and is referred to as the contact cycle, cycle of awareness or contact-withdrawal cycle (Clarkson, 2004:34; Ginger, 2007:30). This awareness cycle is a way of tracking the formation, interruption and completion of emerging figures (Joyce & Sills, 2001:33). But, in daily living "there are a number of ways that we learn to maintain our sense of security, defend our egos, maintain equilibrium, and cope with whatever comes our way in life. Our survival is partially contingent on learning to interrupt contact when it does not feel safe or right for our system of boundaries" (Woldt, 2008). This study revealed two common interruptions used by caregivers and is referred to as retroflection and projection.

Woldt (2008) describes retroflection as the "primary interruption of the contact function called action and interaction. This process involves considerable anxiety and as a result, doing to one's self what we would like to be able to do to others (while usually lacking awareness of that as a possible choice). In its simpler forms, a retroflective person avoids the processes of openly facing or destructuring potentially threatening experiences. Embarrassment, or the prospect of embarrassment, often results in turning potential action back on one's self. Retroflective actions also account for considerable depression – i.e., depressing emotions. It is an inhibiting process that sometimes becomes self-destructive and results in headaches, feeling overly stressed, tightness and stiffness in parts of the body, sore muscles and psychosomatic illness. An extreme example of becoming self-destructive is when one shifts from homicidal feelings to suicidal action." Perls (1973) stated that behaviour is a function of the field and for caregivers retroflection becomes a function of the field they live in. As there is no support for contact, both environmentally and self, retroflection is used to maintain a sense of security.

Projection is considered as a primary interruption of the contact function call motivation and excitement. This process involves inhibiting potential excitement by experiencing on the outside what is actually inside one's self, often blaming others or the environment for what's wrong, not recognising they could be talking about themselves. They experience being the victim of circumstances. They disown personally unacceptable aspects of themselves, such as traits, attitudes and

behaviours, and attribute them to other persons or objects. According to the researcher even though social workers and management are very busy, they are just as helpful and accommodating. However, caregivers indicated that they are judging them and not allowing them to give voice to their emotions. According to the researcher, this is an indication of projection where caregivers see/project unto the environment as being discouraging, but instead it is their own fear of failure. Thus, as caregivers project unto the environment that it is aggressive, they turn away from expressing needs/taking action and push back their needs/retroflect their needs.

Support is considered a “necessary basis of all healthy functioning and the ground that enables satisfying contact” (Joyce & Sills, 2001:83). As seen in Table 3.2.1.6 (Types of support; Joyce & Sills, 2001:83) in Chapter Three, different environmental and self supports are available. It seems that for caregivers both self and environmental supports are depleted.

An *impasse* is a situation in which external support is not forthcoming and the person believes he cannot support himself (Yontef, 1993). An impasse is due in large part to the person's strength being divided between impulse (in this case projecting) and resistance (in this case retroflection), (Yontef, 1993). This impulse, together with the resistance, allows the organism to get ‘stuck’ as one force is pushing out and one force pushing in (See Diagram 3.2.1.6, chapter 3). The researcher believes that caregivers get stuck in an impasse and not able to make or seek contact in the field to support their needs. Are caregivers able to progress to satisfaction of needs? This question could be answered in a future study.

Awareness is explained by Wolds (2008) as “the function or process of experiencing and identifying the thoughts, feelings and behaviours associated with the sensory data, where we cognitively identify what is happening inside and in-between our self and our environment and having sufficient description or understanding of that process to create enough meaning to either move towards or away from the possibility of further contact. Awareness typically involves aspects of our total self – our emotional, physical, and cognitive and *(some-times)* spiritual processes. Awareness is both a process *(what we are experiencing to move toward a goal or to contact the object of our attention)* and an outcome *(experiencing the result of our contact or goal attainment).”* It is the desire of the researcher to see caregivers

move into full awareness, able to have a responsive meeting satisfying their every need.

4.7 TRUSTWORTHINESS AND RIGOUR

Lincoln and Guba (1985:290) propose four constructs that reflect the assumptions of the qualitative paradigm to ensure trustworthiness and rigour in a study. These constructs include credibility, transferability, dependability and conformability. Credibility was ensured by an in-depth description showing complexities of the variables making sure that in the parameters of the setting of this study, the population uses and the theoretical framework underpinning in this study, that the research is valid (De Vos, 2005:346). Transferability was enhanced by describing the theoretical parameters of this research and including these parameters both in the research process and describing of literature, data collection, analysis and findings (De Vos, 2005:346). Trustworthiness (Creswell, 2005:189) of the study was further ensured by making use of data triangulation, which involves the use of a variety of data sources (Teddlie &Tashakkori, 2009:27; 75). These triangulated data included the reflexive journal and field notes, the data from the interviews, and questionnaires and statistical data from the children's home's documents together with the researcher experience (Teddlie & Tashakkori, 2009:297).

Sound quality inferences should capture the meaning of the phenomenon under consideration for study participants (Mertens, 2005:254; Teddlie & Tashakkori, 2009:295; Miles & Huberman, 1994:36). In this study, inference quality (credibility, transferability and trustworthiness) was measured and ensured by member-checking (Teddlie & Tashakkori, 2009:296), thick descriptions (Teddlie & Tashakkori, 2009:296) and a referential adequacy strategy (Teddlie & Tashakkori, 2009:296; Thayer, 2009:369; Eisner, 1998:110). Rich and detailed descriptions of the results of the study indicate the dependability, together with the collection of data and analysis, being grounded in theory (Van Der Riet & Durrheim, 2006).

4.8 CONCLUSION

In this chapter, the design and methodology was discussed together with the data collection procedure. Semi-structured interviews and questionnaires were completed with the caregivers, in order to explore their needs. The process of this study was explained and elaborated on and the analysis of the data was described. The information available on the data was considered where themes, categories and subcategories emerged.

In the analysis of the data, seven main needs emerged with different subcategories. The main needs included the need for support, the need for resources, the need for assistance, the need to make a difference, the need to be acknowledged, the need to give and the need for respect. In this chapter, the impact of the care-giving role was reflected on giving evidence of the trauma and vicarious traumatisation that caregivers live with indicating that the foremost need is that of support in a therapeutic environment.

In the following chapter, summaries, conclusions, recommendations and limitations will be considered.

CHAPTER FIVE

EVALUATION, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves, we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit

E.E. Cummings

5.1 INTRODUCTION

Chapter One served as an introductory orientation to this study, discussing aims, methodology, design and ethical considerations. Chapter Two focused on literature available regarding children's homes, looked-after children and caregivers. The theoretical underpinnings of this study were considered in Chapter Three, an integrating aspect of this study with the school of Gestalt Therapy. Chapter Four served as an in-depth exploration and description of methodology, research design, data collection, the empirical analysis, descriptions and findings.

Finally, the aim of this chapter is to present the summaries, limitations and conclusions of the study. The outcomes of the study with regard to the objectives, together with the aim and research questions, will be evaluated. Recommendations will be made concerning findings of this study, as well as recommendations regarding future research. A note on the researcher's journey will follow, ending with the concluding remarks.

5.2 EVALUATION

The evaluation of this study will be accomplished by considering three aspects namely, the aim and objectives of this study, answering the research problem and finally answering the research questions.

5.2.1 Accomplishment of the aim and objectives of this study

Fouché and Delport (2005:107) stated that the aim identifies the end result that needs to be achieved in a research project. The aim of this study is to explore and describe the needs of caregivers of looked-after children in children's homes, regarding training and care-giving.

The board of social workers in charge of caregivers at the children's home in this study, noticed that caregivers' ability to manage problems in their homes, was inadequate. The inadequate ability to manage problems, together with a literature review on the training and support available to caregivers, indicated poor outcomes and satisfaction of both the caregivers and the looked-after children.

Accordingly, this study aimed to assess the felt needs of a representative sample of caregivers in a children's home in Pretoria, Gauteng. The purpose of this exploration was twofold; to help caregivers get in contact with their needs and to help the board of social workers give better support and training to these caregivers.

A case study was used in a qualitative framework and was successfully carried out. The whole population consisted of 20 caregivers; of which12 at this children's home took part in this study. The researcher gained insight into the phenomenon/needs of caregivers and was able to make recommendations.

More specifically, this study set out to achieve certain objectives. Objectives that guided this study were:

a. To conduct a literature study on the theory of the school of Gestalt Therapy, looked-after children and caregivers in a children's home. This objective was reflected in Chapter Two and Three, giving an in-depth understanding about children's homes, looked-after children and caregivers. A comprehensive study regarding the theoretical underpinnings of Gestalt Therapy was also included. Data capturing and analysis were done in a Gestalt Therapy framework, considering the philosophical grounding of the school.

b. To undertake an in-depth empirical study, exploring the needs of caregivers of looked-after children in a children's home, regarding the care-giving and specific training needs, making use of semi-structured, open ended, one-on-one interviews and questionnaires (Greeff, 2005:286-313; Punch, 2005:169; Flick, 2009:149). The researcher achieved this objective. The data was captured in a Gestalt Therapy paradigm as the researcher was mindful of the research relationship and the phenomenological method of inquiry.

c. To analyse the qualitative data by means of heuristic inquiry (Brownell, 2009:57; Patton, 2002: 107; Gray, 2009:29; Stabile, 2009:234) in the Qualitative Data Analysis model of Miles and Huberman (Punch, 2005:197; Miles & Huberman, 1994:10). The researcher gained knowledge by analysing the data, making use of iterative techniques and attempting to understand the expressed feelings and needs of caregivers.

d. To verify and describe the research findings. This objective was achieved by linking Gestalt Therapy with the data analysis and describing as close as possible the experiences and needs of the caregivers.

e. To draw appropriate conclusions based on the research findings and make recommendations to the board of social workers, people managing children's homes and government officials in control of the quality of care in children's homes. The researcher was able to draw conclusions and make recommendations.

This study achieved each of these objectives successfully. These objectives were specified in order for this study to collect and analyse data that would allow for grounding in the Gestalt Therapy philosophy.

5.2.2 Answering the research problem

Fouché and De Vos (2005:100) state that the formulation of the problem is the foundation of research and engages the reader in the specific focus of the study. In this study, the research focused on the holistic needs of caregivers regarding the care of looked-after children and their particular needs, regarding training.

a. Literature (Strand *et al*, 2010; Child welfare South Africa, 2009; Halverson, 2009; McCrae, 2009; Anderson, 2009; Sempik, Ward & Darker, 2009; Adnopoz, 2007; Little *et al*, 2005; Stanley *et al* , 2005; Harden, 2004; Nicolas *et al*, 2003; Ferris-Manning & Zandstra, 2003; Hudson & Levasseur, 2002; Annie Casey Foundation, 2002) indicated that looked-after children pose behavioural, emotional and psychological difficulties due to being exposed to multiple traumatic events, which increases the difficulty of providing care for them.
b. The problem considered in this study was that of a lack of support and training was available for caregivers to deal with traumatised children in the welfare system (Crosland *et al*; 2008; Bisson & Cohen, 2006).
c. Findings indicated that this problem is indeed present in this children's home and that support and training are not sufficient to provide for the needs of caregivers.
d. The implication of this problem was considered to be the increasing difficulty of giving care for these children owing to a lack of training and support made available to them.
e. Caregivers in this study indicated the increasing difficulty in care for looked-after children owing to the lack of support made available to them.

5.2.3 Answering the research questions

The research questions for this study were:

a) What are the holistic needs of caregivers, regarding the care-giving of looked-after children in children's homes?

b) What are the training needs of caregivers of looked-after children in children's homes?

These research questions guided the data capturing and data analysis. The researcher believes that the questions were sufficiently answered through the process of this study in the qualitative approach. The exploration and detailed descriptions of the interviews and questionnaires facilitated a broader understanding of the phenomenon under study. The answers to the above two questions, after analysis of the data, are as follows:

a) Caregivers have three major needs including support, altruistic needs and the need to be valued.

b) Caregivers feel that it is important to receive training, but that their time schedules and the lack of support do not allow space for any training.

5.3 CHAPTER SUMMARIES

5.3.1 Summary of Chapter One

Chapter One is an overview of the research study. It is an orientation towards the rationale for the study and the problem that was under investigation. The researcher briefly explained the theoretical and philosophical underpinnings to which the researcher subscribed and this study was conducted in. The aim, objectives and

research questions were considered. A research methodology and design was explored in order to elaborate on the working procedure for achieving the aim and objectives of the research. Ethical aspects of this study were included and reflected on, ending with the operational definitions of this research.

5.3.2 Summary of Chapter Two

Chapter Two serves as a literature study on looked-after children, children's homes and caregivers. In this chapter, definitions and difficulties regarding children that are looked after, were considered. The organisational aspects of children's homes were explored and the impact this has on looked-after children and the caregivers. The roles, challenges, training and support of caregivers were reviewed and contemplated on.

5.3.3 Summary of Chapter Three

In this chapter, a philosophical grounding was established. Philosophical considerations regarding the school of Gestalt Therapy has concluded that field ontology, phenomenological epistemology and dialogical axiology are assumed where the researcher embraces the attitudes coherent with the philosophy. A Gestalt Therapy research paradigm was considered in terms of the focus of inquiry, the research setting and the role of the researcher. In this chapter, the researcher aimed at integrating all aspects of this research study with that of Gestalt Therapy.

5.3.4 Summary of Chapter Four

Chapter Four consisted of the data collection procedures being described comprehensively, clearly explaining the context and purpose. A description is given of participants, the research design, the sampling plan, as well as the data collection procedures and the steps that were followed in order to complete collection. A case

study design was used in order to explore and obtain data regarding the awareness, training and holistic needs of caregivers.

In this chapter, the research focus was on the empirical process that was followed in order to evaluate and analyse the results by means of heuristic inquiry in the Qualitative Data Analysis (QDA) model of Miles and Huberman (1994), which was suitable to the research method that was followed for this study. An empirical analysis of data led to answering the research questions indicated in Chapter One. The semi-structured interviews, questionnaires, literature study, researchers experience and statistical documents from the children's homes were included in the analysis of the data leading to triangulation. From the data, analysis themes and categories were explored and identified. Caregiver's direct answers and quotations were incorporated as a way of exploring their phenomenological interpretation and meaning-making.

5.4 SUMMARY OF FINDINGS

5.4.1 Biographical information

The majority of participants and respondents, 75% (9 out of 12), were between the ages of 50 and 59. This table might indicate that caregivers enter this occupation when they are older. When considering developmental psychology, and specific Milton Erikson's psycho-social developmental stages (Appendix T, Bukato & Daehler, 1998:23). Caregivers in this study are classified as being in the stage of generativity versus stagnation.

5.4.2 Themes

5.4.2.1 Organisational functioning

- Owing to the fact that caregivers spend most of their time with looked-after children daily, the goals of children's homes regarding the provision of an environment that is protective, enhances development and promotes growth and well-being, falls to the caregivers' challenges.
- A gap exists between principles and policies that are set for the organisational functioning and the actual day-to-day life of caregivers.
- It is, however, difficult for systems to collaborate and thus the demands on caregivers increase.

5.4.2.2 Challenges

- The challenges included caregivers taking the role of attachment figures, who provide constant physical and emotional care.
- Caregiver challenges include the emotional difficulties and trauma the children display
- The management of daily routines and tasks
- Emotional and physical health difficulties

5.4.2.3 Support

- Consider a protective shield as a support structure
- Protective factors for caregivers were reflected on and it was seen that social workers, management and other caregivers of the children's home were considered as helping factors who protect caregivers form burnout and exhaustion

- Support enhances psychological well-being, feelings of control and a good self-esteem
- Whereas the absence of support may contribute to factors such as loneliness, depression and despair
- Intrinsic support includes open communication and rapport; role satisfaction; participation in decision-making; being valued for opinions and knowledge
- Extrinsic support involves adequate training
- Support is considered a “necessary basis of all healthy functioning and the ground that enables satisfying contact”
- Self-support includes sound physical health, supportive body posture and breathing, effective coping strategies and creative adjustments, relationship with nature, strong sense of identity, realistic beliefs about the self and the world and spiritual practice
- Environmental support include a healthy physical environment, adequate resources, such as food, shelter, intimate relationships, loving family and friends, validation from others, religious or social network, fulfilling employment and enjoyable leisure activities

5.4.2.4 Training

- Training increases confidence, positive interaction, efficiency and the quality of care
- Challenges caregivers face are an indication of the specialised knowledge and skill required to prevent and manage the difficulties of day-to-day living
- A trauma-informed system is considered as a necessity in all children’s homes
- Illiteracy, together with a lack of competence, presents a danger to looked-after children
- A surprisingly low number of participants stated a need for training
- Even though caregivers felt that training was very important and imperative for their work, they just did not have the emotional time resources to include this need

5.4.2.5 Experience as caregiver

- Intrinsic job attributes are highly related to job satisfaction and retention rates
- Extrinsic motivation refers to environmental or situational expectations and rewards extrinsic nature, is monetary
- Another intrinsic motivator is altruism
- When safety and security is assured, the need for novelty, experimentation, discovery and altruistic (which is the need to consider others in need) needs emerges
- When receiving adequate preparation and training, timely crisis intervention, and a sense of being valued and respected by the agency, they are more likely to continue to foster
- Looked-after children's difficulties complicates the caregiving and specialised role deemed to be necessary
- Caregivers indicated not being protected under the labour law in South Africa, which has implications on their daily activities and work hours

5.4.2.6 Emotional well-being

- Caregivers can be seen as parental substitution
- There are typically observed responses to trauma and these have an effect on parenting roles and capacities. Some effects are on the cognitive, affective, behavioural and physiological domains. In this study caregivers showed indications of being affected on all domains.
- Caregivers are exposed to trauma daily, causing vicarious traumatisation or compassion fatigue.
- Diagnostic criteria for PTSD and complex PTSD were found in caregivers.
- Stress on physiological and psychological areas has been known to be associated with increased child-directed hostility, negatively expressed emotion, coercive parent-child interaction styles, lack of warmth and availability, and child maltreatment.

- Depressive symptoms meeting diagnostic criteria were found in caregivers.
- A major concern is that of the strong need for support that was displayed during the investigation

5.4.3 Needs

5.4.3.1 The need for support

- An intense need for support, specifically the need for emotional support and assistance in managing the home with adequate resources.

5.4.3.2 Altruistic needs

- The need to make a difference in the lives of looked-after children and the need to give *"love, acceptance, support, recognition, affection, warmth and care"* was the main encouragement and motivator for caregivers.
- Altruistic needs allow caregivers to feel valued and appreciated, increasing their self-esteem.

5.4.3.3 The need to be valued

- Different kinds of support are established in literature where intrinsic supports include being valued for opinions and knowledge.
- Caregivers indicated a strong need to feel valued

5.5 CONCLUSIONS

5.5.1 Biographical information

The biographical information of participants serves as a background for a better understanding regarding the field of this study.

a. Age and gender of participants.

Caregivers that volunteered for this study, both for questionnaires and interviews were predominantly (91, 6%) female (11 out of 12). This could be an indication of the perceived role expectation as giving care is regarded as a female occupation.

The age of caregivers falls predominantly (75%, 9 out of 12) into the category of fifty to fifty nine years of age. Two caregivers (16, 6%) were between the ages of thirty five and forty nine and only one caregiver (8, 3%) was between the ages of twenty five and thirty four. When considering developmental psychology, and specific Milton Erikson's psycho-social developmental stages (Appendix T, Bukato & Daehler, 1998:23), caregivers in this study are classified as being in the stage of generativity versus stagnation. "Generativity is a wide concept that includes productivity, creativity and the passing on of culture. People, who acquire generativity and care, concern themselves with enriching their own and other people's lives. This can be done in a variety of ways, for instance, by educating children, by producing meaningful work, of by creating cultural products. Generativity presupposes faith in the meaningfulness of life, in the value of the human, race, and in the future of humankind" (Louw, Van Ede & Louw, 1998:54). The researcher concludes that the ages of caregivers in this study indicates that they have entered the phase of generativity successfully. Most important developmental tasks and changes during middle adulthood will be briefly named:

- To adjust to physical changes
- To redefine one's self-concept and identity

- To reassess one's values and philosophy of life
- To develop generativity
- To find renewed job satisfaction
- To become a mentor for younger colleagues
- To prepare for eventual retirement
- To expand social activities as a preparation for retirement
- To become more involved in the community and civic affairs
- To act as mediator and bridge between generations
- To act as a conserving force and moral watchdog in the community

The researcher concludes that the developmental tasks, mentioned above, place a further demand on caregivers' already difficult environment. Eventual retirement, social activities and job satisfaction are aspects that need to be taken in consideration when contemplating intervention.

b. Qualification of participants.

As indicated in Chapter Four, of the participants of this study, only one caregiver (8, 3%) specified having a degree. Ten out of 12caregivers (83, 3&) indicated having a senior certificate. Chapter Two denoted that training could be beneficent to caregivers (Rushton & Minnis, 2008:494; Teggart, 2006:159; Burns *et al*, 2004; Hills & Child, 2000; Davison, 1995:71; Golding, 2004; Clarke-Steward & Allhusen, 2005:1333-137). It is noted that the caregiver in possession of a degree (in education) was the most positive when answering questions regarding challenges, training and emotional well-being. This sample was too small to conclude that training was a significant factor for both emotional well-being and competence and the researcher concludes that further investigation is required.

5.5.2 Themes

In this study, the researcher focused on areas that emerged from literature and both interviews and questionnaires, which include: organisational functioning, challenges, support, training, experience as caregiver and the emotional well-being of caregivers. Themes were thoroughly discussed in Chapter Two and Three and findings regarding these themes were comprehensively discussed in Chapter Four. The researcher concludes that all themes were relevant to this study. Brief conclusions on themes will follow.

a. The researcher concludes that *organisational functioning* in this children's home needs to be restructured and reorganised as a culture of non-support and intolerance exists.
b. *Challenges* caregivers face daily are immense and it is concluded that support structures are not in place.
c. The theme of *support* in this study indicated a lack thereof and it is concluded that loneliness, depression and despair of caregivers are due to the lack of support.
d. *Training* was considered in the literature review and data analysis as important for the literacy and competence of caregivers. The researcher concludes that the lack of training in this children's home present a danger to both looked-after children and caregivers. The low need for training in this study was revealed as an indication of the lack of support and the researcher concludes that training needs will emerge when sufficient support is made available to caregivers.
e. Work motivation was considered in the theme of *experience as a caregiver* and indicated that intrinsic altruistic motivators were the most dominant motivators to continue working.
f. The exploration of *daily caregiving* revealed the extent of caregiver's exposure to trauma daily. The Constitutional rights of children and caregivers were explored and options that could enhance daily caregiving for caregivers were explicated. The researcher concludes that investigation into the Constitutional

rights of caregivers needs to be considered, as well as the altering and increasing of organisational options enhancing support.

g. The exploration of the emotional well-being of caregivers indicated symptoms of trauma, depression, PTSD and a general feeling of being burned-out. The researcher concludes that immediate therapeutic support is necessary.

5.5.3 The need for support

In the data analysis phase of this study, the need for support emerged with subcategories that included assistance, resources and emotional support. In Chapter Four, findings regarding the needs, mentioned above, were methodically and comprehensively discussed and only brief conclusions will follow.

a. Assistance

The researcher concludes that the need for assistance regarding discipline and therapy for looked-after children should be considered the most important assistance need. Looked-after children pose to be an overwhelming difficulty for caregivers and long waiting lists and the shortage of psychological aids increases the challenges caregivers face.

b. Resources

The researcher maintains that the need for more physical, tangible resources is an important aspect of caregivers' needs.

c. Emotional support

The researcher argues that emotional support was the most significant theme throughout this study. The need for emotional support was a theme that occurred continuously, a clear indication of the urgency and importance of the

need. Caregivers in this study were affected in cognitive, affective, behavioural and physiological domains, displaying symptoms of vicarious traumatisation, compassion fatigue, PTSD and depression. The researcher concludes that therapeutic assistance and intervention for caregivers should be considered in intervention, as well as the motivation to form social networks and collegial connection.

5.5.4 Altruistic needs

Altruistic needs indicated the quality a person possesses regarding the unselfish concerns for the welfare of others and the devotion to the interests of others. For the caregivers of this study, the need to make a difference and the need to give was considered aspects of intrinsic work motivation. Altruism was revealed a higher order need in Maslow's hierarchy of needs and for caregivers, this need is not satisfied. The researcher concludes that the constant pressure to perform together with time pressures depletes caregivers of the feelings of 'unselfish concern for the welfare of others.'

5.5.5 The need to be valued

Being valued for opinions and knowledge was seen in literature as an intrinsic support. Caregivers in this study indicated a strong need to feel valued and the exploration of this need indicated the need to be respected and acknowledged. The researcher concludes that caregivers have the need to be valued, be included in decision-making, be recognised and treated equally.

5.5.6 Conclusion

The general conclusion regarding the empirical findings of this study is that caregivers have needs that are not being met. Needs of caregivers include the following: the need for support, altruistic needs and the need to be valued.

From the conclusions, mentioned above, the following recommendations are made.

