

UNIVERSITY OF ZULULAND

**THE PROMOTION OF PSYCHOLOGICAL WELL-BEING
OF CAREGIVERS AT CHILDRENS' HOMES IN THE
GREATER DURBAN AREA**

by

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DECLARATION

I, Narainsami Chetty, declare that this thesis, “ Promoting the psychological well-being of caregivers in children’s homes in the greater Durban area”, is my own work and that all sources used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, appearing to read 'N Chetty', written over a horizontal line.

N Chetty
Durban

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ABSTRACT

This investigation was contextualised within the community psychological model of mental health promotion and Zimmerman's empowerment theory (1995) and psychological intervention being conceptualized as a positive component with a view to enhancing psychological well-being. This study investigated psychological intervention as a strategy for the promotion of well-being among caregivers in a children's home. The primary focus was the caregivers in children's homes in the greater Durban area and the secondary consideration was the positive cascade effect it had on the children under their care. The research design comprised an experimental and control group. A psychological intervention was implemented and the Maslach burnout inventory (1986) was used to measure the well-being outcomes. This was complemented with qualitative techniques that included a needs assessment questionnaire, intervention, consultation, focus group, appreciative enquiry, children's behaviour profile and the principal's pre and post intervention evaluation. The improvement in caregivers' well-being was also evaluated in the positive behaviour changes of selected children assessed by the Conners rating scale (1979). The SPSS findings indicated negligible change in the pre and post test MBI scores for caregivers. There was no significant differences in the pre and post test scores on the Conners rating scale. However, the descriptive qualitative measures indicated significant levels of improved psychological well-being by caregivers which generated a positive cascading effect on selected children under their charge. These descriptive improvement trends are attributed to the comprehensive treatment or intervention.

CHAPTER ONE

INTRODUCTION

1.1 PREAMBLE

This study examines the promotion of well-being of caregivers in children's homes.

The investigation is predicated on the following key questions, viz:

- Why promote the well being of caregivers?
- How can the well being of caregivers be promoted?
- How can empowerment benefit caregivers ?

1.2 MOTIVATION

The focus of this research is the well-being of caregivers and their charges in children's homes. In 1978 the World Health Organisation proposed a view of health as not merely the absence of disease but a positive state of complete physical, mental and social well being (Swartz, 1998). Edwards (2002,a) concurs through his model of well-being which embraces both illness prevention and health promotion. Psychological well-being (Ryff, 1989) or wellness promotion (Edwards, 2002) have relevance for caregivers at children's homes which serve as important social systems (Duncan & van Niekerk, 2001). Caregivers and their recipients are the key constituents of the social system in a residential care or children's home milieu. The emphasis of this study is on caregivers and their coping strategies in a social system that is unique to a children's home. It is inevitable that the caregivers inextricable

connectedness with the children make the latter a secondary but integral focus of the study.

At a generalised level the motivation for this study of promoting the well-being of caregivers is inspired by the dramatic progress of South Africa in ten years from the depths of Apartheid to a peaceful, practicing democracy. This period has been characterised by notable gains in almost all major spheres of South African life at national level. Through sound leadership and innovative policies significant improvement has been noted in *e.g.* Education, Justice and Transportation. These gains have been possible through transformation as one of the cornerstones on which the South African government of a decade continues to be highly committed to. It is also noted that our government has been among the first signatories of the International Declaration on Children's Rights. Our country has a Children's Rights Charter entrenched as part of our most liberal and widely acclaimed Constitution. These initiatives at a macro level are highly commendable. However, in the context of this study, how qualitatively has the status quo of children in general and their caregivers specifically in children's homes changed in the post democracy phase. Thus the focus in this study is the well-being of caregivers in children's homes. The latter are employed in children's homes that are both state managed and community run. This study will concentrate on caregivers from a community-based organisation. The promotion of the caregivers well-being will be the focal point of this study and the cascade effects that it will have on their children.

Any study is primarily propelled by self-motivation. It is a passionate concern in this need-felt focus area of caregiving that sustains the academic interest for more insight and greater understanding through a rigorous scientific process. The study that began as the exploration of a personal agenda extended itself into the general research terrain. The beneficial outcomes are bound to accrue to the wider scientific community with its intended impact concentrated around the notion of well-being of caregivers.

At a conceptual level the study is grounded in the discussion of the progressive role of community psychology. In this regard, community psychology in South Africa still has to achieve distributive sufficiency that examines questions of need (Seedat, Duncan & Lazarus, 2001). Despite the Swampscott Conference which tried to engender communities and social change (Seedat *et al*, 2001) caregivers in children's homes continue to work in an environment characterised by greater need, fewer resources and fewer progressive psychologists to work for change (Pretorius-Heuchert & Ahmed, 2001). There is a greater urgency now for involvement in issues of relevancy (Dawes, 1986) based on distributive sufficiency or need (Seedat *et al*, 2001) In the context of the study the relative silence in the literature concerning caregivers makes this investigation relevant ((Dawes, 1986). In respect of trends in community psychology in the post apartheid era decade one study concentrated on children as participants (Seedat, Mackenzie & Stevens, 2005). Furthermore, knowledge is being generated chiefly about urban, middle-class adults with university

students being the most popular source of participants (Macleod, 2005). This notable lack of emphasis on children and the concentration on urban class adults is contrary to the spirit of the Swampscott conference and is ignoring working class issues (Dawes, 1986).

Macleod (2005) notes that in a five year situational analysis, investigations by local South African researchers relevant to this study were as follows,:

- Child care 1,3 %
- Quality of life /wellness 1,6 %
- Primary school children 2,3 %
- Child care institution 1,0 %.

On inspection of the above, research on children and child care is hardly a thriving enterprise but a newly emerging and still very rudimentary activity in South Africa. However, those observations are still relevant in the face of an increasing awareness of the pressing need for local research on caregivers in children's homes. Current South African literature on caregiving in a children's home is similar to the United States of America experience of twenty five years ago that necessitated the Swampscott conference. Though the need has been recognised but researchers have only begun to respond to address child caregivers issues. It can be concluded that of all local community psychology research in the last five years, 1,3 % on child care and 1,0 % on child care institutions represents a noticeable gap in South African

literature on child care and caregivers in children's home (Macleod , 2005).

Therefore, child care research must be an enabling activity to meet particular needs in the context of this study research questions have professional, training, and developmental child and youth care implications. The central theme of promoting caregiver well-being through a treatment or intervention will include these needs. There appears to be a compelling need to address the promotion of caregivers well-being which will now be explored in the aim of this study.

1.3 AIM

The primary aim of this research is to focus on the well-being of caregivers and their charges in children's homes. Edwards (2002,b) model of well-being which focuses on illness prevention and health promotion is a development of the early view of well-being that merely included physical, mental and social aspects of an individual (WHO, 1978). In addition (Edwards, Ngcobo & Pillay, 2004) note that well-being is influenced by personal, interpersonal and environmental factors, and, invariably, by changes within the context of life stages and developmental tasks. Given the environmental context of a children's home with its myriad of interpersonal dynamics, well-being or wellness promotion has relevance for caregivers and care receivers at children's homes (Duncan & van Niekerk, 2001). This psychological well-being develops through a combination of emotional regulation, personality characteristics, identity and life experiences (Helson & Srivastava, 2001). In effect

the intent in this study is to enhance the life- experience (Helson & Srivastava, 2001) of caregivers through the promotion of their psychological well-being. Community psychology has a special concern with empowering the oppressed and vulnerable. Thus there appears to be a need to address issues around caregivers in children's homes. One such issue is the promotion of well-being of caregivers.

Research on well-being has flourished in recent decades (Diener, Suh, Lucas & Smith, 1999). However, the literature on the effects of care giving on personal well-being is equivocal. While some findings point to the positive benefits derived by caregivers in general, most studies focus on the stressful and negative health-effects of care giving.

Positive benefits of care giving include increased self-esteem and self- respect, satisfaction with having fulfilled obligations, a sense of competence, mastery in managing care giving tasks and feeling needed and useful (Toseland, Smith & McCallion, 2001). There is evidence that caregivers can be at increased risk of becoming depressed (Schultz, O'Brien, Bookwala, & Fleisner, 1995), feeling stressed, strained, exhausted or fatigued (National Alliance for Caregiving, 1997; Ryff, 1989; Maslach, 1986) and reporting more health problems e.g. insomnia, weight gain and obesity (Schultz et al, 1995).

There is currently an acute shortage of mental health care professionals to assist in

dealing with the problems faced by South African children, particularly children in marginalised communities (Pillay, Magwaza & Petersen, 1992). Children and caregivers, “those who work with children and youth at risk”, (National Association for Child Care Workers, 2003) are marginalised communities and their problems of psychological well-being can be promoted in two ways (Cowen, 1999):

- Community institutions, settings, and processes become important study foci in their own right insofar as they relate to wellness.
- The community offers settings that are more relevant and functional than the consulting room to actions and interventions that can enhance the well-being of large numbers of people.

This study acknowledges that children’s homes are key settings of the community (Cowen,1999) and it is more functional and relevant to initiate intervention with a larger number of caregivers and their charges. Furthermore, children with difficulties are often best helped by those who understand and share their life experiences (Orford, 1992; Rappaport, 1981; Serrano-Garcia, Lopez and Rivera-Medina, 1987).

This study intends to equip child and youth caregivers with knowledge and skills to promote their well-being and prevent their mental and emotional exhaustion (Maslach & Jackson, 1986). A preventive intervention would enable positively functioning caregivers to contribute to the optimal development of their care-receivers. Such an approach is vital since children have historically constituted one of the most neglected and disadvantaged sectors of the South African population, Seedat *et al* (2001). The

problem with these children is compounded since there are complex growing behaviour problems (Butrick, 1992).

Furthermore, there are three major limitations from studies concerning the characteristics of caregivers that are summarised by (Neal & Wagner, 2001) as follows,:

- In comparison with the number of studies that have assessed negative consequences of care giving, knowledge of the positive effects of care giving is extremely limited.
- The findings of most studies to date have been limited because they are based upon cross-sectional data that represent only a “snapshot” in time.
- Most studies rely exclusively on caregivers’ self reports which can sometimes be inaccurate. This study will use triangulated data.

Nevertheless, children with difficulties are often best helped by those who understand and share their life experiences (Orford,1992; Rapport,1981; Serrano-García, Lopez & Riveria-Medina,1987). This study intends to equip caregivers with knowledge and skills that will promote their psychological well-being and prevent burnout (Maslach & Jackson, 1986). Besides having lacked a natural home environment and upbringing, (Barker, 1995) many children from children’s homes have psychological and developmental difficulties (Duncan & van Niekerk, 2001).

This poses the question of how best we can repair psychological malfunction (Cowen, 1999). One solution is to empower caregivers through intervention to prevent burnout and promote their psychological well-being. The empowerment of people should be based on solutions using structures with which they are familiar and over which they can exert some control (Barker, 1995). The familiar structure for the caregivers is the children's home over which they can exert some control and may contribute to the promotion of their empowerment and competence (Cowen, 1999).

Empowerment of caregivers drives the comprehensive treatment.

1.4 METHOD

This study presents an opportunity for triangulated methodology (Moyle & Suschitzky, 1997) that is a multi data-gathering technique. This study is both quantitative as well as qualitative in nature. Qualitative statistics lend itself to descriptive statistics that refer to procedures for organising, summarising and describing information or data (McCall, 1980). Descriptive statistics are employed when the research is also qualitative in orientation. Qualitative study is an inquiry process of understanding a social or human problem based on building a complex, holistic process formed with words, reporting detailed views of informants and conducted in a natural setting (Creswell, 1994). The human problem (Creswell, 1994) in this study is a community-oriented agency, where the children's home is the natural setting and the key role-players are both the caregivers and the children. The

secondary informants (Creswell, 1994) are the principals of children's homes, parents, the administrative staff, the ancillary staff and the schools the children attend.

From initial contact with children's homes it is anticipated that the following techniques will be employed, viz:

- Structured interviews
- Unstructured interviews
- Needs Analysis
- Administration of questionnaires
- Intervention
- Individual Consultation
- Focus groups
- Appreciative inquiry

Subsequently, the quantitative data-gathering process will centre around an experimental design with two children's homes allocated to either an experimental or control group. There will be an intervention with caregivers from the experimental group. Caregivers will be pre-tested and post-tested on a qualitative and quantitative measure, *e.g.* burnout scale (Maslach, 1986). The children will be assessed on the Connors (1989) behavioural questionnaire. The quantitative assessment will be analysed with the SPSS statistical package and following the intervention, caregivers evaluation will take the form of an appreciative inquiry (Cooperrider & Srivastva, 1987). This comprehensive approach embracing both qualitative and quantitative

components of research in examining the promotion of well-being or psychological wellness (Cowen,1999) will contribute to the reliability and validity of the study.

1.5 VALUE OF THE STUDY

- From a national perspective this study is expected to create awareness among policy makers of the need to focus on children's homes as forms of disadvantaged communities that have been accorded sparse research attention (Macleod, 2005; Seedat, Mackenzie & Stevens, 2005).
- From an academic perspective a well-being theory base, created on the marginalised caregiver will probably stimulate further research.
- It is also envisaged that through this investigation, caregivers of children will be given greater recognition to the extent that they will be regarded as respected members of the helping profession through an enabling sense of professional pride.

1.6 ETHICS

Ethical issues arise in discussions about codes of professional conduct for researchers Creswell (2003). Some relevant ethical issues that are integral aspects of a study which Creswell (2003) draws attention to are,:

- The inquirer not further marginalising or disempowering the study

participants. This study is positively-oriented around the promotion of psychological well-being or empowerment of the caregiver.

- The purpose of the study needs to be conveyed to the participants. Meetings were held with the CEO of Site X and the principal of the children's homes. The permission for use of Site X was obtained and the purpose of the study was explained. This was followed up with appropriate letters.

At the introductory session, caregivers were briefed about the purpose of the study, their participation was invited and their written informed consent was obtained before the commencement of the study. Furthermore, the informed consent drew attention to caregivers' right to participate voluntarily, assured about privacy, strict confidentiality guaranteed with regard to all personal identifying information, the benefits that are likely to accrue to the caregiver and feedback concerning the outcome of the study. In the first session these salient but critical issues were explicated. At the appropriate time the recipients in the children's home will be informed.

Following appropriate approval from the heads of the relevant children's homes, informed consent will be obtained from all participants.

1.7 DEFINITION OF TERMS

Well-being : Well-being or wellness will be used interchangeably referring to mental

or psychological health promotion and illness prevention.

Caregivers : Qualified or unqualified personnel who are employed at children's home or residential child care home and interact with "troubled children or youth at risk" (National Association of Child Careworkers -NACCW , 2003).

Children's Homes : Children's Home are places where children are removed to from their parents or guardians and placed in an institution or environment recognised by the Child Care Act 74 of 1983 as a place of safety.

Children : According to the NACCW (2003), children who are troubled and youth at risk who reside in a children's home.

1.8 RESUME

A synopsis of the study is outlined.

Chapter one is concerned with outlining the study. It states the motivation and the aim of the study as well as the critical questions that inform this study. The location of this research and a conceptual framework is summarised. A brief outline of the methodology is also given. This is followed by the benefits of the study. A preliminary literature search is an integral part of the chapter. Key terms are defined and a summary concludes the chapter. Chapter two is a review of the related literature on

promotion of well-being of care givers in children's homes. Chapter three focuses on methodology of this study. The use of the tools of research is reported on. Chapter four analyses and interprets the research findings. Chapter five overviews the study and makes recommendations for further research.

1.9 CONCLUSION

The family is the most important feature of a child's environment with the obvious exception of those unfortunate children who do not grow up in a family setting (Barker, 1995). A children's home would be such a setting. Therefore, the challenge to provide and create conditions that will promote optimal development despite adverse circumstances that are bound to prevail in such a residential setting like a children's home. Furthermore, at children's homes in particular, a number of children present with problems that they are ill equipped to deal with (Duncan & van Niekerk, 2001). Thus it is intended to equip caregivers with the requisite skills and knowledge to assist children in resolving the multifarious difficulties that confront them. Several children show signs of psychological and developmental difficulties, social adjustment problems and various stress-related difficulties which appear to be related to environmental factors. The concern of how best can we best repair psychological malfunction is posed by Cowen (1999). The empowerment of caregivers through the promotion of their well-being that is postulated to be one of the solutions in addressing and improving issues of troubled children and youth at risk in a children's home.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Nobody's child
Nobody's child
Just like a flower
They are growing wild
Got no mama's kiss
And no Daddy's smile
Nobody wants them
They are nobody's child

Nobody's child (song)
Coben & Mel Foreen

A close examination of the “Nobody’s child” song suggests that the gist of the song is an implied summary of the study which seeks to empower caregivers and address the many and varied issues of neglected and troubled children. The children depicted come from an environment lacking care and nurturing. They are bereft of parental love and alienated from the family. They do not experience the fundamental emotions integral in a wholesome parent –child relationship. The child is also bound to feel rejected with serious negative implications for her self-esteem and self-concept contributing to her poor self-image. The song is relevant to the study. While the focus is promoting the psychological well-being of the caregiver in a children’s home, it is intended for the empowered caregiver to create positive outcomes for the recipient,

that is, the child who is in her care in a residential setting.

In this regard mental health promotion is a form of general health promotion particularly aimed at activating positive health in terms of increased vitality in an empowered context (Edwards, 2002). However, in respect of Community Psychology, Seedat et al (2004) found 18 out of 47 articles with the key word community and community psychology which were selected for content analysis. Of the 18 empirical studies which provided participant-sample characteristics, one study concerned itself with children. (Seedat *et al* , 2005). Furthermore, an analysis of how relevant articles from 1999 to 2003, in the South African Journal of Psychology are, was conducted by Macleod (2005). There was an examination of all abstracts appearing under the key words South Africa in PsycINFO in the peer-reviewed journal section from 1999 to mid 2004, (Macleod, 2005). In this situational analysis on “:relevance” psychology, Macleod (2005) concentrated on three aspects, viz.:

- What are the key issues being investigated?
- What types of research are being conducted?
- About whom is psychology generating knowledge?

While, Macleod (2005) noted that psychology appeared to be engaged in reflective practice, issues that made this study pertinent are reflected in table one as follows,:

TABLE 1

Summarised from South African Journal of Psychology – 1999-2004:

Topic	SAJP	Psyc INFO
Children	1,3%	0%
Children's Homes	0%	0%
Caregivers	0%	0%
Well-being /Wellness	0%	1,6%
Empowerment	0%	0%

The literature search takes on an added challenging dimension due to the unit of analysis being the caregiver in a children's home. There appears to be gaps and silences on the issue of the caregiver. There were studies on aspects of children's homes in the greater Durban area (Ngcobo, 1992; Ramesar, 1971). Research in this country has been skewed concentrating on advantaged and urban children with the result that little is known about the problems of children from poorer, rural and peri-urban communities (Pillay & Lockhat, 2001). It is largely children from this socio-economic strata of society that are placed in residential care. In the main, studies continue to ignore some of the pressing issues facing South Africa today (Macleod, 2005) e.g. issues around children, empowerment and caregivers. This investigation then responds in its comprehensive literature search to address these critical issues. The key questions of the study, viz:

- Why promote the well being of caregivers?
- How can the well being of caregivers be promoted?
- How can empowerment benefit caregivers ?

will be addressed through the following themes that are sequential and relevant to the study :

- The family
- Children's homes
- Child care in South Africa
- Caregivers challenges
- Well-being theory
- Intervention
- Empowerment
- Ecological model

2.2 THE FAMILY

“ Family” is a common term since it is often assumed that almost every child is part of one (Felker, 1982). The ideal family is still viewed as two parents and the offspring (Skidmore, 1994). In this social milieu a person's life cycle should undergo the normal process of development from helpless infant to independent adult (Barker, 1995). This is achieved in a child's usual environment comprising the family group in which she is growing up and the wider social setting in which the family is living (Barker, 1995). It is for this reason that families are regarded as miniature societies in

that children make their first attempt at adapting to others and in which they have patterns of social behaviour that persist throughout life (Barker, 1995). Since the family is the basic unit of caring in our society, members of the family feel best and most cheerful when they are surrounded by their family (Skidmore, 1994). This is a normal and healthy environment where all family members love and care for each other. Most children grow up in families in which their development proceeds smoothly and their parents spend time consciously considering goals for their development (Felker,1982). They may also have special goals for their children that are part of the family's traditional expectations (Felker, 1982). Therefore the family is perceived as providing the ideal context within which child development can take place (Bonn, 1995).

It is appropriate to take into account the so-called " parent paradox", where in retrospect while parents are very glad that they had children but usually score very low on happiness indicators (Baumeister, 1992). There is an implication here that raising children may tend to decrease parental happiness but increase meaning in life. It is gathered that familyhood is a challenge both for the parents and the children (Baumeister, 1992). This challenge is a reality for a significant part of a country's child population, where family does not mean the father, mother and two children idealised in commercials as these are the children who have no families or cannot live with their families (Felker, 1982).