5.5 RECOMMENDATIONS

Recommendations are made in order to enable role players to form a helping partnership with caregivers for the improvement of service delivery, assistance and support and training possibilities. As Gestalt Therapy incorporates a field theory, recommendations could be made to all systems in the welfare field. Owing to the limited scope of this dissertation, recommendations will be made to caregivers, management and social workers responsible for caregivers and government and welfare officials responsible for the insurance of quality care in children's homes.

a. *Main recommendation*

- The researcher recommends that it is imperative and essential that caregivers undergo training before caring after looked-after children.
- The researcher recommends that immediate therapeutic care be made available to caregivers as she considers it a pressing and very urgent need in the system of children's homes.

b. *It is recommended that caregivers:*

- Take responsibility for ensuring that collegial bonds are established (environmental supports).

- Take responsibility for establishing social connections and ensuring the growth of protective factors (environmental supports).

- Take responsibility for ensuring that enjoyable leisure activities are performed and consider fulfilling employment (environmental supports).

- Become more aware of their developmental phases in order to consider aspects that could enhance their growth potential (self-support). Eventual retirement, social activities and job satisfaction are aspects that need to be taken into consideration.

- Focus on self supports which include physical health and coping strategies.

c. Recommendations to management and social workers responsible for caregivers

- It is recommended that the goal of children's homes be revisited for the inclusion of caregivers' needs in children's homes, thus focussing resources and attention more equally between the looked-after child and the caregiver.

- It is recommended that therapeutic services for looked-after children be increased with immediate effect as this is a vital kind of support for caregivers.

- It is recommended that intrinsic support structures be re-evaluated including aspects of open communication and rapport in the children's home.

- It is recommended that caregivers be included in decision-making procedures, regarding looked-after children.

- To increase the need to be valued, it is recommended that caregivers be given the opportunity to share opinions and knowledge and could be in the form of a presentation or discussion that should be presented by them.

- It is recommended that caregivers be given the opportunity for development of self-support. Seminars on coping strategies could be considered. Aspects such as how to use support systems, problem solving, self-relaxation, maintaining internal control, coping with depression, coping with loneliness, coping with anxiety, coping with aging, could be considered when thinking about and implementing strategies for intervention.

- It is recommended that immediate training regarding vicarious traumatisation, compassion fatigue, depression and PTSD be implemented allowing caregivers self-support structures to grow.

- It is recommended that training regarding the specialised needs of looked-after children be made available to caregivers.

- It is recommended that monetary compensation to caregivers increases.

- Money made available for the keeping of homes, has to be increased. This could lead to the increase of extrinsic job motivation.

- It is recommended that administration of homes be more flexible in order to allow the time caregivers are off duty to be spent as leisure/social/connection time.

d. Recommendations to government and welfare officials responsible for ensuring quality of care in children's homes

- It is recommended that financial support to children's homes be increased in order for them to increase training and support to caregivers, as it is essential and vital for the quality of care received by looked-after children.
- It is recommended that an act on the roles and rights of caregivers be investigated.
- The labour law does not include policy on children's homes and caregivers, as this service was declared an essential service. This implicates that caregivers are not protected by the law leaving them vulnerable. It is recommended that an amendment be made, as far as caregivers are concerned.

5.6 LIMITATIONS

In the course of the research study, there were certain limitations that were identified. The most significant limitations were the following:

a. Time frame: The researcher conducted this research over a period of two months. More time at the children's home, conducting more interviews, might have improved the richness of the data.

b. Focus was on one children's home: This research study was conducted only at one children's home, which limits the generalisation of the research findings.

c. Although the sample size was small, sixty percent of the population in the children's home took part in this study. The sample was a means to explore some facet of this population and, even though it was small, an indication of what caregivers need, was recognised.

d. As results show in this research, administration difficulties were also experienced by the researcher. An unforeseen difficulty emerged where due

to administration difficulties, eight questionnaires were misplaced and could not be retrieved by the administration of this children's home.

5.7 RECOMENDATIONS FOR FUTURE RESEARCH

In this research study, voids in literature, regarding caregivers were found. Based on conclusions and the researcher's experience in this field, it is recommended that attention be drawn to research regarding caregivers.

As a result of this study, the possibilities for future research are:

a. To identify and describe the role of the caregiver of looked-after children in children's homes.

b. The development of a programme for the support of caregivers.

c. Those investigated in this research study identified the need for therapeutic services. Further exploration regarding the specific therapeutic needs of caregivers could be investigated.

d. The exploration of the efficacy of a Gestalt Therapeutic approach with caregivers.

e. Exploration of the efficacy of Gestalt Therapeutic strategies for vicarious traumatisation and compassion fatigue for caregivers.

f. Exploring efficacy of group therapy with caregivers in accordance with a Gestalt Therapy approach.

g. Programme development for the training modules for caregivers regarding coping strategies, specific needs of looked-after children, management training and training of self-support.

h. To research the possibility of including caregivers in the labour law of South Africa.

i. To investigate a development of a national act regarding the rights and responsibilities of caregivers.

j. In this study, the researcher discovered that there are no set traditions and methods in the school of Gestalt Therapy. An exploration and delineation, regarding the methodology of Gestalt Therapy research, could be investigated.

5.8 CONCLUSION

This study focused on the perceived needs of caregivers of looked-after children in children's homes. Children's homes are considered to be a place, which provides an environment that is protecting, enhances development and promotes the growth and well-being of children. In this study, it was seen that all goals and aims of children's homes focused on the children in their care, leaving caregivers with no support and vulnerable to emotional burnout. Caregivers are considered front-end workers caring for looked-after children daily, providing emotional, physical, and social factors. Research indicated that caregivers has a great influence in the children's lives and the researcher is of the opinion that the focus of children's homes should shift more towards the caregivers, allowing for a balanced goal orientation. Caregivers face tremendous challenges daily, including the behavioural, emotional, social, cultural and developmental difficulties of looked-after children. Together with difficulties, managerial aspects of the home and the organisational functioning add to the pressure.

The researcher is of the opinion that caregivers should be more valued in the welfare system and for this reason this study was undertaken. Caregivers are the "mothers and fathers" of unwanted, neglected and abused children, allowing for special care and love – something these children might have never been exposed to. The researcher maintains that caregivers should be applauded and celebrated and their willingness to give to society, should be highly regarded. Supporting caregivers

needs should be a priority to all members in society as looked-after children become the responsibility of society the moment they have been removed from their homes.

This study was conducted in the hope of giving and developing a support system for caregivers, aiming to help caregivers understand their own needs and helping them to give voice to the needs, while allowing knowledge to expand to the research community. The researchers' understanding was indeed expanded and a deeper appreciation for caregivers and the job they do, was developed through this study. For the researcher, this was truly a journey worth taking.

BIBLIOGRAPHY

1. Ackoff, R. L., Addison, H. J. & Bibb, S. 2007. *Management f-laws: How organisations really work*. Devon: Triarchy Press.
2. Adnopoz, J. 2007. Addressing symptoms of depression in foster Caregivers may improve the quality of care children receive. *Child Abuse and Neglect*, 31: 291–293.
3. Ainsworth, M. 1989. Attachment beyond infancy. *American Psychologist,* 44(4):709-716.
4. Aldgate, J. 2006. 'Ordinary children in Extraordinary Circumstances.' In Iwaniec, (Ed.). 2006. T*he Child's journey through Care.* West Sussex: John Wiley & Sons Ltd.
5. Aldgate, J., Jones, D., Rose, W., &Jeffery, D. 2006. *The Developing World of the Child*. London: Jessica Kingsley.
6. Ambrose, M. and Kulik, C. (1999) 'Old Friends, New Faces: Motivation Research in the 1990's', *Journal of Management* 25(3): 231–92.
7. American Psychiatric Association (APA). *Diagnostic and statistical manual of mental disorders (*4th ed., text revised*).* Washington: Author.
8. Anderson, B. & Johansson, J. 2008. Personal Approaches to treatment among staff in residential care: A case study. *Journal of Social Work,* 8(2): 117-134.
9. Anderson, P. 1968. Quoted in Koestler, A. *The Ghost in the Machine.* New York: Macmillan.
10. Anglin, J.P. 2002. *Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth.* New York: The Haworth Press.
11. Annie Casey Foundation. 2002. *Recruitment, Training, and Support: The Essential Tools for Foster Care.* Baltimore: Family to Family Publications.
12. APA. 2000. Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. Text Revision. Washington: American Psychiatric Association.
13. Argyris, C. 1990. *Overcoming organisational defences.* Boston: Allyn & Bacon.

14. Armstrong, D.M., Bacon, J., Campbell, K. & Reinhardt, L. 1993. *Ontology, causality, and mind: essays in honour of D.M. Armstrong.* Cambridge: Cambridge University Press.
15. Babbie, E. R. & Mouton, J. 2004. *The Practice of Social Research.* Cape Town: Oxford University Press.
16. Babbie, E.R. 2007. *The practice of social research. International student edition.* London: Cengage Learning.
17. Bahm, A.J. 1993. *Axiology: The Science of values.* Amsterdam: Rodopi.
18. Barber, J.G., Delfabbro, P.H., & Cooper, L.L. 2001. Mental health of 'looked after' children: A needs Assessment. *Journal of Child Psychology and Psychiatry,* 42(6): 785-790.
19. Barber, P. & Brownell, P. 2008. 'Qualitative Research'. 62-89. In Brownell, P. (Ed), 2008. *Handbook for theory, research, and practice in Gestalt Therapy.* Newcastle: Cambridge Scholars Publishing.
20. Barlow, A.R. 2010. Gestalt Therapy and Gestalt Psychology. Gestalt-antecedent influence or historical accident. [Online]. Available: http://www.gestalt.org/barlow.htm. Accessed on 2010/03/10.
21. Barnes, F.H. 'From Warehouse to Greenhouse: Play, Work, and the routines of daily living in Groups as the Core of Milieu Treatment.' 123-156. In Beker & Eisikovits (Ed), 1993. *Knowledge Utilisation in residential child and youth care practice.* Washington: Child Welfare League of America.
22. Baron, R. (1998) *Psychology*, 4th edn. Needham Heights, MA: Allyn and Bacon.
23. Barth, R. (2001) 'Policy Implications of Foster Family Characteristics', *Family Relations* 50(1): 16–19.
24. Bass, S., Shields, M.K. & Behrman, R.E. 2004. Children, Families, and Foster Care: Analysis and Recommendations. *The Future of Children,* 14(1): 5-29.
25. Baum, A., Crase, S. and Crase, K. (2001) 'Influences on the Decision to Become or Not Become a Foster Parent',*Families in Society:The Journal of Contemporary Human Services* 82(2): 202–13.
26. Belsky, J. (1984). The determinants of parenting: A process model. *Child Development*, *55*, 83–96.

27. Belsky, J. (1996). Parent, infant, and social-contextual determinants of father-son attachment security. *Developmental Psychology*, *32*, 905–914.
28. Belsky, J. (1999). Interactional and contextual determinants of attachment security. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 249–264). New York: The Guilford Press, New York.
29. Bisson, J.I. & Cohen J.A. 2006. Disseminating early interventions following trauma. *Journal of Traumatic Stress,* 19(5):583-595.
30. Bloom, D. 2010 b. Sensing Animals/Knowing Persons: A Challenge to Some Basic Ideas in Gestalt Therapy. E-mail to E. Greyvenstein [Online], 8 April 2010. Available at e-mail: Elizabeth.greyvenstein@gmail.com
31. Bloom, D. 2010. Not just and academic question, E-mail to E. Greyvenstein [Online], 1 April 2010. Available at e-mail: Elizabeth.greyvenstein@gmail.com.
32. Blower, A., Addo, A., Hodgson, J., Lamington, L., & Towlson, K. 2004. Mental health of looked-after children: A needs assessment. *Clinical Child Psychology and Psychiatry,* 9(1): 117-129.
33. Boghossian, P.A. 2006. *Fear of knowledge: against relativism and constructivism.* Oxford: Oxford University Press.
34. Bonnet, C., & Welbury, J. 2004. Meeting the mental-health needs of looked-after children: An example of routine psychological assessment. *Adoption and Fostering,* 28(3): 81-82.
35. Bowlby, J. 1966. *Maternal care and mental health.* New York: Schocken Books.
36. Bowlby, J. 1969/1982. *Attachment and Loss, Volume 1: Attachment, Second Edition.* London: Pimlico.
37. Bowman, C.E. & Nevis, E.C. 2005. 'The History and development of Gestalt Therapy.' 3-20. In Woldt, A.L. & Toman, S. (Eds.), 2005. *Gestalt therapy. History, Theory and Practice*. Thousand Oaks: Sage Publications.
38. Boyd Webb, N. 2006. *Working with traumatised youth in child welfare*. New York: the Guilford Press.
39. Brannen, J., Mooney, A. & Statham, J. 2009. Childhood Experiences: a Commitment to Caring and Care work with vulnerable children. *Childhood*. 16: 377-394.

40. Brazier, D.D. 1992. Phenomenological counselling and psychotherapy. [Online]. Available: www.amidatrust.com/article_phenomenological.html. Accessed on 1020/02/10.
41. Brennan, A. 2004. 'The Legal status of the Child.' 194-202. In Wyse, D. 2004. *Childhood Studies. An Introduction.* Oxford: Blackwell publishing ltd.
42. Briere, J. Kaltman, S. & Green, B.L. 2008. Accumulated childhood trauma and symptom complexity. *Journal of traumatic stress,* 21(2):223-226.
43. Bronfenbrenner, U. 1979. *The ecology of human development: Experiments by nature and design.* Cambridge: Harvard University Press.
44. Brown, J.D. 2008. Foster Parents Perceptions of Factors Needed for Successful Foster Placements. *Journal of Child and Family Studies,* 17:538–554.
45. Brownell, P. 2008 b. *Perceiving you perceiving me: Self-conscious emotions and gestalt therapy.* [Online].Available: http://www.g-gej.org/8-1/selfconscious.html. Accessed on 2010/03/10.
46. Brownell, P. 2008. *Handbook for theory, research, and practice in gestalt therapy.* Newcastle: Cambridge Scholars Publishing.
47. Brownell, P. 2010. Not just and academic question, E-mail to E. Greyvenstein [Online], 1 April 2010. Available at: Elizabeth.greyvenstein@gmail.com.
48. Brownell, P., Meara, A. & Polak, A. 2008. 'Introduction and purpose of the handbook.' In Brownell, P. (Ed.), 2008. *Handbook for Theory, Research, and Practice in Gestalt Therapy*. Newcastle: Cambridge Scholars Publishing.
49. Buber, M. 1970. *I and Thou*. New York: Scribner.
50. Buehler, C., Cox, M. and Cuddeback, G. (2003) 'Foster Parents' Perceptions of Factors that Promote or Inhibit Successful Fostering', *Qualitative Social Work* 2(1): 61–83.
51. Bukato, D. & Daehler, M.W. 1998. *Child Development. A Thematic approach.* Third Edition. New York: Houghton Mifflin Company.
52. Burley, T. 2000. 'A Phenomenologically based theory of personality.' In Estrup, L. Home Study Course, *What's Behind the Empty Chair? Gestalt Therapy Theory and Methodology.* Santa Monica: Liv Estrup.

53. Burley, T., & Bloom, D. 2008. ‘Phenomenological method.’ In Brownell, P. (Ed.), 2008. *Handbook for Theory, Research, and Practice in Gestalt Therapy*. Newcastle: Cambridge Scholars Publishing.
54. Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. 2004. Mental health need and access to mental health services by youth involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry,* 43: 960-970.
55. Calam, R., Bolton, C., Barrowclough, C., & Roberts, J. 2002. Maternal expressed emotion and clinician ratings of emotional maltreatment potential. *Child Abuse and Neglect,* 26, 1101-1106.
56. Ceballo, R., & McLoyd, V.C. 2002. Social support and parenting in poor, dangerous neighbourhoods. *Child Development,* 73, 1310-1321.
57. Champion K.M., Shipman, K., Bonner, B.L., Hensley, L. & Howe, A.C. 2003. Child Maltreatment Training in Doctoral Programmes in Clinical, Counselling, and School Psychology: Where do we go from here? *Child Maltreatment,* 8: 211-217.
58. Chapman, M.V., Wall, A., Barth, R.P. & National Survey of Child and Adolescent Well-Being Research Group. 2004. Children’s voices: The Perceptions of children in foster care. *American Journal of Orthopsychiatry,* 74(3): 293-304.
59. Child Welfare South Africa. 2009. [Online]. Available: http://cwsa.galore.co.za/. Accessed on 2010/02/10.
60. Cicchetti, D., Rogosh, F. A. &Toth, S. (1998). Maternal depressive disorder and contextual risk: Contributions to the development of attachment insecurity and behaviour problems in toddlerhood. *Development and Psychopathology*, *10*, 283–300.
61. Clarke-Stewart, A. & Allhusen, V.D. 2005. *What we know about Childcare.* London: Harvard University Press.
62. Clarkson, P. 1999. *Gestalt counselling in action*. Second edition. London. SAGE Publications.
63. Clemmons, J.C., Walsh, K., DiLillo, D. & Messman-Moore, T.L. 2007. Unique and Combined Contributions of Multiple Child Abuse Types and Abuse Severity to Adult Trauma Symptomatology. *Child Maltreatment,* 12:172-181.

64. Cole, S.A. & Keegan Eamon, M. 2007. Predictors of depressive symptoms among foster caregivers. Child Abuse & Neglect 31 (2007) 295–310
65. Condon, J.T., & Corkindale, C. 1997. The correlates of antenatal attachment in pregnant women. *British Journal of Medical Psychology,* 70, 359-372.
66. Cooper, R.J. 2000. The impact of child abuse on children's play: A conceptual model. *Occupational Therapy International,* 7(4), 259-276.
67. Crano, W.D., & Brewer, M.B. 2002. *Principles and methods of social research.* Routledge.
68. Craven P.A. & Lee, R.E. 2006. Therapeutic interventions for foster children: A systematic research synthesis. *Research on social work practice,* 16:287-304.
69. Crenshaw, D.A. & Hardy, K.V. 2006. 'Understanding and Treating the Aggression of Traumatised Children in Out-of-Home Care.' 171-195. In Boyd Webb, N. (Ed), 2006. *Working with traumatised youth in child welfare*. New York: Guilford Press.
70. Creswell, J.W. & Maietta, R.C. 2002. 'Qualitative Research'. 162-199. In Miller, D.C. & Salkind, N.J. (Ed). 2002. *Handbook of research design and social measurement.* London: Sage Publications.
71. Creswell, J.W. 2005. *Educational research*. Pearson Prentice Hall: New Jersey.
72. Crosland K.A., Cigales, M., Dunlap, G., Neff, B., Clark, H.B., Giddings, T. & Blanco, A. 2008. Using staff Training to Decrease the Use of Restrictive Procedures at Two facilities for Foster Care. *Research on Social work Practice,* 18:401-409.
73. Crosland, K.A., Dunlap, G., Sager, W., Neff, B., Wilcox, C., Blanco, A., & Giddings, T. 2008. Effects of staff training of the types of interactions observed at two group homes for foster care children.
74. Daniel, B., Wassell, S., & Gilligan, R. 1999. *Child Development for Child Care and Protection Workers.* London: Jessica Kingsley.
75. Davies, J & Write, J. 2008. Children's Voices: A Review of the Literature Pertinent to Looked-After Children's Views of Mental Health Services. *Child and Adolescent Mental Health Volume,* 13(1): 26–31.

76. Davison, A.J. 1995. *Residential Care. The provision of quality care in residential and educational group care settings.* Vermont: Ashgate Publishing Company.
77. De Vos, AS. 2005. *Research at grass roots. For the social sciences and human service professions.* Pretoria: Van Schaik Publishers.
78. Denby, R., Rindfleisch,N. & Bean,G. (1999) 'Predictors of Foster Parents' Satisfaction and Intent to Continue to Foster', *Child Abuse and Neglect* 23(3): 287–303.
79. Denzin, N.K. & Lincoln, Y.S. 2005. *The SAGE handbook of qualitative research.* California: SAGE Publications.
80. Department of health (DoH). 1991c. *Residential Care: The Children Act 1989, Guidance and Regulations,* 4, HMSO.
81. Department of Social Development [Online]. 2010. Available: http://www.dsd.gov.za/index.php?option=com_content&task=view&id=88. Accessed on 2010/01/11.
82. DeRosa, R. & Pelcovitz, D. 2006. Treating traumatized adolescent mothers: a structured approach. In N. Webb (Ed.), *Working with traumatized youth in child welfare.* 219-245. New York: Guilford Press.
83. Dozier, M. 2005. Challenges of foster care. *Attachment and Human Development,* 7(1): 27-30.
84. Duggal, S., Carlson, E. A., Sroufe, L. A., & Egeland, B. (2001). Depressive symptomatology in childhood and adolescence. *Development and Psychopathology*, *13*, 143–164.
85. Eisner, E.W. 1998. *The enlightened eye: Qualitative inquiry and the enhancement of educational practice.* Upper Saddle River NJ: Merrill.
86. Emanuel, L. 2002. Deprivation X 3: The contribution of organisational dynamics to the 'triple deprivation' of looked-after children.' *Journal of Child Psychotherapy,* 28. 163-179.
87. Epprecht, M.L., Matlakala, D.M., Moremi, K.S., Muller, J., Nieuwoudt, L., Raganya, E., Rich, V., & Timm, V. 2001. Children's homes: A comparison of Approaches. *Reports from the Psychology Department,* 41:1-56.
88. Erskine, R.G. 2010. *A gestalt therapy approach to shame and self-righteousness: theory and methods.* Available:

http://www.integrativetherapy.com/en/articles.php?id=30. Accessed on 2010/03/10.

89. Essex, M. J., Klein, M. H., Miech, R., & Smider, N. A. (2001). Timing of initial exposure to maternal major depression and children's behavioural health symptoms in kindergarten. *British Journal of Psychiatry*, *179*, 151–156.
90. Estrup, L. 2000. What's behind the empty chair? Gestalt Therapy Theory and Methodology. Video/DVD © 2000.
91. Evans, L.D. 2004. Academic Achievement of students in Foster Care: Impeded or improved? *Psychology in the schools,* 41(5):527-535.
92. Evans, L.D., Scott, S.S., & Schultz, E.G. 2004. The need for educational assessment of children entering foster care. *Child Welfare,* 83, 565-580.
93. Evans, R. 2002. Ethnic differences in ADHA and the mad/bad debate. [Comment]. *American Journal of Psychiatry,* 161, 932. Author replied 932.
94. Farris-Manning, C., & Zandstra, M. 2003. *Children in care in Canada*. Ottawa: Child Welfare League of Canada.
95. Figley, C.R. 1995. *Compassion Fatigue: Secondary Traumatic Stress.* New York: Brunner/Mazel.
96. Figley, C.R. 2002. 'Compassion fatigue: Psychotherapists' chronic lack of self care.' *Journal of Clinical Psychology In session: Psychotherapy in Practice,* 58(11), 1433- 1441.
97. Finlay, L. 2008. A dance between the reduction and reflexivity: Explicating the phenomenological psychological attitude. *Journal of Phenomenological Psychology,* 39, 1-32.
98. Finlay, L., & Evans, K. 2009. *Relational-centred Research for Psychotherapist: Exploring Meanings and Experience.* West Sussex: John Wiley and Sons.
99. Fisher, P; Burraston, B, & Pears, K. 2006. Permanency in Foster Care: conceptual and methodological Issues. *Child Maltreat,* 11:92-94.
100. Fleming-Crocker, S. 2008. 'A Unified Theory.' In Brownell, P. (Ed.), *Handbook for Theory, Research, and Practice in Gestalt Therapy*. Newcastle: Cambridge Scholars Publishing.
101. Fletcher, J. 1966. *Situation ethics: The new morality*. Philadelphia: Westminster Press.

102. Flick, U. 2006. *An introduction to qualitative research.* Thousand Oaks: Sage Publications.

103. Flick, U. 2009. *An introduction to qualitative research.* London: Sage Publications.

104. Fosnot, C.T. 2005. *Constructivism: theory, perspectives and practice.* Teachers College Press.

105. Fouché, C.B. & De Vos, A.S. 2005. Problem Formulation in De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Ed). *Research at grass roots: for social services and human service professions.* Pretoria: Van Schaik Publications. 100-110.

106. Fouché, C.B. & Delport, C.S.L. 2005. Introduction to the research process, in De Vos, A.S.; Strydom, H.; Fouché, C.B. & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers. 71-88.

107. Fouché, C.S. 2005. Qualitative research designs, in De Vos, A.S.; Strydom, H.; Fouché, C.B. & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions.* Pretoria: Van Schaik Publishers.

108. Fowler, F.J. 2002. *Survey research methods.* Thousand Oaks: Sage publications.

109. Frazao, L.M. 1999. Healthy and Unhealthy functioning and Process-Oriented diagnostic Thinking. *Gestalt!* 3(3).

110. Friedmann, R.R. 1991. 'The Child and Youth Care Worker and the Organisation.' 237-254. In Beker & Eisikovits, *Knowledge Utilisation in residential child an youth care practice.* Washington: Child Welfare League of America.

111. Fulcher, L. C. & Ainsworth, F. Eds, (2006) Group care for children & young people revisited. New York: Haworth Press.

112. Fumerton, R.A. 2006. *Epistemology*. Oxford: Blackwell Publishing.

113. Gelles, R.J. 1999. 'Family preservation and child maltreatment.' In McKenzie, R.B. *Rethinking orphanages for the 21st Century.* Thousand Oaks: Sage Publications.

114. Gerring, J. 2007. *Case study research: principles and practices.* Cambridge: Cambridge University press.

115. Gibbs, I., & Sinclair, I. 1999. 'Treatment and treatment outcomes in children's homes. '*Child and Family Social Work,* 4, 1-8.