Notwithstanding, the family is the most important feature of a child's environment

with the obvious exception of those unfortunate children who do not grow up in a family setting but are living in a children's home (Barker, 1995). Among the many reasons, abuse and neglect are the most frequently cited causes for a child's entry into the child welfare system (Howing *et al* 1992). Abuse, neglect, emotional maltreatment and sexual abuse are the four major types of maltreatment that are meted out to children (Howing *et al*, 1992). Hence there is a need for the child to have an ordered past and present, to ensure that her future would not be chaotic (Skidmore, 1994). Therefore, it can be surmised that a disturbed child is not really the root of the family problem but a victim of the family instead. The child needs help to change the negative behaviour patterns that he may have developed (McGregor and Little, 1998) before he joined the restructured family (Felker, 1982) with his caregiver as the new and substitute parent. A brief examination of child care in South Africa will help in the understanding of legal provisions for such children in need of help under the supervision of caregivers in children's homes.

2.3 CHILD CARE IN SOUTH AFRICA

2.3.1 Background

Children have first priority on the nation's resources (Carsons, Butcher & Coleman 1988). However, children have historically constituted one of the most neglected and disadvantaged sectors of the South African population (Seedat, 2001). Furthermore, it is those children from poorer families that are more disadvantaged in terms of access to services, with the result that underlying and manifest problems are left untreated,

only to develop into more chronic or complicated conditions (Pillay & Lockhat, 2001). When there is breakdown in family dynamics resulting in children being physically and psychologically harmed there is need for some alternative placement (Carsons, Butcher and Coleman, 1988). Children are also not receiving services commensurate with their need (Carsons, Butcher and Coleman, 1988). Caregivers are not being discussed in isolation. It is necessary to context their roles in a residential setting *vis-a-vis troubled* children and youth at risk, the most important component with whom they interact.

2.3.2 Child Care Legislation

Child care Act No 74 of 1983 during the course of this investigation is still the overarching national policy that governs the removal of children from their so-called natural setting into a protective environment like a children's home or residential care. Children's Act 38 of 2005 is still to be proclaimed.

A brief chronology of preceding legislative arrangements will contextualise the development of Child Care in South Africa. See table two.

TABLE 2

Brief historical development of child care legislation in South Africa

1908	Child Life Protection Society was established. Nurses worked with infants
1913	Children Protection Act 25 of 1913. State more formally involved.
1960	Children's Act No 33 replaces Children Protection Act No 25 of 1913.
1983	Child care Act no 74 of 1983. The prevailing Child Care legislation

2.3.3 Implementation of the Child Care Act 74 of 1983

When the Child care Act no 74 of 1983 was promulgated, the Child Welfare Advisory Council was introduced, whose members are Ministers appointed from various state departments, *e.g.* Welfare, Education and Justice. They make recommendations to the Minister responsible regarding Child Welfare and for the prevention of the neglect and ill-treatment of children.

Children admitted into the children's homes are those that the children's court has ordered to be placed in alternative care in accordance with Section 15 (1) of the Child Care Act No 74 of 1983. Children who are brought before this court are those that have been identified by any responsible citizen as needing protection. The child's home circumstances are investigated and a report is compiled with recommendations. The children's court will decide what to do about the child. The court will decide whether the child has no parent/guardian or has a parent/guardian who is unfit to keep the child. The decision made will be based on whether the child has a problem or has problematic parents and therefore needs protection.

After this brief elaboration of the salient issues of the Child Care Act 74 of 1983 the residential setting or children's home where the caregiver plays a key role is examined.

2.4 CHILDREN'S HOMES

Ewalt, Freeman & Poole (2001 refer to an often quoted African proverb,

"it takes a village to raise a child "

In the village of the past, face to face relationships dominated within a close knit group (Ewalt *et al*, 2001). Unlike in a children's home, as there were no strangers in a village, life situations were characterised by a high degree of dependency. All the village folk are inextricably involved in child-rearing. Children in modern society would benefit tremendously if the whole village concept of child rearing is followed. Unfortunately, neglected and abandoned children in South Africa is a serious issue due to poverty and poor living conditions (Seedat, 1988). Children's homes serve as an interim measure to temporarily accommodate such neglected and abandoned children after the formalities of Child Care Act 74 of 1983 have been complied with. Institutions like children's homes can be of great help to troubled children and youth at risk who need to be removed from aversive environments and given a chance to learn about themselves and their world, to further their education and develop needed skills, and to find purpose and meaning in their lives (McGregor & Little, 1998).

2.4.1 Entry into Children's Homes

The quality of the child's new home is a crucial determinant of whether the child's problem will be alleviated or made worse by the placement (Carsons, Butcher and Coleman, 1988). An assumption is made that a child or youth's entry into a children's home is consequent to a negative life-experience with his nuclear family. Restructured or functional family is an appropriate description for this relationship dynamics in the children's home (Felker, 1982). A restructured family arises because the caregiver and children are linked together through this new familial arrangement. It is also befitting for the new relationship dynamics between the caregiver and the children to

be regarded as a functional family as they interface primarily to serve a legal function in each other's lives. Besides, the restructured family faces an additional challenge trying to unite a group of people who are characterised by diversity and not homogeneity (Carlson, 1996). The home has a variety of issues, concerns, problems and anxieties generated by diverse persons and personalities. It is envisaged that the proactive endeavours of the caregivers after the promotion of their well-being will contribute to the holistic enhancing of a quality lifestyle for the children in the home. In such a condition the children must flourish towards optimal development.

2.4.2 Role of Children's Homes

The state's policy is that children are the responsibility of their biological parents. The state also believes that children's most important bonds are those made with their biological parents. Removal of children to a children's institution which is traumatic both to the child and his family must be the last resort when all other means have failed (Child Care Act No 74 of 1983). If the circumstances of the child are such that substitute placement is the only option, the children's court will order that the child be placed in a children's home.

Under ideal conditions the new setting should approximate to the natural environment (Barker, 1995). Settings at children's homes can serve as important social support systems in addressing those children exposed to social trauma (Duncan & van Niekerk, 2001). The trauma can be manifold, *viz.:*

- The trauma of negative life-experiences that necessitates placement at the children's home.
- The trauma of separation from family.
- The trauma of meeting other troubled children.
- The trauma of meeting strange adults who will act as substitute parents.
- The trauma of a new and unfamiliar environment.

Though the restructured family in the children's home has all of the joys and difficulties of any other family it nevertheless has special problems and extraordinary opportunities because of its social make-up (Felker, 1982). There is a social construction of children at risk and their caregivers that creates a unique ecological environment. Therefore, attempts must be made to provide and create conditions that will promote optimal development despite challenging circumstances that are bound to prevail in a residential setting like a children's home (Barker, 1995). Optimal development is indicated for the caregiver and the troubled child and youth at risk. Children with multiple problems require coordinated systems of care (LeCroy & Ashford, 1992). The caregiver needs to provide help to the troubled child to change the negative behaviour patterns the child has previously learned (Felker, 1982). The acknowledgement of the multitude of challenges that the caregivers will face and need to address will impact on their psychological well-being.

2.4.3 Caregivers' challenges

Before the challenges that confront a caregiver are examined, mention is made of

some essential characteristics of good care for children in the out-of home context

(Fahlberg, 1991). Some of these essential characteristics are:

- a primary caregiver for the child
- care by adults to whom the child can become attached
- continuous contact with these adults on a day to day basis
- gradually changing relationships with a small number of individuals over a lifetime
- safety and security
- stimulation and encouragement for growth
- reasonable expectations
- experience in identifying and expressing emotions
- support in times of stress
- share success

Good care of children is given by caregivers, a special group of people who help children in need that are not biologically their own, cope in a challenging residential care setting (Fahlberg, 1991). Child-rearing literature does not take much notice of their special needs. Pillay & Lockhat (2001) make reference to these gaps and silences in the literature in respect of childhood mental health problems. There are numerous challenges that the child care worker encounters in the course of discharging her multifarious responsibilities. The role of a caregiver is critical in a “troubled” child’s life. In order that the caregiver performs her role effectively, an insight is provided into some of the ecological factors that further militates the child’s

wholesome development and natural growing-up. Caregiver may feel unhappy about their miserable conditions but a cherished cause may infuse their lives with meaning. (McGregor & Little, 1998). The child needs a loving adult who will fill a parental role. Together they will become a functional family (Skidmore, 1994). The caregiver's goal will be to transform the "troubled child's" dysfunctional environment and provide conditions for him that contributes to a functional family. Caregivers work with troubled children, who are emotionally disturbed, emotionally dependent, emotionally neglected, delinquent, and developmentally disturbed youth in community and home-based centres (Kreuger, 1986). Therefore, caregivers ought to give due attention to this veritable psychological minefield while they go about their daily tasks of providing adequate care for troubled children and youth at risk.

The quality of the child's new home is a crucial determinant of whether the child's problem will be alleviated or made worse by the placement (Carsons, Butcher and Coleman, 1988). The caregiver ought to recognise that transition from his original environment to the new residential context is not easy on the child. In addition to the difficulties that the child may have already experienced, he finds himself in a strange, unfamiliar social setting with the inevitable anxiety of the unknown. Therefore, when children are taken from their own homes and placed in an impersonal institution that promptly tries to change them where they do not obviously do not belong, they are likely to feel additional rejection, unwanted by the new caregivers, constantly insecure, lonely and bitter (Carsons, Butcher and Coleman, 1988). The child responds

with quick adjustment or takes a longer time to assimilate the new social context and sufficiently integrate into this residential environment. Unfortunately, children who are removed to a new environment often interpret this as further rejection, not only by parents but by society as whole. In the confined environment of a children's home the caregiver may represent a microcosm of society. The issue of rejection is a fundamental concern that the caregiver must be equipped to address.

The caregiver must be alert to risk factors that exemplify the complex interaction between children and their environments. (LeCroy & Ashford, 1992). These children may have been living with adults who could not provide for their emotional needs. Such children may have been subject to harsh sanctions and physical abuse. It is possible that some kind of tragedy struck their family. They may have had parents who fought constantly and bitterly. The death of their parents may have resulted in the children becoming uncared for orphans. These risk factor experienced by children are related to environmental considerations (Duncan & van Niekerk, 2001). These environmental factors relate to the negative experiences of the child with their biological parents or nuclear family. It is expected of caregivers to play substitute parental roles. These risk factors may predominate to the extent that children may identify their new caregivers with the previous unhappy familial experiences.

2.4.4 Summary of children's homes

It is imperative that the caregiver is acutely aware of the vulnerability of children in her care. In addition to the serious unresolved issues that occasioned the child's

admission into the residential care centre in the first place, the child now has to contend with the challenging psycho-social dynamics of his new home. There have been reported instances of mistreatment of children in institutions. Thus in these settings the caregiver needs to be aware that a number of children present with problems which they are ill - equipped to deal with (Duncan & van Niekerk, 2001). Several children show signs of developmental difficulties, social adjustment problem and various stress-related difficulties (Duncan & van Niekerk, 2001). It has been observed that children who have had to be removed from their families because of neglect or abuse also show evidence of abnormal psychological development (Barker, 1995). This arrested psychological development is manifested through serious behaviour problems, emotional difficulties, low self-esteem, disorders of development, emotional difficulties and educational concerns (Barker, 1995). It is often difficult meeting the needs that these children have for love, security and rebuilding their shattered self-esteem. It will indeed be a major challenge for the caregiver to address the child's vulnerability brought about by a poor self-image and low self-concept. The child's fragile emotional state is another challenge caregivers have to deal with (Barker, 1995).

A decisive consideration for the caregiver is the lack of stability in a child's life. In this regard quite a number of children join a new family after several years of inadequate care or wilful abuse or a series of moves from one living arrangement to another (Felker, 1982). The child experiences both emotional and physical instability. Such years of childhood stress affect these children in many different ways. Studies

that focus on the effects of abuse and neglect have found that maltreated children exhibit depression, low frustration, withdrawal, anxiety, poor social skills and developmental deficits (Berdie, Berdie, Wexler & Fisher, 1983; Green, 1989; Martin & Breezley, 1977). A critical role that the caregiver may be called on to perform is that of a mental health helper. This is an endogenous challenge since it brings to bear the inherent capacity of the caregiver to exercise this crucial helping skill.

Poor early adjustment to family life is often followed by poor adjustment to society at large (Barker, 1995). It can be surmised that in the absence of natural family life it follows that the adjustment to society later will be more challenging. This creates the dilemma of seriously reflecting on how current programmes will ensure and enhance the psychological well-being of children. Thus the future years will require substantial effort on the part of professionals to maintain past gains and to service other needed areas. There must be efforts to identify and help high-risk children.

The delivery of human services to client group has never been easy (Baldwin, 1993). There has been a lack of quality services for range of client groups. The recent lack of emphasis in the literature on troubled children in residential care centres and the scant attention on caregivers in such homes will do little to improve the quality of service for these client groups, the caregivers and the children in need of care. A massive commitment is needed not only to provide adequate care facilities for children with problems but also to provide the physical and social conditions that will foster the

optimal development of all children. This is all the more necessary because unless the changed environment offers a warm, kindly, accepting, yet consistent and firm setting they are likely to make little progress (Skidmore, 1994).

Therefore, concerted efforts must be made to enable caregivers to contribute to the optimal development of their charges (Barker, 1995). The optimal development will create an ordered past and present, thus ensuring the future would not be chaotic (Skidmore, 1994). Thus by promoting the well-being of caregivers it is intended to equip them with the requisite skills and knowledge to assist in optimising the development of children and to aid children in difficulty. Such a proactive approach is desirable since complex human and social problems require multiple, divergent and changing solutions (Cowen, 1999). In this context, well-being, intervention and empowerment are some of the creative solutions proposed for caregivers.

2.5 PSYCHOLOGICAL WELL – BEING OR WELLNESS

Emphasis on distress is characteristic of research as well as practice (Conway & Macleod, 2002). This is borne out by the ratio of 17:1, articles examining negative psychological states to those examining positive states (Diener et al, 1999). This reflects the prevailing view that an illness model predominates. The promotion of psychological well-being or wellness promotion of caregivers in children's homes is central to this study. This study then moves away from the illness model and the focus is on health promotion and disease prevention. Furthermore, there is sparse South African literature on children's home in general and caregivers in particular. In

an investigation by MacLeod (2005) negligible emphasis was placed on the concept of well-being or wellness.

Researchers argue that rather than attempting to meet the needs of children on their own, professional mental health care workers could put their skills to better use by training and supervising para-professional and mental health care workers. The empowerment of people should be based on solutions using structures with which they are familiar and over which they can exert some control-structures such as family, community and pre-school. This study argues for caregivers in children's homes as well. Therefore, attempts must be made to provide and create conditions that will promote optimal development despite challenging circumstances that are bound to prevail in a residential setting like a children's homes (Barker, 1995).

Hence some definitions around the theme of wellness promotion or psychological well-being will help in the exploration of the concept which is critical to this aspect of the study on caregivers.

2.5.1. Definition

For Cowen (1999), wellness involves important facets of a person's life which involves recuperability in the face of adversity, having control over one's fate, feeling a sense of purpose and belonging and experiencing basic satisfaction in one's self and existence. Psychological wellness is sufficiently comprehensive to enfold concepts such as primary prevention, empowerment, competence, and heightened resilience (Cowen, 1999).

Another view is that well-being is enhanced when health promotion concentrates on improving attitudes and behaviours (Edwards, 1999).

Wellness according to the World Health Organisation is a state of complete physical, mental and social being (Jones-Nicol, 2001). Wellness as a preventive component is stressed from three levels (Mann, 1978). See table three.

TABLE 3

Mann's (1978) three levels of prevention

Primary prevention	Which seeks to reduce the incidence of disease.
Secondary prevention	Reduces prevalence rates by reducing the number of old cases that exists.
Tertiary prevention	Seeks to reduce the prevalence rate by preventing relapses among recovered cases.

Further, this study proposes that by promoting psychological well-being of caregivers is in effect preventing burnout which according to Maslach (1986) will impact their work performance and the behaviour outcomes of children in their care.

2.5.2 Essential features of psychological well-being

The following are some essential features of well-being (Cowen, 1999) viz.:

- The family background, early development and experiences.
- The effectiveness of one's total educational experience.
- The nature and impact of the social settings and systems in which a person interacts.
- The extent to which society and its structures are just, empowering and enabling.

2.5.3. *Threats to wellness*

The following have been identified as threats to well-being (Cowen, 1999):

- One's early development may fail to provide the necessary condition for psychological wellness, *e.g.* secure relationship, physical health and support.
- The formal and non-formal environment may not provide the essential skills, competencies and self-views that mediate wellness.
- Events or circumstances may occur that undermine psychological wellness.
- People may be faced with injustice, lack of opportunity to use skills, exclusion and disempowerment.

2.5.4. *Factors that promote well-being*

The following key factors promote wellness (Cowen, 1999), *viz*:

2.5.4.1 Competence

Competence means doing well in all stages and areas of life (Cowen, 1999). When a task is accomplished competently it is acknowledged by others. The latter shows respect and displays positive regard. This contributes to improving self-esteem and enhancing self-worth. Therefore, consideration be given to creating opportunities for

competence and promoting actions to strengthen adaptive competencies throughout life (Cowen, 1999).

2.5.4.2 Empowerment

Empowerment enables people to gain control over their lives (Cowen, 1999). This is necessary because vast segments of the population are disempowered (Rappaport, 1997). These disempowered groups could include ethnic minorities, the elderly, physically and emotionally disabled persons, children, women and the homeless (Swift & Levine, 1987). Therefore, the provision of conditions that promote people's empowerment (caregivers of children) is an essential facilitator towards psychological wellness (Cowen, 1999) which is the focus of this study. Some of these empowering conditions are a combination of emotional regulation, personality characteristics, identity and life experiences (Helson & Srivistava, 2001).

2.5.4.3 Heightened resilience

Children and people in general grow up amidst stressors (Cowen, 1999). However, such people show heightened resilience where they not only cope but learn adaptive skills and competencies (Cowen, 1999). This is achieved through attempting a mastery of their environments and control of their destinies. Children especially have this ability of heightened resilience which enable them to survive and to adapt (Garnezy, 1982).

Psychological well-being may be predisposed to personal, interpersonal and environmental factors. Furthermore, this development increases with age, education,

extraversion and consciousness (Keyes, Shmotkin, & Ryff, 2002). If the momentum of promoting the psychological well-being of caregivers can be maintained there ought to be a concomitant improvement in the psychological environment for children.

2.6 INTERVENTION

In some ways modern forms of community psychology represents a paradigm shift in its recognition that the real psychological interventions are typically carried out by non-professionals (Orford, 1992). Research has demonstrated the positive effects of training (Barth, 1986; Jones & Biesecker, 1980). Fundamental to this study is an intervention programme that has been devised to empower the caregivers. A brief theoretical background is furnished to elucidate this key aspect of the study.

- Theory
- Intervention Model

2.6.1 Theory

Intervention is a phenomenological approach (Edwards, 2001). This is because in everyday life we cannot but intervene in each other's world and influence each other in that as human beings our individually unique existence are essentially inter-subjective and radically social (Edwards, 2001). This is the essence of the dynamic relationships between the caregiver and the care recipient. While each has his/her identity it is inevitable that given this contextual situation both the former and the latter will inextricably impact each other's lives. This is so because people continuously influence each other through interpersonal encounters or interventions in

one another's world (Spinelli, 1989). In other words the caregiver is a vital part of the child's life-space and vice versa.

The fundamental point of departure of the phenomenological approach is that priority is given to the phenomenon under investigation (Stones, 1986). The general phenomenon studied is the caregiver. The promotion of her psychological well-being is the central phenomenological construct of the study. This is underpinned by empowerment theory. Any study of concrete human phenomenon requires that the approach, method and content be seriously considered in relationship to one another (Giorgio, 1970). This study fulfils this requirement in that the inter-dependency between the caregiver and the trouble child is consistently highlighted.

2.6.2 Intervention Model

The model for intervention chosen is practical, and relevant to the study. Given the limitations of time the model was workable. This model was created by Morrill, Oetting & Hurst (1974) and has three broad dimensions, *viz.*:

- Whom the psychologist will work with?
- What the purpose of the psychologist's involvement will be?
- The methods or techniques that will be used.

The intervention model of Morrill *et al* (1974) is designed to produce changes in clients, groups or institutions (Gibson & Mitchell, 1986). Hence the model has the potential of a broad range of possible interventions. It permits interventions in a variety of settings. It was convenient to implement this model in a children's home

where the caregivers were the clients or groups. The three dimensions of this intervention model alluded to are:

□ *The target of intervention*

Interventions may be aimed at:

- The individual
- The individual's primary group
- The individual's associational group
- The institution that influences the individual's behaviour

□ *The purpose of the intervention*

The purpose may be :

- Remediation
- Prevention
- Development

□ *The methods of reaching the target population*

The target population may be reached through:

- Direct professional involvement with the target.
- Consultation with other professional or paraprofessional.
- Indirect intervention using print or electronic media.

The observations of Gibson & Mitchell (1986) in the use of this intervention model resonate with the motivation for the study, viz.

- The interest of the psychologist,
- What the psychologist wants to achieve?

- What is the self-motivation?
- What are the rewards?
- What are the resources he is working with?
- What is perceived as the appropriate intervention for a given setting?

This intervention model is based on a continuum, spectrum or spiral view of prevention (Mrazek & Haggerty (1994). Psychologists and other professionals are coming to grips with the idea that traditional roles and delivery systems in human services may have imposed real limitations on their ability to deal directly and effectively with the critical needs of clients. This is a call also to become increasingly active in preventive interventions.

It is envisaged that the insights generated through intervention may lead to behavioural change. In this study intervention is underpinned by empowerment which is intended to make the caregiver more effective and efficient in her work with troubled children and youth at risk whose behaviour ought to improve concomitantly.