116. Gillis-Arnold, R., Crase, S., Stockdale, D. and Shelley, M. (1998) 'Parenting Attitudes, Foster Parenting Attitudes, and Motivations of Adoptive and Non-adoptive Foster Parent Trainees', *Children and Youth Services Review* 20(8): 715–32.

117. Golding, K. 2004. 'Providing specialist psychological support to foster carers: A consultation model.' *Child and Adolescent Mental Health, 9(2), 71-76.*

118. Gooch, D. 1996. 'Home and away: The residential care, education and control of children in historical and political context.' *Child and Family Social Work,* 1, 19-32.

119. Goodman, R. 'The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric cases and consequent burden.' *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 40, 791-799.

120. Goodman, R., Ford, T., Corbin, T., & Meltzer, H. 2004. 'Using the Strengths and Difficulties (SDQ) multi-informant algorithm to screen loode-after children for psychiatric disorders.' *European Child and Adolescent Psychiatry,* 13(2), 25-31.

121. Gotlib, I. H., & Goodman, S. H. (2002). Children of depressed parents: Introduction. In S. H. Goodman & I. H. Gotlib (Eds.), *Children of depressed parents: Mechanisms of risk and implications for treatment* (pp. 3–9). Washington, DC: American Psychological Association.

122. Government Gazette number 27104. 24 December 2004. p42.

123. Government. 2010. [Online]. Available: www.info.gov.zaspeechesdocschildrenshomes_table2.pdf.pdf.

124. Gray, D.E. 2009. *Doing research in the real world.* London: Sage Publications.

125. Greeff, M. 2005. Information Collection: Interviewing, in De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. (Eds.). *Research at grass roots:*

For the social services and human service professions. Pretoria: van Schaik. 286-313.

126. Greenberg, L.S. & Paivio, S.C. 1997. *Working with emotions in psychotherapy.* New York: Guilford Press.

127. Greenwald, R., Maguin, E., Smyth, N.J., Greenwald, H., Johnston, K.G., & Weiss, R.L. 2008. 'Teaching Trauma-Related Insight Improves Attitudes and Behaviors Toward Challenging Clients.' *Traumatology,* 14(2), 1-11.

128. Gendlin, E.T. 1996. *Focusing-oriented Psychotherapy: A manual of experiential method.* London: Guilford Press.

129. Groark, C.J., Muhamedrahimov, R.J., Palmov, O.I., Nikiforova, N.V., & McCall, R.B. 2005. 'Improvements in early care in Russian orphanages and their relationship to observed behaviours. *Infant Mental Health Journal,* 26, 96-109.

130. Guishard-Pine, J., McCall, S. & Hamilton, L. 2007. *Understanding Looked-after children: An Introduction to Psychology of Foster Care.* London: Jessica Kingsley Publications.

131. Gummeson, E. 2003. All research is interpretive! *Journal of Business & Industrial Marketing,* 18(6/7), 482-492.

132. Halverson, A. 2009. What counts in Child Protection and Welfare? *Qualitative Social Work,* 8:65-81.

133. Harden, B. J. 2004. Safety and stability for foster children: A developmental perspective in the future of children. *The David and Lucile Packard Foundation*, *14*(1): 31–44.

134. Herczog, M., Pagee, R. and Pasztor, E. (2001) 'The Multinational Transfer of Competency-Based Foster Parent Assessment, Selection, and Training: A Nine- Country Case Study', *Child Welfare* 80(5): 631–44.

135. Hills, D. & Child, C. 2000. *Leadership in Residential Child Care: Evaluating Qualification Training.* New York: John Wiley & Sons.

136. Hipwell, A. E., Goossens, F. A., Melhuish, E. C., & Kumar, R. (2000). Severe maternal psychopathology & infant-mother attachment. *Development & Psychopathology*, *12*, 157–175.

137. Hobbs, G., Hobbs, C., & Wynnes, j. 1999. ‘Abuse of Children in foster and residential care.’ *Child Abuse and Neglect,* 23, 1239-1252.

138. Hollway, W. 2006. *The capacity to Care: Gender and Ethical Subjectivity.* London: Routledge.

139. Horwitz, J.A., Bell, m., Trybulski, J., Munro, B.H., Moser, D., Hartz, S.A., 2001. ‘Promoting responsiveness between mothers with depressive symptoms and their infants. *Journal of Nursing Scholarship,* 33, 323-329.

140. Horwitz, M.S., Owens, P., & Simms, M.D. 2000. ‘Specialised assessments for children in foster care. *Paediatrics,* 106, 59-66.

141. Houston, G. 2003. *Brief Gestalt Therapy.* London: Sage publications.

142. Howes, C. 2008. ‘Attachment relationships in the context of multiple caregivers.’ 317-332. In J. Cassidy & P, Shaver (Eds), *Handbook of Attachment. Second Edition. Theory, Research and Clinical Applications.* New York: Guilford Press.

143. Hudson, P. and Levasseur, K. 2002 Supporting Foster Parents: Caring Voices. *Child Welfare* 81(6): 853–77.

144. Husserl, E. 1970. *The idea of phenomenology*. The Hague: Martinus Nijhoff.

145. International Social Service & UNICEF. 2004. *Improving protection for children without parental care: A call for international standards*. New York & Geneva: A joint working paper of UNICEF and ISS.

146. Isomaki, V. (2002) ‘The Fuzzy Foster Parenting: A Theoretical Approach’, *The Social Science Journal* 39: 625–38.

147. Iwaniec, D.2006. *The Child’s Journey through Care. Placement stability, Care planning, and Achieving Permanency.* West Sussex: John Wiley & Sons Ltd.

148. Johnson, R., Bowne, K., & Hamilton-Giachritsis, C. 2006. ‘Young Children in Institutional Care at Risk of Harm.’ *Trauma, Violence, Abuse,* 7, 34-60.

149. Jordan, R.R. 1997. *English for academic purposes. Cambridge: Cambridge University press.*

150. Joyce, P. & Sills, C. 2001. *Skills in Gestalt Counselling & Psychotherapy.* London: Sage Publications

151. Kant, I. 1958. *The critique of pure reason.* Translated by Norman Kemp Smith. London: Macmillan & Co.

152. Kaufman, R. & English, F.W. 1979. *Needs assessment: Concept and application.* Englewood Cliffs, N.J.: Educational Technology Publications.

153. Kimmel, A.J. *Ethics and values in applied social research.* Thousand Oaks: Sage Publications.

154. Kirchner, M. 2000. Gestalt Therapy Theory: An overview. *Gestalt, 4(3).* [Online]. Available: http://www.g-gej.org/4-3/theoryoverview.html. Accessed on 2010/02/10.

155. Ko, S.J., Kassam-Adams, N., Wilson, C., Ford, F., Berkowitz, S.J. & Wong, M. 2008. Creating Trauma-Informed Systems: Child Welfare, Education, First responders, Health Care, Juvenile Justice. *Professional Psychology: Research and Practice,* 39(4): 396-404.

156. Kohler, W. 1925. *The mentality of apes*. New York: Harcourt, Brace and World.

157. Kools, S., & Kennedy, C. 2002. 'Child sexual abuse treatment: Misinterpretations and mismanagement of child sexual behaviour.' *Child Care Health and Development,* 28, 211-218.

158. Korb, Margaret P. 1975. Changes in perceptual field characteristics of students in gestalt oriented training. *Unpublished doctoral dissertation*, University of Florida.

159. Kukla, A. 2000. *Social Constructivism and Philosophy as Science.* California: Routledge.

160. Kurstjens, S., &Wolke, D. (2001). The effects of maternal depression on cognitive development of children over the first 7 years of life. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *42*, 623–636.

161. Kwok,S., & Wong, D. 2000. 'Mental health of parents with young children in Hong Kong: The roles of parenting stress and parenting self-efficacy.' *Child and Family Social Work,* 5, 57-65.

162. Larkin, E. 2006. 'The importance of Developing Emotional Bonds between Parents and Children'. In Iwaniec, *the Child's journey through Care.* West Sussex: John Wiley & Sons Ltd.

163. Latner, J. 2008. *The Self.* Available: www.pgti.org/gestalt/the_self.html

164. Lauterbach, D. 2001. Personality Profiles of Trauma Survivors.' *Traumatology,* 7(1), 5-18.

165. Lee, F.G. & Wheeler, G. 1996. *The voice of shame. Silence and connection in psychotherapy.* San Francisco. Jossey-Bass Publishers.

166. Leon C Fulcher, MSW, PhD, Working Together with Purpose. [Online]. Available:http://www.naccw.org.za/static/pdf/Fulcher%20Keynote%20-%20Working%20Together%20with%20Purpose.pdf

167. Leslie, L.K., Hurlburt, M.S., Landsverk, J., Barth, R., & Slymen, D.J. 2004. 'Outpatient mental health services for children in foster care: A national perspective.' *Child Abuse and Neglect,* 28, 697-712.

168. Leslie, L.K., Hurlburt, M.S., Landsverk, J., Rolls, J.A., Wood, P.A., & Kelleher, K.J. 2003. 'Comprehensive assessments for children entering foster care: A national perspective. *Pediatrics,* 112, 134-142.

169. Levitsky, A., and Perls, F. 1970. Rules and games of gestalt therapy, in J. Fagan & I. L. Shepherd (Eds.). *Gestalt therapy now*. New York: Harper & Row. 140-49.

170. Lewis, H. 2000. 'Children in public care: Overcoming the barriers to effective mental health care.' *Young Minds,* 46, 17-19..

171. Lichtman, M. 2009. *Qualitative research in education: a user's guide.* London: Sage Publications.

172. Lieberman, A.F. & Van Horn, P. 2004. 'Assessment and treatment of young children exposed to traumatic events. In J.D. Osofsky (Ed.), *Young children and trauma: Intervention and treatment.* 111-154. New York: Guilford Press.

173. Linares, L.O., Li, M., Shourt, P.E., Brody, G.H. & Pettit, G.S. 2007. Placement Shift, Sibling Relationship Quality, and Child Outcomes in Foster Care: A Controlled Study. *Journal of Family Psychology,* 21(4): 736-743.

174. Lincoln, Y.S., & Guba, E.G. 1985. Naturalistic inquiry. In Denzin, N;K., & Lincoln, Y.S. (Ed.), *Handbook of qualitative research.* Thousand Oaks: Sage publications.

175. Little, M. Kohm, A. & Thompson. 2005: The impact of residential placement on child development: research and policy implications. *International journal of social welfare,* 14:200-209.

176. Little, S.G., Akin-Little, A. & Gutierrez, G. 2009. Children and Traumatic Events: Therapeutic Techniques for Psychologists working in the Schools. *Psychology in schools,* 46(3): 199-205.

177. Littleton, H., Horsley, S., John, S. & Nelson, D.V. 2007. Trauma Coping strategies and Psychological distress: A Meta-Analysis. *Journal of traumatic stress,* 20(6):977-988.

178. Litz, B.T. 2008. Early Intervention for Trauma: Where are we and where do we need to go? A Commentary. *Journal of Traumatic Stress,* 21(6):503-506.

179. Lobb, M. S. 2000. The Theory of Self in Gestalt Therapy, in Gestalt Therapy. Hermeneutics and Clinical. (2000) Editor Lobb, M. S., Angeli Publishing House Milan.

180. Lobb, M. S., (2007) What's Gestalt Therapy. Accessed online April 2007. http://www.gestalt.it/inglese/get-e.htm

181. Louise, A. 2004. 'A naturalize approach to the A priori.' In Sosa, E., & Villanueva, E. (Eds.); *Epistemology: Philosophical Issues: Volume 4*. Oxford: Blackwell Publishing.

182. Louw, D.A., Van Ede, D.M. & Louw, A.E. 1998. *Human Development.* 2nd Ed. Pretoria: Kagiso Publishers

183. Mackewn, J. 1997. *Developing Gestalt counselling: A field theoretical and relational model of contemporary Gestalt counselling and psychotherapy.* Thousand Oaks, CA. SAGE Publications.

184. Maier, H.W. 1991. 'Developmental Foundations of child and Youth Care Work.' 25-48. In Beker, J., & Eisikovits, A., *Knowledge Utilisation in residential child and youth care practice.* Washington: Child Welfare league of America.

185. Maluccio, A.N. 2006. 'The nature and Scope of the Problem.' In N. Boy Webb, (Ed.), *Working with Traumatised Youth in Child Welfare. 3-12.* New York; Guilford Press.

186. Maslow, A. 1968. *Toward a Psychology of Being.* Michigan: John Wiley and Sons.

187. Maurer, R., & Gaffney, S. 2005. 'Gestalt Approaches with organisations and large systems'. In Woldt, A.L., & Toman, S.M., *Gestalt Therapy. History, Theory, and Practice.* Thousand Oaks: Sage Publications.

188. McCall, J.N. 1999. 'Research on the Psychological Effects of Orphanage Care.' In McKenzie, R.B., *Rethinking Orphanages for the 21st Century.* Thousand Oaks: SAGE Publications.

189. McCann, I.L., & Pearlman, L.A. 1990. 'Vicarious traumatisation: A framework for understanding the psychological effects of working with victims.' *Journal of Traumatic Stress,* 3, 131-149.

190. McCarthy, G., Janeway, J., & Geddes, A. 2003. 'The impact of emotional and behavioural problems on the lives of children growing up in the care-system.' *Adoption and Fostering,* 28(4), 60-65.

191. McCrae, J.S. 2009. Emotional and behavioural problems reported in child welfare over 3 years. *Journal of emotional and behavioural disorder,* 17:17-28.

192. McDonald, H.P. 2004. *Radical axiology: a first philosophy of values.* Amsterdam: Rodopi

193. McGreggor, T.E., Rodger, S., Cummings, A.L. & Leschied, A.W. 2006. The needs of foster parents. A qualitative study of motivation, support and retention. *Qualitative Social Work;* 5(3): 351-368.

194. McKenzie, R.B. 1999. *Rethinking Orphanages for the 21st Century.* Thousand Oaks: SAGE Publications.

195. McLeod, J. 1999. *Practitioner Research in counselling.* London: Sage publications.

196. McLeod, L., 1993. The Self in Gestalt Therapy Theory. The British Gestalt Journal, vol2 No1, pp25-40

197. McMillen, J.C., Zima, B.T., Scott, L.D., Auslander, W.F., Munson, M.R., Ollie, M.T. *et al*. 2005. 'Prevalence of psychiatric disorders among older youths in the foster care-system. *Journal of the American Academy of Child and Adolescent Psychiatry,* 44(1), 88-95.

198. McSherry, D., & Larkin, E. 2006. 'Developments in residential care in northern Ireland.' 134 – 145. In Iwaniec, *the Child's journey through Care.* West Sussex: John Wiley & Sons Ltd.

199. McWey, L. 2000. 'I promise to act better if you let me see my family: Attachment theory and foster care visitation.' *Journal of Family Social Work, 5(1), 91-105.*

200. Meadows, D.H. 2008. *Thinking in Systems. A Primer.* USA: Sustainability Institute.

201. Meintjes, H., Moses, S., & 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.

202. Mekki, A. 2004. 'The role of the child and Family Social worker.' 116-121. In Wyse, D., *Childhood Studies. An Introduction.* Oxford: Blackwell publishing ltd.

203. Melnick, J., Nevis, S.M., & Shub, N. 2005. Gestalt therapy methodology.101-116. In Woldt, A., & Toman, S. (Eds.), *Gestalt therapy history, theory and practice.* Thousand Oaks: Sage Publications.

204. Meltzer, H. 2003. *The mental health of young people looked after by local authorities in England.* London: HMSO.

205. Mertens, D.M. 2003. Mixed models and the politics of human research: The transformative-emancipatory perspective. In Tashakkori, A. And Teddlie, C. (Ed), *Handbook of mixed methods in social and behavioural research.* Thousand Oaks: SAGE publications.

206. Milanak, M.E. & Berenbaum, H. 2009. The relationship between PTSD symptom factors and emotion. *Journal of Traumatic Stress, 22(2); 139-145.*

207. Milburn, N.L., Lynch, M. & Jackson, J. 2008. 'Early identification of Mental Health Needs for Children in Care: A Therapeutic Assessment Programme for Statutory Clients of Child Protection.' *Clinical Child Psychology and Psychiatry,* 13(1), 31-47.

208. Miles, M.B. & Huberman, A.M. 1994. *Qualitative data analysis: an expanded sourcebook*. London: Sage publications.

209. Minimum standards for South African Child and Youth Care Centres

210. Mistler, B. 2010 b. Emergent needs and Curiosities. [Online]. Available: http://mistlerinternational.com/gestalt/gestalt_emergent_needs.html. Accessed on 2010/03/10.

211. Morgan, D. 2007. Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research.* 1:48-76.

212. Morgan, J., Robinson, D., & Aldridge, J. 2002. 'Parenting stress and externalising child behaviour: Research review. '*Child and family Social Work,* 7, 219-225.

213. Mount J., Lister, A., & Bennum, I. 2004. 'Identifying the mental-health needs of looked after people.' *Clinical Child Psychology and Psychiatry,* 9(3), 363-382.

214. Nabozny, S., & Carlson, C. 2001. *Published Internet dialogue. I[online]. Available:* www.keypartners.ws/field_theory_and_its_implications_in_organisations.htm.

215. Neuman, W.L. 2003. *Social Research Methods: Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon.

216. Nicolas, B., Roberts, S. & Wurr, C. 2003. Looked-after children in residential Homes. *Child and Adolescent Mental Health, 8(2): 78-83.*

217. Nicole, R., Stretch, D., Whitney, I., Jones, K., Garfield, P., Turner, K. *Et al*. 2000. 'Mental health needs and services for severely troubled and troubling young people including young offenders in an NHS region. *Journal of Adolescence,* 23, 243-261.

218. Nunno, M.A., Holden, M.J., & Leidy, B.D. 2003. 'Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility.' *Children and Youth Services Review,* 25(4), 295-315.

219. Office on Children's Rights South Africa [Online]. 2007. Available: http://www.pmg.org.za/docs/2007/071031researchunit.htm. [2007, January].

220. Olasky, M. 1999. 'The rise and Fall of American Orphanages.' In McKenzie, R.B., *Rethinking orphanages for the 21st century.* Thousand Oaks: Sage Publications.

221. OVC Policy Framework and National Action Plan

222. Padgett, D.K. 2008. *Qualitative methods in social work research.* London: Sage Publications.

223. Palmer, G.H. 2009. *Altruism*. Biblio Bazaar LLC.

224. Paratz, D. 2000. 'Training Youth Workers in Residential Treatment.' *Residential Treatment for Children & Youth,* 18(1), 35-53.

225. Parlett, M. & Lee, R.G. 2005. 'Contemporary Gestalt Therapy: Field Theory.' In Woldt, A.L. & Toman, S., *Gestalt therapy. History, Theory,, and Practice*. Thousand Oaks: Sage Publications.

226. Parlett, M. 1991. 'Reflections on Field Theory.' *The British Gestalt Journal,* 1:68-91.

227. Parlett, M. 1993. 'Towards a more Lewinian gestalt therapy. *British Gestalt Journal,* 2(2), 111-114.

228. Patton, M.Q. 2002. *Qualitative research and evaluation methods*. Thousand Oaks: Sage Publications.

229. Perls, F. 1957. *Finding self through gestalt therapy.* Available: http:/www.gestalt.org/self.htm

230. Perls, Fritz S. 1969. *Gestalt therapy verbatim. With introduction by Michael Vincent Miller*. Highland, N. Y.: The Centre for Gestalt Development.

231. Perls, Fritz S. 1973. *The Gestalt approach and eyewitness to therapy*. Palo Alto, CA: Science and Behaviour Books, Bantam Books edition.

232. Perls, L. 1992. *Living at the Boundary.* Highlands: Gestalt Journal Press.

233. Perls, L. 1992. Notes on fundamental support of the contact process. In J. Wysong (Ed.), *Laura Perls: Living at the boundary* (83-91. New York: Gestalt Journal press.

234. Perry, B.D. 2006. 'Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatised Children. The Neurosequential Model of Therapeutics.' In N. Boy Webb,(ed), *Working with Traumatised Youth in Child Welfare. 3-12.* New York; Guilford Press.

235. Perry, B.D., Conrad, D.J., Dobson, C., Schick, S., Ryan, D. 2000. *The children's crisis centre model: A proactive multidimensional child and family assessment process.* Texas: The Child Trauma Academy.

236. Perry, B.D., Pollard, R.A., Blakley, T.L., & Vigilante, D. 1995. 'Childhood trauma, the neurobiology of adaption, and "use-dependent" development of the brain: How "states" become "traits". *Infant Mental Health Journal,* 16, 271-291.

237. Peters, D.L. & Madle, R.A. 1991. 'The Development of Effective Child and Youth Care workers.' 291-311. In Beker & Eisikovits, *Knowledge Utilisation in residential child an youth care practice.* Washington: Child Welfare League of America.

238. Philippson, P. 2001 *Self in relation*.: The Gestalt Journal Press, Highland, NY,

239. Philippson, P. 2001. Self in Relation, Karnac Books, London

240. Philippson, P. Not just and academic question, E-mail to E. Greyvenstein [Online], 1 April 2010. Available at: Elizabeth.greyvenstein@gmail.com.

241. Pinkerton, J. 2002. 'Developing an international perspective on leaving care. In A. Wheal (Ed). *The RHP Companion to Leaving Care.* Lyme Regis: Russell House Publishing.

242. Pinkerton, J., & McCrea, R. 1999. *Meeting the Challenge? Young People Leaving Care in Northern Ireland.* Aldershot: Ashgate.

243. Pithouse, A., Hill-Trout, J. & Lowe, K. 2002. Training foster carers in challenging behaviour: a case study in disappointment? *Child and Family Social Work,* 7: 203-214.

244. Polster, E. 1995. *A population of Selves. A Therapeutic Exploration of Personal Diversity.* San Francisco. Jossey-Bass Publishers.

245. Prior, V., & Glaser, D. 2006. *Understanding attachment and attachment disorders. Theory, evidence and Practice.* Philadelphia: Jessica Kingsley Publishers.

246. Punch, K. 2005. *Introduction to social research: quantitative and Qualitative approaches.* London: Sage Publications.

247. Purcell-Lee, C. 1999. Dialogue and Being. *Gestalt!. 4(2):1-13.*

248. Radke-Yarrow, M., & Klimes-Dougan, B. (2002). Parental depression and offspring disorders: A developmental perspective. In S. H. Goodman & I. H. Gotlib (Eds.), *Children of depressed parents: Mechanisms of risk and implications for treatment* (pp. 155–174). Washington, DC: American Psychological Association.

249. Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. G. (2005). Paternal depression in the postnatal period and child development: A prospective population study. *The Lancet*, *365*, 2201–2205.

250. Redding, R., Fried, C. and Britner, P. (2000) 'Predictors of Placement Outcomes in Treatment Foster Care: Implications for Foster Parent Selection and Service Delivery', *Journal of Child and Family Studies* 9(4): 425–47.

251. Redding, R., Fried, C. and Britner, P. (2000) 'Predictors of Placement Outcomes in Treatment Foster Care: Implications for Foster Parent Selection and Service Delivery', *Journal of Child and Family Studies* 9(4): 425–47.

252. Rescher, N. 2003. *Imagining irreality: a study of unreal possibilities.* Chicago: Open Court Publishings.

253. Resnick, R & Resnick, R. [Online]. 2010. School of Psychology, E-mail to E. Greyvenstein [Online], 27 January. Available: E-mail: Elizabeth.greyvenstein@gmail.com

254. Resnick, R.W. 1997. *The recursive loop of shame: an alternate gestalt therapy viewpoint.* Gestalt Review. 1(3): 256-269.

255. Resnick. & Parlett, M. 1995. Gestalt Therapy: Principles, Prisms, and Perspectives. *British Gestalt Journal,* 4(1).

256. Rhodes, K., Orme, J. and Buehler, C. (2001) 'A Comparison of Family Foster Parents Who Quit, Consider Quitting, and Plan to Continue Fostering', *Social Service Review* 75(1): 84–193.

257. Rhodes, K., Orme, J., Cox, M. and Buehler, C. (2003) 'Foster Family Resources, psychosocial Functioning, and Retention', *Social Work Research* 3: 135–50.

258. Rhodes, K.W., Orme, J.G. & Buehler, C. 2001. A Comparison of family foster parents who quit, considers quitting, and plan to Continue Fostering. *The social Service Review,* 75(1):84-114.

259. Richards, J.C. 1990. *The language teaching matrix.* New York: Cambridge University Press.

260. Richardson, J., & Lelliot, P. 2003. 'Mental health of looked-after children.' *Advances in Psychiatric Treatment,* 9, 249-251.

261. Rushton, A. & Minnis, H. 2008. 'Residential and Foster Family Care.' 487-501. In Rutter *et al*. *Rutter's Child and Adolescent Psychiatry.* Massachusetts*:* Blackwell Publishing

262. Rushton, A., & Minnis, H. 2002. 'Residential and foster family care.' 487-501. In M. Rutter & E. Taylor (Eds.), *Child and Adolescent Psychiatry: Modern Approaches.* Oxford: Blackwell.

263. Rwomire, A., Nyamnjoh, F.B., & Organisation for social Science Research in Eastern and Southern Africa. *Challenges and responsibilities of social research in Africa: ethical issues.* Organisation for Social Science Research in Eastern and Southern Africa (OSSREA).

264. Ryan, G.W. & Bernhard, H.R. 2003. Data management and analysis methods, in Denzin, N.K. & Lincoln, Y.S. *Collecting and Interpreting Qualitative materials*, 2003. London: Sage Publications. 259-209.

265. S 213(a) of the labour relations act 66 of 1995

266. Saakvitne, K.W., Pearlman, L.A. 1996. *Transforming the pain: A workbook on vicarious traumatisation.* New York: Norton.

267. Sanchirico, A., Lau, W. and Russell, S. (1998) 'Foster Parent Involvement in Service Planning: Does It Increase Job Satisfaction?',*Children and Youth Services Review* 20(4):325–46.

268. Savin-Baden, M., & Fisher, A. 2002. Negotiating honesties in the research process. *British Journal of Occupational Therapy,* 65, 191-193.

269. Scholte, E. & van der Ploeg, J. 2000. 'Exploring factors governing successful residential treatment of youngsters with serious behavioural difficulties: findings from a longitudinal study in Holland.' *Childhood*, 7, 129-153.

270. Scholz, R.W. & Tietje, O. 2002. *Embedded case study methods: integrating quantitative and QUALITATIVE knowledge.* California: Sage publications.

271. Schore, A.N. 2003. 'Early relational trauma, disorganised attachment and the development of a predisposition to violence.' In M.F. Solomon & D.J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain.* 107-167. New York: Norton.

272. Schutt, R.K. 2008. *Investigating the Social World: The process and Practice of Research.* Thousand Oaks: Sage Publications.

273. Scottish Office. 1997. *The Children (Scotland) Act 1995, Regulations and Guidance,* vol. 2*, Children Looked After by Local Authorities*. Edinburgh: The Stationery Office.

274. Sempik, J., Ward, H. & Darker, I. 2009. 'Emotional and behavioural difficulties of children and young people at entry into care.' *Clinical Child Psychology and Psychiatry,* 13: 221-233.

275. Shiner, R. L., & Marmorstein, N. R. (1998). Family environments of adolescents with lifetime depression: Associations with maternal depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*, 1152–1160.

276. Sinclair, I. 2005. *Fostering Now: Messages from Research.* Department for education and Skills. London: Jessica Kingsley.

277. Sinclair, I., & Gibbs, I. 1998. *Children's homes: A study in Diversity.* London: John Wiley & Sons.

278. Sinclair, I., Baker, C., Wilson.& Gibbs, I. 2005. *Fostering Children – Where they go and how they get on.* London: Jessica Kingsley Publishers.

279. Skeleton, A. 2005. *Costing the children's Bill: The provision of alternative care in child and youth care centres.* Cornerstone Economic Research report submitted to the Department of Social Development.

280. Social care and health – Westminster [Online]. 2010. Available: http://www.westminster.gov.uk/services/healthandsocialcare/familycare/lookedafterchildren/. [2010, January].

281. Social Services Inspectorate (SSI). 1989. *Homes are for Living In,* Department of Health, HMSO (1992 edition).

282. Solomon, E.P. & Heide, K.M. 'The Biology of Trauma. Implications for Treatment.' *Journal of Interpersonal Violence,* 20(1), 51-60.

283. South Africa. 2005. *Towards social welfare services for all vulnerable children in South Africa. A review of policy development, budgeting and service delivery*. Pretoria: Occasional Papers.

284. South Africa. 2007-2008. *Situational Analysis of children in South Africa*. Tshwane: Government Printing.

285. South Africa. 2005. Child Care Act South Africa, no.150 of 2005.

286. South Africa. 2006. *Children's Amendment Bill.* Pretoria: Government Publishing.

287. South Africa. Office on Children's Rights South Africa. [Online]. Available: http://www.thepresidency.gov.za/main.asp?include=docs/pcsa/gdch/orc.html. Accessed: 10 March 2010.

288. Spagnuolo Lobb M. 2007, "Being at the contact boundary with the other: The challenge of every couple," *British Gestalt Journal*, vol. 16, no.1, pp.44-52.

289. Sparling, J., Dragomir, C., Ramey, S. & Florescu, L. 2005. 'Intervention in Romanian orphanages.' *Infant Mental Health Journal,* 26, 127-142.

290. Spinelli, E. 1989. *The interpreted world: An introduction to phenomenological psychology.* Newbury Park: Sage Publications.

291. Springer, C. 2007. Working with Traumatised Youth in Child Welfare. *Clinical Social Work Journal,* 35:71-73.

292. Stabile, M. 2009. Problematizing educational inclusion, in Piantanida, M. & Garman, N.B. *The Qualitative dissertation: A guide for student and faculty.* USA: Corwin Press. 234-243.

293. Staemmler, F-M. 2007, "On Macaque monkeys, players, and clairvoyants: Some newideas for a gestalt therapeutic concept of empathy." *Studies in Gestalt Therapy: Dialogical Bridges,* 1(2):43-64*.*

294. Stanley, N., Riordan, D. & Alaszewski, H. 2005. 'The mental health of looked-after children: matching response to need.' *Health and Social Care in the Community,* 13(3): 239-248.

295. Stevens, I. 2004. 'Cognitive-behavioural interventions for adolescents in residential child care in Scotland: An examination of practice and lessons from research.' *Child and Family Social Work, 9, 237-246.*

296. Strand, V.C, Sarmiento, T.L., & Pasquale, L.E. 2005. Assessment and Screening tools for trauma in children and adolescents: A Review. *Trauma, Violence, and Abuse,* 6(55): 55-78.

297. Strand, V.C., Spath, R. & Bosco-Ruggiero, S. 2010. So you have a stable child welfare workforce: What's next? *Children and Youth Services Review,* 32(2010): 338-345.

298. Strydom, H. & Delport, C.S.L. 2005. Sampling and Pilot study in Qualitative Research, in De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: for social services and human service professions.* Pretoria: Van Schaik Publications. 327-332.

299. Strydom, H. 2005. Sampling and Sampling methods, in De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: for social services and human service professions.* Pretoria: Van Schaik Publications. 192-204.

300. Strydom, H.; Fouché, C.B. & Delport, C.S.L. 2005. *Research at Grass Roots: For the Social Sciences and Human Service Professions:*3rd edition. Pretoria: Van Schaik Publishers.

301. Symington, N. 1986. *The Analytic Experience.* London: Free Association.

302. Teddlie, C. & Tashakkori, A. 2009. *Handbook on mixed methods in the behavioural and social science*. Thousand Oaks: Sage Publications.

303. Teggart, T. 2006. 'The mental-Health needs of Looked-after children.' 147-167. In Iwaniec, *The child's Journey through care.* West Sussex: John Wiley & Sons.

304. Teggart, T., & Menary, J. 2005. An investigation of the needs of children looked after by Craigavon and Banbridge Health and Social Services Trust.' *Child Care in Practice, 11(1), 39-49.*

305. Terpstra, J. 1999. 'Administration, Power and Kids in Group Care. 'Residential *Treatment for Children & Youth,* 17(1), 1-11.

306. Terpstra. 1999. 'Administrations, power and kids in group care.' *Residential Treatment for Children and Youth,* 17(1). 1-11.

307. Terre Blanche, M., Durrheim, K., & Kelly, K. 2006. First steps in qualitative data analysis. In M. Terre Blanche, K. Durrheim & D. Painter,

(eds.), *Research in practice: applied methods for the social sciences.* 320-344. Cape Town: UCT Press.

308. Testa, M. and Rolock, N. (1999) 'Professional Foster Care: A Future worth Pursuing?' *Child Welfare* 81(1): 108–24.

309. Thyer, B. 2009. *The handbook of social work research methods.* Thousand Oaks: Sage Publications.

310. Tracy, E.M. & Johnson. 2006. 'The Intergenerational Transmission of Family Violence.' 113-134. In Boyd Webb, N. *Working withtraumatised youth in child welfare*. New York: the Guilford Press.

311. Tronto, J. 1993. *Moral Boundaries: A Political Argument for the Ethics of Care.* London: Routledge.

312. Turner, F.J. 2008 Interviewing skills, in Sowers, K.M. & Dulmus, C.N. *Comprehensive handbook of social work and social welfare, 4 volumes set.* New Jersey: John Wiley and Sons. 29-45.

313. Tutt, L.M. & Rothery, M.A. 2009. Needs Assessments, Thyer, B. (Ed). T*he Handbook of Social work Research Methods.* California: Sage Publications. 149-162.

314. Van De Riet, V., Korb, M.P. & Gorrell, J.J. 1980. *Gestalt therapy: An introduction*. New York: Pergamon.

315. Viner, R.M., & Taylor, B. 2005. 'Adult health and social outcomes of children who have been in public care: Population based study. *Pediatrics,* 115(4), 894-899.

316. Watson, D. 2003. 'Defining Quality Caare for Looked-after children: Frontline Workers' Perspectives on Standards and All that?' *Child and Family Social Work,* 8(1), 67-77.

317. Weiner, A. 1991. 'Providing a Development-Enhancing Environment: The child and Youth Care Worker as Observer and Interpreter of Behaviour.' 85-98. In Beker & Eisikovits, *Knowledge Utilisation in residential child an youth care practice.* Washington: Child Welfare League of America.

318. Weinman, J., Write, S., & Johnson, M. 1995. *Measures in Health Psychology: A User's Portfolio. Social \Support.* Windsor: Nfer-Nelson.

319. Wertheimer, M. 1959. *Productive thinking.* New York: Harper.

320. West, R. 1994. Needs analysis in language teaching. *Language Teaching, 27(1): 1-19.*

321. Wheeler, G. 1997. *Self and shame: A gestalt approach.* Gestalt Review. 1(3):221-244.

322. Wheeler, G. [Online]. 1999. Relationship as Shadow: Toward a Relational Practice. Available: http://www.esalenctr.org/display/confpage.cfm?confid=1&pageid=42&pgtype=1). [2010, 27 January].

323. Wheeler, G. 1996. *Gestalt therapy reconsidered: a new approach to contact and resistance.* Routledge.

324. Whitaker, D., Archer, L., Hicks, L. 1998. *Working in Children's homes – Challenges and Complexities.* Chichester: Wiley Publications

325. Whitaker, J.K. 2004 'The Re-invention of Residential Treatment: An agenda for Research and Practice'. *Child and Adolescent Psychiatric Clinics of North America,* 13(2), 267-278.

326. Wiersma, W. And Jurs, S.G. 2008. *Research Methods in Education: An Introduction.* London: SAGE publications.

327. Williams, M., Tutty, L.M. & Grinnell, R.M. 1995. *Research in Social Work: An Introduction.* Illinois: F.E Peacock Publishers.

328. Wilson, K., Petrie, S., & Sinclair, I. 2003. 'A kind of loving: A model of effective foster care. *British Journal of Social Work,* 33, 991-1004.

329. World Health Organisation. 2007. *Ethical challenges in study design and informed consent for health research in resource-poor settings.* World Health Organisation.

330. Yin, R.K. 2008. *Case study research: design and methods.* California: Sage Publications.

331. Yontef, G. 1993. *Awareness, Dialogue and Process. Essays on Gestalt therapy.* Highland: The gestalt journal press.

332. Yontef, G. 1993. *Awareness, Dialogue and Process: Essays on Gestalt Therapy.* USA: The Gestalt Journal Press.

333. Yontef, G. 2002. The relational attitude in Gestalt Journal, *25ractice.* International Gestalt Journal, *25(1), 15-35.*

334. Yontef, G., & Bar-Yoseph, T.L. 2008. 'Dialogical Relationship.' 184-197. In Brownell, P. (Ed.), *Handbook for Theory, Research, and Practice in Gestalt Therapy*. Newcastle: Cambridge Scholars Publishing.

335. Zeanah, C.H., Smyke, A.T. & Settles, L.D. 2008. Orphanages as a developmental context for early childhood, in McCartney, K & Phillips, D. *Blackwell handbook of early child development.* Oxford: Wiley-Blackwell. 424–454.

336. Zinker, J. Nevis, S. 1994. The Aesthetics of Gestalt Couples Therapy. In Wheeler, G., & Backman, S. (Eds.), *On Intimate Gound: A Gestalt Approach to working with couples.* San Francisco: Gestalt Institute of Cleveland Press.

337. Cohen, D. 2006. Qualitative Research Guidelines Project. [Online]. Available: www.qualres.org/HomeMemb-3696.html.

338. Polit, D.F. and Tatano Beck, C. 2008. *Nursing research: generating and assessing evidence for nursing practice.*Lippincott Williams & Wilkins.

339. Zukerman, E.L. 2005. *Clinician's Thesaurus.* New York: The Guilford Press.

340. Walliman,N.S.R. *Your research project: a step-by-step guide for the first-time researcher.* London: SAGE Publications.

LIST OF APPENDICES

APPENDIX A: INFORMED CONSENT

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

A NEEDS ASSESSMENT OF CAREGIVERS IN CHILDREN'S HOMES.

Caregivers

You, _____ are asked to participate in a research study conducted by Elizabeth Greyvenstein, BA; BA Hons Psychology, from the play therapy department Huguenot College in conjunction with Stellenbosch University.

PURPOSE AND PROCEDURES OF THE STUDY

The aim of this study is to explore your needs regarding the care giving of the children in Jacaranda Children's home and your particular training needs in order to provide and assist in improving service delivery to you as caregivers. Should you be willing to participate in this study, you would be asked to be interviewed by the researcher. In this interview you will be asked to share your needs regarding, what you see as resources, challenges, support structures, what sustains you as a caregiver and training opportunities and interactions with social workers.

1.1 Duration

This interview will be conducted in a two hour session.

2.2 Location

The research will be conducted at Jacaranda Children's Home.

POTENTIAL RISKS AND DISCOMFORTS

Sharing your needs might be uncomfortable and make you more aware of your them leading to the intensification of emotional difficulty and dissatisfaction. Should emotional difficulty increase during or after this research investigation please contact the researcher and discuss possible options for release.

POTENTIAL BENEFITS

There will be no direct benefit for caregivers but the needs of you, the caregiver, might be acknowledged and service delivery to you as a caregiver might be improved.

PAYMENT FOR PARTICIPATION

No payment.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with the participant will remain confidential and will be disclosed only with you permission or as required by law.

PARTICIPATION AND WITHDRAWAL

Participants may choose whether to be in this study or not. If you, the caregiver, volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions that you don't want to answer and still remain in the study. The investigator may withdraw participants from this research if circumstances arise which warrant doing so.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the following people.

Elizabeth Greyvenstein 084 6786789

Dr Susanne Jacobs 082 7837474

Department of Play therapy 021 8731181

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Dr Rheta Bloem, head of the Institute of Child, Youth and Family studies, Hugenote College [(021) 8731181] at the Unit for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to ……by ……..in [*Afrikaans/English/Xhosa/other]* and [*I am/the subject is/the participant is]* in command of this language or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject]* were given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study. I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____

Signature of Subject/Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]* and/or [his/her] representative _____ [*name of the representative]. [H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English/*Xhosa/*Other*] and [*no translator was used/this conversation was translated into* _____ by _____].

_____ _____

Signature of Investigator Date

APPENDIX B: SYMPTOMS OF TRAUMA AMONG CHILDREN AND ADOLESCENTS DURING DEVELOPMENTAL STAGES

(Cameron, Elkins & Guterman, 2006:56)

Infants	**Toddlers**	**Pre-schoolers**	**School-age children**	**Adolescents**
Eating and sleeping problems	All of the symptoms of infancy	All of the symptoms of earlier stages	Psychic numbing	Psychic numbing
Distressing dreams	Posttraumatic play re-enacting some aspect of the traumatic event(s)	Preoccupation with body integrity	Flashbacks	Avoidance of places, situations, or people associated with the traumatic event(s)
Persistent crying and upset	Generalised fears	Power plays in relationships	Nightmares	Flashbacks

Recurrent recollections of traumatic event(s)	Recklessness		Featurelessness	Featurelessness
Separation anxiety	Pre-emptive and self-protective aggression		Avoidance of places, situations, or people associated with the traumatic event(s)	Dissociation
Head banging and other self-injuring behaviours	Angry disobedience		Panic Attacks triggered by stimuli simulating the traumatic event(s)	Sudden decline in academic performance/truancy
Intense affect			Dissociation	Dangerous and reckless behaviours
Inability to evoke protective responses from parents			Truancy or sudden decline in academic performance	Delinquency

				Suicidal ideation
				Running away
				Promiscuity Dating violence

APPENDIX C: TABLE 2.2.3 COMMON IMPLICATIONS OF CHILD ABUSE

(Guishard-Pine, McCall & Hamilton, 2007:77)

'Soft signs of child abuse	**'Hard signs of child abuse**	**Physical effects of child abuse and neglect**	**Short-term psychological effects of child abuse and neglect**	**Long-term psychological effects of child abuse and neglect**
Fear of adults	Bleeding and bruising	Scarring	Low self-esteem	Delinquency
Excessive crying	Sudden violent behaviour towards self and others	Disfigurement	Low self-efficacy	Aggression
Low motivation	Sexualised behaviour and language inappropriate to their age	Neurological damage	Poor linguistic and cognitive competence	Domestic violence
Poor peer group relationships	Recurrent hospitalisation or admissions to 'accident and emergency'	Sensory impairments	Hard to regulate their emotions	Child Abuse
Anxiety		Failure to thrive	Excesses of internalising and externalising behavioural problems	Self-injury

Depression			Relationship difficulties	Anxiety
Absconding				Depression
				Somatisation
				Difficulty making and maintaining intimate relationships
				Suicide

APPENDIX D: GOVERNMENT SERVICE SPECIFICATIONS PERTAINING TO CHILDREN'S HOMES 2010/2011

Available online:

www.socdev.fs.gov.za/.../SPECS%20-%202010-11%20%20Children's%20Homes.doc

category of service: Children

service description: CHILDREN'S HOMES/ CHILD AND YOUTH CARE CENTRES

district:

AREA

Name of Town	All Towns in Province

AIM

Aim of Service/Project	To provide residential care services for children in need of care and protection and children in conflict with the law in the Free State Province

SERVICES REQUIRED

Target Group (s)	Children who are found in need of care in terms of section 14(4) of the Child Care Act, 1983 (Act 74 of 1983) and committed in terms of section 15(1)(c) of the Child Care Act, 1983 (Act 74 of 1983) Children who need care in a place of safety

OBJECTIVES AND OUTPUTS REQUIRED

Objective (s)	Output(s)
To provide residential care programme(s) as prescribed in section 15(1)(c) of the Child Care Act, 1983 (Act 74 of 1983) for 730 children in need of care in terms of section 14(4)	Children's homes/group homes The aims of the programme should focus on the following: Meet the children's physical, social, emotional mental, physiological and spiritual needs. Promotion of the children's quality of life and a healthy life style Family reunification services to children and families. Meeting the Minimum Standards of the SA Child and Youth Care System. Meeting the requirements of the Child Care Act, 1983 (Act 74 of 1983) and its Regulations on children's homes Enhance the quality of the children's lives at all levels

	Type of Service: Basic physical care Medical care Social work services Psychological Services where necessary Remedial Education, where necessary Occupation Therapy and physiotherapy where necessary. HIV/AIDS Education Life and social skills Education School Attendance Information and Education Holiday Programmes Leisure and Recreation Programmes Networking with reunification and after care services with a view of planning the child's future and permanency. Recruitment, selection and training of volunteers, holiday parents and foster parents.

	Outreach programmes and services to the community Work methods: Developmental Group Care Developmental Assessment Professional methods in accordance with each discipline involved Child and youth care practice Management and administration Adequate supervision of staff Use of personnel and volunteers
Provincial Management of child and youth care centres in the Free State Province (Assessment in accordance with the Department of Social Development Financing Norms)	To manage child and youth care centres in the Free State Province To provide guidance and support to child and youth care centres on professional and administrative services To facilitate capacity building and in-service training for staff in child and youth care centres To monitor the implementation of policies, legislative provisions and the Minimum Standards for the South African Child and Youth Care System To develop and implement internal and provincial organisational-based policies for child and youth care practice in child and youth care centres.

	To facilitate quality assurance in child and youth care centre programmes To ensure effective and efficient financial management of the programme.

ENQUIRIES

PROVINCIAL OFFICE OFFICIAL
Official: W. Sapsford / Me H. Dippenaar
Tel Nr: 051-4090549 / 051-4090558

NOTE: Additional information on this specific service and requirements could be obtained from the relevant legislation, departmental policies, position papers and circulars.

SUBMIT TO:

PROVINCIAL OFFICES:

Office: Dept of Social Development
Physical Address: Liberty Life Building, St Andrew Street, Bloemfontein.
Official: Me H. Dippenaar
Office Nr: Romm 213

APPROVED:

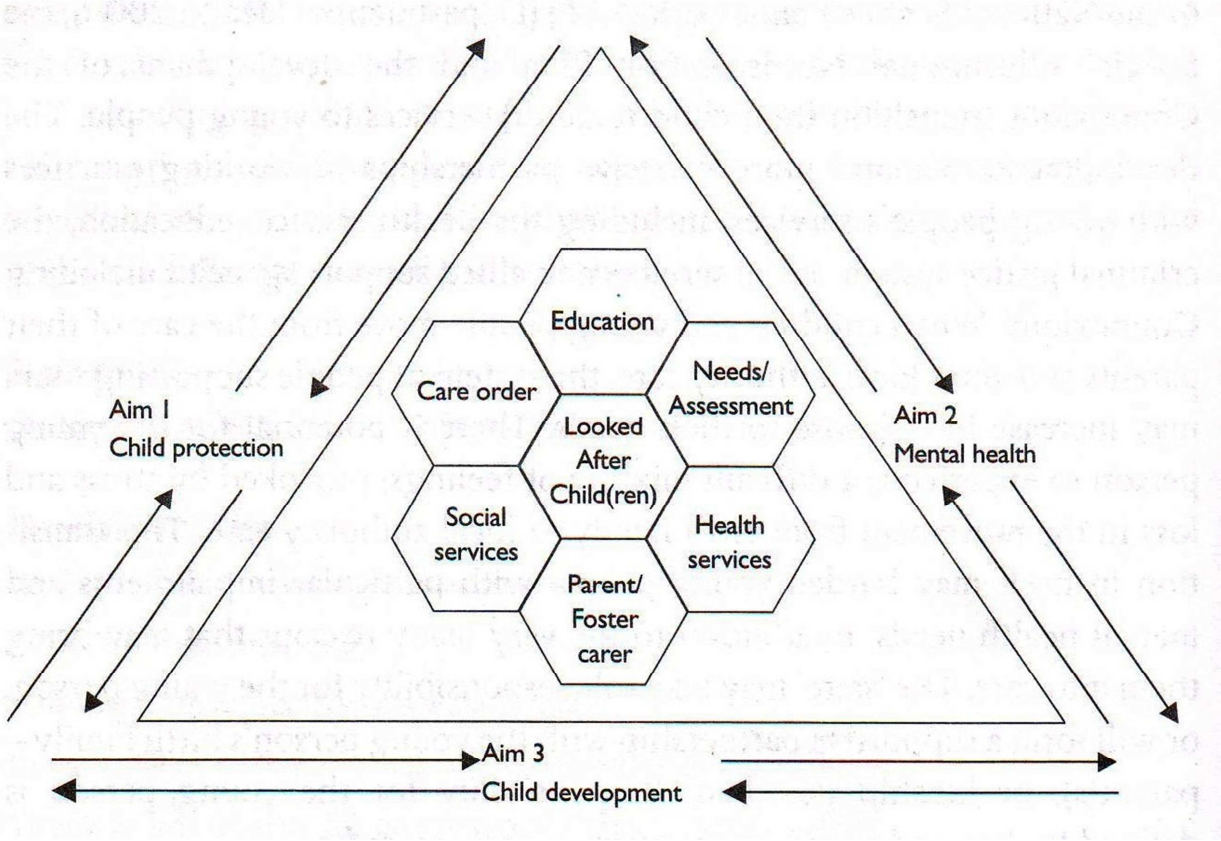
_____

EXECUTIVE MANAGER: SWS

APPENDIX E: DEVELOPMENTAL QUALITY ASSSURANCE

APPENDIX F: THE CORPORATE PARENT: PROFESSIONAL SUBSYSTEMS AS A PROTECTIVE SHIELD

(Guishard-Pine, McCall & Hamilton; 2007:110)



APPENDIX G: TRAUMA SYMPTOMS AND POTENTIAL EFFECTS ON PARENTING

(Tracy & Johnson, 2006:117)

Domain	**Typically observed responses to trauma**	**Potential effects on parenting**
Cognitive	- Intrusive thoughts - Intrusive images - Amnesia - Derealisation/depersonalisation - Dissociation	- Preoccupation, withdrawal, lack of presence, and lack of focused attention while attempting to parent - Difficulty in providing stability, adhering to routines, and keeping track of scheduled activities involving the child
Affective	- Anger/irritability - Anxiety/nervousness - Depression - Shame - Hopelessness - Sense of isolation, loneliness - Emotional numbing - Feeling different from others	- Difficulty in feeling close or connected to child, withdrawal - Low tolerance for child's age-appropriate "acting out" - Pervasive fear of hurting child, feeling unable to keep child safe - Inadvertent communication of negative emotions regarding physical contact, bodily functions of child (e.g., changing diapers, bathing)

Behavioural	- Increased activity - Aggression - High tolerance for inappropriate behaviour - Low tolerance for chaotic, busy, or complex environments/situations - Avoidance (often unconscious) of triggering and/or trauma related situations	- Increased risk of child maltreatment - Difficulty setting appropriate boundaries and limits - Easily overwhelmed with everyday demands of parenting - Restriction of child's range of activities and experiences due to the mother's avoidance of perceived threats
Physiological	- Arousal due to autonomic hyperactivity to trauma triggers - Sensory numbing - Absence of "normal" reaction to events	- Child must often cope with mother's erratic and unpredictable behavioural reactions and mood states, which do not always correspond in easily understandable ways with situations and events
Multiple domains	- Flashbacks - Age regression - Nightmares - Rigid and/or limited notion of range of acceptable behaviours - Unsure as to what constitutes "normal" family life and parenting	- Mother's intense mood states, levels of fear, and emotional instability may frighten child - Chronic fatigue due to sleep problems may undermine coping skills - Difficulty assuming authority, making decisions, advocating for self and/or child - Difficulty distinguishing between discipline and

	behaviours	punishment - Difficulty establishing safe environment for child

APPENDIX H: COMPARING VARIOUS PARADIGMS

(Meara, A., 2010)

	Gestalt Therapy	**Transcendental Realism**	**Ecological**	**Chaology**
	(Korb,Gorrell &de Riet)	Bhaskar Manicas and Seccord	Bateson, Jantsch, SOS	Gregersen and Sailer
Cosmological Assumption	The nature of reality is an ongoing, constantly changing process. Objects are also processes, not observable except for special equipment. All things exist in relation to other things and are thus engaged in process. Consequences are not necessarily	Three domains -real -actual -empirical Stratified systems with emergent properties Space and time causally inert	Everything is in interdependent balance, circular causality. Balance requires stability and change. Whole is greater than sum of parts, where wholes have properties of self-organisation and autonomy. Paradox arises between different levels of logical type.	The nature of reality is a dynamic, recursive process, which contains chaotic and non-chaotic characteristics, and exhibits self similarity. General processes are determinable, but specific outcomes are unpredictable.

	explainable by causality.			
Ontological Assumption	Behaviour is determined by the relationship between an individual and their environment. Awareness of and responsibility for the total field, for the self as well as the other, give meaning and pattern to the individual's life.	Behaviour is determined by interacting mechanisms on open systems constant conjunction of events may not occur	Humans are interdependent with nature, they don't control it. Individuals are self organising autonomous wholes that are inter-dependently related to society, which is also self organising and autonomous.	Behaviour is determined by a combination of determinism and chance. Mind, body and emotions are inseparable, as are individual, group and social behaviour. A small change at one level can lead to large scale change.
Epistemological Assumption	Knowledge arises from awareness of experience. Knowing why and knowing how are differentiated, the latter being more important	Structures exist independent of our knowledge of them Reproduction	Knowledge arises via the use of multiple perspectives and is grounded in the ability to ensure ecological survival. Observation is participatory, purposive, personal and	Knowledge

			value laden.	
Ethical Assumption	Values are self and societal determined. There is no intrinsic right or wrong. Ethical action is situational and the individual is responsible for their choice, whether it is for self, other, or society.		Fact and value are inseparable. They are committed to survival of whole and parts. Diversity and flexibility are essential. Value self-determination, self organisation and openness.	