Intervention is dependent on various factors, *e.g.*, the authenticity of the researcher, its recognition that the “real” psychological interventions are typically carried out by non-professional community helpers and at least as effectively as professionals (Orford, 1992). A study found that 85000 children were attended to by non-government welfare services in children’s home (Duncan & Rock, 1994). These children interact with caregivers who are providing essential community helping

resources far in excess of the approximately 5000 psychologists or 10 000 social workers (Edwards, 2002). This implies that the critical need to optimise such resources becomes apparent (Edwards, 2002). A practical way to optimise this resource is through intervention and empowerment.

2.7 EMPOWERMENT

Empowerment is both a value orientation for working in the community and a theoretical model for understanding the processes and consequences to exert control and influence over decisions that affect one's life, organisational functioning and the quality of community life (Perkins & Zimmerman, 1995). In this study the emphasis is on empowerment as a theory that provides principles and for providing a framework (Zimmerman, 1995). Two views of empowerment relevant for caregivers are indicated.

Mechanic (1991) contends that empowerment is an intentional on-going process where individuals learn to see a closer correspondence between their goals and a sense of how to achieve them. There is also a relationship between their efforts and life outcomes (Mechanic, 1991).

Rappaport (1984) maintains that empowerment is viewed as a process, the mechanism by which people, organisations, and communities gain mastery over their lives.

These definitions suggest that empowerment is a process in which efforts to exert

control are central. In the context of the study self-control by the caregivers is the desired objective. An empowerment approach goes beyond ameliorating the negative aspects of a situation by searching for those that are positive. Thus enhancing wellness instead of fixing problems characterises an empowerment approach (Cowen, 1999). In this regard, Fawcett et al (1994) provide a framework of empowering strategies that focus on capacity building for individuals and groups and creating environments that support the development of empowerment.

A theory of empowerment includes both processes and outcomes (Swift & Levine, 1987). The theory suggests that actions, activities, or structures may be empowering, and that the outcomes of such processes result in a level of being empowered (Zimmerman, 1995). This empowering process helps one to understand one's social environment better. The process is empowering if it helps develop skills.

Empowerment at the individual level may be referred to as psychological empowerment (Zimmerman, 1990a). Psychological empowerment includes beliefs about one's competence. This belief and an insight into one's ability to be in control brings about self-mastery. This is enabling in that one can successfully negotiate the socio-political environment. An empowered person might be expected to exhibit a sense of personal control, a critical awareness of one's environment, and the behaviours necessary to exert control (Zimmerman,1995). Furthermore, the different dimensions of psychological empowerment can be identified as intrapersonal,

interactional and behavioural components (Zimmerman, 1995).

In this regard two studies suggest that psychological empowerment is a combination of personal beliefs of control, involvement in activities to exert control and a critical awareness of one's environment. In a qualitative approach to describe the development of psychological empowerment among community leaders it was reported that individuals felt more powerful as a result of involvement even if they did not gain more power (Kiefer, 1984).

In a quantitative study examining the common variance of perceived control in students and community samples it was concluded that the results support the notion of the desire to exercise control, and participation (Zimmerman & Rappaport, 1988). This view by Zimmerman and Rappaport (1988) accords with the understanding of mental health promotion as a form of general health promotion particularly aimed at activating positive health in terms of increased vitality in an empowered context (Edwards, 2002).

2.8 TOWARDS A THEORETICAL FRAMEWORK

The complexity of the study permits the location of the study from more than one theoretical perspective. An eclectic approach will serve the investigation adequately. In justifying intervention recourse has been made to the empowerment. Given the construction of the social reality of the participants and the setting, the investigation

best resides in the ecological theoretical framework.

The ecological model is concerned with person-environment relationships, systems fit and harmonisation in order to optimise resources. Lewin (1951) is recognised as the pioneer of this model in his,

$$B=F(P.E.)$$

i.e : “behaviour is function of person-environment relationships” (Orford, 1992).

If persons and their environment are interdependent in determining behaviour, this means people are a function of their environment and, or the environment is a function of people. In respect of this person and environment relationship, human behaviour may be viewed as a person’s adaptation to resources and circumstances (Levine & Perkins, 1987).

Levine & Perkins (1980) proposed five principles against which the work by caregivers in a children’s home provide a practical relevant example:

- Problems arise in situations that cause, exacerbate and maintain them.
- Some element in the situation or social setting blocks effective problem solving behaviour.
- Help has to be located in the situation where the problem arises.
- The goals and values of help and helpers should be consistent with the goals and values of the setting.
- Help should have potential for being systematised through using the

natural resources of the setting or through introducing resources that can become part of the setting.

The ecological focus is central to this study (Bishop *et al*, 2001). The ecological approach is represented in various ways, *e.g.*: Reiff (1968) uses six levels of analysis, *viz.*:

- individual
- family
- group
- community organisation
- community
- society

Bronfenbrenner (1977) described the ecological model in four categories, *viz.*:

- the micro- ecosystem
- meso- ecosystem
- exo- ecosystem
- macro ecosystem.

Considerations of the human environment necessitate knowledge of diverse systems involved in interaction (Hartman & Laird, 1983). These conceptual tools have been used to develop the ecological framework within community psychology at large. In the Australian conceptualisation of society, individuals exist at all levels and the

levels exist in humans (Bishop *et al*, 2001). This implies that people constitute social systems and social systems are people. The structure exists because of the common world views that are so powerful that we do not recognise the extent to which we are prisoners of this socially constructed reality (Sarason, 1984). In Dokecki's (1996) ecological model of research practice, the emphasis is on research at the qualitative macro-level. It is argued that the model provides the community with a metaphor that is easily understood. In reality, research needs to address all aspects simultaneously as people operate in all phases. The implication is that there is an emphasis on process as well as outcome.

In the context of this study of promoting the well-being of caregivers the four basic principles enunciated by Levine & Perkins (1987) have particular relevance, *viz.*:

- Change takes place in a social system and not just in an individual due to the interdependency in the social unit.
- Factors like time, money and power differentials define resource exchanges in community systems.
- There is a strong relationship between an individual's competence and his adaptation to change to the environment.
- The environment is not static. Change will not suit all groups simultaneously. At times there will be favourable conditions for one group and less favourable for the other. This allows for new and different levels of interactional equilibrium.

The defining feature of an ecological model is that it takes into account the physical environment and its relationship to people at individual, interpersonal, organisational levels. The implication is that behaviour does not take place in isolation and is an interconnected relationship. The theoretical and conceptual bases are derived from an ecological framework that acknowledges the embeddedness of people in social structures (Bishop *et al*, 2001).

2.9 RESUME

This chapter provided a conceptual background of critical aspects relevant to the caregiver functioning in a children's home. After an elaboration on promoting the caregivers psychological well-being, its attainment through intervention underpinned by empowerment was discussed. Though an eclectic approach appeared permissible, the theoretical framework for this study was located in an ecological model.

At the onset of the chapter a "doom and gloom" scenario was depicted through a brief explanation of "The Nobody's Child" song. The study envisages that after promoting the psychological well-being of the caregiver through intervention and empowerment he will have this positive effect on the troubled child and the youth at risk.

When children know that they are valued,
when they truly feel valued
in the deepest parts of themselves,
then they feel valuable.
This knowledge is worth more
than any gold.

The Road Less Travelled: Samuel Peck

Chapter Three will focus on the research methodology.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter of the study on promoting the well-being of caregivers in children's homes and thus improving the quality of life of children under their care elaborates on the main elements of research methodology. Methodology is regarded as the core concept underlying all research (Leedy, 1997). It is further explained by Leedy (1997, pp.9) that:

“the methodology controls the study, dictates the acquisition of data, arranges them in logical relationships, sets up a means of refining the raw data, so that the meaning that lies below the surface of those data becomes manifest and finally issues a conclusion or a series of conclusions that leads to an expansion of knowledge”

Thus, this chapter can be regarded as critical to this investigation of promoting the well-being of caregivers and the cascade effect it had on children in Site X where reference was made to some of the more general features of research that informed this study and explicated the whole data gathering process (Chetty, 2002). The salient features of this study were,:

- Research population and sample

- General methodological considerations
- Research tools
- Process of data gathering
- Limitations of the study

3.2 RESEARCH POPULATION AND SAMPLE

3.2.1 Population

A population is the aggregate of all cases that conform to some designated set of specifications (Kidder & Judd, 1986). The essential specifications for this study are child and youth careworkers or caregivers in children's homes.

The general population of this study ideally included all child and youth caregivers and children's homes in South Africa. At a provincial level the investigation concentrated on caregivers at children's homes in KwaZulu Natal.

It was intended to provide national and provincial statistics for children's homes and caregivers. Despite, various sources being solicited accurate details were not available. This will be addressed in the next chapter.

3.2.2 Sample

The study employed a purposive sampling plan. In the simplest case, a caregiver has the opportunity of being included in the investigation. The sample comprised

caregivers from two children's home confined to the greater Durban area of KwaZulu- Natal. See table four.

TABLE 4

Sample

Site	Treatment	Number of participants
Site X	The experimental group	seven participants
Site Y	The control group	six participants

The promoter of this study supervised the simple random selection and the assigning of the children's homes to the experimental or control group.

3.3 METHODOLOGICAL CONSIDERATIONS

This investigation is given research rigour through the following, viz.:

- Triangulated approach
- Research parameters
- Validity
- Reliability

3.3.1 Triangulated approach

Triangulation is a conscious combination of quantitative and qualitative methodology (de Vos *et al*, 2002). It is the use of multiple methods of data collection that

contributes to increasing the reliability of the observation (Mouton, 1998).

This is necessary because the researcher seeks out several different types of sources that can provide insights about the same events or relationships (Erlandson, Harris, Skipper & Atlen, 1993). Hence, triangulation permits making observations from multiple positions (Neuman, 2000). However, whether it is a source, position or a measure, the researcher uses a variety of strategies to study the same phenomena. The phenomena of this study is the well-being of caregivers in a children's home and the positive effects it had on children under their care,

This study presented an opportunity for triangulated methodology (Moyles & Suschitzky, 1997), which is a multi data-gathering technique. In this study the following techniques reflected in table five were employed, viz.:

TABLE 5

Research Approaches

Qualitative Approaches	Quantitative Approaches
Structured interview	Administration of questionnaires
Unstructured interview	
Needs assessment	
Focus groups	
Intervention	
Individual consultation	
Appreciative inquiry	
Use of journals	

Furthermore, a triangulated approach was appropriate for the caregiver's interactive ecological context (Bronfenbrenner, 1977). The caregiver interacted in Site X with the following people in the execution of her duties, *viz.*:

- The child and youth "at risk"
- Family of the child and youth "at risk"
- Full-time caregivers
- Day-assistant caregivers
- Senior child careworker
- Principal
- The public

Following the initial contact phase, an experimental design was employed where two children's homes were allocated to either an experimental or control group. There was a pre and post interview with the principal of the children's home Site X. Caregivers were pre-tested and post-tested on a quantitative measure, *i.e.* the Maslach burnout scale (1986). This quantitative assessment was analysed with the SPSS statistical package. After the needs assessment a comprehensive intervention was conducted with caregivers from the experimental group. Caregivers were encouraged to maintain a reflexive journal. Subsequent to the intervention, caregiver evaluation took the form of an appreciative inquiry (Cooperrider & Srivastva, 1987). There was also a focus group discussion. Selected children were assessed on the Conners (1989) behavioural questionnaire.

Triangulation has the following opportunities or advantages (Jick, 1983).

- Allows researchers to be more confident of their results through the overall strength of the multi-method design.
- May also help to uncover the deviant dimension of a phenomenon.
- Divergent results from the multi-method approach can lead to an enriched explanation of the research problem. This study experienced this challenge with a satisfactory outcome.
- The use of multi-methods can lead to a synthesis or integration of theories.

3.3.2 *Research parameters*

Any study presents the possibility of a plethora of data within the parameters of that particular investigation. Such data is fundamental to validating the critical questions and confirms the findings of the study. Nevertheless, instead of data collection being overwhelming it could be parsimonious yet elegant Jansen (1998). Notwithstanding, this study employed a triangulated approach (Moyles & Suschitzky, 1997) that combined the best features of a variety of approaches drawing from qualitative and quantitative methodology. This approach had the promise of creativity and innovation, which helped to enrich the data collection (Vithal & Jansen, 1998). The intervention component, the use of journals, the appreciative inquiry, the focus group, the behaviour profile of children and responses from the interviews with the principal were some of the qualitative strategies that were creatively employed that enhanced the validity of the study.

3.3.3 Validity

Validity is an attempt to “check out” whether the meaning and interpretation of the research instrument is sound (Vithal & Jansen, 1998). It is also noted by Leedy (1997) that validity is about soundness of the measuring instrument. Validity also refers to the degree that an instrument adequately reflects the real meaning of the concepts under consideration (Yegadis & Wembach, 2002).

The following are important distinguishing features of the validity of the measuring instruments (Leedy, 1997) of this study, *viz.*:

- **Face validity:** This type of validity relies basically on the subjective judgement of the researcher. The Maslach burnout inventory (1986) was chosen in that the three constructs or subscales, *viz.*: emotional exhaustion, depersonalisation, lack of personal accomplishment were adequate to establish the psychological well-being of caregivers. The Conners (1989) rating scale was chosen to determine how the effects of the caregivers’ self-empowerment impacted the behaviour change of the children under their care.

- **Content validity:** This type of validity, which is sometimes equated with face validity refers to the accuracy with which an instrument measures the factors under study (Leedy, 1997). Caregivers are human service providers who spent considerable time in intense involvement with numerous role players in the children’s home in Site X. This social context was a demanding environment

that constantly drew on the caregiver's emotional resources that had implications for her psychological well-being. The study attempted to elicit this information.

- Internal validity: Internal validity is the freedom from bias in forming conclusions in view of the data (Leedy, 1997). The study established that, the changes in the dependent variable, the perceptions of caregivers in children's homes, were the results of the influence of the independent variable, the intervention, rather than the way the research was designed.
- External validity: This type of validity is concerned with the generalisability of the conclusions reached through observation of a sample to the universe.(Leedy, 1997). The generalisations from a small sample size in this study cannot be applied to the universe of caregivers.

The study was informed by the Maslach burnout inventory (1986). The use of an experimental design permitted a pre and post test which made possible comparisons of whether the promotion of the caregiver's psychological well-being through the comprehensive interventions was effective. An appreciative inquiry (Cooperrider & Srivistava, 1988), the maintaining of a journal, information from the focus groups and the data from Connors (1989) provided validation data in explaining the outcomes of the Maslach burnout inventory (1986).

3.3.3 Reliability

Reliability is about the consistency of a measure, score or rating (Vithal & Jansen,

1998). An instrument is reliable when it consistently measures the factors for which it was designed (Leedy, 1997). There are a number of methods that establish reliability. One such technique is reliability coefficient, (r), a measure which ranges from $r = 0$ to $r = 1$ (Vithal & Jansen, 1998). However, a score over $(0,70)$ is acceptable, but the higher the score the better the evidence that items in the instrument are measuring the same trait (Leedy, 1997).

Both the Maslach burnout inventory (1986) and the Conners rating checklist (1989) were reliable instruments for this study as they satisfied basic reliability coefficient conditions (Leedy, 1997).

3.4 RESEARCH TOOLS

3.4.1 Quantitative Measures

It should be considered mandatory to state clearly and definitively the specifications of the measuring instrument (Leedy, 1997). Such a requirement will ensure the integrity of any research (Leedy, 1997). In this regard further important characteristics with respect to measuring instruments (Leedy, 1997) are:

- There should be overall review of the instrument. Both the MBI (1986) and the Conners (1989) were reviewed against other instruments before they were considered appropriate for this study.
- Evaluate its applicability in the study. Psychological implications of well-being are wide-embracing. Burnout is indicated for human service providers

work performance (Maslach, 1986). The MBI (1986) was normed on child care protection services. Thus the MBI (1986) was suited to establishing performance related well-being of caregivers. The Conners (1989) rating scale assessed the behaviour of the children in Site X.

- The type of data the instrument generated. Both the MBI (1986) and the Conners (1989) produced data which permitted group and individual analyses and comparisons.
- Describe the instrument in terms of its appearance. The MBI (1986) and the Conners (1989) were adequately described.

The study utilised two measuring instruments that yielded quantitative data, viz,:

- ❖ Maslach burnout inventory
- ❖ Conners rating scale

3.4.1.1 Maslach Burnout inventory (MBI)

□ Preamble

The MBI was chosen to determine relevant aspects of caregivers' psychological well-being. In the performance of their duties caregivers were involved in social interactions on a daily basis, which drew on their inner psychological resources and coping mechanisms that impacted their psychological well-being.

The MBI assessed three aspects of the caregiver's psychological well-being :

- emotional exhaustion
- depersonalisation
- lack of personal accomplishment.

Each of these aspects is measured by a separate subscale. The emotional exhaustion subscale assesses feelings of being emotionally overextended and exhausted by one's work. The depersonalisation subscale measures an unfeeling impersonal response towards recipients of one's service, care, treatment or instruction. The personal accomplishment subscale assesses feelings of competence and successful achievement in one's work with people. The frequency that the respondent experiences feelings on each subscale is assessed using a six-point, fully anchored response format. Burnout is conceptualised as a continuous variable, ranging from low to moderate to high degree of experienced feeling. It is not viewed as a dichotomous variable, which is either present or absent.

□ Administration

The MBI takes about ten to fifteen minutes to fill out. It is self-administered. Complete instructions are provided for the respondent.

□ Reliability

Reliability coefficients reported here were based on samples that were not used in the item selections to avoid any improper inflation of the reliability estimates. Internal consistency was estimated by Cronbach's coefficient alpha ($n = 1,316$). The reliability coefficients for the subscales are reflected in table six.

TABLE 6**MBI Reliability Coefficient**

Subscale	Reliability Coefficient
Emotional exhaustion	<i>0,90</i>
Depersonalisation	<i>0,79</i>
Personal accomplishment	<i>0,71</i>

The standard error of measurement for each subscale is indicated in table seven.

TABLE 7**MBI Standard Error of Measurement**

Subscale	Standard error of measurement
Emotional exhaustion	<i>3,80</i>
Depersonalisation	<i>3,1116</i>
Personal accomplishment	<i>3,73</i>

Data on test-retest reliability on two separate samples are noted in table eight.

TABLE 8**MBI Test-Retest Reliability**

Subscale	Graduate Students on Social Welfare (n = 53)	Teachers (n =248)
Emotional Exhaustion	<i>0,82</i>	<i>0,60</i>
Depersonalisation	<i>0,60</i>	<i>0,54</i>
Personal Accomplishment	<i>0,80</i>	<i>0,57</i>

- Convergent validity and discriminant validity of the MBI are addressed.

Convergent validity was demonstrated in the following ways, *viz.*:

- External validation of personal outcomes

Evidence of outside observers independent assessments of an individual's experience corroborate the individual's self-rating. As predicted people who were rated by co-workers as being emotionally drained by the job scored higher on emotional exhaustion and depersonalisation. Furthermore, people who were rated as appearing physically fatigued also scored higher on emotional exhaustion and depersonalisation.

- Dimensions of the job experience

The validity of the MBI is demonstrated by examining the relationships between various job characteristics and experienced burnout. When caseloads were very large, scores were high on emotional exhaustion and depersonalisation and low on personal accomplishment.

- Personal outcomes

Additional validation of the MBI is provided by data that confirm hypothetical relationships between experienced burnout and various outcomes or personal reactions. Maslach predicted and found support that people experiencing burnout would be dissatisfied with opportunities for personal growth and development on the job.

Discriminant validity of the MBI was obtained by distinguishing it from measures of other psychological constructs *e.g.* burnout experience maybe nothing more than dissatisfaction with one's job.

3.4.1.2 Conners rating scale -revised

□ Preamble

The Conners' rating scales-revised (CRS-R) is the standard instrument for assessment of attention-deficit/hyperactivity disorder and behaviour problems in children and adolescents (Conners, 1989). While the primary focus of the study is the promotion of psychological well-being of caregivers in Site X, it purported to determine the cascade effect it had on improving children's behaviour under their care. It is used as part of a comprehensive examination of children between the ages of three and seventeen (Booth, 2003). It is noted by Conners (1997) that the scales of the short version include:

- Oppositional
- Cognitive problems/inattention
- Hyperactivity
- ADHD index

□ Administration

There is a long version and a short version. In both versions respondents indicate the frequency of behaviours observed in the child during the previous month (Pedigo & Erford, 1999). Frequency of behaviour is determined according to the following descriptors (Pedigo and Erford, 1999):

- Not at all
- Just a little
- Pretty much
- Very much

The CRS-R generally takes under twenty minutes to complete. However, respondents with reading difficulties or whose mother tongue is not English may take longer to complete the form (Conners, 1989). The short forms are ideal for pre and post treatment research designs. (Conners, 1989). It is for this reason that the study made use of the Conners (1989) as a pre and post test research tool.

□ Norming

CRS-R was normed on several large samples of children and adolescents. Over 8000 cases made-up the normative sample. Ratings as well as information on ethnicity, sex, age, socio-economic status and geographic location were gathered. The CRS-R parent version has been developed to assess problem behaviours reported by parents and the normative data for these revised scales came from the ratings of more than 2000 parents (Conners, 1989).