APPENDIX I: POSITIVIST, INTERPRETIVIST, CRITICAL REALIST ASSUMPTIONS

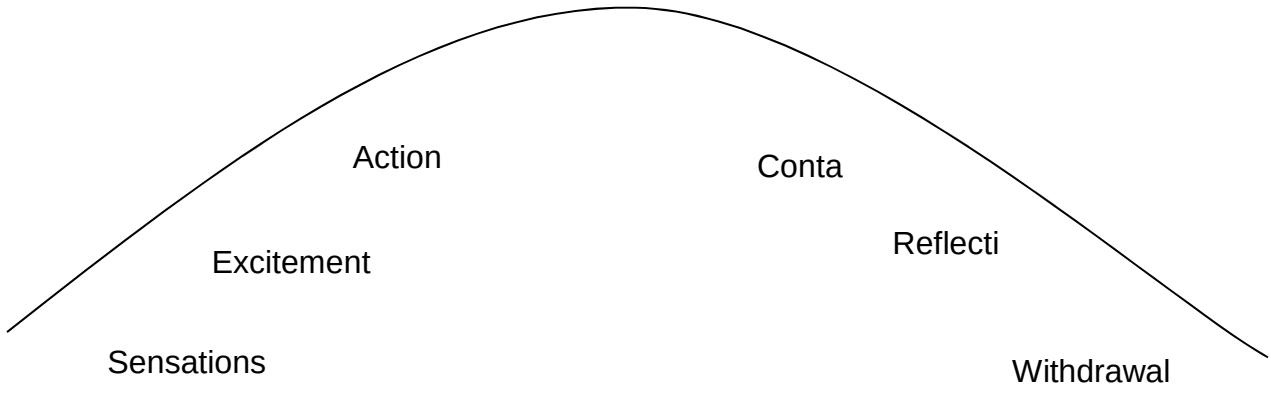
(Meara, 2010).

	POSITIVIST	INTERPRETIVIST	CRITICAL
Cosmological Assumption	Causal determinist view of reality. The world is predictable, knowable and measurable. Fragmentary view of reality (reality can be understood as separate parts).	Knowledge is contextual and a symbolic social construction. Events can be explained and their meaning for people uncovered. Parts can only be understood in context.	All things are internally contradictory and are in a constant process of movement where all processes forms a totality in which each process over determines every other.
Ontological Assumption	Behaviour can be explained in causal, deterministic ways. It has a mechanistic quality. People are able to be manipulated and controlled.	Behaviour is intentional and creative. It can be explained but is not predictable. People shape their own reality.	Human behaviour is social and historic. People shape their world but are shaped by it at the same time
Epistemological Assumption	Knowledge arises from experimentation and observation and is grounded in the certainty of sense experience, with the	Knowledge arises from interpretation and insight and is grounded by empathic communication with	Knowledge arises through action and is grounded in the success of self-conscious action. Research goes

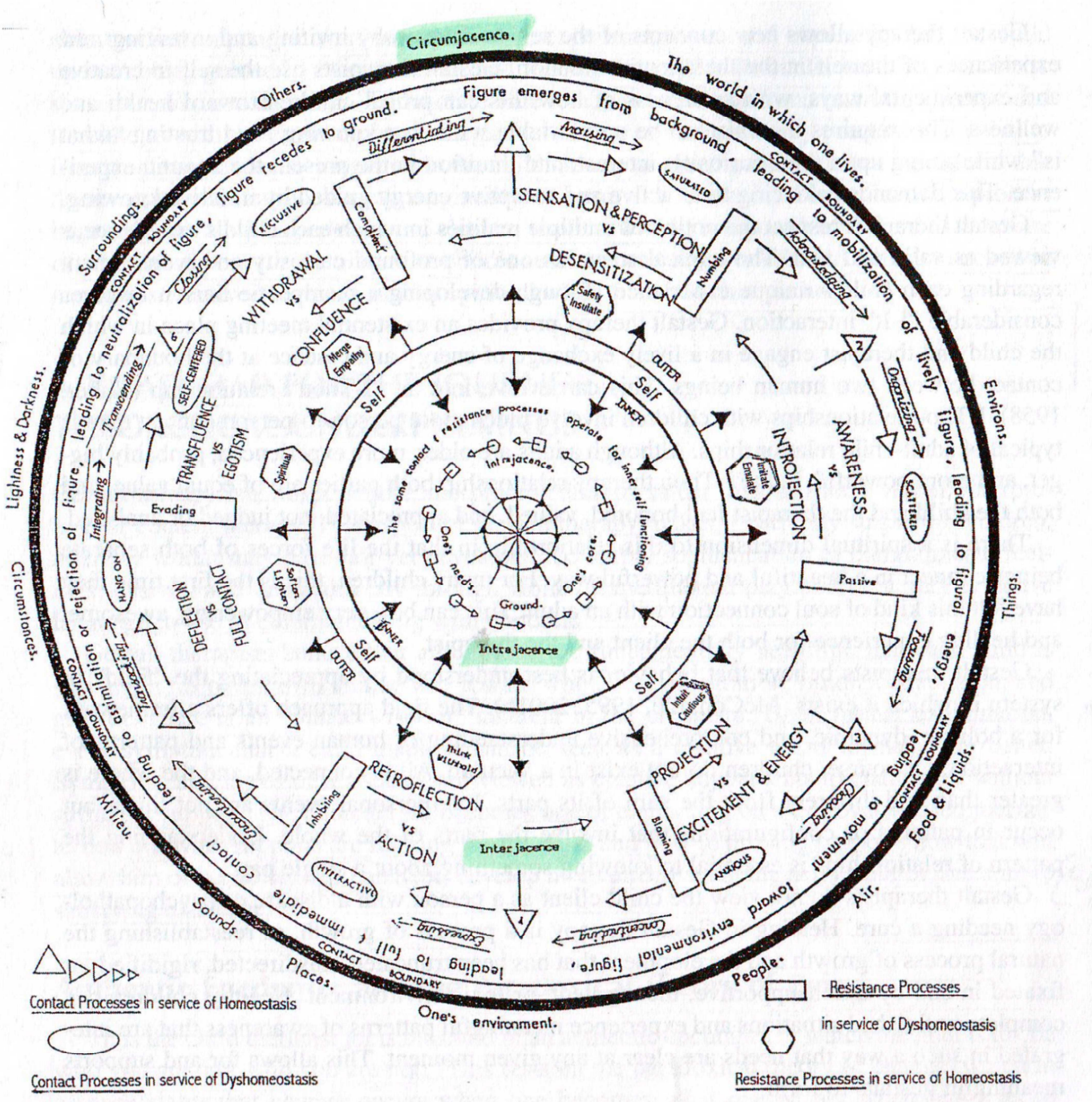
	aim of arriving at universal claims to truth. Quantitative methodologies are highly valued	the subjects of the research. Symbols, meanings and hidden factors are essential to understanding. In depth interviewing, participant observation and other qualitative methods are used.	beyond appearances to what is essential. Action and participatory research methods are advocated
Ethical Assumption	A separation between knowledge and values. Science produces knowledge. How it is used is a value, ethical or moral question and is outside the concern of science.	Values are the subject of research. Moral or ethical relativism. Leads to disinterest in ethical issues or anarchistic individualism.	Knowledge and values cannot be separated. Committed to happiness and the emancipation of people from oppression.

APPENDIX J: THE CONTINUUM OF EXPERIENCE

(Melnick, Nevis & Shub; 2005:104)



APPENDIX K: THE GESTALT HOMEOSTASIS CYCLE (WOLDT, 2005:160)



APPENDIX L: GESTALT CONTACT FUNCTIONS

(Woldt, 2008)

The set of definitions is referred to as Contact Processes. These function to promote health and satisfaction in fulfilling our wants and needs as we seek interaction with our environment. While they operate on a continuum, one leading toward the next in this list, they are not in reality separate or distinct processes as they function in cooperation with each other as well as with the environmental processes and elements present in the field. It is also important to remember that when we engage in these processes excessively or habitually, they might better represent an unhealthy style of interaction with the environment and actually inhibit or limit contact and fulfilment.

Contact function/Process	Definition
SENSATION AND PERCEPTION	This basic human function allows our sensory processes to make contact with our field / environment. These initial processes that Perls, Hefferline and Goodman refer to as “Id functions” are characterised as the arousing of thoughts and feelings about potential contact between self and environs. The sensory processes are Looking, Listening, Feeling, Touching, Tasting, Smelling, Talking (includes Voice & Language), Thinking (includes Intuiting & Imagining), and Moving (includes Gestures & Motions), Our sensory and perceptual data is used to orient and organise our internal processes (e.g., urges, provocations, desires, impulses, appetites, needs, etc.) as well as our experience of the field or environmental influences that affect our awares

	experience. Awareness of these interactive processes between self/other/environs often create or induce some disruption in the balance between us and our present environment. Over-use or exaggeration of one's sensory processes is disruptive of contact in such cases as being so saturated with sensation that one becomes confused about the object of interest or is so super-sensitive that sensations are overwhelming.
AWARENESS*(of Feelings, Ideas, Possibilities, Choices, Direction)*	This is the function or process of experiencing and identifying the thoughts, feelings and behaviors associated with the sensory data, where we cognitively identify what is happening inside and in-between our self and our environment and having sufficient description or understanding of that process to create enough meaning to either move towards or away from the possibility of further contact. Awareness typically involves aspects of our total self – our emotional, physical, cognitive and *(some-times)* spiritual processes. Awareness is both a process *(what we are experiencing to move toward a goal or to contact the object of our attention)* and an outcome *(experiencing the result of our contact or goal attainment).*

EXCITEMENT AND MOBILISATION OF ENERGY	This is the function or process of allowing the ground for contact to grow, opening up to and anticipating possibilities, feeling energy mount and generating sufficient energy to explore the possibilities for pressing onward, stopping or rejecting what we are aware of for potential contact internally and externally. This stage is characterised by focusing, choosing and concentrating on the figural interactive processes.
ACTION AND ENCOUNTER	These active processes involve the functions of expressing our feelings, ideas and/or behaviors in order to interact with the object of our perceptions, wants, wishes, needs, etc. It involves making use of available resources to manipulate the environment for need satisfaction, which involves restructuring and/or destructuring the object of our interest and behavior. This is often referred to as ‘chewing things over,’ rehashing, debating, ‘working on it,’ reframing, re-doing, re-thinking, etc. This stage of contact is characterised by the fuller expression of self in order to encounter, chew-over and destructure the object of our thoughts and feelings and aggressions such that it becomes digestible, not just swallowed whole.

INTERACTION AND FULL CONTACT	This stage of contacting is characterised as the transacting and integrating of that with which we encountered in order to assimilate that with which we are contacting. During this interactive process the person is inseparable from the focus of attention while also remaining separate from it, which results in spontaneous change. This process provides the function of unitary interaction with that which we experience as meeting a demand or satisfying a want or need, resulting in absorption with that element of the field.
ASSIMILATION, INTEGRATION, GESTALT FORMATION, TRANSFLUENCE	This function is the process of completing the figure formation, taking in what we have encountered, dispelling (spitting out) what is unadaptable, then digesting what is assimilable and having it become an integrated part of our being. If we find “it” to be unassimilable, we might disintegrate “it” and be satisfied that we are done with “it,” thereby not haunting us to be revisited. Good figure formation involves a sense of being finished, full or complete – not having unfinished business. Experiencing a “gestalt” is the way in which we organise (or re-organise) our experience into a pattern or whole resulting in a sense of wholeness. Transfluence is characterised as the

	maintenance of full and sustaining contact in a manner that allows for transpersonal contact, which many refer to as engaging in the spiritual realm.
DIFFERENTIATION, CLOSURE AND WITHDRAWAL	This is the process of concluding, finishing and ending contact – ideally involving a sense of completion and diminishing interest in the object of our contact. In arriving at this place/space, people often feel full, whole, complete and relaxed, thus allowing time to recuperate while experiencing freshness, equilibrium, balance, personal space. Arriving at this place/space sometimes provides for the experience of a "fertile void" – the experience of completion, yet not ready for the next contact. Withdrawal is characterised as obtaining closure and being finished in such a manner that you can go on to another new and exciting figure of interest.
FERTILE VOID	is a place or space where we experience solitude, quiet resolution and freshness – being open to new possibilities, new ideas, new tastes, different stimuli. It involves the possibility of letting go of what was to be awakened to what might be – 'having no expectations but great expectancy'. Fertile voids are claimed by many to be the primary prerequisite for

	wonderment and creativity.

APPENDIX M: GESTALT RESISTANCE PROCESSES

(Woldt, 2008)

Resisting functions/Processes	**Definition**
Desensitising	is a primary interruption of the contact function Gestaltists call SENSATION. It involves blinding & anesthetising one's self by limiting our stimulation, dullness, abstracting/voiding/avoiding feelings, becoming "senseless," and closed down in a manner that blocks one's sensory information from being organised and available for awareness, emotional involvement or decision-making. People who favour this style of interruption are more often "thinkers" than "feelers" and often don't notice situations that others find stressful. Since they tend not to feel much, their feelings are not easily hurt.
Introjecting	is a primary interruption of the contact function Gestaltists call **AWARENESS**. This process involves passive acceptance from the environment (e.g., thoughts, foods, behaviors, rules), believing authorities know what is best for you, not chewing over or tasting for one's self, and functioning in a manner that potential excitement is not supported. They want "things to come to them," or be "given things," rather than work for things – getting it passively rather than actively.
Projecting	is a primary interruption of the contact function Gestaltists call **MOTIVATION AND EXCITEMENT**. This process involves inhibiting potential excitement by experiencing on the outside what is actually inside one's self, often blaming others or the environment for what's wrong, not recognising

	they could be talking about themselves. They experience being the victim of circumstances. They disown personally unacceptable aspects of themselves (e.g., traits, attitudes, behaviors) and attribute them to other persons or objects
Retroflecting	is a primary interruption of the contact function Gestaltists call **ACTION AND INTERACTION**. This process involves considerable anxiety and as a result, doing to one's self what we would like to be able to do to others (while usually lacking awareness of that as a possible choice). In its simpler forms, a retroflective person avoids the processes of openly facing or destructuring potentially threatening experiences. Embarrassment, or the prospect of embarrassment, often results in turning potential action back on one's self. Retroflective actions also account for considerable depression – i.e., depressing emotions. It is an inhibiting process that sometimes becomes self-destructive and results in headaches, feeling overly stressed, tightness and stiffness in parts of the body, sore muscles and psychosomatic illness. An extreme example of becoming self-destructive is when one shifts from homicidal feelings to suicidal action.
Proflecting	is a variation of retroflecting that involves the redirecting of what we call **ACTION AND INTERACTION.** This process involves directing contact towards an object outside one's self that is intended or wanted in or for one's self. Examples include scratching someone else's back (or the pet's) when ours is itching for a scratch; or a smoker touching a cigarette in a way s/he would like from someone.
Deflecting	is a primary interruption of the contact function Gestaltists

	call **FULL CONTACT**. This process involves avoiding, misdirecting and turning aside from contact by reducing the intensity of situations or events. Deflectors often experience a vagueness of feelings and are good about beating around the bush. They fret full engagement, as a result they often procrastinate, "blow smoke" (so to speak), come tardy, making lite/light of things about which others are serious, and use humor to lighten situations. Sarcasm tends to be a serious form of deflecting contact. Usually the person has a style of diminishing or re-routing risky encounters, often postponing or avoiding commitments, and in doing so feels disconnected. They find it difficult to finish things.
Egotising	is a primary interruption of the contact function Gestaltists call **ASSIMILATION & INTEGRATION**. This process involves being wanting to stand out from the people they are with, being self-centered, egotistical, often behaving in an arrogant and exclusionary manner. These people actually function out of a feeling of insufficient ego strength, fearing assimilation, integration and full contact. They report experiencing being a spectator of their own life and find it difficult to feel truly connected to someone special.
Confluence	is a primary interruption of the contact function Gestaltists call **DIFFERENTIATION & WITHDRAWAL**. This process involves having undifferentiated boundaries or lack of clarity about self-other boundaries. Their awareness of self becomes lost in another person. They have difficulty saying "No" to people close to them. Confluent people wish people would smooth over their differences, g*et al*ong with everyone, cling to old relationships and hang onto relationships or things when they are no longer of value. They find enmeshment

	comfortable and personal differences or interpersonal distance difficult. Ending relationships and obtaining closure is painfully difficult.
Avoiding	is a primary interruption of the contact function Gestaltists call the **FERTILE VOID**. This process involves being married to the status quo, having no desire for freshness or new ideas or even food or sustenance. These folks need to keep things “as they were” while often busying and/or deadening themselves in the process of avoiding solitude, tasting, new or different stimuli, etc.

APPENDIX N: INTERVIEW SCHEDULE (AFRIKAANS)

Ouderdom
Geslag
Opvoeding en opledings agtergrond
Ondervinding as 'n caregiver 1. Jare 2. Watter tipe ondervinding en opleiding het jy? 3. Jare in hierdie kinderhuis
Organisatoriese funksionering 1. Hoe word Kommunikasie kanale bestuur? 2. Is daar samewerking met die bestuur en hoe word dit bewerkstellig? 3. Is daar spesifieke werks prosedures wat gevolg moet word en wat is dit? 4. Hoe ervaar jy dit om bestuur te word deur die groter organisasie? 5. Hoeveel toegang het jy tot die maatskaplike werkers en bestuur? 6. Tot watter mate is jy deel van die besluitneming rakende die kinders in jou sorg? 7. Het jy 'n behoefte om deel te wees van die besluitneming rakende die kinders in jou sorg? 8. Hoe sal jy meer betrokke wil wees in besluitneming en ander organisatoriese funksies? 9. Wat volgens jou is die grootste uitdaging in die stelsel?
Uitdagings 1. Wat ervaar jy as die uitdagings van jou werk as 'n huisouer? 2. Watter emosionele uitdagings ervaar jy in jou werk? 3. Watter fisieke uitdagings ervaar jy in jou werk? 4. Watter intelektuele uitdagings ervaar jy in jou werk? 5. Watter geestelike uitdagings ervaar jy in jou werk?
Ondersteuning

1. Wat beteken die woord 'ondersteuning' vir jou?
2. Watter tipe ondersteuning is vir jou belangrik?
3. Voel jy dat jy ondersteuning ontvang en deur wie?
4. Sal jy meer of minder ondersteuning wil ontvang?
5. Op watter manier wil jy ondersteun word?
6. Watter bronne het jy nodig om jou take uit te voer?
7. Ervaar jy dat jy toegang het tot bronne/hulpmiddels wat nodig is om jou take uit te voer?
8. Ervaar jy dat jy emosioneel ondersteun word deur die bestuur en op watter manier?
9. Watter sosiale netwerk het jy wat jou ondersteun?
10. Watter mate van toegang het jy tot supervisie en berading?

Opleiding

1. Wat beteken die woord 'opleiding' vir jou?
2. Hoe belangrik is opleiding vir jou?
3. Ontvang jy enige opleiding as 'n caregiver in hierdie kinderhuis?
4. Wat is die omvang van jou opleiding beskikbaar in hierdie kinderhuis?
5. Is daar riglyne waarvolgens jy situasies moet hanteer?
6. Wat is jou behoeftes ivm opleiding?

Ervaring as 'caregiver'

1. Beskryf jou ervaring as 'n caregiver.
2. Wat is die rol van 'n caregiver volgens jou?
3. Wat dink jy is die doel van jou werk?
4. Wat dink jy is die behoeftes van die kinders in jou sorg?
5. Ervaar jy dat jy die vermoe het om die take van caregiving effektief te kan behartig en waarom se
6. Jy so?
7. Ervaar jy dat jy die vermoe het om kinders se gedrag en ontwikkeling positief te kan beinvloed en
8. Waarom se jy so?
9. Wat verwag jy van jouself wanneer jy dink aan jou rol as caregiver?

10. Ervaar jy dat jou rol as caregiver 'n impak op jou lewe het en tot watter mate?
11. Wat was die aanvanklike hoofrede om 'n huisouer te word?
12. Indien jy weer 'n keuse gehad het sou jy geskies het om weer ‘n huisouer te wees en waarom?

Daaglikse versorging

1. Wat is jou daaglikse behoeftes rakende die versorging van die kinders in jou sorg?
2. Wat is jou persoonlike behoeftes rakende die versorging van die kinders in jou sorg?
3. Wat is jou behoeftes rakende die organisatoriese funksionering van die kinderhuis?
4. Wat is jou behoeftes rakdende die kinders se fisieke, emosionele, en geestelike ontwikkeling?
5. Is daar enige ander behoeftes wat jy ervaar?

Emosionele behoeftes

1. Wat is jou behoefte rakende jou emosionele gesondheid?
2. Wat beteken dit vir jou om uitgebrand te voel en het jy al ooit so gevoel?
3. Watter traumatiese gebeure het jy in jou lewe al deurgemaak?
4. Het jy hulp en ondersteuning gehad and watter tipe ondersteuning?
5. Is daar seker plekke, gedagters, gevoelens, aktiwiteite en mense wat verband hou met hierdie gebeure wat jy vermy?
6. Het jy enige slaap probleme, konsentrasie probleme en voel jy dat jy sensories baie bewus is?
7. Watter emosionele ondersteuning ontvang jy tans?
8. Hoe voel jou gemoed meeste van die tyd?

APPENDIX O: SIGNED AGREEMENT FOR RESEARCH AT CHILDREN'S HOME

The Board of Social Workers and Head of Jacaranda Children's Home,

I, Elizabeth Greyvenstein (BA; BA Hons Psychology), am a masters degree student from the play therapy department at Huguenot College in conjunction with Stellenbosch University. With this letter I am asking permission to do research at Jacaranda Children's Home.

The title of my research is:

A NEEDS ASSESSMENT OF CAREGIVERS IN CHILDREN'S HOMES.

In this study the research will focus on the holistic needs of caregivers regarding the care of looked after children and their particular needs regarding training. Limited literature exists concerning the needs of caregivers regarding training and care-giving in Children's Homes. Exploring the needs of these caregivers could provide a broader and more realistic understanding of their problems and needs and improve service delivery to them.