□ Reliability

The coefficient alphas for internal reliability were highly satisfactory for the normative groups. For the long form there was a range from 0,728 to 0,942 and from 0,857 to 0,938 for the short form indicating that the subscales are accurate in measuring the constructs they were intended to measure. The test-retest reliability studies demonstrated the temporal stability of CRS-R (Conners, 1989).

□ Validity

The CRS-R underwent extensive validity studies, demonstrating its factorial, convergent and discriminant validity (Conners, 1989). Factorial validity was tested for exploratory and confirmatory factor analysis and subscale inter-correlations

approaches. Correlations range from 0,97 to 0,98 for males and from 0,96 to 0,97 for females (Pedigo & Erford, 1999). As part of a multimodal assessment, the CRS-R can provide valuable information regarding behaviour as observed by a child's parent or guardian (Pedigo & Erford, 1990). In this study the caregivers in Site X recorded observations on the CRS-R of children under their charge.

3.4.2 *Qualitative Approaches*

This study lent itself to descriptive statistics that refer to procedures for organising, summarising and describing information or data (McCall, 1980). Descriptive statistics are largely employed when the research also has a qualitative orientation.

Qualitative research is an inquiry process of understanding a social or human problem based on building a complex, holistic process formed with words, reporting detailed views of informants and conducted in a natural setting (Creswell, 1994). The human problem in this study concerned the promotion of the psychological well-being of caregivers and the improvement of the behaviour of children under their care. The natural setting is the children's home, Site X, which is the place of employment of the caregivers.

The task of qualitative research is to interpret and understand how participants construct the world around them (Glesne & Peshkin, 1992). This study endeavoured to establish how caregivers in Site X constructed their world around children that are in their care. This makes qualitative research a dynamic process. It allowed for

adaptation as the research inquiry developed. This study had to accommodate changes and developments as the process unfolded. It was not possible to strictly follow the negotiated intervention schedule. Due to work-related reasons, personal matters, family or health emergencies, of both the caregivers and the researcher, schedules had to be regularly re-arranged. It was indeed a challenge to sustain the involvement, motivation and commitment of the caregivers through fourteen sessions each of between one and two hours duration.

Often, qualitative researchers are described as the research instrument (Leedy, 1997) since the researcher is involved in the natural setting engaging the participants directly or indirectly. In this study, the researcher interacted with all the participants individually and as groups at different times of the day and various venues on Site X. This gave the investigator the further opportunity of observing a range of behaviours related to this research (Glesne & Peshkin, 1992). When qualitative researchers observe the specifics of a situation they increase their understanding of the broader phenomenon, of which the situation is the instance (Leedy, 1997). In this regard, other challenges in children's home became evident, *e.g.* concerns of management, academic deficits of children and inter-personal dynamics to name a few investigative phenomena. It emerged that this children's home abounded richly in research possibilities.

The following multi-data measures of a descriptive nature were employed, *viz.:*

- Structured interviews
- Unstructured interviews
- Needs assessment
- Questionnaire
- Intervention
- Individual consultations
- Focus groups
- Appreciative Inquiry
- Use of journals

3.4.2.1 Structured and unstructured interviews

According to Anastasi, (1982), interviews may vary from the highly structured through patterned or guided interviews covering certain pre-determined areas to non-directive interviews in which the interviewer merely sets the stage and encourages the interviewee to talk as freely as possible. Interviews provide chiefly two kinds of information (Anastasi, 1982), *viz.:*

- They afford an opportunity for direct observation of a limited sample of behaviour.
- It also elicits life-history data. The principal of the children's home participated in such interviews.

3.4.2.2 Needs assessment

Needs assessment are concerned with discovering the nature and content of a

particular social problem to determine the most appropriate response (Mouton, 1998). There are different ways in which needs assessment can be executed. Information can be obtained from existing sources or the gathering of new information (de Vos *et al*, 2002). Furthermore, the gathering of new information through the use of a small group or key informants in needs assessment is referred to as an impressionistic approach (de Vos *et al*, 2002). This study used a small sample of caregivers from Site X. The use of key informants means that the opinions are asked of a small number of people known to be involved with the service needed or the client group which may include child protection workers (de Vos *et al*, 2002). The responses will help in the planning of the interventions to meet the needs expressed. Generally a positivist approach is used for needs assessment, since most needs assessment are concerned with the generalisability of results rather than the in-depth understanding of how people experience problems (Mouton, 1998). Needs assessments were conducted with the caregivers from Site X, the experimental group, and the participants from Site Y, the control group. The intervention incorporated some of the outcomes from the needs assessment conducted with the caregivers.

3.4.2.3 Questionnaire

A questionnaire is a set of questions on a form which is completed by the respondent in respect of a research project where the questions can be opened or closed (de Vos *et al*, 2002)

Questionnaires are probably the most generally used instruments in research. The basic objective of a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue (de Vos *et al*, 2002). The questionnaire is usually distributed through the post to be filled in by the respondent. Sometimes, the questionnaire is completed under the supervision of the researcher. While many questionnaires seek factual information others are concerned with obtaining opinions and attitudes.

Questions may be asked in a closed or in an open form or in combination. The closed form facilitates answering and makes it easier to code and classify responses. The open form enables the respondent to state his case freely and to give possible reasons. The open form evokes a fuller and richer response. The needs assessment in this study with caregivers was done through the use of an open form questionnaire. The economic principle, where respondents must communicate as much as possible in the briefest possible time, is the recommended approach (de Vos *et al*, 2002). The needs assessment questionnaire contained three questions which took less than ten minutes to complete.

After having gained successful entry and establishing rapport with caregivers in Site X, a needs assessment questionnaire was administered. The same needs assessment questionnaire was administered to the caregivers, the control group, in Site Y prior to

conducting the pre test on the Maslach burnout inventory (1986). Issues gleaned from the needs assessment were some of the empowerment themes addressed during the intervention sessions that were designed to promote caregiver's well-being and improve children's behaviour.

3.4.2.4 Intervention

Intervention is an exciting new idea of applied research that should be useful to many human professions (de Vos *et al*, (2002). Furthermore, in recent years service delivery has shifted strongly towards providing intervention services (Tilly 111 & Flugum, 1995). According to Flugum & Reschly (1994) the following are some indices of quality intervention,:

- An operational definition of the problem, *i.e* promoting the psychological well-being of caregivers.
- A direct measure of the behaviour in the natural setting prior to the intervention, *i.e* pre-test information based on the Maslach burnout inventory (1986) and the Conners rating scale (1989) at site X.
- A step by step intervention plan, *i.e* fourteen sessions were designed.
- Implementation of the intervention, *i.e* as per schedule. See table nine.
- Comparison of post-intervention performance with baseline data, *i.e* pre and post test results on the SPSS package of the two quantitative instruments used in this study.

TABLE 9

Intervention

Session	Intervention
1	General Session
2	Journey of Self Discovery
3	Enhancing Self Esteem
4	Enhancing Self Concept
5	Discipline without Tears
6	Inter-personal relationships
7	Parenting Skills
8	Self Care
9	The Fragile Child
10	The School and the Child
11	The Family and the Child
12	The Community and the Child
13	Helping Skills
14	Cultural Diversity

3.4.2.5 Consultation

As part of the data-gathering individual consultations were scheduled with the

caregivers. Consultation has become a major approach in providing psychological services (Kratochwill *et al*, 1995). The three major models of consultation used most frequently are mental-health, organisational-development and behavioural consultation (Kratochwill *et al*, 1995).

The most widely recognised feature of consultation is its indirect service delivery approach (Bergan & Kratochwill, 1990). In this context, services are delivered by the researcher (consultant) to the caregiver (consultee) who in turn provided services to a child or youth “at risk” in the children’s home. The goal then was for the caregiver to improve her skills that empowered her to respond effectively to future problems. This approach was advantageous in that it allowed for more children to benefit compared to the direct approach.

The interpersonal relationship between a psychologist and a client is assumed to play a major role in the use and effectiveness of consultation (Kratochwill *et al*, 1995). This was true also for the relationship between the researcher and the sample of the experimental group. Through trust, genuineness and openness (Conoley & Conoley, 1992; Martin, & Breezley 1977), the researcher developed a productive and beneficial working relationship with the caregivers. A constructive and professional interaction was thus established and maintained which yielded mutual benefits for the caregivers, the children and the researcher. Consultations were scheduled at times that were convenient for the caregiver. A basic and planned approach was structured for each

caregiver viz.

- Rapport was established.
- Personal issues were briefly addressed.
- Feedback on selected children was obtained.
- Components of the appreciative inquiry were obtained
- Conclusion

Each caregiver was allowed between sixty and ninety minutes. The responses were manually recorded. Since time was an over-riding issue, follow-up consultations could not be arranged. Consequent to the individual consultations, a focus group was a logical follow through.

3.4.2.6 Focus groups

Monette, Sullivan & de Jong (1998) describe focus groups as an interview with a whole group of people at the same time. However, focus groups are now also used as a strategy for collecting data in their own right (Monette *et al*, 1998).

A focus group usually consists of a facilitator and a small group of participants. It is the task of the facilitator to guide discussion in an organised manner around a set of pre-determined guidelines. At the same time the focus of the study which was the promotion of psychological well-being of the caregivers, was the main issue under consideration. Thereafter, the moderator (researcher) of the focus group directed the

group discussion from general topics in the beginning to more specific issues towards the end of the session (Kreuger, 1986). Since the focus was fast-paced there was no data analysis during the process. The information was recorded and analysed subsequently.

Kreuger (1994) reports that data from a focus group is recorded in the following manner:

- row data format
- descriptive approach
- the interpretive model

The nature of this study permitted the use of both the descriptive and interpretive models. Focus groups have both advantages and disadvantages (Monette *et al*, 1998).

The advantages are its flexibility, lower cost, and provision of quick results (Monette *et al* 1998). Furthermore, focus groups use the interaction between people to stimulate ideas and encourage group members to participate (Monette *et al*, 1998).

Some of the disadvantages are, that results cannot be generalised to a larger population, data is subjective and that focus groups are less likely to produce quantitative data (Monette *et al*, 1998).

One of the key aspects addressed in the focus group session was appreciative inquiry.

3.4.2.7 Appreciative Inquiry

The philosophy of appreciative inquiry is expressed as a set of principles that together convey the set of beliefs and values that guide practice. Appreciative inquiry is informed by four principles (Cooperrider & Srivastva, 1987) viz.:

- Research should begin with appreciation
- Research should be applicable.
- Research should be provocative.
- Research should be collaborative.

This study met these criteria adequately. A genuine culture of appreciation was maintained throughout the study from its inception, during every session and at the conclusion of the investigation. The caregivers acknowledged the appreciation of the researcher. The applicability of the study resided in the empowerment of the caregivers that contributed to the promotion of their psychological well-being. The study was provocative as it addressed a critical issue of people who take care of a nation's assets that have been given scant attention in research. Collaboration was maintained for a sustained period with the caregivers, the children and the principal of Site X. There is an understanding that appreciative inquiry originated from social constructivism and organisational development (Bushe, 1995). This study was about the social construction of the caregivers and their well-being development at site X. Appreciative inquiry feedback contributed to the validity of the study.

3.4.2.8 Use of journals

Personal documents, including autobiographies, letters, diaries and essays are open to social scientific observation, once obtained (Kidder & Judd, 1986). The use of personal documents, journals, can achieve for inner experiences such as beliefs and attitudes what observational techniques can achieve for overt behaviour (Kidder & Judd, 1986). All journals should be continuously maintained as essential elements of exploring one's values and interests (Rodwell, 1998).

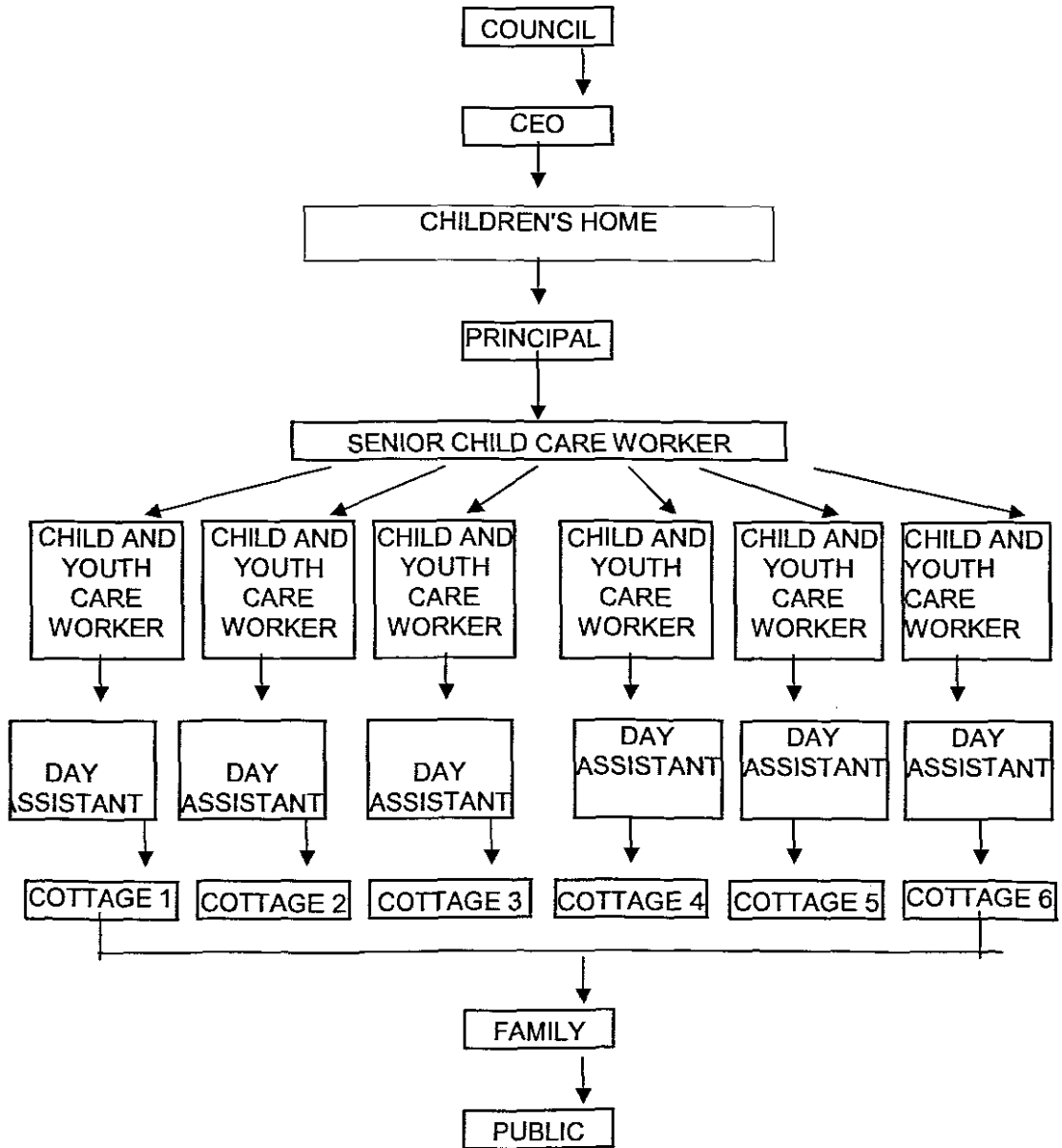
Constructivism takes full advantage of the richness of the interaction complexity in all its subjectivity (Rodwell, 1998). However, implicit in the lack of objectivity in constructivism is a need for balance and fairness. The use of a reflexive journal assures methodological rigour (Rodwell, 1998). The journal can be regarded as an important mechanism for documenting the dependability of the research process (Rodwell, 1998). The use of journals in this study gave descriptive insights into the struggles, challenges and progress towards psychological well-being of caregivers and improvement in selected children's behaviour.

3.5 THE PROCESS OF DATA COLLECTION

The contextual setting in the children's home permits this study to appropriately employ Bronfenbrenner's (1977) ecological model. This is illustrated in table ten.

TABLE 10

Ecological arrangement at Site X



The following comprehensive arrangements facilitated the data collection, viz.:

- Children's Home X was randomly selected. The process was endorsed by the promoter of the study. Thereafter, the CEO of Children's Home X was appraised.
- The Director of Children's Home Y, the control variable was also appropriately informed.
- Meetings were scheduled with the Principal of the Children's Home X to negotiate entry.
- There was an introductory meeting with the participants of the study where basic arrangements were entered into and a needs assessment was undertaken.
- The pre-test questionnaires were administered to both groups.
- Group intervention sessions were organised and presented.
- Individual consultations were conducted.
- Focus group session conducted.
- Appreciative inquiry was facilitated
- Exit session with group
- Structured interview with Principal.

3.6 DATA ANALYSIS AND INTERPRETATION

Data gathered from questionnaires was captured and coded. This was possible because of the small sample. The semi-structured interview was manually recorded. The documents were analysed as they became available.

3.7 LIMITATIONS OF RESEARCH METHODOLOGY

According to Vithal & Jansen (1998) acknowledging limitations provides insights into the constraints that were imposed on the study and to understand the context in which the research claims are set.

This study on promoting the well-being of caregivers worked within the following limitations:

- Considering the small size of the sample, this study has the usual problem of generalisability. The study will not be generalisable to all areas of child and youth care work.
- One of the participants from Site X, the experimental group, withdrew due to a major illness. At the latter stages of the study another participant was dismissed by management due to a serious disciplinary matter.
- It was difficult to follow the arranged schedule. The participants were either unwell, absent or attending to emergencies during the pre-arranged and negotiated time. The researcher also had to reorganise intervention sessions due to work demands, health issues and family circumstances.
- The participants were not very articulate and this hampered communication at times.
- Control groups were reluctant to participate. The concern was that confidentiality would be breached (Chetty, 2002). After much effort a control Site was obtained after the study was well underway.

3.8 RESUME

A comprehensive data-gathering approach suggested that both qualitative and quantitative methods were necessary for evaluation of this study. Thus, this chapter contextualised the research strategies for data collection. It addressed the choice, design and administration of the research tools for the study. The data recording and analysis is documented in the next chapter.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The focus of this chapter is the analysis of the data generated in this study. It attempted to unpack the following critical questions from the data produced :

- Why promote the well-being of caregivers?
- How can the well-being of caregivers be promoted?
- How can empowerment benefit caregivers?

The information on these questions is also reflected in tables or summarised in the appendices. Thus, detailing the data management process and setting the context for an analysis of the data developed this chapter. A uniform approach was adopted in this and the preceding two chapters that ensured consistency and ease of reference.

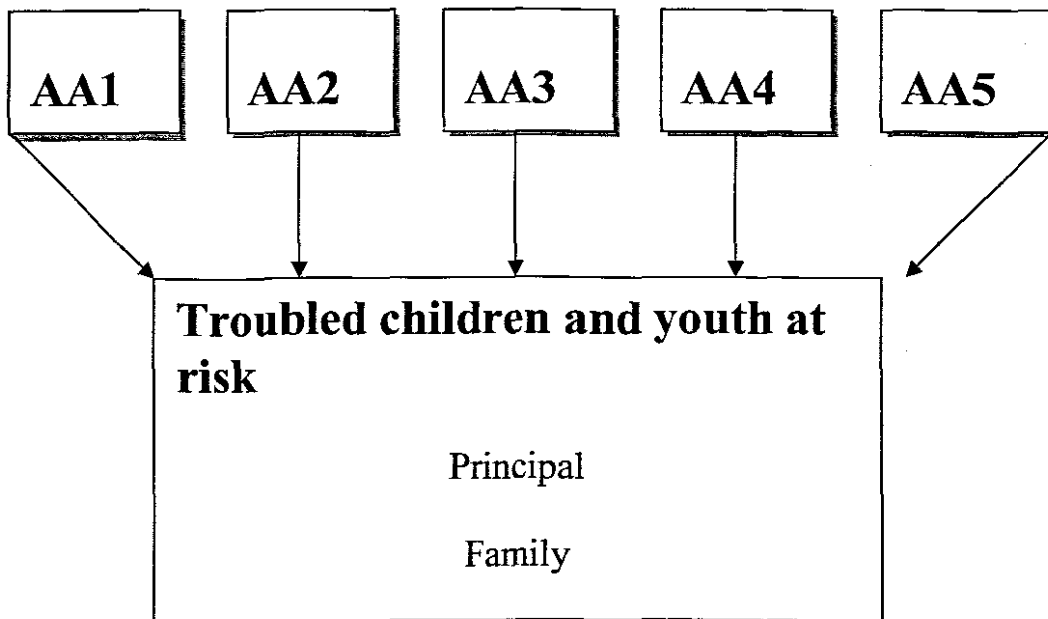
This study was predicated on the ecological model. However, all elements originally referred to were not reported as that was outside the scope of this study. The focus was on promoting the well-being of caregivers and bringing about improved and quality care of the children under their charge.

Flow chart one is a revised representation as the original sample was reduced. Hence, the reference was confined to the interacting dynamics between the remaining

caregivers and the key role-players indicated diagrammatically. Special attention was paid to the interaction among the caregivers, the children under their charge and the Principal. Passing reference was made to the contact by the caregivers between the family of care-receivers and the community.

Flow chart One

Revised ecological context at Site X



After relevant comments on the general population and the purposive sample, there was a comprehensive analysis of the two quantitative techniques followed by a

detailed descriptive discussion on the different qualitative techniques. Appropriate summaries synthesised the main findings. A resume concluded the chapter.

4.2 POPULATION

The contextual focus of this study was children's homes in South Africa. The general population at the children's home included all role- players and stakeholders that are directly and indirectly involved in providing care for children at risk and troubled youth. Since the focus of this study was child and youth careworkers or caregivers, this excluded the other diverse elements of the general population.

However, it was problematical to obtain statistics for the general population of caregivers in South Africa. Extensive attempts were made to elicit this information from official, non-governmental and community-based organisations. There was tremendous bureaucracy. Eventually, it was reported that accurate statistics were not available presently as they were still being compiled (Allsopp, 2006). Childcare work is an emerging profession and a professional board has been constituted which is in the process of gathering statistics and presently this information has not been finalised (Allsopp, 2006). The study was not compromised in any manner without general population statistics.

4.3 SAMPLE

The focus of this study were the caregivers in children's home in the greater Durban area. The experimental group sample was designated, Site X and the control group sample was designated, site Y. Comprehensive details on the purposive sample, Site X and basic details on the control groups Site Y are furnished.

4.3.1 Site X - Experimental group

Essential details from the experimental group are explained.

4.3.1.1 Number

The original purposive sample was seven. By the conclusion of the study the sample was reduced to five. One caregiver fell seriously ill and could not continue as a participant and the other caregiver was dismissed for disciplinary reasons. Small samples compromise statistical significance. The study experienced this as a threat to the validity of the investigation. However, the multi-data qualitative techniques and findings adequately compensated for the small sample size.

4.3.1.2 Locality

The sample for the experimental and control groups were obtained from children's homes in the greater Durban area of KwaZulu Natal. The experimental group was referred to as Site X and the control group was referred to as Site Y.

4.3.1.3 Biographical data

Biographical data was obtained from the participants of Site X. General information about gender, age, qualification, and educational background and experience was elicited.

4.3.1.3.1 Gender

All the caregivers here are females. In residential child settings, issues of discrimination are likely to favour women, as there is bias against men when a job is stereotypically regarded as female (Kiraly, 2001). Furthermore, females have traditionally been caregivers at this Site X for many years (Principal, Site X). See table eleven.

TABLE 11

Gender of caregivers : Site X

Gender	Number
Male	0
Female	5

4.3.1.3.2 Age

Middle-aged and older women are employed in the residential setting. One is relatively young and four are slightly mature women. In the change process the younger caregiver is expected to adapt more easily than her senior colleagues. Age was not a significant criterion as all five participants, despite their age variance responded enthusiastically to the intervention aspect of the study. See table twelve

TABLE 12

Age of caregivers : Site X

Age	Number
21 to 24 years	0
25 to 29 years	0
30 to 39 years	1
40 to 49 years	2
50 to 59 years	2

4.3.1.3.3 Experience

Two of the caregivers have just recently commenced at Site X. One of the caregivers had less than ten years of experience. Two of the more experienced caregivers had less than fifteen years. There appears to be a tenuous working relationship among the caregivers. The more experienced have taken on the responsibility to mentor the new and younger and recently joined caregivers. The experienced caregivers give the impression of being more insightful, dependable, mature and independent. The newer caregivers have more drive and are adventurous. There is a good blend of old and new in this child care environment. See table thirteen.

TABLE 13

Experience of caregivers : Site X

No. of years	Number
1 to 5 years	2
6 to 9 years	1
10 to 14 years	2
15 to 20 years	0
20 to 25 years	0

4.3.1.3.4 Marital Status

Two of the caregivers are married. The other three are single. Four of the caregivers have children. None of the children lived with the caregivers. It emerged that this was a problematical situation. Caregivers observed that they passionately take care of children at a children's home, yet they could not give attention to their own children. This gave rise to further considerations like the possibility of children living with their mothers. If the children's cottage was to simulate the traditional "home" condition,

then there is an argument for children and spouses of caregivers' families living together in this residential setting. See table fourteen.

TABLE 14

Marital status of caregivers : Site X

Marital status	Number
Single	4
Married	1
Divorced	0
Widow/er	0

4.3.1.3.5 Qualifications

Three caregivers basic schooling is below grade twelve. Two have attained grade twelve. The new schooling system provides for completion of formal schooling at grade ten which ought to equip a learner to be basically employable. However, minimum requirements for tertiary admission is grade twelve. A key function of the caregiver is to be involved in the child's education in a supervisory role outside school. Difficulties in assisting children in the higher grades are inevitable where caregivers do not possess at least a matriculation qualification. It was noteworthy that caregivers have either completed or are completing their basic child care qualification (BCCQ). See table fifteen.

TABLE 15

Qualifications of caregivers : Site X

Qualifications	Number
Standard Six : Grade 08	1
Standard Seven : Grade 09	1
Standard Eight : Grade 10	0
Standard Nine : Grade 11	1
Standard Ten : Grade 12	2
BCCQ	5

4.3.1.3.6 Number of working hours per week. Nil response.

No data was important data. Lack of uniform and normative working hours was raised as a major concern for the caregivers and a militating factor in the optimum performance of their roles and responsibilities.

4.3.1.4 Summary of Site X sample

Site X is a female-oriented caregiver environment. The caregivers are mature, experienced with basic school qualification. The issue of biological children living with the caregivers was raised . It was significant in the context of the study of promoting their well-being that caregivers did not respond to the question of the number of working hours per week.

4.3.2 Site Y - Control group

Essential details from the control group are explained.

4.3.2.1 Gender

There are six caregivers in the control group. Unlike the traditional norm one of the caregivers is a male. See table sixteen.

TABLE 16

Gender of caregivers: Site Y

Gender	Number
Male	1
Female	5

4.3.2.2 Age

The caregivers from the control group comprised largely middle-aged personnel whose ages ranged from thirty to forty nine years. See table seventeen.

TABLE 17

Age of caregivers: Site Y

Age	Number
21 to 24 years	0
25 to 29 years	0
30 to 39 years	4
40 to 49 years	2
50 to 59 years	0

4.3.2.3 Experience

Five of the caregivers are experienced personnel with the sixth one having just recently joined. See table eighteen.

TABLE 18

Experience of Caregivers : Site Y

No. of years	Number
1 to 5 years	1
6 to 9 years	2
10 to 14 years	3
15 to 20 years	0
20 to 25 years	0

4.3.2.4 Marital Status

All six caregivers are single. This had implications for the simulated family context that could be considered for children in residential care settings. See table nineteen.

TABLE 19

Marital status of caregivers: Site Y

Marital status	Number
Single	6
Married	0
Divorced	0
Widow/er	0

4.3.2.5 Qualifications

One caregiver matriculated and the qualification of the other five ranged from grade ten to eleven. See table twenty.

TABLE 20

Qualifications of caregivers : Site Y

Qualifications	Number
Standard Six : Grade 8	0
Standard Seven : Grade 9	0
Standard Eight : Grade 10	2
Standard Nine : Grade 11	3
Standard Ten : Grade 12	1

4.3.2.6 Number of working hours per week. Nil response.

The control group also did not respond to the number of hours worked per week.

4.3.2.7 Summary of Site Y caregivers

The details of the control group are indicated for brief comparisons. The following needs to be pointed.

- **Age** : There was little difference in the age range of both groups.
- **Gender** : There was a male in the control group.
- **Marital Status** : Except for one married caregiver in the experimental group, the others in both groups were single persons.
- **Experience** : The level of experience in both groups are almost similar.
- **Qualifications** : Two caregivers in the experimental group and one colleague from the control group matriculated.
- **Hours worked** : It was significant that neither group indicated number of hours worked per week.

4.4 NEEDS ASSESSMENT

The needs assessment was determined at different levels. During the initial and unstructured interview with the principal she mentioned her general concerns about the caregivers and the children. These concerns were noted and taken into consideration.

Thereafter, a needs assessment was conducted with both the experimental and control groups prior to the intervention process. Some of the issues referred to by the

caregivers in the needs assessment were incorporated in the comprehensive intervention programme.

An analysis of the items from the needs assessment revealed three categories of needs, viz.:

4.4.1 Children-related needs

The caregivers pointed out that children under their care manifested the following,

viz.:

- Behaviour problems
- Large numbers contributing to unmanageable supervision.
- Peer pressure
- Anti social habits
- Drugs
- Alcohol
- Promiscuity

4.4.2 Caregiver employment-related needs

The following were employment-related concerns indicated by the caregivers, viz.:

- Conditions of service
- Salary
- Housing
- Medical aid

4.4.3 Caregiver psychologically-related needs

- Lack of intrinsic motivation
- Burn out
- Poor interpersonal skills
- Negative self esteem and low self- worth
- Inadequate listening skills
- Lack of helping skills
- Invisible transformation
- Cross cultural misunderstanding
- High stress
- Pressure situations
- Low morale

4.4.4 Summary of needs assessment

Some of these concerns were also expressed by the principal and revealed in the MBI. completed by caregivers. Hence, the intervention was structured in a way that the themes resonated with some of these concerns. The incorporation of these concerns made the intervention meaningful, addressed important expressed needs and generated self-improvement. This conscious change in behaviour impacted positively to an extent on some of the children and an improvement in the general ethos in each cottage.

4.5 QUANTITATIVE TECHNIQUES

Two quantitative techniques were administered. Pre and post data were obtained for caregivers from Site X and Site Y using the Maslach burnout inventory. Selected children from Site X were tested on the Conners rating scale and pre and post data were gathered. Detailed interpretation on the MBI and the Conners follows.

4.5.1 Maslach Burnout Inventory (MBI)

The MBI is designed to assess three aspects of burnout syndrome that were relevant in the context of the study for the psychological well-being of caregivers.

Emotional Exhaustion

The emotional exhaustion subscale assessed feelings of being emotionally overextended and exhausted by one's work

□ Depersonalisation

The depersonalisation subscale measured an unfeeling and impersonal response towards recipients of one's care or service.

□ Lack of personal accomplishment

The personal accomplishment subscale assessed feelings of competence and successful achievement in one's work with people.

Burnout is conceptualised as a continual variable with three levels ranging from low to average to a high degrees of experienced feeling.

- A high degree of burnout was reflected in high scores on the emotional exhaustion and depersonalisation subscales and in low scores on the personal accomplishment subscale.
- An average degree of burnout was reflected in average scores on the three subscales.
- A low degree of burnout was reflected in low scores on the emotional exhaustion and depersonalisation subscales and in high scores on the personal accomplishment subscale.

One of the delimitations of the study was the small sample size, which compromised statistical significance. However, the small sample size also permitted general sample analysis as well as interpretation of results from individual caregiver perspectives. This was possible because the Maslach range of experienced burnout was presented

both statistically and in categories. See table twenty one.

TABLE 21

Range of experienced burnout: norm

Subscales	Level		
	Low	Average	High
Emotional Exhaustion	≤ 31	14 – 23	≥ 42
Depersonalisation	≤ 2	3 – 8	≥ 9
Personal Accomplishment	≤ 34	42 – 36	≤ 53

The SPSS analysis of the pre and post test MBI scores will be followed by a descriptive comparison of the burnout status of the two sample groups, Site X and Site Y against the MBI norm reflected in table twenty one. Thereafter, individual comparisons are made using the norms from table twenty one.

4.5.1.1 SPSS analysis of MBI

The pre and post test MBI scores of caregivers from Site X and Site Y were subjected to SPSS analysis. See table twenty two.

TABLE 22

Maslach burnout summary means table

Sample	Pre test	Post test
Site X: Control group	62.67	61,00
Site Y: Experimental group	69.6	68.8

From inspection of table twenty two it was apparent that there were no major differences between groups with regard to MBI pre and post test scores. Analysis of variance with repeated measures confirmed this non-significant finding ($t = 1,25$; $p = 0,29$). However, on examination of the subscales of the MBI for each caregiver in the experimental group there were aspects of positive trends, which were possible after the comprehensive intervention. Group and individual analyses followed.

4.5.1.2 Group MBI analysis of Site X caregivers: experimental group

The three subscales, viz.: emotional exhaustion, depersonalisation and personal accomplishment of the group are subjected to further analysis. See table twenty three.

4.5.1.2.1 Emotional exhaustion

For this subscale in the pre-test, one respondent experienced average burnout and four high levels of burnout. In the post test one respondent experienced low, one average and three high levels of experienced burnout. According to experienced levels there was an improvement in two caregivers after intervention. In respect of scores five caregivers experienced an improvement after intervention.

4.5.1.2.2 Depersonalisation

For this subscale in the pre-test, two respondents experienced low, one average and two high levels of burnout. In the post test, two respondents experienced low, one average and two high levels of experienced burnout. According to experienced levels

there was an improvement in two caregivers after intervention. One significantly changed from high level to average level. There were two negative changes *i.e* from average to high level of experienced burnout. There were some major family (death and illness) issues with these two caregivers. In respect of scores there was an improvement by one caregiver after intervention. One score remained unchanged. There was a negligible difference of one with a caregiver.

4.5.1.2.3 Personal Accomplishment

In the pre-test one respondent experienced low, two average and two high levels of burnout. In the post test four respondents experienced low, and one a high level of experienced burnout.

4.5.1.3 Summary of Group MBI analysis

According to levels of experience there was an improvement in two caregivers after intervention. In respect of scores two caregivers changed their levels. One moved from high to low and one caregiver from average to low. Three caregivers level did not change. Nevertheless, there was moderate improvement in each of the caregivers suggesting that they benefited from the intervention. See table twenty three.

TABLE 23

Group range of experienced burnout: Site X Caregivers

Subscales	PRE - TEST			POST- TEST		
	Low	Average	High	Low	Average	High
Emotional Exhaustion	0	1	4	1	1	3
Depersonalisation	2	1	2	2	1	2
Personal Accomplishment	2	1	2	4	0	1

4.5.1.2 Group MBI analysis of Site Y Caregivers: Control Group

There were six caregivers in Site Y, the control group. They were subjected to pre and post tests on the MBI without an intervention or placebo programme. This is discussed briefly.

4.5.1.2.1 Emotional exhaustion

There was no change of experienced burnout in this subscale.

4.5.1.2.2 Depersonalisation

There was no change of experienced burnout in this subscale.

4.5.1.2.3. Personal accomplishment

There was a change in two caregivers who moved from high to average experienced burnout. This was a negative trend.

4.5.1.2.4 Summary of group MBI analysis of Site Y caregivers

In terms of levels of experienced burnout there were no changes in the emotional exhaustion and depersonalisation subscales. There was a negative change in the personal accomplishment subscales with two caregivers. It was observed that there were no changes in the emotional exhaustion and depersonalisation subscales as well as a negative trend in the personal accomplishment subscale. It can be concluded that caregivers from Site Y, the control group would have benefited from an intervention programme even if were on a moderate scale. Since the caregivers from Site Y were the control group there was no detailed individual analysis. See table twenty four.

TABLE 24

Group range of experienced burnout: Site Y Caregivers

Subscales	PRE - TEST			POST- TEST		
	Low	Average	High	Low	Average	High
Emotional Exhaustion	2	3	1	2	3	1
Depersonalisation	1	4	1	1	4	1
Personal Accomplishment	0	1	5	0	3	3

4.5.1.3 Individual MBI Analysis of Site X Caregivers: Experimental Group

The range of experienced burnout after intervention of each of the five caregivers from Site X will be analysed using table twenty one as the basis of reference. Furthermore, (x) in the tables below denoted low, average or high levels of

experienced burnout. The original questionnaire was re-configured to obtain separate scores for each subscale of the MBI. This arrangement facilitated methodical analysis.

4.5.1.3.1 Caregiver AA 1

4.5.1.3.1.1 Emotional exhaustion

There was no change in this subscale, however, the score decreased by one.

4.5.1.3.1.2 Depersonalisation

There was no change in the subscale and the score.

4.5.1.3.1.3 Personal Accomplishment

There was a positive change from average to low level of experienced burnout. This was an improvement in the score by one. See table twenty five.

TABLE 25

Range of experienced burnout: Site X Caregiver AA 1

Subscales	PRE - TEST				POST- TEST			
	Score	Level			Score	Level		
		Low	Average	High		Low	Average	High
Emotional Exhaustion	30			x	29			x
Depersonalisation	5			x	5		x	
Personal Accomplishment	36		x		37	x		

4.5.1.3.2 Caregiver AA 2

4.5.1.3.2.1 Emotional exhaustion

There was no change in the subscale. However, the score decreased by eight. This was an improvement.

4.5.1.3.2.2 Depersonalisation

There was no change in the subscale or the score.

4.5.1.3.2.3 Personal Accomplishment

There was a change in the subscale from high to low. The increase in the score by eight represents an improvement. See table twenty six.

TABLE 26

Range of experienced burnout: Site X Caregiver AA 2

Subscales	PRE - TEST				Score	POST- TEST			
	Score	Level				Score	Level		
		Low	Average	High			Low	Average	High
Emotional Exhaustion	33			X	25			x	
Depersonalisation	1	x			1	x			
Personal Accomplishment	38		x		44	x			

4.5.1.3.3 Caregiver AA 3

4.5.1.3.3.1 Emotional exhaustion

There was a positive change in this subscale from average to low. The score decreased by four.

4.5.1.3.3.2 Depersonalisation

There was a change in the subscale from low to average. The score increased by one.

4.5.1.3.3 Personal Accomplishment

There was no change in the subscale. However, the score increased by two, which represented an improvement. See table twenty seven.

TABLE 27

Range of experienced burnout: Site X caregiver AA 3

Subscales	PRE - TEST				POST-TEST			
	Score	Level			Score	Level		
		Low	Average	High		Low	Average	High
Emotional Exhaustion	16		x		12	x		
Depersonalisation	2	x			3		x	
Personal Accomplishment	44	x			46	x		

4.5.1.3.4 Caregiver AA 4

4.5.1.3.4.1 Emotional exhaustion

There was a positive change in this subscale from high to average. The score decreased by fourteen.

4.5.1.3.4.2 Depersonalisation

There was a significant change in the subscale from average to high. The score increased by six. This was a negative trend.

4.5.1.3.4.3 Personal Accomplishment

There was no change in the subscale. However, there was a decrease in the score by eight. See table twenty eight.

TABLE 28

Range of experienced burnout: Site X Caregiver AA 4

Subscales	PRE - TEST			
	Score	Level		
		Low	Average	High
Emotional Exhaustion	37			x
Depersonalisation	4		x	
Personal Accomplishment	26			x

Subscales	POST-TEST			
	Score	Level		
		Low	Average	High
Emotional Exhaustion	23		x	
Depersonalisation	10			x
Personal Accomplishment	18			x

4.5.1.3.5 Caregiver AA 5

4.5.1.3.5.1 Emotional exhaustion

There was no change in this subscale and experienced burnout was in the high category. However, the score decreased by seven.

4.5.1.3.5.2 Depersonalisation

There was a negative change from average to high. The score increased by seven.

4.5.1.3.5.3 Personal Accomplishment

The subscale changed from average to high. However, this is a positive trend and the score increased by four. See table twenty nine.

TABLE 29

Range of experienced burnout: Site X Caregiver AA 5

Subscales	PRE - TEST				Score	POST- TEST			
	Score	Level				Score	Level		
		Low	Average	High			Low	Average	High
Emotional Exhaustion	33			x	26			x	
Depersonalisation	7		x		14			x	
Personal Accomplishment	42		x		46			x	

4.5.1.4 Summary of Site X caregiver individual experienced burnout

The small sample permitted a more in-depth analysis of the change in experienced burnout after intervention. There was discussion on each of the three subscales. The change trends were categorized as positive, negative or no change. It was observed that two caregivers experienced positive changes in the emotional exhaustion subscale, one experienced a positive change in the depersonalisation subscale and three in the personal accomplishment subscale. This suggested that the intervention programme enjoyed moderate success. Furthermore, every caregiver from Site X experienced a positive change in at least one subscale and one experienced an improvement in two subscales. There was some improvement in the psychological well being of caregivers. See table thirty.

TABLE 30**Improvement trends of experienced burnout: Site X caregivers**

Caregiver	Emotional Exhaustion	Depersonalisation	Personal Accomplishment
Caregiver AA1	No change	No change	Positive
Caregiver AA2	No change	No change	Positive
Caregiver AA3	Positive	Positive	No change
Caregiver AA4	Positive	Negative	No change
Caregiver AA5	No change	Negative	Positive

4.5.3 *Conners rating Scale*

The short version of Conners was administered as a pre and post test. The responses from the questionnaires were coded. See table thirty one.

TABLE 31

Conners rating scale codes

Rating	Responses
1	Not at all
2	A little
3	Pretty much
4	Very much

Thereafter, a summation pre and post test score was obtained for each selected child. The Conners rating scale was used to evaluate fourteen children from Site X who were selected by their caregivers. Pre-test data was obtained prior to the comprehensive intervention programme with the caregivers. Post-data information was acquired at the conclusion of the programme. Group and individual analyses are presented. Pre and post behaviour profile on each learner by the caregivers consolidated the findings from the Conners rating scale. Findings from the SPSS analysis is first reported followed by a detailed group and individual interpretation of the Conners rating scale.

4.5.3.1 SPSS analysis of Conners rating scale.

The pre and post test Conners scores of the children were subjected to a SPSS analysis. See table thirty two.

TABLE 32

Mean scores for pre and post testing of experimental group children on Conners rating scale.

Pre test	Post test
<i>68,04</i>	<i>64,29</i>

t tests for independent means indicated no significant differences between pre and post test measures ($t = 1,5; p = 0,14$). However, from table 31 there appeared to be a general trend in the direction of decreased problem behaviour as assessed by caregivers of children over the test times. This was evident after detailed group and individual analyses of the children's scores, which follows.