Interviews will be conducted with participating caregivers that will be held at Jacaranda Children's Home. These interviews will focus on their holistic needs regarding the care-giving of the children and the caregiver's particular training needs, within a two hour framework. It is estimated that there will be between six and eight interviews. For caregivers that will not be interviewed, a questionnaire will be given in order to provide them the opportunity to express their needs as well. Participation is voluntary. Feedback will be given to the board and to the caregivers after research has been finished.

If you have any questions or concerns about the research, please feel free to contact the following people.

Elizabeth Greyvenstein	084 6786789
Dr Susanne Jacobs	082 7837474
Department of Play therapy	021 8731181

Kind regards and best wishes

Elizabeth Greyvenstein

SIGNATURE PAGE

With this I, Cvd Meiwe as Head of Jacaranda Children's Home, give permission to Elizabeth Greyvenstein that she is allowed to do research In Jacaranda Children's Home. She is allowed to do interviews with participating caregivers and give questionnaires to all other caregivers.

2010/03/25

Date

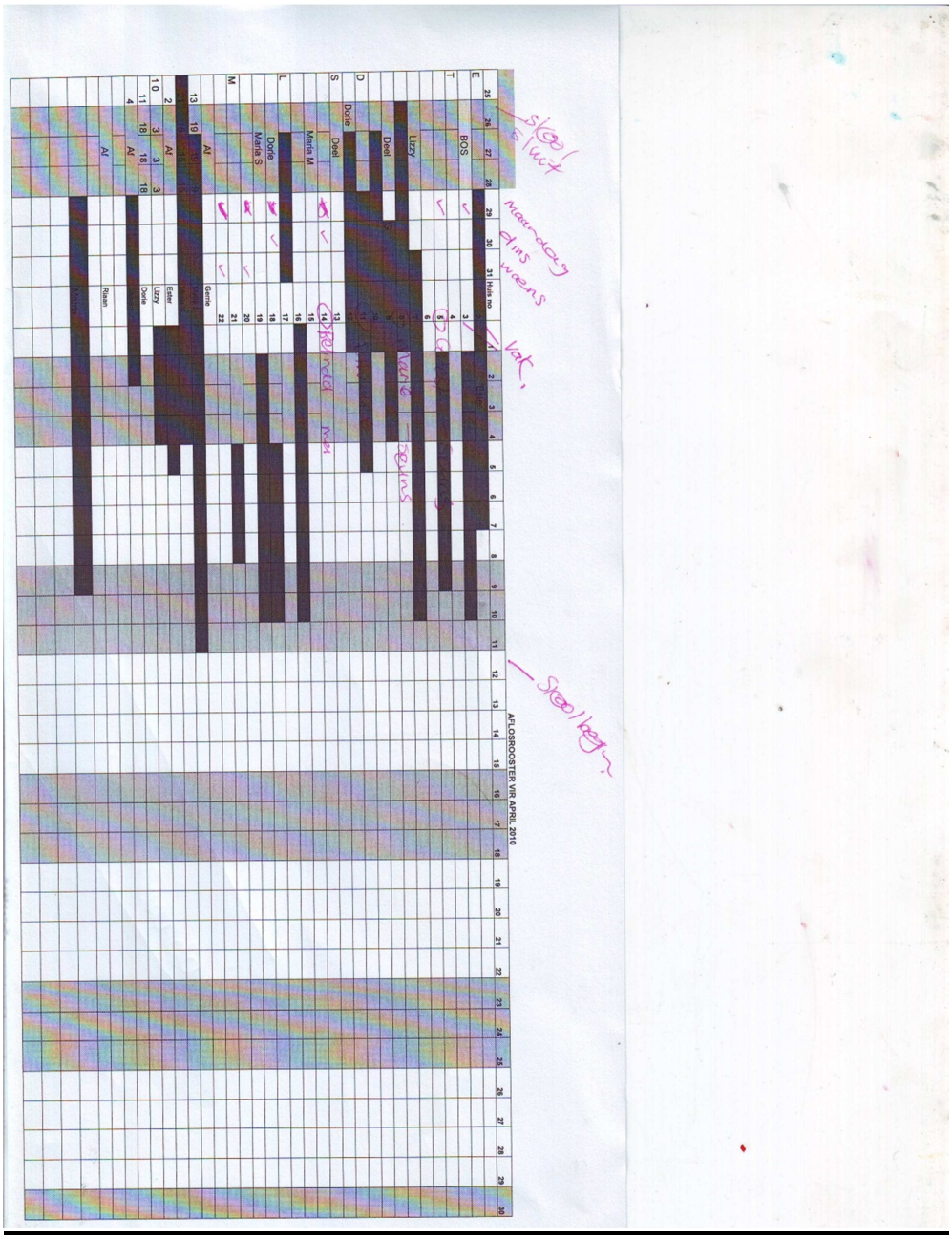
Pta

Place

Cvd Meiwe

Signed

APPENDIX P: TIMES OF AVAILABILITY OF CAREGIVERS FOR INTERVIEWS



APPENDIX Q: ANALYSED TRANSCRIPTS OF INTERVIEWS

Participant A

Participant A

Age: 29

Gender: Female

Educational background: Senior certificate

Number of years here: 3

Previous training: None

Researcher: Good morning, as you know we are here to talk about your needs as a caregiver in this children's home. Did you read through the documentation that you received?

P: Yes. I am Participants A and welcome here in my home.

R: Thank you. Do you have any questions regarding the interview or the research?

P: No I don't.

R: Ok, I am a play therapist as you know and work with children in a therapeutic environment. I am here to try and understand what your needs. As I see it, there are always resources available to the children but when it comes to the caregivers, there is little know about your actual needs. I do feel that it is important that you receive support and I would like to find out what kind of support and recources you would need.

P: Oh yes, I do need a lot more support.

R: I have some questions that I would like to discuss with you and if you don't want to answer any of them you are invited to say so and I will move on. So the questions focus on organizational functioning, challenges, support, training, personal, needs

and emotional needs. So if you want to stop at any time please go ahead and as you go through this and want to move back to any other question feel free to do so.

P: Yes I will.

R: How old are you?

P: 29

R: How many years' experience do you have?

P: As a caregiver in these children's home, 3 years and for the rest I have always been involved at my children's schools and church and everywhere with children.

R: It seems that you like children?

P: Yes I really like being a mother and working with children.

R: Before you came into the children's home as a caregiver have you received training and instruction?

P: You know, no, but here in real life is where I get my experience from. And the people here are sometimes supportive and help me when I struggle.

R: I hear you say that here in practice/in die praktyk you learned some valuable things.

P: yes, your right.

R: When I speak about communication channels here, what would you say about that. Do you feel satisfied with the way it is handled, do you feel there is a need for improvement, does it work for you of do you feel left out..

P: You know, I have an excellent social worker which is now leaving us but, and I do feel worried about that but I sort out the problems of the children by myself and it is really not often that I have to go for help. I do feel that the way they handle problems are ok and that I can talk to them should I want to. I just don't know about the new social worker.

R: So there is rules and regulations as to when and how you can make contact with them

P: Yes. There are enough policies for the whole Africa.

R: Explain to me how the process work. Do they come to you or do eyou have to go to them?

P: Well, we have supervision once a month, which is a personal conversation between her and me. Once a month we have a group session where all four caregivers under here sit with her where we talk about algemene problems and then if I want answers I put it into writing and she then reponds to me or I am also allowed to phone. There is also a file that we need to fill in every day which is handed in as a monthly report to her.

R: So it seems that you feel satisfied with your communication with your social worker.

P; Yes, I just don't know about the new one.

R: Ok, the samewerking between the management and you how does that work for you?

P: A lot of other caregivers do complain a lot but I might have been just lucky so far and I get done what should get done and I have no hick ups

R: So you do feel that there is anything bothering you but that there is other caregivers

P: Yes, I think I am a very open person and I ask and I think they like me for that and thus give me what I need.

R: So you feel that your personality opens up doors for you?

P: Yes, and therefore I don't think I have problems with that.

Interruption: Children entered the home asking questions and the caregivers said they should go out and that she will be with them now. Tone is relaxed and children responded well.

P: We received toys from someone and now they just want to go through it and play.

R: It seems that You say that the availability and access to social workers are good for you and that you do not have to make an appointment long before time?

P: Yes, I think I feel satisfied. But I think it is because of my social worker. And she gives you answers before you need it and keep you informed.

R: So you do feel that the social worker that is over you have a big role to play?

P: Yes, definitely and makes a big difference as the previous social worker was totally a different experience.

R: Ok. How was it different?

P: Well, she was not available and very quiet and I felt lonely and depressed as I didn't get to do anything as she never helped me solve a problem

R: I see. Now, the next. The decision making prosess with regards to the children, do you have insette there or how does that work?

P: It something needs to be dicided, I will talk to my children and here what they have to say but do not make the final decision – that should be done by the social worker. And if I see that a child needs something and he/she feels very strong about that I will do my best to motivate it and see that they receive what they need.

R: So you want to help them receive what they need?

P: yes, I think that is the role of a mother.

R: Thus, the decision making lies with the social workers. Are you ok with that and do you think that is how it should be?

P: Yes I think it is good, because I do not want that amount of responsibility on my shoulders and I don't want to make the wrong choices and sit with that.I try to do my best but I cannot keep these children safe all the time and it drives me insane.

R: Is that a part of your support structure – not having to make the choices?

P: Yes, definitely that helps me to cope.

R: I hear you say that it takes some responsibility away from you when the social workers make the decisions – what are your responsibilities?

P: I am the mother. Make food, wash clothes, play with children, do homework. I need to give them a home life.

R: Ok, so you give love and stability to them?

P: Yes, I am very good friends with my children it might be because I am young and I click with them.

R: You feel you connect with them.

P: Yes, I told the other caregivers the other day in a meeting that they have to adapt to the children as they have different music tastes and behaviours that the older people are not use to. I play cricket with them and rugby and jump trampoline with them and camped with them. I want to be accepted and respected and want to be treated fair so they should have that from me as well.

R: You feel that your age makes the difference?

P: Yes, I have a lot more energy and I do all my work in the mornings before they come from school and thus spending a lot of time with them in the afternoon.

R: It seems that you are in a place.

P: Yes, I am busy going through a divorce and I do not even feel anything. I think here I am going through a healing process but I feel numb towards it. And the children appreciate me where he (her husband) didn't.

R: The divorce..

P: Its been going on for 7 months now. He lived here with me for the past 3 years and now he moved out and does not talk to me. He is hatefull and aggressive and he think he is verontreg. We have a son and he doesn't want to visit there anymore which is not nice.

R: Biggest challenges?

P: Communication, you phone one social worker and the answer is that and you phone another and the answer is different. I think it is because it is such a big organization. To keep a place running with 250 children is a challenge.

R: So do you think that less children will make a difference and how?

P: Yes definitely. We have a meeting then thing would be discussed but not resolved

R: ….Which is a frustration?

P: Definetly a huge frustration. And then the children is a big challenge as well – to show them that life continues and to get them positive and not thinking " we sit in the children's home' . I do wish they will change this places name. But my children does not think that cause I am positive.

R: So tell me about the practical side of being a caregiver and the challenges regarding daily activities.

P: I love making food! And keeping house thus that is not a problem. I would like if someone could help more with the practical day to day things.

R: Emotional challenges?

P: You know, the childrens stories and their past take a lot from you. But I do not get involved in their past I ask that from the office that they provide them with therapy.

R: When it is difficult for the children, you feel that difficulty too and then you ask for help. Do you know about their history?

P: Yes, we have their files and we read that to know how to handle the children and why they do not feel well all the time.

R: Ok. Physical challenges? I see there is someone helping you her in the home.

P: The children is the ones who help the most here. They are excellent. I have rules that they have to follow and each one has a task, like making their own beds, cleaning the kitchen.

R: So you are responsible for the daily tasks?

P: Yes, I am. Some walk to school others go with bus and we take turns to drive a bus.

R: So you don't have to be responsible for that all the time. What about off time?

P: I have off every second weekend and then holidays are split in halve between two caregivers. If there isi children staying in they go to the other caregiver and in the second halve they come to me. And we have two days a month off.

R: Mornings?

P: We have off in the mornings but that time is spend with the days preparations and household tasks. Making food, cleaning house, doing everything. I cannot sit still and I finish everting so I can be with them in the afternoons

R: Thus you created a support structure for yourself in which you can cope with all the tasks.

P: Yes

R: If I say support – what does that mean to you?

P: When I pick up the phone someone listens or when someone makes your day easier or understand when you don't feel well and that I do get here.

R: What type of support is important to you?

P: Emotional support and to be straight with me. I have a family which is close and they support me in this. And a previous caregiver also.

R: What about the other caregivers here?

P: Me and the lady from house 9 comes a long way . (Her son entered the room)

R: How is your son doing in this environment?

P: Very well. We were very lonely and dad was never home so he enjoys the family. And when he does not want to be with the other children he comes to our side.

R: Would you like more support?

P: No, I give all the support to others nd I influence others.

R: Resources that you need like food, books, ect

P: Everything is to little! Any training!! I need a lot of training but my physical experience is great.

R: What emotional resources do you have available to you like therapists or something

P: Nothing, just the social workder and as I said it depends on the which one is over you. This people look after me.

R: so you feel satisfied.

P: Yes, and I am happy about the divorce.

R: Is there any guidelines as to how you need to bring up the children and what would tat be.

P: Yes there is, and I handle the discipline in the house and phone for the difficult behaviours.

R: Which gives you the disciplie and beheer.

P: Your personal experience as a caregiver – explain to me what you think and feel.

P: It is amazing and it brings me satisfaction tp see that you bring things to your children. I connect with them and feel joyful and its nice to give back to them. And I will tell them when I am tired and everything I do is honest. And you know, I want to make a difference in these children's life and in society.

R: So you feel you can give back . What do you see your role here

P: To give them a life and show them a lifestyle and to show them that they can be successful. I will not be able to handle one failure in my home so I put in a lot of effort. And I didn't have an easy childhood and I want to show them you need to stop the circle and want to show them that life is good. I like to pick them up and troos them.

R: Your childhood helps you to know what they have gone through.

P: Yes, and I think I do right and it feels right to me.

R: The children's needs regarding emotional, spiritual, physical and developmental needs. What do you think of that?

P: I think in sport and school 50/50. I would ike more people involved to help tutor them but here in home. In school there is no personal involvement and the subjects they do I cannot help them with. Physically I get clothes and search for borge. Emotional they are close to me as I am like a friend to them .

R:Would you say that they have enough access to emotional support?

P: I have a church involved with me and they help the children. And my mom and my sister are involved. And they cannot live without me.

R: How about your emotional needs?

P: I am a strong person and do not need support. The bad is not the bad it is the opportunity.

R: What about behavioural difficulties of the children

P: They are not difficult with me it is other children and other teachers that cause these children to behave badly. I have strong discipline rules and I want them to behave.

R: How do role as caregiver impact on your life?

P: yes, I feel proud of the word I do.

R: Is there any other needs that you feel you have?

P: No, I do not complain.

R: If you could complain?

P: A new home that is beautiful.

R: I hear you talk about your past, do you think that influence your role?

P: Yes, my sister was born and she was very sick and we prayed for here and she is normal. I cry about this still and I believe that God is the only support you need. But there is nothing that was so bad.

R: It seems that God is a support structure to you. When you think about burn out wht do you think

P: I don’t get tired and never felt burned out.

R: What about sleeping problems and concentration problems

P: Yes, I am really tired sometimes and feel a bit numb but I know I cant get tired.

R: So we are at the end of the interview and was wondering if there is still anything you need form me?

P: Champagne!! I feel so good now that I was able to talk to someone. I think I realized that there is a lot of things I feel confused about.

R: This might have stirred some more feelings in you over the coming week or so and I invite you to come and talk should you feel the need to. I’ve heard you feel supported and in some areas not. I also noted that you talked a bit about your divorce that your going through and that you feel tired but think you should not. Should there arise a need to discuss this please let me know that I can refer you to someone and help you get the help you want.

P: Thank you, I will.

Participant B

Interview

PARTISIPANT B

Age: 49

Gender: Female

Educational background: Senior certificate

Number of years here: 2

Previous training: None

P: Why do we need a DVD and who will watch this?

R: Good morning participant B. Please know that this DVD will only be for me and that you need not worry about privacy and confidentiality as this is implicit. No one will see this tape but me. As you know I am here to talk about your needs.

P: Yes, you my biggest need are rest. I do not even rest in holidays – everyone is here with me all the time and I just can't take it anymore. Now in this holiday I have children from all the different homes and they do not know my discipline rules and the way we do things here and that cause tremendous stress and I am so tired and do not even look forward to another day. This is sleg really sleg. I never go off duty. I get the feeling that they do not want me to rest because there is always more to do.

R: I hear you say you feel tired.

P: Yes, I expect to get some rest in in holidays but now even that time is consumed with work and work. I want to cry the whole time. I do not close my door behind me and say they should go on – I don't work so I am with them 24 hours of the day and I care for them the whole time. I work from 5 in the mornings till 12 at night. But you know if you talk about your pain and suffering they think you have failed and might replace you.

R: Yes

P: You know I sit with their work and their school work and I work with everyone of them. I give attention to all of them, I go to their activities swim, trampoline, dance. I am there for them and I sit in for them I am not just here doing nothing and they (bestuur) do not give me rest. They give me 13 extra children during the holiday – I want to rest and feel terribly tired. I just feel like I am running around the whole time without completing anything.

R: Ok, so you feel overwhelmed and exhausted

P: Yes I cannot take this anymore

R: Participant, I am here today to talk about your needs with regards to organizational functioning, challenges, support, training, personal, needs and emotional needs. So if you want to stop at any time please go ahead and as you go through this and want to move back to any other question feel free to do so. I see there is always space for the children in the rules and regulations of children's homes and I was wondering if there is some needs that caregivers have regarding their needs in the children's home

P: I definitely think they should look into a support system for the caregivers You know what they get good people with good hearts. I don't think the people who work here can only love children they need to have a feeling and calling to work with these children. That love for children people talk about is nonsense because if you worked with these children for a while that love just disappear. Here you have to take it as it comes. And I have what it takes to care for them but the social workers and management kill there workers.

R: Is that from management side that you feel there is no support?

P: Yes, I think they should take their systems as it is now and see if what they give caregivers are enough. Especially with regards to rest and emotional support and money.

R: So if you say support – what kind of support would you like to have?

P : Holiday rest for quality time with my own children. My goal here is to give them a place where they belong. They must feel that there is love, security and somebody

to care. And is I am so tired an without rest I am tired. So in three months I build them up and now they have to go out to their holiday parents they don't want to.

R: So would you like to make a decision with your children if they should go or leave for holiday?

P: Yes, I don't get a vote in anything. The children kry swaar and the social workers don't see that. So when they go out they come back confused and depressed and I hate to see them so. This is such a complicated situation as I do get that they have to build relationships outside this place but I am their mother – the only one they trust and now we force them also into all kinds of roles.

R: The communication between you and the social workers?

P: My social worker is really great and we acan talk to her whenever I need to.

R: Is there procedures and regulations as to how it needs to happen?

P: Yes, that is well. I do think that the social worker play a huge role . I don't have a difficulty with the management or social workers. These policies just don't work in the real world and there is a tremendous amount of administration.

R: Challenges that you feel?

P: Wow, there is a lot. I have to manage this place and do everything for the children. From school right through to sleeping time. I want my children to know that they are not childrens home children they are mine and I love and care for them like a family unit.

R: SO you care for them as a mother would and you have to make sure everything is in order.

P: Yes.

R: Supervision

P: Yes once a month we have supervision with the social worker and I can talk about needs and what I cant handle. My social worker really helps me.

R: Are there any emotional support you have like therapists that you can talk to?

P: No, I don't ask for that they will think I am weak.

R: Would you like to have someone available for that kind of support that is not connected with the management of this place ?

P: Just to talk to someone on a regular basis – that would be wonderfull. The days are so busy with admin admin admin that we rearely get to talk about frustrations.

R: Ok what about training?

P: No training is available before you enter this place and afterwards we had only one training regarding discipline which was helpful. They tell you afterwards how your dong.

R: I here you say that you received one training here, would you have liked it to be more and what sort of trainings would be nice to you?

P: Well, I don't think you will be able to know everything, and what the impact really was on this children. I did not study psychology although I worked with these children a lot of years! My social worker help me with the psychological side that I do not understand. I am actually just too tired and cannot do any training

R: Would you like to understand the psychological side?

P: Yes, the children here is so difficult and I would like to understand why they behave in different ways and it would give me more insight into the childs world. Is woud be great to know psyhologically

R: I want to know about your role you have here?

P: I am their mother ok, and that is what I do. Love, care, nurture, but I am so tired and feel so depressed.

R:Tell me about personal needs you have

P: We have enough things in this home so physically I don't think anything really. My son lives here he is 22 and he helps a lot.

R: So any personal needs you have?

P: I want to rest. Ek voel afgeskeep!! Ek lyk sleg en kan nie meer vir myself sorg nie. I work hard here and do not feel cared for of loved. I need to recuperate emotionally. I feel worthless and guilty about that and I cant sleep. I am very irritated and sometimes feel hostile towards everything. Even when I am off I do not rest here I need to go away for a while.

R: Would you like to have a place to go to?

P: Yes, a holiday place would be wonderfull. They take emotionally, physically, and I have to carry them and when I am so down I cannot carry them. My salary is not much and therefore I cannot really go anywhere on holiday to go rest and go away. I cannot book myself in somewhere. There is no system in place so we can go rest.

R: So, I hear you say there is a lot of pressure and a lot of work but no support to help you cope the amount of work.

P: Yes, I cannot shut off as I cannot say no and push them away . I have to respond and I need to recuperate somewhere away from this place. There is always something else to do here.

R: It sounds that sometimes you get burned out.

P: Yes, most of the time I feel like that and I cannot take it anymore. You know these children's children end up here as well and I try to teach them to be a mother but that is not. I think it is my own fault that I feel vurned out

R: How long have you been working here?

P: 10 years with other children and here 2 years. I have 4 boys of my own and now I have 10 daughters in this home.

R: Tell me more.

P: I didn't have a husband but I raised my children on my own and I worked hard. I had a difficult childhood and that influenced my life in quite a traumatic way. I sometimes still tink of all the things but I do think it helped me to care for these children.

R: Have you ever talked to someone about that ?

P: No .

R: So , I ust want to say thank you for your time. Should you wish to talk to me please you know where I am.

P: Thank you that you care for us and I will definitely talk to you soon.

Participant C

Interview: PARTISIPANT C

Age: 55

Gender: Female

Educational background: Senior certificate

Number of years here: 14

Previous training: None

R: I am here to try and understand what your needs. As I see it, there are always resources available to the children but when it comes to the caregivers, there is little know about your actual needs. I do feel that it is important that you receive support and I would like to find out what kind of support and resources you would need.

P: Thank you – I think it is a timely study as over the years the needs have really escalated.

R: How long have you here

P: 14 years already

R: And you have been living in this house all along?

P: Yes.

R: it been a long time

P: Yes, sometimes I get so frustrated and moedeloos and it is really hard work but you just carry on every day.

R: Are you married?

P: My husband died here after we moved in here. I have children who are 22 and he lives here with me. Its nice if he is here. I have 13 other to care for but they are not my children and it is different. I have been here 13 years and saw them leave so I do not attach to them anymore.

R: You have been here for a long time which gives you insight into the organization and management of a home which will help me find deeper insights iinto the organizational functioning, challenges, support, training, personal, needs and emotional needs. It would be great if we can talk a bit about these things and feel free to elaborate as much as you want on a subject. Lets start with the communication chalnnels in the organization. Canyou elaborta a bit on this matter?

P: Yes, everything have a procedure and there is a way and guidelines that we do things. Eveyon has a social worker over her home. I have to write repords every month to her. If there is a crisis somewhere you can phone immediately or I can walk in to her office. I have supervision once a month where we talk about all the children individually. After this she has an discussion with the head social worker that overlook everything. We do a incident record as well. We have once personel meeting once a month and the a group meeting with the other caregivers of the other homes once a month. At the personel meeting we discussion personel problems and at the goup meeting we discuss individual home problems. Thus I think there is a lot of ime and opportunity to put your things on the table and discuss your needs. There is always someone on duty should there be a crisis as well.

R: So you feel that there is enough communication and time available to you to discuss whatever you need to discuss regarding the daily management of the house.

P: Yes, I think there is a space where you can get help with the management should you wish to. If you do not communicate it is your own problem. There are a lot of meetings, and enough time to raise concerns.

R: Talk to me about the challenges you experience.

P: Well, the children is our challeng. To opvoed them so that they can become fully contributing adults. To bele in their future and train them to become something and make something with their lives. So they can contribute to society. A lot of their children end up here again and I try to break the cycle but I do not always succeed.

R: You say that your biggest challenge is the children. Tell me about the support that is abailable regarding their needs

P: You know, I think we need a lot more psychologists and therapists and the children need to go onto a waiting list to see them and that waiting takes too long which increases their behavioural and emotional difficulty. It is also too long for us as caregivers as it makes our tasks more difficult as they get out of control. Their problems just keep piling up, and nobody can see them to help them. Occupational therapists we have one but she sees only the small ones. You know all our children are traumatized and now if there is some child that is doing ok,she gets little attention but actually also need a lot of therapy. All of them need therapy and don't get it.

R: So you sa that the longer these children go without therapy their difficulty builds up and makes it harder for them to cope.

P: Yes.

R: Would you like training into the psychological side and impact of these trauma events on the children?

P: That would be great but, the practical experience is where we learn. So no, I think we don't have the time to do that as well for the children – psychological counselling – and that the people that is trained should help support us in that way. I do not have the time to get so deep involved in their emotions. I am too tired to do training I am in the role of a mother and I have to do all that tasks. Should I then get involved and try to help them on a deeper level I will let the other 12 down and not spend as much time with them. The knowledge however would be nice to have.

R: I hear you say that you consider your role here as a mother

P: Yes, I look after them and care for them. Feed them take them to school see that they do not get into trouble.

R: Ok, is I say support, what does that mean to you.

P: My social worker is my support but now I have to say that each social worker has 65 children under them that they have to care for and look at the legal stuff. And they have all 5 mothers under them. We should actually be able to make the groups smaller so that there will be time for everyone. I know they cannot affort to pay social workers and even in the houses it would be great if we can have less children in one home. This group of children is a hand full and I think if we can have less in a house we can achieve much more.

R: Thus, the number of children is a challenge to you.

P: Yes, I know that is how it is and I need to accept that but that would be great. So support, from the social worker yes but hey do not work weekends like we do. Support is needed on other levels as well not only for a social worker.

R: (Client sug deep and cover her face). What about other support?

P: No, nohing really. The church that should look after us is really never here. They bring food and that is that.

R: So you feel that you need more emotional support?

P: Yes, BUT BUT BUT… you need the right person that can understand. More counsellors – somewhere that you can let go. You don't want to talk to the management as it is personal and they would think that you have failed in your work and that you are incapable and not emotionally strong enough even though that is not what you want to say – I just want to say Help sometimes but feel that that is not acceptable. And you know *t*he system is only focussing on the children.

R: You just need someone to listen.

P: oh yes, there is a pastoral counsellour here but that time goes to the children as well

R: So there is no specific emotional support here for you

P: No not at all

R: Ok, what about your daily challenges, like physical needs?

P: You know, we never sleep hungy or go without clothing. It is not nice to get old things and now my children have to look like childrens home children.

R: It is important to you that the children look well care for.

P: Each home should do their own maketing which is very difficult for us as we are not marketing people. We are not sales ladies.

R: Could that be a need you have?

P: Yes, definitely. I would like for each home to have their own marketing person that helps to get stuff in. The childrens home have marketers but they need to fill the daily rekening so that the home do not go down. Water and lights, personal salaries and things like that. We do not have time and skills to market the home and it would be a wonderful support to us. We have a lot of needs in each home. School clothes, stationary, medicine, toiletries, cleaning things everything a child needs need to be considered and pay with the R5000 we get for the home to run it with. Could somebody assist with the marketing of the house? I am not a saleslady.

R: That seems difficult.

P: Yes, out of that little money we have to run a home with 14 people in it. It is just impossible to do if we do not get help from others. That is what we have to do on our own – marketing to fill your needs through the month. My milk alone is R800. Skenkings would be great.

R: What about personal needs you have?

P: Vehicles – the children's home have their own but is is not always available. We do have our own but not enough money to fill it with petrol everyday. Maybe holiday places to go to. Definitely a bigger salary would help even though our food and housing is included. Then we do not have a medical aid or a pension which is a great need for us. Every home have an assistant but when she is not here we need

to do everything self. It would be great to have an extra help available should she not be here. I think the financial implication is the biggest.

R: Yes, I here this is difficult. Would you do it again if you could choose again?

P: If I had a husband and my circumstances changed I don't think so. I came from a background of krediteure en debiteiure. Maybe I would have done that again. You know, our working times are horrible and long and we do not get overtime. We get two weekends of and two days.

R: What is happening in those weekends?

P: Children stay in the first weekend and a aflos lives then here for the weekend and the other weekend the children go out. You know we are excluded from the employment equity act which makes it difficult as we cannot complain somewhere. You know the whole country can only work 45 hours a week but we as caregivers – which is our job – have to work for a lot more hours. I need a place where I can complain about my work hours like every other employee. You know I am emotionally drained – nothing work anymore and I feel that nothing makes sense anymore. And you know, I am supposed to rest in the mornings but there is just too much to do.

R: I wonder about emotional support again.

P; Yes, I need that a lot!!!

R: Tell me about you own life.

P: Well, I also went through traumatic things and I sometimes do wonder why my life ended up here.

R: Do you fel drained and burnt our?

P: Yes I do as I am tired the whole time but cannot sleep, I feel irritated sometimes and even bitter but life goes on.

R: I can see tears.

P: Yes

R: What kind of tears is that?

P: I am sad and depressed and think I need rest. But, now I sit here and cry.

R: Should you wish to talk to someone please let me know that I can arrange that for you and you know where I am so just pop in and we can see how we can move forward from here. Thank you for your time you have been a great help. I do appreciate your time and insight.

P: No, thank you. What a kind person you are.

Participant D

Interview

PARTISIPANT D

Age: 51

Gender: Female

Educational background: Senior certificate

Number of years here: 3

Previous training: None

R: Good morning. Are you comfortable?(After seeing the nervousness of the participant)

P: I just need some coffee.

R: Let’s get some.

P: I don’t want to waste your time.

R: No on the contrary I also needs some coffee.

R: ok, are you comfortable now.

P: Yes, I feel ok now.

R: I am glad you could tell me what you need as I hope that we can discuss some aspects of your work as a caregiver. And more specific, some areas of organizational functioning, challenges, support, training, personal, needs and emotional needs that pertain to your work. So if you want to stop at any time please do so and as you go through this and want to move back to any other question feel free to do so. Is there something you would like to ask or have me explained?

P: Will anyone see this DVD?

R: No, this is for me to remember what have been said so I don't have to write down every word you say. No names will be used in this research and full confidentiality as we have discussed before will be considered.

P: So I can speak the truth? Great that is a relief. "I do not feel that I can manage the home, I am too tired.

R: What do you want to start with?

P: I am so very very tired. I am depressed and lonely. I am burned out and worried. I want to leave this place as soon as I can but there are no other options for me. I have been in and out of hospital and have been operated on my back. They do not offer help or support I had to get to work straight out of hospital. There were no one here to say are you ok no telephone call. I have no one to talk to. I fall on my knees every day and cry before God and that is what is keeping me going. I cry myself to sleep. You know I am a grandma and want to play with my grandchildren – now I sit here and see them once in a time. I want to leave but there is no hope.

R: I hear you feel empty and without hope.

P: Yes, they should give us a therapist here that is not attached to anyone where we can go for help. But you know there is a culture here that we do not say that it is a difficult job because then others view you as a failure and not emotionally tough. We cannot talk to them they judge you immediately. This is such a challenging job. The children I have is the roughest of all – from horrible houses and then they get dumped here and they don't want to be here and they make my life a living hell. I

work and work and work – long hours evening after evening I get after 12 in bed. Everything that is considered in this place revolves around the children , they just don't think about us. My body can't take it anymore and I fall sick constantly. I do not get support from the church that is supposed to look out for me and spiritually I am burned out. I pray to the roof you know!!

R: I see tears and I hear your deep breaths.

P: I am desperate but there is no hope. I have nowhere to go with my pain.

R: So when I say support, what does that mean to you?

P: Nothing. Not from the social worker, not from management, I have no friends that want to come here, the caregivers talk behind my back and you know I need to feed these children and clothe them and nurture them all on my own. I do have supervision but that is just to discuss the children. An you know I got here and they threw me in a house without training or money or someone to help me figure out what is going to happen and I got the shock of a lifetime and it hit me that I might die here. If they could help me emotionally with this management things that would be great. No, I sit here with no training whatsoever and just move on day by day not knowing what to do with these children. Why can't they just give us some training of something before we get here and some trauma things to help me cope withal this pain. We witness pain and suffering every day – it is horrible. I feel so low and cry all the time

R: Would you want to go for training?

P: No, I am too tired. I do not have time for that. I would have wanted it before I came here

R: Ok, what do you think your role is here?

P: To give care – caregiver. Run this place. Wash, clean, feed, love, nurture, but how can I if I do not get any nurturing from anyone else. Not even my husband helps me or listens to me. *Can they not see that I do so much? They never acknowledge what I sit in."*

R: Do you feel you have the ability to influence these children?

P: No

R: So would you do this again if you could?

P: Never ever.

R: Would you like to stop here as I can see that this is bring up a lot of unfinished feelings for you and that it is a very emotional subject.

P: You know, you are the first one I can talk to about this and I feel so much better just to be able to talk about my emotions for a change. I think you get the picture – I feel there is no organizational support whatsoever and no support structures in place. I need a lot of things in my home and nothing happens They do not value me – I could just die and they would not even notice. I have my own trauma and feel left alone. I just wish they could help with the admin that is way to much and the children's discipline – they are just never available. I wish the other caregivers were there to talk to so we can work together or something. Well, I guess I just want to give to these children but now I am left alone and cannot do this on my own.

R: I hear that you feel abandoned and isolated and that it is difficult for you to cope with this job.

P: Yes, but I will not be here for long.

R: If you want to talk about what has come up for you in this interview please contact me, you know where my office are. Let us work together and see how we can get you what you need. I would like for you to consider a referral to a therapist should as I feel that you might benefit from some support.

P: Please, that would be very helpful. And thank you for giving your time to me. I thought it would be some intellectual conversation and I am so tired.

R: Thank you.

Participant E

Interview

PARTISIPANT E

Age: 57

Gender: Female

Educational background: Senior certificate

Number of years here: 3

Previous training: None

Participant: I only want to say a few things as I am in a hurry. This is a system for children and not for the caregiver. I feel very lonely and unsupported in this place. If I just didn't have to worry about the food, clothes and medicine of the children, then I would be o.k but now it is so much more. Everything is just too much to bear. Sometimes I do not know where I am and do not know what time it is as I am always on the run never time to rest. I just wish they could see what work I do. I want to be accepted and respected and want to be treated fair. I need help with all this admin and with the childrens discipline and everything.

Researcher: Do you feel like that most of the time?

Participant: Yes, but I really have to go now. Sorry I forgot.

Participant F

Interview

PARTISIPANT F

Age: 52

Gender: Female

Educational background: Senior certificate

Number of years here: 1

Previous training: ONE COURSE

“They (referring to management) are very good for the children, but very hard on the caregivers, there is no place for me and nobody looks out for me.”

There are things that I cannot live without but since I do not have them, what should I do?”

“I have to wear a mask as they (referring to management and social workers) should not see my tiredness.”

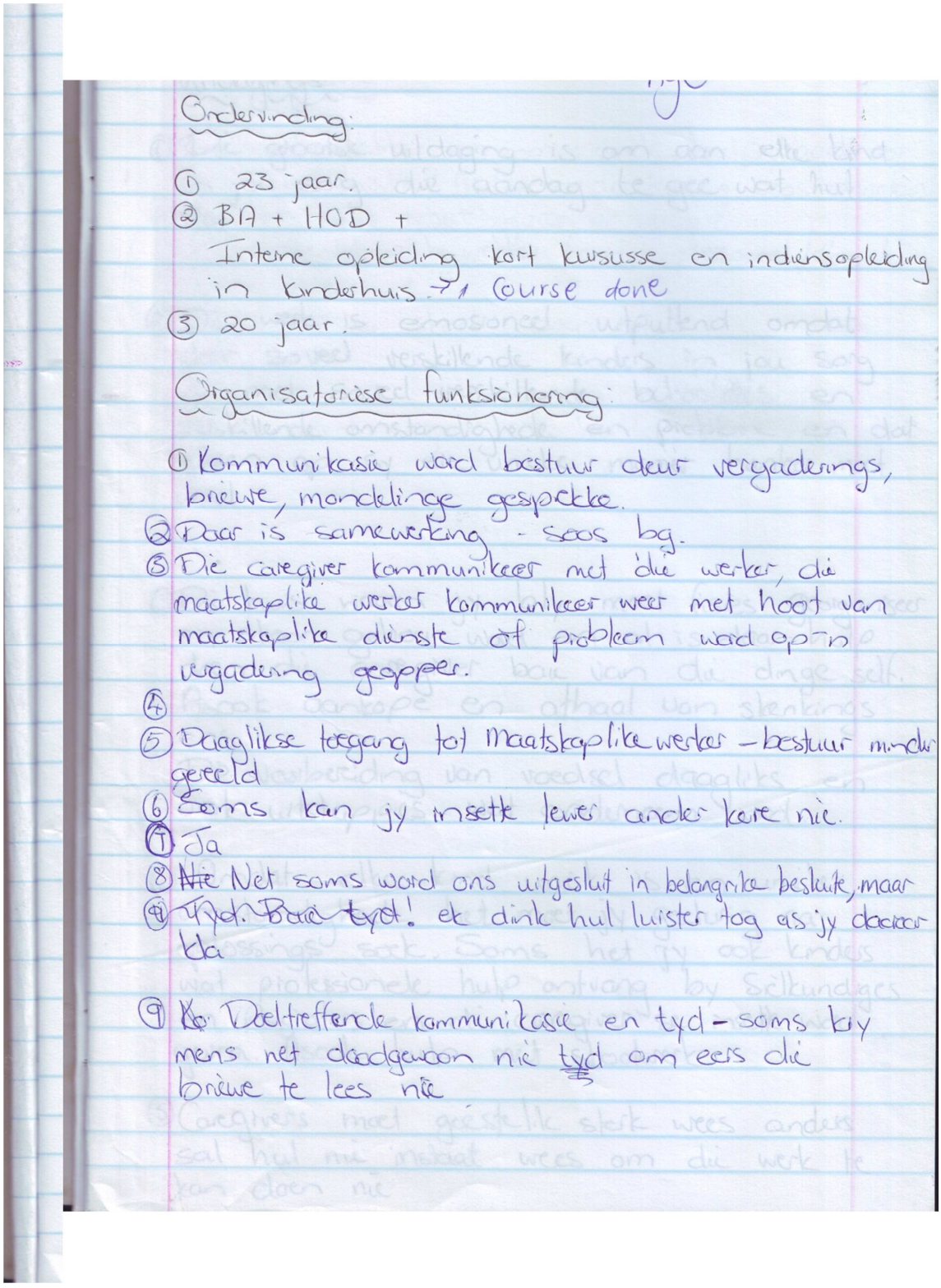
“I sometimes dream of the children’s difficulties” (

“*They (referring to children) treat me as if I don’t exist.”* (Participant)

“I need a lot of assistance with all the admin and management of this place” (Participant F)

APPENDIX R: ANALYSED ANSWER SHEETS OF PARTICIPANTS QUESTIONNAIRES

Participant G



Ondervinding:

① 23 jaar.
② BA + HOD +
Interne opleiding kort kursusse en indiensopleiding in kinderhuis → Course done
③ 20 jaar.

Organisatoriese funksionering:

① Kommunikasie word bestuur deur vergaderings, briewe, mondelinge gesprekke.
② Daar is samewerking - soos bg.
③ Die caregiver kommunikeer met die werker, die maatskaplike werker kommunikeer weer met hoof van maatskaplike dienste of probleem word op-n vergadering gegooi.
④
⑤ Daaglikse toegang tot maatskaplike werker - bestuur mindergeeld
⑥ Soms kan jy insette lewer ander kere nie.
⑦ Ja
⑧ ~~Nie~~ Net soms word ons uitgesluit in belangrike besluite, maar
⑨ ~~Tyd. Baie tyd!~~ ek dink hul luister tog as jy daarvan kla

⑨ ~~Ko~~ Doeltreffende kommunikasie en tyd - soms kry mens net doodgewoon nie tyd om eers die briewe te lees nie

Ondersteuning:

① fisiese / geestelike en emosionele hulp / raad / oor om te luister. / fisiese ondersteuning soos donateurs.
② bg. en hulle moet gaan vir terapie.
③ Ja. Maatskaplike werker / ander personeel / donateurs.
④ gemeente
⑤ Meer sal nie skade doen nie.

hulle word erger as hulle nie interapie is nie

Opleiding:

1. Raad en hulp om jou werk beter te kan doen.
2. 'n „nuwe" Caretaker het baie opleiding en leiding nodig / Ondersteuning is baie belangrik.
3. Ja
4. Van tyd tot tyd het ons 'n spreker of professionele persoon wat ons opleiding kom gee. / asook maandelikse opleiding by die maatskaplike werker in 'n kleiner groepie.
5. Ja ons het riglyne - dit is egter moeilik om eers te gaan „naslaan" wat om te doen want baie situasie moet op die ingewing van die oomblik geskied.
6. Praktiese raad / Baie persone wat opleiding kom gee het nie altyd ervaring in 'n kinderhuis nie en kan nie altyd regtig vir ons van hulp wees nie.

Respondent:

① Hierdie is 'n baie komplekse werk aangesien daar met soveel verskillende kinders gewerk word.
② Dit is kinders met emosionele probleme/ fisiese gebreke soms / soms leergesondheid / Baie slegte "bagasie" wat hul met hul saamdra.
③ Kinders uit verskillende gesinne / omstandighede word saamgegooi in een huishouding en die caregiver moet vir hul 'n veilige versorging fisies / geestelik en emosioneel kan bied.

④ liefde / aanraking / aandag / gesprekvoering / opvoeding aanleer van trots / selfrespek / fisiese versorging

⑤ Ja, soms kap 'n mens klei maar met ervaring
⑥ en ondervinding gaan dit beter.

⑦ Ja, dit is egter moeilik om by al die kinders uit te kom want jy is net 1 persoon.
⑧ Ek doen die werk al lank genoeg om tesugvoer te kry van kinders wat lankal uit die kinderhuis is en 'n sukses van hul lewens gemaak het.
⑨ Ek verwag van my self konsekwentheid / stabiliteit. ~~Geen~~ liefde positiewe gesondheid - sodat ek 'n goeie voorbeeld en mentor vir die kinders & in my sorg kan wees
⑩ Ja - dit is geweldig vervullend asook uitputtend.
⑪ Ek wou graag 'n verskil maak in iemand se lewe
⑫ Ja dit is 'n baie vervullende werk en lewensverryking

Behoeftes

1. Genoeg finansiële ondersteuning. Donateurs / emosionele en fisiese hulp.
2. Genoeg emosionele / geestelike ondersteuning
3. Die tuiskuis is in komplekse organisasie en goei kommunikasie is belangrik.
4. Genoeg donateurs / finansiële ondersteuning / bedrokke maatskaplike werkers en geestelike werkers asook insette van vrywilligers en vakansie en naweek ouers.
5. Ek dink die maatskaplike werkers word baie oorlaai sodat hulle ook nie altyd die tyd het om regtig te luister nie.

Emosionele pyn.

① Emosionele verligting word verkry deur dalk net 'n oor te hê wat luister

② Uitgebrand - is emosionele / geestelike / fisiese uitputting sodat jy nie die werk na wense kan doen nie Ja. ek voel hou so.

③ Ek weet nie of die vraag op my persoonlike of kinderhuis gerig is nie.
Maar > ek het 'n baba verloor.
> Was ook in 'n ernstige motor ongeluk met kinderhuis kinders
> Minder ernstige trauma was moeilike kinders wat probeer selfmoord pleeg. Dit het al 5 keer gebeur tydens my werk hier by die kinderhuis.

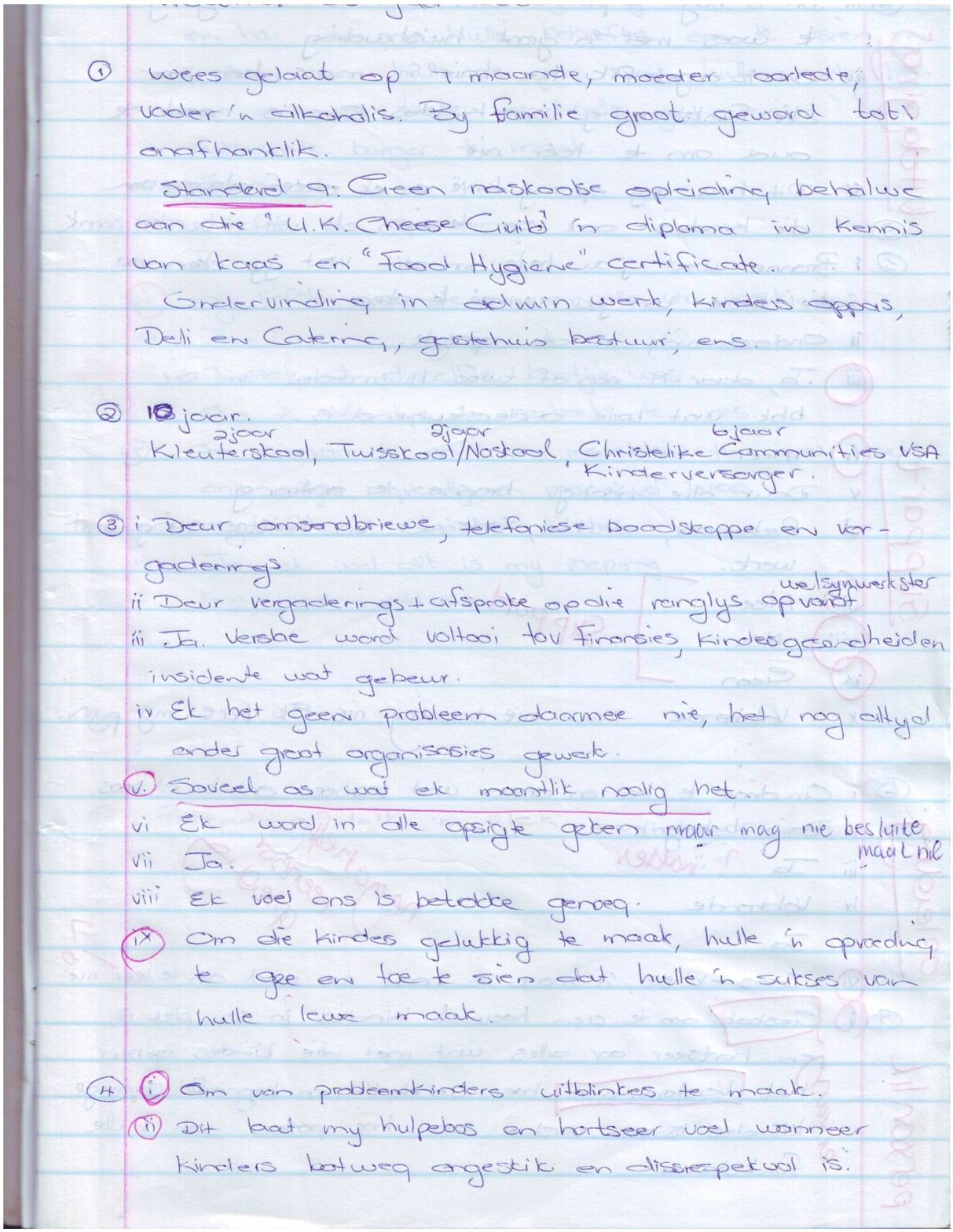
④ Ja mediese en emosionele asook geestelike ondersteuning deur familie / vriende en kollegas

⑤ Soms.

⑥ Geen slaap probleem / Konsentrasie soms
Sensories soms veral klank

⑦ Hier is 'n geestelike werker betrokke wat weeklikse besoek asook emosionele ondersteuning van maatskaplike werker.

Partisipant H

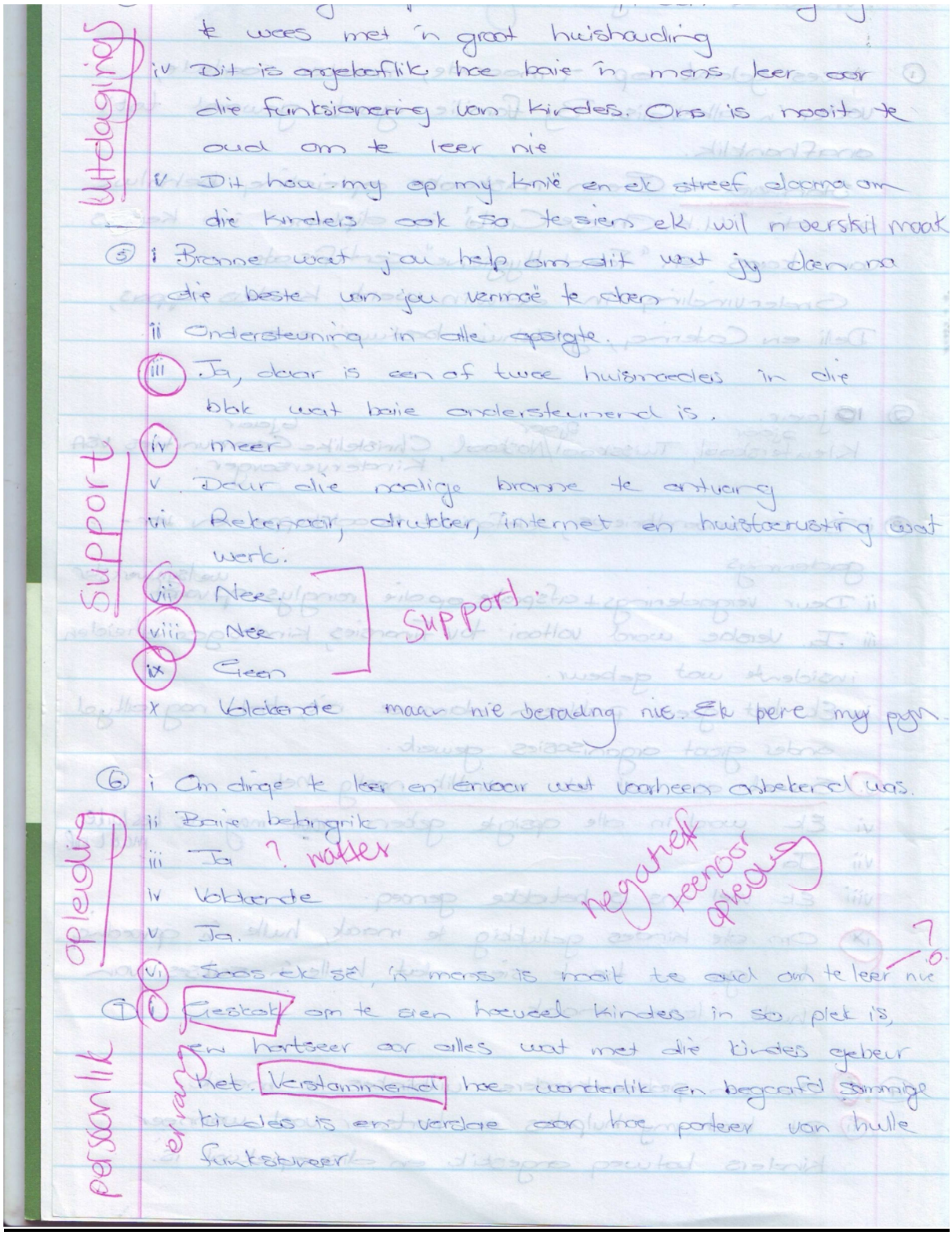


① Wees gelaat op 7 maande, moeder oorlede, vader 'n alkoholis. By familie groot geword tot ↓ onafhanklik.
Standerd 9. Geen naskoolse opleiding behalwe aan die "U.K. Cheese Guild" in diploma iw kennis van kaas en "Food Hygiene" certificate.
Ondervinding in admin werk, kindersorg, Deli en Catering, gastehuis bestuur, ens.