4.5.3.2 Group analysis of children from Site X

Caregivers were requested to select four difficult children each. The basic selection criteria were,:

- Children with whom they had close interaction.
- Children who presented with behaviour problems.
- Children with scholastic difficulties.
- Children who had problems of interaction with peers.

However, all did not chose four children each. Eventually, there were fourteen children that were reported on. The pre and post test observations are reported in table thirty three.

TABLE 33**Pre and post test scores of Site X children on Conners rating scale**

Child	Pre-Test	Post-Test
AA 1.1	84	85
AA 1.2	84	88
AA 2.1	49	51
AA 2.2	51	47
AA 2.3	53	63
AA 2.4	48	45
AA 3.1	72	75
AA 3.2	68	59
AA 3.3	70	70
AA 3.4	95	79
AA 4.1	62	64
AA 4.2	70	62
AA 5.1	83	52
AA 5.2	72	60

4.5.3.3 Summary of group analysis of Site X children on Conners rating scale.

In comparing the pre and post test scores of the fourteen selected children the following observations were noted. See table thirty four.

TABLE 34

Children improvement trends after caregiver intervention

Improvement trend	Number
Positive	7
No change	1
Negative	6

Despite the inconclusive findings of the SPSS analysis, the post test scores reflected a moderately successful intervention. The caregivers assimilated and internalised key aspects of the intervention and implemented them on their selected charges.

It was significant that fifty percent of the selected group improved. Six children deteriorated. One child regressed by a score of ten. This suggested it was a tremendous challenge to cope with troubled children and youth at risk with their myriad of psycho-social problems in a residential setting. The objective to improve the general conduct level of children was partially achieved after intervention with their caregivers. The change in behaviour with seven children was possible as a result of some improvement in the psychological well-being of the caregivers. There were positive outcomes for both children and their caregivers. Individual analysis and interpretation elucidated these findings.

4.5.3.4 Individual analysis of children from Site X.

Pre and post test scores are compared. The post test scores ought to have changed.

However, three trends of improvement are noted, *viz.*:tive trend indicated that the post test score decreased. A negative trend indicated that the post-test score increased. No change indicated that the pre and post test scores remained the same. These trends are presented on an individual basis. The Conners ratings are discussed in relation to the pre and post observations by the caregivers reflected in the Behaviour profile for each child.

4.5.3.4.1 Child AA 1.1

There was a negative trend. The post test score increased by one. According to the Conners the child was still restless and overactive. Furthermore, the concern according to the behaviour profile was that this child still ignored group norms and showed a preference for individual norms. However, the behaviour profile suggested that there was some improvement. See table thirty five.

TABLE 35

Analysis of AA 1.1 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 1.1	84	85

4.5.3.4.2 Child AA 1.2

There was a negative trend. The post test score increased by four. From the Conners it was noted that the child continued to lack concentration, told lies and teased. From observations reflected in the Behaviour profile this child's anger, disrespectfulness and aggressiveness tendencies explained this negative trend. See table thirty six.

TABLE 36

Analysis of AA 1.2 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 1.2	84	88

4.5.3.4.3 Child AA 2.1

There was a negative trend. The post test score increased by two. The Conners noted that the child was inattentive, restless and excitable. From the observations reflected in the Behaviour profile the child's impatience, immediate needs gratification and disinterest in school explained this negative trend. See table thirty seven.

TABLE 37

Analysis of AA 2.1 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 2.1	49	51

4.5.3.4.4 Child AA 2

There was a positive trend. The post test score increased by four. The Conners indicated that the child was less defiant, coped better with stress, and was less interfering with children. The observations from the Behaviour profile suggested that there was an improved attitude to school, reading, greater co-operation and reduced aggressiveness clarified this positive trend. See table thirty eight.

TABLE 38

Analysis of AA 2.2 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 2.2	51	47

4.5.3.4.5 Child AA 2.3

There was a positive trend. The post test score decreased by ten. This significant improvement was reflected in a range of issue reflected in the Conners and from the observations in the Behaviour profile. This child was,:

- Dealing with stress better.
- Interacting with peers.
- Less prone to temper outbursts.
- Less attention seeking.

The Behaviour profile indicated that there were fewer complaints from other children, was more co-operative and gave more attention to reading, homework and school work. See table thirty nine.

TABLE 39

Analysis of AA 2.3 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 2.3	53	63

4.5.3.4.6 Child AA 2.4

There was a positive trend. The post test score decreased by three. The Conners suggested that this child was showing greater concentration, less serious-minded and not easily led as before by others. Furthermore, the Behaviour profile recorded that this child was more outgoing, mixed more freely and was more assertive. These were factors that contributed to a positive trend. See table forty.

TABLE 40

Analysis of AA 2.4 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 2.4	48	45

4.5.3.4.7 Child AA 3.1

There was a negative trend. The post test score increased by three. The Connors indicated that this child continued to be easily excitable and there was little improvement in concentration. The Behaviour profile recorded on-going struggles in coping with mainstream schooling. These factors explained the negative trend. See table forty one.

TABLE 41

Analysis of AA 3.1 on the Connors rating scale

Child	Pre-Test	Post-Test
AA 3.1	72	75

4.5.3.4.8 Child AA 3.2

There was a positive trend. The post test score increased by eleven. This was a significant improvement in this child's score. The Connors indicated appreciable improvement in many areas, *e.g.*:

- Less excitable
- Greater concentration
- Less sensitive
- Better relationships

- Less defiant
- Not fearful as previously

The Behaviour profile suggested a happier and more settled child whose confidence had improved, who communicated better and was more comfortable with other children. See table forty two.

TABLE 42

Analysis of AA 3.2 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 3.2	68	59

4.5.3.4.9 Child AA 3.3

The status quo remained. There was no change in the post test score. This child needed to improve in key areas of general functioning. Poor locus of control, little respect for others, need for immediate gratification and little improvement in school were areas of concern reflected in the Behaviour profile. See table forty three.

TABLE 43

Analysis of AA 3.3 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 3.3	70	70

4.5.3.4.10 Child AA 3.4

There was a positive trend. The post test score increased by sixteen. This was a significant improvement after caregiver intervention. The Conners reflect marked changes in the following areas, viz.:

- Less excitable
- Concentrated more
- Not as serious-minded
- Does not act “ smart”
- Stole less
- Was not a great attention-seeker as before
- Not so anxious to please

The Behaviour profile reflected that this child was less of a bully now, was controlling aggressiveness, listened more to authority, got on better with children and was making efforts to improve in school. These wide range of issues explained this significant positive trend. See table forty four.

TABLE 44

Analysis of AA 3.4 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 3.4	95	79

4.5.3.4.11 Child AA 4.1

There was a negative trend. The post test score increased by two. The Conners reflected that this child continued to be restless, sensitive, told tales, still had temper outbursts and was not easily accepted by the group. The Behaviour profile noted a persistent negative attitude, disrespect and being rude as further factors that explained a negative trend. See table forty five.

TABLE 45

Analysis of AA 4.1 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 4.1	62	64

4.5.3.4.12 Child AA 4.2

There was a positive trend. The post test score decreased by eight. The Conners indicated improvement in:

- Coping better with stress.
- Not so restless
- Improved concentration
- More attentive
- Less sensitive
- Not telling much tales
- Improved relationships
- Less stubborn.

The Behaviour profile indicated decreased stubbornness, improved manners, better relationships with other children and a generally more positive attitude. These factors contributed to a positive trend. See table forty six.

TABLE 46

Analysis of AA 4.2 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 4.2	70	62

4.5.3.4.13 Child AA 5.1

There was a positive trend. The post test score decreased by thirty one. This was highly significant. The Conners reflected improvement in the following areas, viz.:

- More attentive
- Better concentration
- Not so selfish
- Does not disturb children so often
- Not prone to temper outbursts as much.
- Mixing more with children
- Not so easily led
- Better relationships with children.

The Behaviour profile positively indicated that this child was friendlier, read more widely, smiled more often, increased the circle of friends, interacted more often with friends and was starting to relax more. See table forty seven.

TABLE 47

Analysis of AA 5.1 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 5.1	83	52

4.5.3.4.14 Child AA 5.2

There was a positive trend. The post test score decreased by twelve. The Conners reflected improvement in,:

- Not so excitable
- Concentrating more
- Not so selfish
- More constructive
- Improved relationships

The behaviour profile indicated that this child was becoming more aware of his better self, more discriminating about right and wrong, handled peer pressure better, was less involved in fights, followed rules and was more interested in school. These were significant factors that contributed to a positive trend. See forty eight.

TABLE 48

Analysis of AA 5.2 on the Conners rating scale

Child	Pre-Test	Post-Test
AA 5.2	72	60

4.5.3.5 Summary of individual analysis of children from Site X.

The specific areas from the Conners were noted. These were considered with a pre and post behaviour profile. Generally, there was some congruence with the identified areas from the Conners with observations of the caregivers reflected in the Behaviour profile. There was perceptible improvement with seven difficult children.

4.5.3.6 Behaviour Profile

The Behaviour profile was not a quantitative measure. However, it was compiled to complement the Conners rating scale by providing an observed description and comparison. Caregivers were requested to chose four children with whom they interacted more closely; took a greater personal interest in their social, emotional, psychological and academic aspects; counselled one on one; provided additional guidance and support all with the objective of general improvement of the children under their care. The following number of children were given this pastoral care and monitored. See table forty nine.

TABLE 49

Caregiver	Number of children selected
Caregiver AA1	Two children
Caregiver AA2	Four children
Caregiver AA3	Four children
Caregiver AA4	Two children
Caregiver AA5	Two children

Observations of the caregivers in the conduct profile before and after the administration of the Conners rating scale were noted. The descriptions are both precise and concise. The observations listed were not necessarily correlated with each other.

4.5.3.6.1 Caregiver AA 1

A Behaviour profile is presented for two children under the charge of caregiver AA 1.

4.5.3.6.1.1 Child AA.1.1

The pre and post Behaviour profile for child AA 1.1 is recorded in table fifty.

TABLE 50

Behaviour Profile of Child AA 1.1

Pre – Administration	Post Intervention
<ul style="list-style-type: none"> ▪ Does not study. ▪ Does not do homework. ▪ Disturbs children in class. ▪ Always angry. ▪ Fights with other children. ▪ Not friendly. ▪ Does not follow rules. ▪ Poor punctuality at all times. ▪ Does not return borrowed items and is always in trouble. 	<ul style="list-style-type: none"> ▪ Showing some interest in school. ▪ Some homework attempted. ▪ Class behaviour still needs to improve. ▪ Anger under some control. ▪ Not fighting so frequently. ▪ Getting on better with other children. ▪ Still likes to have her way. ▪ Room for improvement with punctuality. ▪ Borrowing is a hard habit to break but is more responsible about returning.

4.5.3.6.1.2 Child AA. 1.2

The pre and post Behaviour profile for child AA 1.2 is recorded in table fifty one.

TABLE 51

Behaviour Profile of Child AA 1.2

Pre – Administration	Post Intervention
<ul style="list-style-type: none"> ▪ Has a bad attitude. ▪ Shows much disrespect. ▪ Does not pay attention to studying. ▪ Fights excessively with other children. ▪ Gets angry easily. ▪ Has a problem with communication. ▪ Does not attend to duties. ▪ Complains and fusses over everything. 	<ul style="list-style-type: none"> ▪ Slight improvement in her general attitude. ▪ Greets elders more often but still disrespectful. ▪ Beginning to take studies more seriously. ▪ Starting to get on with children but still aggressive. ▪ Some improvement with control of anger. ▪ Still has a problem with communication. ▪ Doing her share of duties. ▪ Is slightly more agreeable now. ▪ More punctual now.

4.5.3.6.2.1 Child AA 2.1

The pre and post Behaviour profile for child AA 2.1 is recorded in table fifty two.

TABLE 52

Behaviour Profile of Child AA 2.1

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Impatient.▪ Needs must be met immediately.▪ Poor sense of responsibility. ▪ Spends some time over homework.▪ Studies are erratic.	<ul style="list-style-type: none">▪ Settling but still impatient.▪ Not so demanding but still selfish.▪ Accepting more responsibility for tasks. Pleasing improvement.▪ Taking homework more seriously.▪ Trying but not taking studies seriously.▪ Uninterested in reading.▪ Showing greater self-respect.

4.5.3.6.1.4 Child AA 2.2

The pre and post Behaviour profile for child AA 2.2 is recorded in table fifty three.

TABLE 53
Behaviour Profile of Child AA 2.2

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Has a bullying tendency.▪ Must have her way.▪ Quite aggressive towards little children.▪ Not coping adequately in school.▪ Poor reading habits.▪ No studying plan.▪ Gets stressed easily.▪ Irritates other children.	<ul style="list-style-type: none">▪ Beginning to settle.▪ Getting more co-operative.▪ Not overly aggressive.▪ Trying harder with schoolwork.▪ Some interest in reading.▪ Slight improvement with studies.▪ Handling stress better.▪ Does not interfere with children that often.

4.5.3.6.1.5 Child AA 2.3

The pre and post Behaviour profile for child AA 2.3 is recorded in table fifty four.

TABLE 54

Behaviour Profile of Child AA 2.3

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Boisterous.▪ Big bully.▪ Defies authority.▪ Must have his way.▪ Aggressive.▪ Poor attitude to school work.	<ul style="list-style-type: none">▪ Is calming down.▪ Less engaging in power struggle.▪ More co-operative.▪ Children are complaining less about him.▪ Small improvement.▪ Is doing some homework and studies.

4.5.3.6.1.6 Child AA 2.4

The pre and post Behaviour profile for child AA 2.4 is recorded in table fifty five.

TABLE 55

Behaviour Profile of Child AA 2.4.

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Very quiet.▪ Quite withdrawn.▪ Does not have many friends.▪ Poor social skills.▪ Easily taken advantage over.▪ Lacks assertiveness.▪ Inadequate attention to studies and schoolwork in general.	<ul style="list-style-type: none">▪ Still on the quite side.▪ A little more outgoing.▪ Only select few friends.▪ Trying to mix more with others.▪ Beginning to stand up to others.▪ Trying to be assertive.▪ More effort but still struggling with schoolwork.

4.5.3.6.3 Caregiver AA 3

A Behaviour profile is presented for four children under the charge of caregiver AA 3

4.5.3.6.3.1 Child AA 3.1

The pre and post Behaviour profile for child AA 3.1 is recorded in table fifty six.

TABLE 56

Behaviour Profile of Child AA 3.1

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Isolated.▪ Lacks confidence.▪ Learning disability.▪ Has special needs.	<ul style="list-style-type: none">▪ Makes efforts to interact more.▪ Confidence level has not improved.▪ Status quo remains.

4.5.3.6.3.2 Child AA 3.2

The pre and post Behaviour profile for child AA 3.2 is recorded in table fifty seven.

TABLE 57

Behaviour Profile of Child AA 3.2

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Unhappy.▪ Attention seeker.▪ Lacks confidence.▪ Intolerant.▪ Fearful.▪ Insecure.▪ Disturbs other children.	<ul style="list-style-type: none">▪ Happier.▪ More settled.▪ Gaining in confidence.▪ Communicates a little better.▪ More outgoing.▪ Getting comfortable with others.▪ Gets on better with children.

4.5.3.6.3.3 Child AA 3.3

The pre and post Behaviour profile for child AA 3.3. is recorded in table fifty eight.

TABLE 58

Behaviour Profile of Child AA 3.3

Pre –Administration	Post Intervention
<ul style="list-style-type: none">▪ Inappropriately fearless.▪ Does not discriminate between right and wrong.▪ Easily led by others.▪ Demands immediate gratification.▪ Does homework.▪ Interested in school.▪ Reads generally.	<ul style="list-style-type: none">▪ Need to improve locus of control.▪ Listens to authority only.▪ Still influenced by others.▪ Little improvement.▪ Showing some interest in homework.▪ Maintains some interest in school.

4.5.3.6.3 4 Child AA 3.4

The pre and post Behaviour profile for child AA 3.4 is recorded in table fifty nine.

TABLE 59

Behaviour Profile of Child AA 3.4

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Bully.▪ Very aggressive.▪ Inappropriately fearless.▪ Intimidates children.▪ Challenges authority.▪ Slow achiever in school.▪ Dislikes reading.	<ul style="list-style-type: none">▪ Bullying habits have changed appreciably.▪ Controlling aggressive habits.▪ Listens more to authority.▪ More understanding of role in the cottage.▪ Not so defensive now.▪ Is making efforts to improve but is still struggling in school.▪ Poor reading habits still.▪ Very caring and protective of own caregiver

4.5.3.6.4 Caregiver AA 4

A Behaviour profile is presented for two children under the charge of caregiver AA 4.

4.5.3.6.4.1 Child AA 4.1

The pre and post Behaviour profile for child AA 4.1 is recorded in table sixty.

TABLE 60

Behaviour Profile of Child AA 4.1

Pre – Administration	Post- Intervention
<ul style="list-style-type: none">▪ Shy.▪ Negative attitude.▪ Disrespectful behaviour.▪ Rude.▪ Does not like school.▪ Does not attend to homework.	<ul style="list-style-type: none">▪ Appreciates more praise.▪ Less negative.▪ Behaviour getting better.▪ Beginning to show respect.▪ Better attitude to school this term.▪ Helps other children.

4.5.3.6.4.2 Child AA 4.2

The pre and post Behaviour profile for child AA 4.2 is recorded in table sixty one.

TABLE 61

Behaviour Profile of Child AA 4.2

Pre –Administration	Post Intervention
<ul style="list-style-type: none">▪ Very stubborn▪ Rude.▪ Negatively influenced by father.▪ Has a racist tendency.▪ Does not like school.▪ Does little or no homework.▪ Not doing well at school.	<ul style="list-style-type: none">▪ Is beginning to listen.▪ Manners improving.▪ Father still has an influence on her.▪ Is getting on better with other children.▪ Changing attitude to school.▪ Homework done more regularly.▪ Room for improvement.▪ Started attending church.

4.5.3.6.5 Caregiver AA 5

A Behaviour profile is presented for two children under the charge of caregiver AA 5.

4.5.3.6.5.1 Child AA 5.1

The pre and post Behaviour profile for child AA 5.1 is recorded in table sixty two.

TABLE 62

Behaviour Profile of Child AA 5.1

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Shy.▪ Reads.▪ Does her homework.▪ Withdrawn.▪ Does not mix easily.▪ Is a loner.▪ Does not play enough.▪ Quite serious-minded most of the time.	<ul style="list-style-type: none">▪ Is friendlier.▪ Motivated and reads more widely.▪ Still very good at completing homework.▪ Coming out of her shell slowly.▪ Still reserved. Smiles more.▪ Few select friends now.▪ Interacts with select friends.▪ Starting to relax a little.▪ Is becoming a better child.▪ Growing in responsibility.

4.5.3.6.5.2 Child AA 5.2

The pre and post Behaviour profile for child AA 5.2 is recorded in table sixty three.

TABLE 63

Behaviour Profile of Child AA 5.2

Pre – Administration	Post Intervention
<ul style="list-style-type: none">▪ Good child.▪ Likes reading.▪ Spends some time with homework.▪ Prepares for examination.	<ul style="list-style-type: none">▪ Continues to be a good child. Takes care of other children.▪ Joined the library. Encouraged to read.▪ Diligent about homework.▪ Works hard preparing for examination.▪ Improving in school.▪ Very helpful.▪ Growing to be very responsible.▪ Coping very well with outside part-time job.▪ Generally a better child now.

4.5.3.5.6 Summary of Site X children behaviour profile

The pre and post Behaviour profile was a source of vital information for the study. The pre and post descriptive data complemented the findings from the Conners rating scale e.g. around academic issues like interest in school, attendance, completion of homework, studying, and reading. There were useful comments about family dynamics. The furnishing of details by the caregivers gave them a heightened feeling of self-worth. It also felt empowering for caregivers who experienced the improvement in their children as a sense of personal accomplishment that positively contributed to the promotion of their psychological well-being.

4.6 INTERVENTION

The intervention was a critical component of the study since this was an experimental design. Fourteen sessions were conducted. The theme for each session was a synthesis of some of the needs expressed by the principal and some of issues raised by the caregivers. It was not possible to address all the concerns raised. Consideration was also given to matters raised in the literature mentioned in chapter two. The following were the important features of intervention.

4.6.1 Logistical Arrangements.

After the intervention programme was compiled caregivers provided feedback on the contents. The themes were accepted. A request was made for new and urgent issues to be accommodated when the need arose. This flexibility was allowed. However, there

were no adjustments made to the original programme of interventions. A schedule for the sessions was negotiated. The intervention times were arranged at the convenience of the caregivers. There was an understanding that the schedule would not be rigidly followed. Due to various circumstances, the original schedule was subjected to adjustments that were mutually agreed to. Sessions were between sixty to ninety minutes.

4.6.1 Format of each Intervention session

In order to enhance validity there was a fixed format of presentation for each session. The session commenced with a prayer. This was a diverse group of cultures, languages, religion and race. One of the concerns raised was the apparent tension around these issues. The prayer took this into account and embraced the language, cultural, religious and racial divide. The caregivers accepted this arrangement. This helped improve relationships among colleagues who grew more comfortable with each other.