② 18 jaar.
2 jaar Kleuterskool, Twisskool/Naskool 2 jaar, Christelike 6 jaar Kinderverseorger Communities VSA

③ i Deur omsendbriewe, telefoniese boodskappe en vergaderings
ii Deur vergaderings + afsprake op die ranglys op welsynwerksters vorm
iii Ja. Verslae word voltooi tov finansies, kindesgesondheiden insidente wat gebeur.
iv Ek het geen probleem daarmee nie, het nog altyd onder groot organisasies gewerk.
v. Soveel as wat ek maandlik nodig het.
vi Ek word in alle opsigte gesteun maar mag nie besluite maak nie
vii Ja.
viii Ek voel ons is betrokke genoeg.
ix Om die kindes gelukkig te maak, hulle 'n opvoeding te gee en toe te sien dat hulle 'n sukses van hulle lewe maak.

④ i Om van probleemkinders uitblinkers te maak.
ii Dit laat my hulpeloos en hartseer voel wanneer kinders botweg angstig en disrespekvol is.



te wees met 'n groot huishouding
iv Dit is angelaaflik hoe baie in mens leer oor die funksionering van kindes. Ons is nooit te oud om te leer nie
v Dit hou my op my knië en ek streef daarna om die kindeis ook so te sien ek wil n verskil maak
⑤ i Bronne wat jou help om dit wat jy doen na die beste van jou vermoë te doen
ii Ondersteuning in alle opsigte.
iii Ja, daar is een of twee huisraadjes in die blok wat baie ondersteunend is.
iv meer
v Deur die nodige bronne te ontvang
vi Rekenaar, drukker, internet en huistoerusting wat werk.
vii Nee
viii Nee
ix Geen
x Voldoende maar nie oorvloedig nie. Ek pers my pyn.
⑥ i Om dinge te leer en ervaar wat voorheen onbekend was.
ii Baie belangrik
iii Ja ? matter
iv Voldoende
v Ja.
vi Soos ek sê, is mens is nooit te oud om te leer nie
① i Gestak om te sien hoeveel kindes in so plek is, en hartseer oor alles wat met die kindes gebeur het. Verstommend hoe wonderlik en begaafd sommige kindes is en verdere oor hoe porteer van hulle funksioneer

Uitdagings
Support
opleiding
persoonlik
ervaring
support.
negatief teenoor opleiding
?

en hou, om na hulle behoeftes om te sien en probeer om hulle te gee wat hulle nodig het en om van hulle respekvolle, gehoorsame en suksesvolle burger te maak.

iii Soos bo.

iv Liefde en opvoeding

v Ja.

vi my liefde, simpatie en empatie vir weeskinders

vii Ja.

viii Omdat ek dieselfde baatjie was.

ix Om te alle tye 'n voorbeeld te wees.

x Om aanvaar te word en respekteer te word, moet ons altyd regverdig en respekvol wees.

xi my liefde vir tuislose kinders

xii Ja, ek voel dit is my roeping

8 i Kos, klere, medikasie

ii

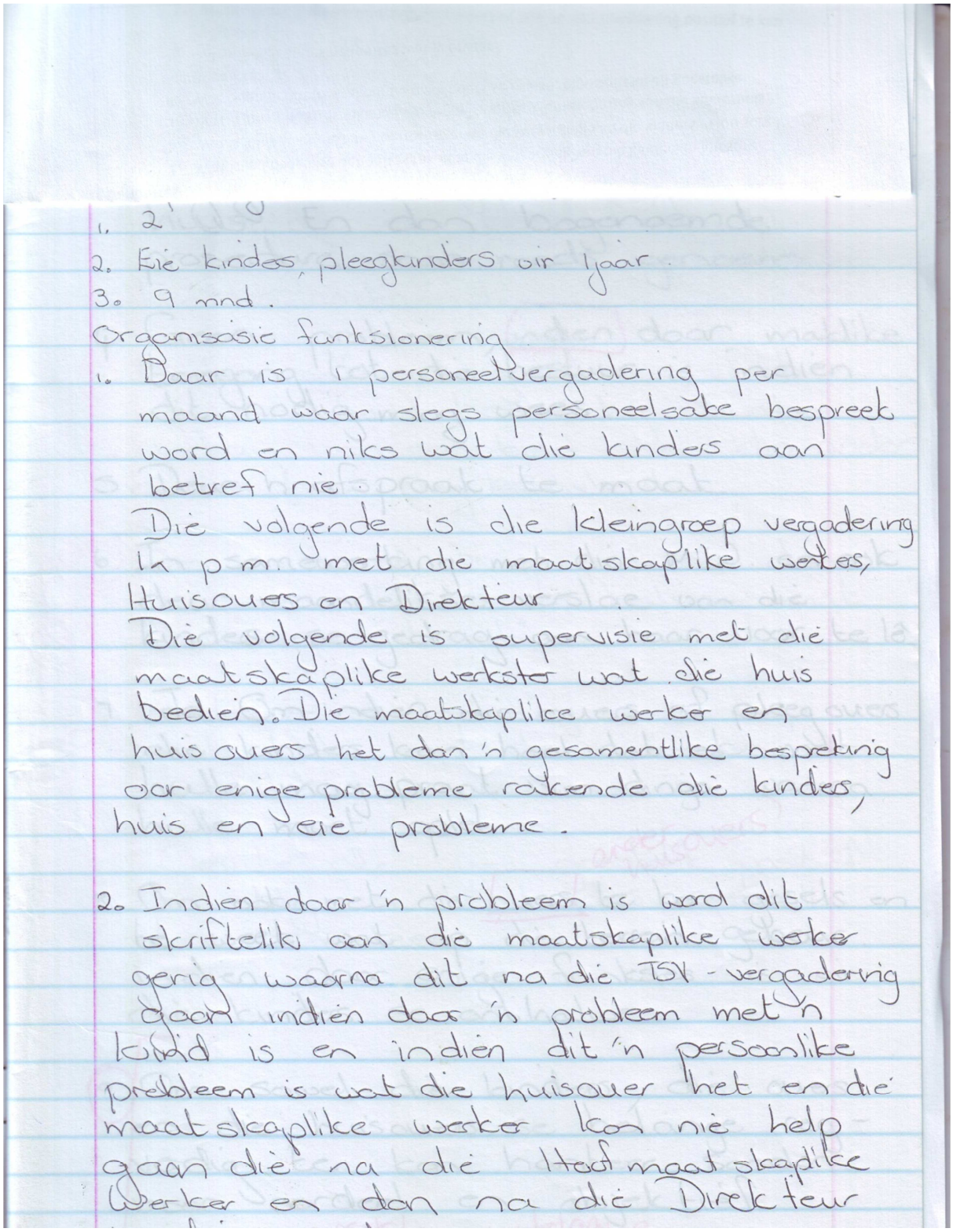
iii

iv

v

9 i Berading dalk. 'n plek om te praat.

Partisipant I



1. 2'
2. Eie kindes, pleegkinders vir 1jaar.
3. 9 mnd.

Organisasie funksionering

1. Daar is 1 personeelvergadering per maand waar slegs personeelsake bespreek word en niks wat die kinders aan betref nie.
   Die volgende is die kleingroep vergadering 1a p m. met die maatskaplike werkes, Huisouers en Direkteur.
   Die volgende is supervisie met die maatskaplike werkster wat die huis bedien. Die maatskaplike werker en huisouers het dan 'n gesamentlike bespreking oor enige probleme rakende die kindes, huis en eie probleme.

2. Indien daar 'n probleem is word dit skriftelik aan die maatskaplike werker gerig waarna dit na die TSV - vergadering gaan indien daar 'n probleem met 'n kind is en indien dit 'n persoonlike probleem is wat die huisouer het en die maatskaplike werker kan nie help gaan die na die Hoof maatskaplike Werker en dan na die Direkteur

Daar is 'n pligstaat vir elke huisouer wat die nodige pligte aandui en as riglyn dien vir die bestuur van die huis. En dan bogenoemde prosedure soos reeds genoem.

4 Geen probleem, indien daar matlike toegang tot die bestuur is indien dit nodig mag wees.

5. Deur 'n afspraak te maak.

6. In samewerking met die M.W. en ook deur maandelikse verslae van die kinders se gedrag aan haar voor te lê.

7. Ja. Om indien die ouers of pleegouers die kinders kom haal dat ek met hulle mag praat i.v.m. dinge waarna hulle moet oplet

8. Om ook met die ouers (andere huisouers) te kan gesels en te weet wat op die terrein gebeur. indien daar enige funksies is vir die kinders se ontwikkeling.

9. Om sowel die kinders, die ouers en die huisouers se belange reg-vaardig te kan hanteer sonder voor oordeel en objektief

grootste uitdaging

1. Om die nodige geduld aan die dag te lê al voel jy partykeer baie ongeduldig, om positief te bly ongeag. terug slae wat jy met die kinders ondervind

2. Kinders wat gedurig skree, vloek en die inhoud beskadig. Swak gedrag van een kind kan die ander kinders baie sleg beinvloed

3. Om so te sê 24uur p.d. aan diens te wees. Kinders te kalmeer wat "se kappe uithaak".

NB Treine

4. Kinders se skoolopleiding en te help met bake met die minimum beskikbare bronne.

5. Om te alle tye geestelik. positief te bly en die kindes geestelik te stimuleer

assistance

1. Ondersteuning beteken onderskraging in besluite wat jy neem ondersteuning met dissiplinie toepassing, konsekwensie in straf. Uitvoer van straf prosedure.

2. Om wanneer daar 'n waarskuwing gerig is i.v. 'n probleem en die probleem duur voort die nodige ondersteuning daar is om die dissiplinne toe te pas

3. Ja, maatskaplike werker

4. Genoeg ondersteuning van maatskaplike werkster se kant.

5. Praktiès, uitvoerbaar, positief.

6. Internet, kinderwet, samewerking, objektiewe benadering. Geld.

7. Geredelik

8. Ja, luister na probleme met kinders.

9. Kerk, maatskaplike werkster, polisie kennisse.

10. Te alle tye. maar nie met berading ive. Ek kan nie met bestuur praat nie want hulle sal dink ek is nie stark genoeg nie.

1. Om meer kennis op te doen i.v.m die verskeie fasette van jou beroep. Om meer as een taak met die nodige kennis te kan verrig.
2. Baie 'n persoon is nooit te oud om te leer nie.
3. Ja, Opleiding oor toepassing van dissipline, eerstehulp.
4. Beperk. Sal graag meer wil weet oor medikasie wat kindes gebruik.
5. Nee, gebruik die diskressie volgens kinderwet. Probeer kindes grootmaak volgens reëls wat jy vir jou eie kindes voorgehou het.
6. Meer insig oor hoekom en waarom kindes opgeneem is. Kursus i.v.m "Health + Safety".

1. Is slegs 9mde hier. Ondervind dat kinders gewoonlik n ruk neem om aan te pas, lief om konsse te vat om na vorige persoon se reëls te verwys.

2. Om te sorg dat die kindes voel dit is hulle huis en belangrik om tuis te voel in die huis.

3. Die kindes te leer om verdraagsaam, en saam te kan werk. Vir hulle huislike standvastigheid te kan bied

4. Om elkeen tuis te voel, te voel dit is hulle huis, om te kan kommunikeer soos hulle maats by die skool met hulle ouers doen.

5:6. Elke is n kind-mens, kan maklik op hulle ouderdom inskakel, weet van groeipyne en ouderdom stadiums. Is n positiewe, rustige, kalm persoon wat nie maklik gesteë word nie en n sin vir humor het.

7.8. Ja. Gedurende my tydperk het ek een onbaantlike kind baie rustiger gekry, een heeltemal van sy opvlëndheid genees. Kindes sien my werklik as Kul ma. Selfs groter kinders

9. Om my beste te alle tye te gee en hulle die wêreld in te stuur met 'n positiewe houding oor hulle self.

10. Nie regtig nie.

11. Omdat ek nog altyd deur kinders omring is en enige kind maklik met my gesels.

12. Ja, ek geniet dit baie, ongeag die uitdagings.

1. Om vir die kandas te voorsien van belangrike ondersteuning kos, klere, medikasie, goeie daaglikse kook benodighede en skoonmaakmiddels not enough???
2. Goeie gesondheid, geduld
3. Dat daar vinniger op'n probleem gereageer word. Ek voel so alleen.
4. Daar meer aktiwiteite en ontspannings-gerieve moet wees. bv. 'n biblioteek vir naslaan, maatskaplike weksters doen nou meer naslaan werk, 'n gym byvoorbeeld. Meer betrokkenheid deur jeugaksies.
5. Nee.

1. 'n paar minute per dag vir myself

2. Ja.

3. Pa oorlede. (Geen rérige traumatiese ervaring nie, behalwe in inbraak.

4 Ja, familie + vriende

5 Nee en Ja

6 Nee

7. Vriende, familie

Partisipant **J**

Ouderdom - 51 jaar
Geslag - Vroulik
Opvoeding + opleidings agtergrond

Ondervinding as 'n caregiver
1) 3 jaar 4 maande
2) Klerikaal, Winkelbestuur, ontvangsdame
3) 3 jaar 4 maande

Organisatoriese funksionering
1) Goed
2) Ja, Vergaderings en omsendbriewe
3) Ja, maandeindes (Aankope, statistieke, medies ens.)
4) Geen probleem.
5) Genoeg
6) Die bestuur + maatskaplike werkers het die finale beslut.
7) Ja, definitief
8) Om in die vergadering te sit waar die kind en probleme bespreek word.
9) Ek dink nie hulle gebruik ons kennis nie. Ek dink dis 'n uitdaging vir hulle om ons te vertrou. Ek sal graag erken wil word.

1) Om te sien dat elke kind in my huis suksesvol uitdraai. en te sien dat ek en my man in stempel op elke kind kan afdruk.

2) As in kind oor sy ouers huil.

3)

4)

5) Almal kan die Here en dat hulle almal deelneem in huisgodsdiens., Bybel lees en bid.

Ondersteuning

1) Dat daar meer na huisouers geluister moet word en hulle waardeer.

2) Luister, huisouers moet baie meer in sake gekan word.

3) Ja, maatskaplike werker en my man.

4) Meer Alles is te veel om te dra.

5) Om na my storie ook te luister en nie altyd die kind se woord te vat nie

6) Geen

7) Soms

8) Ja, luister en vra altyd uit oor welsyn

9) Maatskaplike werker

10) Genoeg

Opleiding

1) Meer kennis en ondervinding

2) Nie belangrik nie. Hanteer probleem soos dit kom.

3) Ja

4)

5) Nee

Persoonlik

1) Suksesvol, uitdagend, geniet dit.
2) Om vir die kinders 'n ma te kan wees wat hul nie elke dag het nie.
3) Om die kinders opte voed soos my eie en te dissiplineer.
4) Baie liefde en aandag
5) Ja, 6) Sien die ruseltate.
7) Ja,
8) Sien die verbetering
9) Om vir hulle soos hul eie ma te wees
10) Ja, het baie min tyd vir my eie familie
11) Was huisvrou, wou iets met my lewe maak.
12) Ja, ek weet ek bereik iets met die kinders

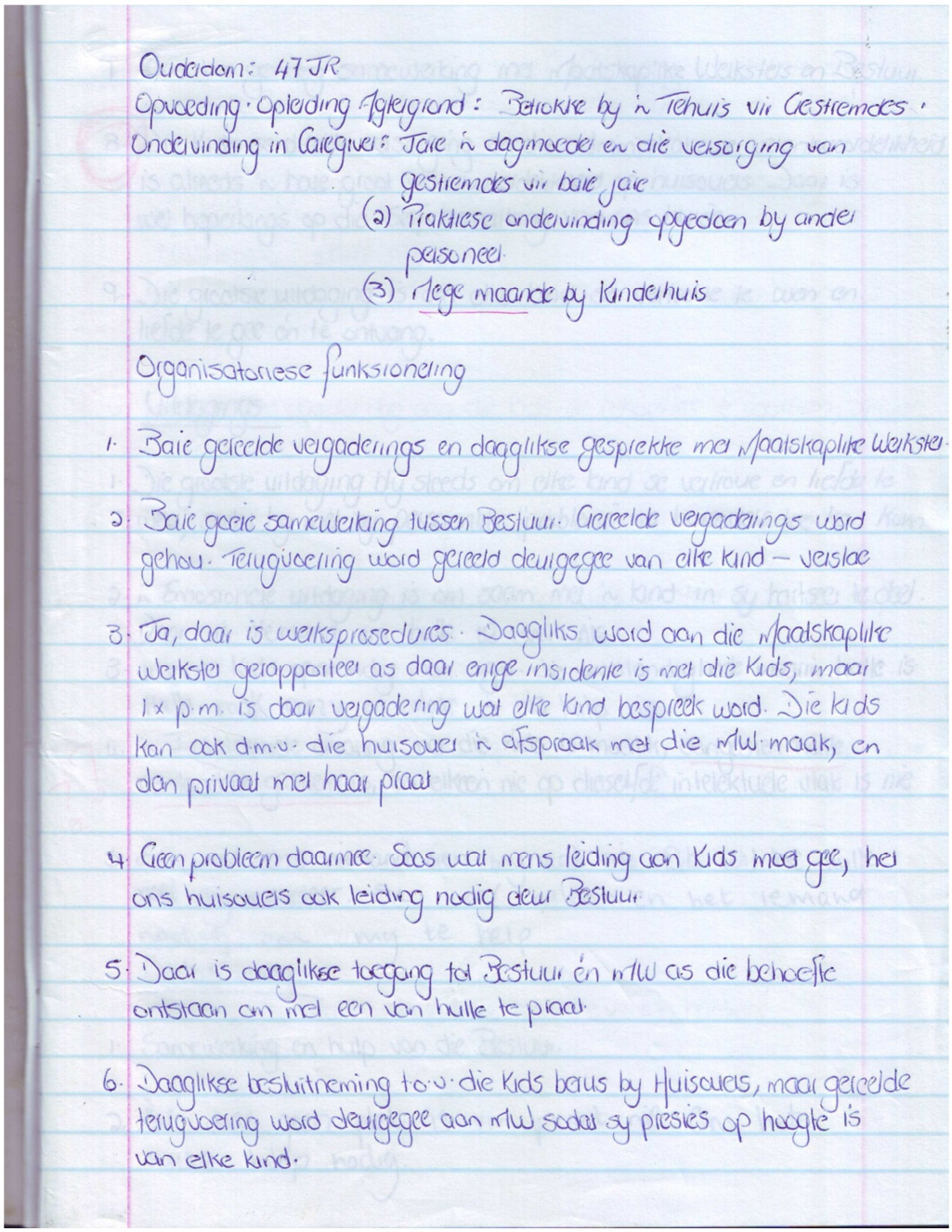
Behoeftes

1) Kos, klere, Ek wens ek kan meer gee
2) Meer donateurs.
3) Geen.
4) Daar is genoeg ondersteuning.
5) Nee.

Emosionele behoeftes

1) Mediese fonds vir terapie.
2) Het al so gevoel. Werk vereis baie
3) Nie wat ek van weet nie
4) Nee
5) Nee
6) Nee
7) My man.

Partisipant K



Ouderdom: 47 JR
Opvoeding · opleiding Agtergrond: Betrokke by in Tehuis vir Gestremdes ·
Ondervinding in Caregiver: Jare in dagmoeder en die versorging van gestremdes vir baie jare
(2) Praktiese ondervinding opgedaan by ander personeel
(3) Nege maande by Kinderhuis

Organisatoriese funksionering

1. Baie gereelde vergaderings en daaglikse gesprekke met Maatskaplike Werkster
2. Baie goeie samewerking tussen Bestuur. Gereelde vergaderings word gehou. Terugvoering word gereeld deurgegee van elke kind – verslae
3. Ja, daar is werksprosedures. Daagliks word aan die Maatskaplike Werkster gerapporteer as daar enige insidente is met die Kids, maar 1 x p.m. is daar vergadering wat elke kind bespreek word. Die kids kan ook d.m.v. die huisouer in afspraak met die MW maak, en dan privaat met haar praat
4. Geen probleem daarmee. Soos wat mens leiding aan Kids moet gee, het ons huisouers ook leiding nodig deur Bestuur
5. Daar is daaglikse toegang tot Bestuur en MW as die behoefte ontstaan om met een van hulle te praat
6. Daaglikse besluitneming t.o.v. die Kids berus by Huisouers, maar gereelde terugvoering word deurgegee aan MW sodat sy presies op hoogte is van elke kind.

7. Ons het genoeg samewerking met maatskaplike Welksteis en Bestuur.

8. Die Kids se direkte versorging en die administratiewe verantwoordelikheid is alreeds 'n baie groot verantwoordelikheid op huisouers. Daar is wel beperkings op die self-bemarking van ons huise.

9. Die grootste uitdaging is om elke kind se vertroue te wen en liefde te gee én te ontvang.

Uitdagings

1. Die grootste uitdaging bly steeds om elke kind se vertroue en liefde te wen, sodat hy met sy persoonlike "probleme" na huisouers toe kan kom.

2. 'n Emosionele uitdaging is om saam met 'n kind in sy hartseer te deel. Daar is niemand om hulle te sien nie.

3. Wanneer Kids opstandig raak agv. die omstandighede waarin hulle is. Hulle raak crazy en daar is nie hulp nie.

4. 'n Intelektuele ervaring met die Kids is moeilik, aangesien hulle verstandelik gestrem is, en elkeen nie op dieselfde intelektuele vlak is nie

5. Ek voel soms niemand sien my raak nie. Ek wil hê hulle moet my waardeer. Ek voel alleen en het iemand nodig om my te help.

Ondersteuning

1. Samewerking en hulp van die Bestuur.

2. Dat daar geen plek is vir praat nie. Ons het sulke hulp nodig.

3. Ja ons ontvang ondersteuning vanaf Maatskaplike Welksiei en Finansiële Bestuur en Mediese Sorg en ons waardeer dit BAIE.

4. Ons kry genoegsame ondersteuning. Genoegsame ondersteuning is van groot belang en is onontbeerlik. maar ... daar is nie emosionele stuff nie.

5. Mediese ondersteuning, Maatskaplike en Finansiële ondersteuning is baie noodsaaklik.

6. Finansies om dag tot dag aan die kids se behoeftes te voorsien, sowel as Donateurs.

7. Ja, Finansies, Medies en Maatskaplike welksiei is baie betrokke.

8. Ja ons kry ondersteuning en kan op Bestuur staat maak vir hulp.

9. Mede Huisoueis werk goed saam.

10. Baie gereeld saam met Maatskaplike welksiei. net nie terapie nie.

Opleiding

1. Om Kennis te verbreed

2. Opleiding is noodsaaklik om kids se situasie te kan hanteer.

3. Ja

4.

5 Ja beslis. Hoe om kids te dissiplineer en te motiveer.

6. Genoegsame opleiding word verskaf aan Huisouers

Persoonlik.

1. Dit is 'n geweldige verantwoordelikheid

2. Alledaagse versorging van kids wat insluit voedsel, sekuriteit en liefde.

3. Om die kids te lei tot verantwoordelike volwasse mense.

4. Liefde, Sekuriteit, Aandag, vertroue, Kos & Klere

5. Ja

6. Ons kry goeie ondersteuning en motivering van Bestuur a.g.v. neergelegte reëls

7. Ja

8. Met die hulp van Maatskaplike Dienste en Bestuur en die voorbeeld wat jy as Huisouer vir hulle stel