Thereafter, allowance was made for feedback. Each caregiver made a brief input based on the contents of the previous session, issues about children and additional matters they raised. Once this was adequately taken care of the theme for the session was presented. Caregivers derived maximum benefit because the language was pitched at their level. There were opportunities to seek clarification and ask questions. Each session was concluded with a summarisation of the main points.

4.6.3 Intervention Techniques

Considerable attention was given to the presentation of the intervention, which was the critical component of the study. The presentation was organised and guided by a pre-planned script of the main issues that were discussed.

A relaxed, casual and informal atmosphere was created. This enabled the caregivers to be fully involved in the presentation. A dialogical method allowed a free flow of discussion. Every caregiver was encouraged to participate and affirmed for her contribution. Therefore, caregivers verbalised more easily, communicated more with each other, became more articulate, gained confidence and began to experience a sense of self-worth. Since the caregivers appeared to be a serious-minded group, humour was built into all sessions. As the interventions progressed, all caregivers happily contributed some form of humour.

The mode of presentation facilitated the general growth of the caregivers. A variety of strategies were employed interchangeably. In addition to the group lecture arrangement, caregivers made short individual presentations, worked in dyadic groups, and debated themes. Caregivers were also practically involved in projects, which they presented during the intervention session. This approach was complemented with case studies, worksheets, informational handouts, inspirational documents and commercially - prepared pamphlets. Information was placed in files provided by the researcher.

4.6.2 Implementation of Intervention

The theme in each session was not only theory-based. There was a practical

component attached to it. Caregivers were encouraged to make notes, record responses in their journals and practically implement an aspect of the thematic discussion. At the conclusion of a session, caregivers were allowed some time to synthesise the presentation through a discussion among themselves. Observations or a direct implementation was elaborated upon and clarified at the start of the next session.

4.6.3 Feedback of Intervention

Feedback was obtained regularly at the commencement of each session. Caregivers also recorded some feedback in their journals. However, each caregiver provided detailed feedback during the focus group discussion. In essence, caregivers indicated that they benefited greatly and they felt more empowered.

4.6.5 Summary of Intervention

The comprehensive intervention over fourteen sessions was central to the study. The caregivers responded with enthusiasm and interest. They were committed to the intervention. Missed sessions were due to genuine reasons. Caregivers were impressed with the empowerment theme and the benefits that accrued to them. Caregivers indicated that the sessions were meaningful as it addressed issues that they had identified. Positive feedback of a descriptive nature was provided by the caregivers during the course of the intervention sessions, the focus group, the

individual consultation, the appreciative inquiry and their journals. The principal's post evaluation validated the positive observations of the caregivers. This descriptive data indicated the progress the caregivers made towards their psychological well-being after intervention.

4.7 INDIVIDUAL CONSULTATION

The individual consultation had multi-objectives. Besides being a personal counselling session, data for aspects of the qualitative techniques employed were obtained. Each session was scheduled to last between sixty and ninety minutes. However, because three aspects were addressed, the time extended beyond this.

Firstly, the individual consultation was designed to be an acknowledgement for participation in the study. Caregivers were permitted to address in a therapeutic encounter personal issues related or unrelated to work. This was a non-fee paying counselling session. The five caregivers availed themselves of this professional counselling opportunity. The caregivers were comfortable and briefly addressed very personalised concerns. Issues raised included:

- Family
- Relationships
- Finances
- Conditions of Service
- Uncertain future
- Stress

It was pointed out to caregivers that it was not practically possible to address these personal concerns in-depth. Caregivers were given leads on where to go for further assistance, *e.g.* Life Line and Crisis Centre.

Brief behavioural feedback on selected children was obtained. The caregivers then were given guidance on how to address some children's behavioural issues.

It was expedient and convenient to obtain feedback on the Appreciative Inquiry.

Caregivers responded to the following questions, *viz.*:

- How did they benefit from the intervention?
- What are the challenges still?
- If they had an opportunity to improve in the programme, what would they have done?

4.7.1 Summary of individual consultation

The individual consultation was part of the empowering process for the caregiver. It afforded the caregivers an opportunity to address issues in privacy and confidentiality. The individual consultation contributed to the caregivers' personal development and the promotion of their psychological well-being.

4.8 FOCUS GROUP

The focus group was conducted just before the conclusion of the entire process. At the

appointed time only four of the remaining study respondents were available. One of the caregivers had to attend court on behalf of a child. By consensus due to time constraints the group agreed to continue with the session. The deliberations were guided by three questions, viz.:

- Briefly describe your psychological state before the intervention?
- How did you benefit from the intervention sessions?
- What are your recommendations for this programme?

The caregivers responded to the appreciative inquiry during the focus group discussion. The responses were manually recorded and transcribed. These were not expressed in great detail. They were largely short at times with one-word replies. A summary of the caregivers' responses are noted.

4.8.1 Caregiver AA 1

4.8.1.1 Psychological state before intervention.

- Tired.
- Angry.

4.8.1.2 How did you benefit from the intervention sessions?

- Am happier now.
- Feel empowered.
- Stronger.
- Self-esteem has improved.

- Dealing with stress better.
- Am understanding things better.
- Am more motivated.
- Now more caring.

4.8.1.3 What are your recommendations for the intervention programme?

- The programme must continue.
- Everyone will improve if there are more sessions.

4.8.2 *Caregiver AA 2*

4.8.2.1. Psychological state before intervention.

- Could not cope with the job.
- Was frustrated.
- Found it hard to change.
- Concentrated on children and did not take care of self.
- Did not express feelings.
- Not happy.
- Felt tired.
- Took out frustration on children.

4.8.2.2 How did you benefit from the intervention sessions?

- Learnt how to solve problems.
- Better counselling skills with children's problems.
- Growing more proactive.

- More focussed.
- Generally more alert.
- Uses better discipline techniques.
- More motivated and happier.
- Not so stressful.
- Better organised.
- More punctual.
- Coping better with colleagues and authority.
- More capable.
- Moved to a higher level and the challenge is to move further.

4.8.2.3 What are your recommendations for the intervention programme?

- No recommendations.
- Learnt a lot.
- Require follow-up sessions.

4.8.3 Caregiver AA 3

4.8.3.1 Psychological state before intervention

- Stressful.
- Unhappy.
- Uninterested.
- Tired.

4.8.3.2 How did you benefit from the intervention sessions?

- Felt good.

- Helped in my development.
- It empowered.
- Improved my self-esteem.
- Am happier.
- More steady and stable.
- Feel more encouraged.
- Greater understanding.
- Low stress.
- Can act as a role-model.
- Children's behaviour is improving.
- Helping with team building.
- More honesty in my work.

4.8.3.3 What are your recommendations for the intervention programme?

- Continue programme, as it is very motivating.

4.8.4 Caregiver AA 4

4.8.4.1 Psychological state before intervention

- Stressed-out.
- Sad.
- Did not achieve much.
- Wanted to leave.

4.8.4.2 How did you benefit from the intervention sessions?

- Feel better than before.
- Am empowered.
- Trust in my own abilities.
- Can deal with stress.
- Show more understanding.
- More caring now.
- Beginning to show more love for children and my job.

4.8.4.3 What are your recommendations for the intervention programme?

- Look forward to more such experiences.
- Enjoyed this experience.

4.8.5 *Caregiver AA 5*

4.8.5.1 Psychological state before intervention

- Angry.
- Unhappy.
- Stressed-out.

4.8.5.2. How did you benefit from the intervention sessions?

- Have improved.
- Feel empowered.
- More confident.
- Am stronger.
- Coping with stress better.

- Expressing good and strong ideas.
- More polite when working with children and authority.

4.8.5.3 What are your recommendations for the intervention programme?

- Feels very empowered.
- Feels like a new me.

4.8.6 Summary of focus group

Each of the caregivers expressed considerable psychological improvement consequent to the intervention that adequately suggested they experienced some promotion of their psychological well-being. It was also noteworthy that they were emotionally stronger, had better personalisation skills and experienced a sense of accomplishment in their work. These qualitative responses amplified observed patterns on the MBI subscales of experienced burnout.

4.9 ANALYSIS OF CAREGIVERS' JOURNALS

Responses from caregiver's journals are summarised. For the sake of analytical convenience, the caregiver's observations are categorised as follows, *viz.*:

- Self
- Colleagues
- Children
- Family (own families and family of care receivers)

A summary of the journal record is tabulated for each caregiver.

4.9.1 Caregiver AAI

Caregiver AA1 journal observations are recorded in table sixty four.

TABLE 64

Caregivers AA1: journal observations

Self	Colleagues	Children	Family
First entry. Was sick often.	Are happy when I return from weekend.	Are happy to see her return after illness.	Do not treat their children well during holiday placement.
Sad when I miss sessions.	Showed concern for a colleague by telephoning.	Can be disrespectful and disobedient.	
Like myself more.	Staff relations can improve.	Seek assistance of office with difficult children.	
Getting stronger.	Concerned about racism.	Visit school to enquire about progress.	
Feels empowered.	Not happy with low salary.	Talking to children more often.	
		Motivating children.	
		Enjoy being with children.	
		Encouraging children to be more religious.	
		Problems of sexual conduct of some children seeking assistance.	
		See children as my own.	
		Using well – behaved children as role models for others.	

4.9.2 Caregiver AA.2

Caregiver AA2 journal observations are recorded in table sixty five.

TABLE 65

Caregivers AA2: journal observations

Self	Colleagues	Children	Family
Breathing problems when working two shifts in a row.	Not a team.	Children fight a lot.	Not much contact with families of children.
Easily frustrated.	Everyone is more helpful.	Children push me to the limit.	Need to improve relationship with families.
Studying not going well.	Senior colleagues more supportive.	Children frustrate me.	Doing some home visits.
Want to consider another employment.	Dealing with racism better.	School work of some children improved.	Approach with parents is improving.
Feeling like a winner.	Not so concerned about racism.	Children need to make more progress with school work.	Providing parents with better feedback.
Am happier with my work.	Colleagues getting closer.	Boy-girl relationship a problem.	Feeling a great sense of accomplishment after successful with a placement.
Look forward to my work.	We are helping each other.	Sexual experimentation.	
Am less stressed.	Better team work.	Children from other cottages open up to me.	
Don't enjoy line supervision.	Complaints not well handled.	Enjoying better rapport with children.	

4.9.3 Caregiver AA.3

Caregiver AA3 journal observations are recorded in table sixty six.

TABLE 66

Caregivers AA3: journal observations

Self	Colleagues	Children	Family
Improved very much.	Working closely with colleagues.	Very close relationship with children.	Winning families over.
Gained a lot from the sessions.	There are problems and differences.	Am understanding them better.	
Using aspects of sessions in my work.	Trying to work as a team.	Some children are very troubled.	
		Children are very angry.	
		Making more conversation with children.	
		Behaviour problems are easing up.	
		AA3.1 One to one relationship. Getting closer to her.	
		AA3.2 One on one relationship. More personal attention. Teaching her life skills. Giving her more responsibilities.	
		AA3.4 Encouraging her singing and dancing interest.	

4.9.4 Caregiver AA.4

Caregiver AA4 journal observations are recorded in table sixty seven

TABLE 67

Caregivers AA4: journal observations

Self	Colleagues	Children	Family
Learnt a lot of things.	Work well.	Children are validating her.	Own: Serious problems. Very stressful.
Developing, achieving, understanding.	Put downs – do not develop us.	She does not get angry with children.	
Progress, that helped so much.	Team work to be practised more.	Children are more trusting.	
I am special, helped improve her sense of self.	Relationship with office to be better.	Acting as a role model for children.	
Self-anger at not completing tasks.	Appreciate collegiality from some caregivers.	Children request for help when not well.	
	Helped by a senior caregiver with a child's overdose problem.	Sing with children when working in the garden.	
		Reward children. e.g. special breakfast.	
		Social worker thanks her when making home visits.	
		Children are growing more responsible, doing chores.	
		Children help each other when someone is sick.	

4.9.5 Caregiver AA.5

Caregiver AA5 journal observations are recorded in table sixty eight

TABLE 68

Caregivers AA5: journal observations

Self	Colleagues	Children	Family
Showing more love, care and understanding.	Good relationships.	Regard children like my own family.	Proud of own daughter's accomplishment.
Learning from mistakes.	Encouraging colleagues to be positive.	Enjoy working with children.	Problem of disagreement.
Appreciate self recognition.	Trying out team work	Doing home visits.	Lack of co-operation from some families.
Feeling special.	Visiting colleagues when ill or for social reasons.	Counselling children.	Positive follow up with some families.
Realising mistakes and making changes.	Appreciate assistance from another colleague.	Encourage children to help each other.	Greater understanding with some families.
Learnt a lot from workshops and like workshops to continue.	Showing concern for each other's safety.	Proud to have played an important role in a child's re-unification.	
Lack of financial resources.	Cultural diversity needs to be addressed. Supervision – a challenge. Some tensions are unresolved.		

4.10 INTERVIEWS WITH PRINCIPAL OF CHILDREN'S HOME- SITE X

The principal was very helpful, supportive and encouraging throughout the investigative process. She personally attended to logistical arrangements, schedules, and making different venues available on Site X. This helped the researcher to observe the caregivers and their charges in different roles. Interactions with the principal were manually recorded and then transcribed.

The initial contact was an unstructured interview. There were general introductions, permission was obtained, purpose of the study was outlined, a *modus operandi* was negotiated and ethical issues of informed consent and confidentiality agreed upon.

Thereafter, two formal interviews were conducted with the Principal from Site X. The objective was to obtain pre and post intervention data concerning the caregivers. On both occasions the principal obliged with brief but pertinent information of the caregivers.

4.10.1 Pre- intervention profiles of caregivers.

4.10.1.1 Caregiver AA1

Is an unhappy person. There is need for rejuvenation. Has a poor sense of self-worth. Being in this environment for a prolonged period appears to be counter-productive to her growth. Expresses needs for recognition. Does not connect with her charges easily. Engages in power struggles with some of the older children. She does not cope adequately with adolescent girls. Does not understand their growing-up needs. Is inflexible in the general management of the senior girls. Steeped in negativity.

4.10.1.2 Caregiver AA2

Is unsure of herself and feels insecure. Does not display leadership qualities. She is a “ follower” type of person. More comfortable in a secondary supportive role and is not one who is the initiator. Potentially, has a lot to offer. However, is unassertive and passive. Is more than willing to please.

4.10.1.3 Caregiver AA3

Has been in this environment for many years. Appears to have a problem with capacity. Her output is repetitive and has limitations. Is abrupt with children and colleagues, Most times has an unhappy disposition. Feels unloved and unappreciated. Gives the impression of a “ victim syndrome” Transfers blame to others. Always defensive in her interpersonal dynamics. Not very comfortable working with peers.

4.10.1.4 Caregiver AA4

Is soft-spoken and an unassuming person, at the same time is insecure. Since she is not assertive can be easily influenced. Lacks confidence in her interpersonal contact with colleagues. Gets overwhelmed easily in matters that are outside of her routine. Has personal and family issues that at times impacts negatively on her work.

4.10.1.5 Caregiver AA5

Is a strong-willed and dominating person. Highly opinionated and is not tolerant of the next person’s views. Shows scant regard for children, colleagues and authority.

Has a general inflexible approach to all aspects of work and must be done through her perspective. She is quite ego-centred. At most times is an unhappy person. Finds reasons to be regularly complaining. Gets angry easily. Cannot handle difficult children. Needs to be constantly affirmed.

4.10.2 Post-intervention profiles of caregivers.

4.10.2.1 Caregiver AA1

There has been the philosophical “paradigm shift” in this caregiver. Change has been remarkable almost a “mega” transformation. Is more tolerant and open to new ideas and is more amenable to suggestions. More at ease with self, children and colleagues. Quite willing to adapt to changes. Is very positive about children. Growing more tolerant and less frustrated. Interacts better with all around her. Now appears settled, calm and peaceful.

4.10.2.2 Caregiver AA2

Is growing in stature and confidence. Showing perceptible leadership qualities. Beginning to test her leadership strengths in-group settings. Making more suggestions. Values support and guidance. Is now more innovative in the way she manages children. Smiles more often and appears to be much happier. More goal-oriented. Keen on making child and youth care her long-term career. Good positive determination in evidence. Wants to vigorously pursue advanced studies. Notable attitudinal shift. Showing better people skills. Is a stabilising factor and brings about peace and harmony among the group.

4.10.2.3 Caregiver AA3

Now is more composed and presently more settled with self. Not as aggressive but appropriately assertive. Is more open and less defensive. Follows and carries out instructions more easily. Improved listening skills. Shows more caring for people around her. Sets high demands with children but more tolerant if these are not met according to her standards. Becoming more of a team player. Integrating better with colleagues. Showing better understanding of children's needs. Her strengths are working with girls and younger children. While these will be abilities will be further developed needs to enhance her skills with working with boys and older children. However, is now making a conscious effort to relate better to all children. Her general progress is attributed to her willingness to see the big picture and that she is more insightful of how her approach positively impacts the children and her colleagues.

4.10.2.4 Caregiver AA4

Gaining in general confidence. Understands her role better. Is well meaning in all she now does. Has new insights on self-ability and now makes up her own mind. More trusting of colleagues and authority in that she now shares information easily. Is more assertive and communicates her needs and viewpoints more effectively with the team. Shows a happier disposition and smiles more often. Expresses appreciation more easily. Children in her cottage are settling well. Does not indulge in power struggles with her children. They are more respectful towards her. Is finding her place in the team. Developing group dynamics and understands individuals better. Has better regard for authority. Significant growth in confidence.

4.10.2.5 Caregiver AA5

Is a much happier person now. More consultation with authority and colleagues. Heeds guidance and advice more than she used to. Controls her anger. Appreciates being valued. Tries very hard with children. Spending more quality time with them. Is now seen as a helper who guides and counsels children. Does her line supervision role more seriously. She recognises the status that comes with this role. Seeks affirmation. Is more tolerant of colleagues. Takes time now to see it from their perspective of others. Displays less aggression and appropriate assertiveness.

4.10.3 Summary of principal's observations

The post intervention information about the caregivers was obtained from the principal at the conclusion of the programme. It was co-incidental that the principal had just completed her annual evaluation of the caregivers. This facilitated her feedback. As observed above her comments centred around, viz.:

- Psychological state : Self-growth; Self-Esteem; Self-worth Stress.
- Personality traits : Confidence; Motivation
- Relationship with children : Understanding
- Interaction with peers : More accepting
- Respect for authority : Some positive change but scope for improvement.

4.11 RESUME

The results of the study were influenced by the small purposive sample. However,

the mixed-method or triangulated approach provided an opportunity for detailed interpretation. It was possible to draw inter and intra comparisons on the MBI for the caregivers and on the Conners rating scale for selected children. At the same time appropriate qualitative measures permitted comprehensive analysis and discussion.

The SPSS indicated no major inter group differences between the experimental and control groups. However, there was moderate improvement experienced by all caregivers from the experimental group in respect of one or two of the subscales of the MBI.

There was also no significant difference between the pre and post Conners rating scale scores. However, at an individual level seven of the selected fourteen children showed a positive trend in decreased behaviour problems.

It can be concluded that caregivers experienced moderate improvement in their psychological well-being after treatment through the comprehensive intervention programme. This in turn had a positive effect on changing the behaviour of some of the selected children.

Chapter five concludes the study.

CHAPTER FIVE

CONCLUSION

5.1 INTRODUCTION

This chapter synthesizes the key elements of the investigation that endeavoured to promote the well-being of caregivers in children's homes and hence through improved care assess the cascade effect of the caregiver's intervention on the children. In the overview reference is made to the gist of the preceding four chapters. As the study proceeded limitations presented themselves. Limitations are acknowledged in that it impacted the main findings. It is for this reason that the main findings follow the limitations. The main findings are primarily influenced by the multi-method data. Thereafter, recommendations are proposed prior to the concluding remarks.

5.2 OVERVIEW

The overview encompasses the essential aspects of the preceding four chapters.

5.2.1 *Chapter One*

This chapter was concerned with outlining the study. Three central research questions and one sub-question informed this study *viz*,:

- Why promote the well- being of caregivers?

- How can the well-being of caregivers be promoted?
- How can empowerment benefit caregivers ?

The study addressed the following as its secondary focus, *viz.*:

- To what extent do children under the charge of caregivers improve their behaviour after the treatment programme with the caregivers?

These critical questions that informed the study were conceptually linked to the central theme of caregiver well-being which supported the general health promotion and illness prevention premise of this investigation. It emerged that the study was also extrinsically motivated to have contextual relevance and community benefit (Edwards, 2005). Studies suggested that children's homes and caregivers in particular received scant research attention in the recent past (MacLeod, 2005). The investigation met this contextual need and endeavoured to benefit the well-being considerations of a much overlooked but vital segment of this caregiver community. The research was located in the broader efforts of progressive community psychologists who promoted the interests of the working class (Dawes, 1986). Being a classical experiment, the treatment or intervention was driven by Zimmerman's empowerment conceptual framework. At the same time the study lent itself to be triangulated with qualitative measures. The benefits of the study were enumerated. The preliminary and challenging literature search was an integral part of the chapter. Key terms were defined and a summary concluded the chapter.

5.2.2 Chapter Two

This chapter was about knowledge claim or knowledge production. The issue of knowledge production was guided by the critical questions, viz.:

- Why promote the well- being of caregivers?
- How can the well- being of caregivers be promoted?
- How can empowerment benefit caregivers ?

The broad-based approach was practical and logical. The obtained information was organised in an inverse pyramid form from the general to the particular. The relevant critical questions were addressed by the following themes and feedback which were elaborated upon in chapters two, as well as in chapters three and four.

- **Why promote the well- being of caregivers?**
 - The family
 - Children's homes
 - Child care in South Africa
 - Caregivers challenges
- **How can the well- being of caregivers be promoted?**
 - Well -being theory
 - Intervention
 - Empowerment
- **How can empowerment benefit caregivers ?**
 - Principal's feedback
 - Children's Behaviour profile.

Due to its contextual nature, the investigation was conceptualised on the ecological model of Bronfenbrenner (1977) which appropriately explained the interpersonal

dynamics of the caregivers and the relevant role-players.

5.2.3 Chapter Three

Chapter three focused on the methodology of this study. This study used mixed method data gathering techniques. Quantitative and qualitative techniques were triangulated.

As this was an experimental design, the Maslach burnout inventory (1986) was employed to establish an aspect of the psychological well-being status of the caregivers that was relevant for the study. Participants from the experimental and control group were pre and post tested. The children from Site X, the experimental group were pre and post tested on the Conners rating scale. A pre and post Behaviour profile compiled by the caregivers helped in explaining the Conners data.

These two quantitative techniques were complemented by the employment of appropriate qualitative techniques. These descriptive techniques were selected to blend in with the ecological perspective of the study.

The validity of the study was greatly enhanced by the following descriptive qualitative techniques, *viz.*:

- structured interview
- unstructured interview

- needs assessment
- intervention
- focus groups
- individual consultation
- appreciative inquiry
- use of journals

These aspects were comprehensively reported on. The data from these qualitative techniques enriched the study and were critical to the study especially in the light of the moderately significant statistics. The data from the qualitative measures gave the study greater validity.

5.2.3 Chapter Four

Chapter four analysed the research findings and explicated the results. Information was manually recorded, transcribed and reported on. This was a challenging aspect of the study. A uniform and systematised logical flow from chapter three was maintained. A plethora of relevant data was generated despite the small sample size. The analysis was in-depth and comprehensive since the small sample presented possibilities for group and individual interpretation. Thus inter and intra comparisons were possible. The SPSS analysis of the Maslach burnout inventory (1986) and the Conners rating scale (1989) yielded inconclusive findings. However, the qualitative data gave greater clarity and insight into the efficacy of the intervention observed through some positive trends in psychological well-being of caregivers and improved

behaviour profiles of selected children.

Post data after intervention from individual consultations, focus groups, appreciative enquiry, journals and interview with the principal indicated perceptible improvement by caregivers and significant changes in selected children's behaviour.

5.3 LIMITATIONS

Limitations in a study provide a reality check for the researcher of what is achievable or what cannot be accomplished due to factors within or outside the investigative process. This study on promoting the psychological well-being of caregivers and the cascade effect on children under their care experienced limitations at the commencement and during the research process. The following limitations became evident as the study progressed.

5.3.1 Sample

5.3.1.1 Experimental Group

- **Size**

Due to sample size, the study was not generalisable to the general universe of caregivers.

- **Reduction**

The already small sample of seven was further reduced by two when one of the caregivers fell seriously ill and the other was dismissed arising out of a misconduct matter. The latter two did not participate further in the study.

- Educational Level

Three out of the five caregivers in Site X do not possess a basic matriculation certificate. This lack of basic schooling became evident in the level of written communication by the caregivers in their journals.

- Schedule

It was difficult to follow the arranged schedule. The participants were either, unwell, absent or attending to emergencies during the pre-arranged and negotiated time. The researcher also had to reorganize intervention sessions due to work demands, health issues and family circumstances.

- Verbal communication

The participants were not very articulate and hampered communication at times.

- Motivation

The caregivers from Site X volunteered their time and participation in the study. A convenient intervention time was when their children were in school. However, this was their free time. It had to be remembered that caregivers were involved in needs assessment, completion of questionnaires, fourteen intervention sessions, individual consultations, focus group and weekly maintenance of journals. This was indeed a great sacrifice of time. Participants were very enthusiastic at the commencement of the project.

As the study progressed attendance was a little erratic, journals were not always completed timeously and participation and contribution was diluted. Strategies were employed that sustained the interest and motivation of the participants. The researcher

was unwavering in his determination in ensuring that all participants received all aspects of the intervention which meant at times working with individuals outside of the negotiated schedule. Just before the conclusion of the intervention all caregivers participated with renewed interest and commitment.

5.3.1.1 Control Group

Identified control groups were reluctant to participate. The concern was that confidentiality will be breached (Chetty, 2002). After much effort a control Site was obtained.

5.3.2 *The Quantitative Measures*

The Maslach burnout inventory and the Conners rating scale were employed in the study.

- Self-Administration

Respondents experienced difficulty in self-administering both test instruments. Items in the Maslach subscales and Conners rating scale were not easily comprehended by the caregivers.

- Second Language Users

Maslach (1986) pointed out that second language user experienced difficulties in comprehension of the individual test items. The respondents left a number of blanks that were subsequently completed under the supervision of the researcher.

5.3.3 *Logistical arrangements*

Logistical arrangements were not rigorously maintained. Though there were mitigating factors the demanding schedule could not be adhered to. It was indeed a challenge to create and sustain a high level of motivation of the respondents to continue participation. It was at times problematical not being able to work with the full complement of the sample.

5.4 MAIN FINDINGS

5.4.1 *Statistical findings*

Essential findings on the Maslach burnout inventory and the Conners rating scale are reported on.

5.4.1.1 Maslach Burnout Inventory

Analysis of variance with repeated measures confirmed this non-significant finding ($t = 1,25$; $p = 0,29$). However, on closer examination of the subscales of the MBI for each caregiver in the experimental group there are aspects of positive trends, which were possible after the comprehensive intervention.

5.4.1.2 Conners rating scale

The SPSS analysis reported no significant difference. While the t test for independent means indicated no significant differences between pre and post outcomes ($t = 1,57$; $p = 0,14$) there have been significant improvement with seven learners out of the selected fourteen learners. There was no change with one learner. There was

regression of behaviour in six learners.

5.4.2 Behaviour profile

The Behaviour profile yielded valuable data. The caregivers were able to comment critically on the change in the children's behaviour. In many respects this confirmed the observations of the caregivers on the Conners rating scale. The Behaviour profile drew positive attention to improvement in the children's behaviour, improved attitude to school as well as more acceptable interpersonal relationships with peers and caregivers. Seven of the selected fourteen children improved largely as the result of enhanced psychological well-being of their caregivers which had a cascading effect on the children.

5.4.3 Intervention

Intervention was the treatment component of the study. There were a minimum of fourteen sessions. The intervention programme was designed after taking into account the needs assessment, the principal's concerns as well as caregivers challenges gleaned from the literature. The objective was to promote their psychological well-being. All caregivers did not respond positively in the three post test aspects of well-being from the Maslach inventory. However, the moderate improvement in some aspects was essentially due to the intervention programme. It could be motivated that if the caregivers did not experience the intervention or treatment, they together with the selected learners would not have made the significant progress recorded.

5.4.4 Control group

The control group was not subjected to an intervention. There ought to be no differences between the pre and post test scores on the Maslach burnout inventory. However, the SPSS analysis revealed a *0.08* improvement in the post Maslach inventory means score. Though this change was insignificant and negligible it could be ascribed to an awareness by the caregivers that they were involved in a project and began the process of improvement intrinsically.

5.4.5 Children

The children were not the focus of the study. However, the promotion of their caregivers' well-being was in turn to have a positive impact on the children. Seven of the selected fourteen children made significant progress. One made no change. Six regressed in their behaviour. Data from the Behaviour profile, feedback from the caregivers and the principal as well entries from the journals indicated qualitative improvement in the following areas, *viz.:*

- Personality Characteristics
- Behaviour
- Interpersonal relationships
- Schooling
- Reading
- Homework
- Respect for authority

5.4.6 Burnout

The performance of one's duty depends on one's general well-being which is an all-embracing concept. This study used the Maslach burnout inventory to tap into three aspects of well-being, *viz.* emotional exhaustion, depersonalisation and lack of personal accomplishment. These three factors are integral to work performance in human service (Maslach, 1986). Furthermore, social services were one of the occupational subgroups on whom the Maslach (1986) norms were obtained and specifically child protective service workers formed part of this social services group. An appropriate intervention programme addressed the three burnout categories. Post test data indicated an appreciable improvement trend by the caregivers in the three subscales. This was confirmed in entries in the journal, feedback from the focus group, appreciative inquiry, feedback from the principal and during the individual consultation.

5.4.7 Psychological well-being

This investigation purported to promote the psychological well-being of caregivers in children's homes. After establishing the well-being status a comprehensive treatment programme was implemented. While the statistical findings suggested moderate success, data from the various qualitative measures indicated that caregivers made perceptible gains in the following psychologically-related areas, *viz.:*

- Exhaustion levels decreased as they have learnt to pace themselves.
- Enjoyed their work as caregivers better than before.

- Had a sense that their general work performance improved.
- Collegial dynamics are more congenial.
- More respectful relationship with authorities in place.
- Significant enhancement of self-esteem and self-worth.
- Began to appropriately personalize their relationship with children more.
- Experienced a greater sense of personal accomplishment in their work with children.
- Interacted far more meaningfully and positively with the families of their charges.
- Employed better stress coping techniques.
- Displayed more intrinsic motivation and performed better
- There was a positive attitude to work as a caregiver.

In essence the psychological well-being of caregivers showed significant improvement which promoted improved work performance.

5.5 RECOMMENDATIONS

The recommendations for this study will be discussed in three categories:

- Research
- Policy
- Practice

5.5.1 *Research*

- This study could be replicated considering that the SPSS findings were not statistically significant.
- The study could be replicated with a larger sample.
- The myriad of issues concerning caregivers could be brought into the research focus more greatly.
- Community psychologists should concentrate their research efforts on children's homes, children in such settings and caregivers in this self same environment.

5.5.2 *Policy*

- Gender

Males must be encouraged to become child and youth care workers and break the stereotypical mould of child care being primarily a female occupation.

- Families

Intact and wholesome families ought to work in children's homes. It has beneficial effects for the worker not to be concerned about being separated from their families and at the same time to act as role models for the care recipients who by and large are from broken and dysfunctional homes.

- Cultural diversity

Due to culturally diverse nature of caregivers, care recipients and the inevitable tension and misunderstandings at the children's homes this needs to be addressed as a matter of policy.

- Minimum qualifications

The possession of a matriculation certificate should be minimum schooling qualification at entry level. Thereafter, all caregivers must study and successfully complete BCCQ as a minimum professional requirement.

- Professional status

The status of caregivers must be elevated to the level of a professional discipline.

Caregivers apply for membership after meeting minimum schooling and professional criteria. This enables them to have a personalized membership number and be part of a caregivers national register, enjoy benefits and also abide by code and ethics.

- Pre- screening of applicants

All caregiver must consent to a pre-screening. This should include background checks for criminal conduct, history of abusive behaviour and paedophile records.

- Service conditions

As part of professionalising this discipline, there ought to be improved service conditions. This should include uniform salary scales, fixed working hours, pension scheme, medical aid and provision for seniority acknowledgement.

5.5.3 Training

- Literacy levels

Caregivers must be encouraged to constantly upgrade their literacy levels.

- Training manual

The treatment programme could be compiled into a training manual. Staff could be involved in Train the Trainer programme. After having attained minimum competency, staff could cascade such information to colleagues.

- Elementary Helping skills

There is a need to train caregivers in elementary helping or counseling skills.

- Well-being

The study observed that promoting well-being and preventing burnout has the potential of improving caregivers work performance and generating a positive cascading effect on their children.

5.6 CONCLUSION

This study drew its influence from the Swampscott conference which inspired a *corps* of progressive psychologists to address the needs of the various disadvantaged community sectors. There are gaps in the literature around issues of caregivers in children's homes .

Thus, this investigation focused on promoting the psychological well-being of caregivers in a children's home. Since well-being has a myriad of psychological constructs the three MBI subscales of emotional exhaustion, depersonalisation and personal accomplishment adequately assessed the well-being status of caregivers. The children's behaviour was evaluated on the Conners rating scale. Central to the process was the comprehensive treatment or intervention programme.

The SPSS findings indicated negligible change in the pre and post test MBI scores for the caregivers. There was *no significant differences in the pre and post test scores on the Conners rating scale.*

It is perhaps for these reasons that triangulated methodologies have great research benefits. The appropriate and variety of qualitative measures complemented and provided validity for the quantitative measures. The various tabular representations indicated the different levels of experienced self-improvement by caregivers who then also generated a positive cascading effect on selected children under their charge. There are qualitative descriptions as well as tabulations to this effect.

There was moderate improvement in the psychological well-being of caregivers and children's behaviour. These improvement trends in both the caregivers and the children could be attributed to the comprehensive treatment or intervention. It can be argued that since there was little or no change with the caregivers from the control group intervention could positively effect possible change through improvement of their psychological well-being.

The empowerment of caregivers through the promotion of their psychological well-being which was the focus of this study contributed to caregivers self-improvement and positively impacted in addressing issues of troubled children and youth at risk in a children's home.

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APPENDIX ONE

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site X EMPOWERMENT

CAREGIVER BIOGRAPHICAL QUESTIONNAIRE

1. GENDER

Male	
Female	

2 AGE

21 to 24 years	
25 to 29 years	
30 to 39 years	
40 to 49 years	
50 to 59 years	

3 EXPERIENCE

1 to 5 years	
5 to 9 years	
10 to 14 years	
15 to 20 years	
20 to 25 years	

4 QUALIFICATIONS

Academic : _____

Professional : _____

APPENDIX TWO

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site X
EMPOWERMENT

NEEDS ASSESSMENT QUESTIONNAIRE

1. **Qualifications:** _____

2. **Experience :** _____ **Years**

3. **Challenges in child and youth care work**

4. **How can child and youth care work be improved?**

APPENDIX THREE

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site Y EMPOWERMENT

CAREGIVER BIOGRAPHICAL QUESTIONNAIRE

1. GENDER

Male	
Female	

2 AGE

21 to 24 years	
25 to 29 years	
30 to 39 years	
40 to 49 years	
50 to 59 years	

3 EXPERIENCE

1 to 5 years	
5 to 9 years	
10 to 14 years	
15 to 20 years	
20 to 25 years	

4 QUALIFICATIONS

Academic : _____

Professional : _____

APPENDIX FOUR

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site Y
EMPOWERMENT

NEEDS ASSESSMENT QUESTIONNAIRE

1. **Qualifications:** _____

2. **Experience :** _____ **Years**

3. **Challenges in child and youth care work**

4. **How can child and youth care work be improved?**

APPENDIX FIVE

CHILD AND YOUTH CARE WORKER (CAREGIVER): Site X EMPOWERMENT

HUMAN SERVICES SURVEY: PRE -TEST

NOTE: Use 0 to 6 for each item to indicate how often.

0	Never	4	A few times a month
1	Every Day	5	Once a week
2	A few times or less	6	A few times a week
3	Once a month or less		

No.	Statements	Pre
1	I feel emotionally drained from my work.	
2	I feel used up at the end of the workday.	
3	I feel fatigued when I get up I the morning and have to face another day on the job.	
4	I can easily understand how my recipients feel about things.	
5	I feel I treat some recipients as if they were impersonal objects.	
6	Working with people all day is really a strain for me.	
7	I deal very effectively with the problems of my recipients.	
8	I feel burned out from my work.	
9	I feel I'm positively influencing other people's lives through my work.	
10	I've become more callouts toward people since I took this job	
11	I worry that this job is hardening me emotionally	
12	I feel very energetic.	
13	I feel frustrated by my job.	
14	I feel I'm working too hard on my job.	
15	I don't really care what happens to some recipients.	
16	Working with people directly puts too much stress on me.	
17	I can easily create a relaxed atmosphere with my recipients.	
18	I feel exhilarated after working closely with my recipients.	
19	I have accomplished many worthwhile things in this job.	
20	I fee like I'm at the end of my rope.	
21	In my work, I deal with emotional problems very calmly.	
22	I feel recipients blame me for some of their problems.	

APPENDIX SIX

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site X EMPOWERMENT

HUMAN SERVICES SURVEY : POST –TEST

NOTE: Use 0 to 6 for each item to indicate how often.

0 Never	4 Once week
1 A few times a year	5 A few times a week
2 Once a month or less	6 Every day
3 A few times a month	

No.	Statements	Post
1	I feel emotionally drained from my work.	
2	I feel used up at the end of the workday.	
3	I feel fatigued when I get up I the morning and have to face another day on the job.	
4	I can easily understand how my recipients feel about things.	
5	I feel I treat some recipients as if they were impersonal objects.	
6	Working with people all day is really a strain for me.	
7	I deal very effectively with the problems of my recipients.	
8	I feel burned out from my work.	
9	I feel I'm positively influencing other people's lives through my work.	
10	<i>I've become more callouts toward people since I took this job</i>	
11	I worry that this job is hardening me emotionally	
12	I feel very energetic.	
13	I feel frustrated by my job.	
14	I feel I'm working too hard on my job.	
15	I don't really care what happens to some recipients.	
16	Working with people directly puts too much stress on me.	
17	I can easily create a relaxed atmosphere with my recipients.	
18	I feel exhilarated after working closely with my recipients.	
19	I have accomplished many worthwhile things in this job.	
20	I fee like I'm at the end of my rope.	
21	In my work, I deal with emotional problems very calmly.	
22	I feel recipients blame me for some of their problems.	

APPENDIX SEVEN

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site Y EMPOWERMENT

HUMAN SERVICES SURVEY:PRE TEST

NOTE: Use 0 to 6 for each item to indicate how often.

0 Never	4 Once week
1 A few times a year	5 A few times a week
2 Once a month or less	6 Every day
3 A few times a month	

No.	Statements	Pre
1	I feel emotionally drained from my work.	
2	I feel used up at the end of the workday.	
3	I feel fatigued when I get up I the morning and have to face another day on the job.	
4	I can easily understand how my recipients feel about things.	
5	I feel I treat some recipients as if they were impersonal objects.	
6	Working with people all day is really a strain for me.	
7	I deal very effectively with the problems of my recipients.	
8	I feel burned out from my work.	
9	I feel I'm positively influencing other people's lives through my work.	
10	I've become more callouts toward people since I took this job	
11	I worry that this job is hardening me emotionally	
12	I feel very energetic.	
13	I feel frustrated by my job.	
14	I feel I'm working too hard on my job.	
15	I don't really care what happens to some recipients.	
16	Working with people directly puts too much stress on me.	
17	I can easily create a relaxed atmosphere with my recipients.	
18	I feel exhilarated after working closely with my recipients.	
19	I have accomplished many worthwhile things in this job.	
20	I fee like I'm at the end of my rope.	
21	In my work, I deal with emotional problems very calmly.	
22	I feel recipients blame me for some of their problems.	

APPENDIX EIGHT

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site Y EMPOWERMENT

HUMAN SERVICES SURVEY:POST -TEST

NOTE: Use 0 to 6 for each item to indicate how often

0 Never	4 Once a week
1 A few times a year	5 A few times a week
2 Once a month or less	6 Every day
3 A few times a month	

No.	Statements	Post
1	I feel emotionally drained from my work.	
2	I feel used up at the end of the workday.	
3	I feel fatigued when I get up I the morning and have to face another day on the job.	
4	I can easily understand how my recipients feel about things.	
5	I feel I treat some recipients as if they were impersonal objects.	
6	Working with people all day is really a strain for me.	
7	I deal very effectively with the problems of my recipients.	
8	I feel burned out from my work.	
9	I feel I'm positively influencing other people's lives through my work.	
10	I've become more callouts toward people since I took this job	
11	I worry that this job is hardening me emotionally	
12	I feel very energetic.	
13	I feel frustrated by my job.	
14	I feel I'm working too hard on my job.	
15	I don't really care what happens to some recipients.	
16	Working with people directly puts too much stress on me.	
17	I can easily create a relaxed atmosphere with my recipients.	
18	I feel exhilarated after working closely with my recipients.	
19	I have accomplished many worthwhile things in this job.	
20	I fee like I'm at the end of my rope.	
21	In my work, I deal with emotional problems very calmly.	
22	I feel recipients blame me for some of their problems.	

APPENDIX NINE

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site X EMPOWERMENT

RE-CONFIGURED:HUMAN SERVICES SURVEY

Pre	Post
-----	------

Subscale: Emotional Exhaustion

1	I feel emotionally drained from my work.		
2	I feel used up at the end of the workday.		
3	I feel fatigued when I get up in the morning and have to face another day on the job.		
6	Working with people all day is really a strain for me.		
8	I feel burned out from my work.		
13	I feel frustrated by my job.		
14	I feel I'm working too hard on my job.		
16	Working with people directly puts too much stress on me.		
20	I feel like I'm at the end of my rope.		

Subscale: Depersonalisation

5	I feel I treat some recipients as if they were impersonal objects.		
10	I've become more callous toward people since I took this job		
11	I worry that this job is hardening me emotionally		
15	I don't really care what happens to some recipients.		
22	I feel recipients blame me for some of their problems.		

Subscale: Personal Accomplishment

4	I can easily understand how my recipients feel about things.		
7	I deal very effectively with the problems of my recipients.		
9	I feel I'm positively influencing other people's lives through my work.		
12	I feel very energetic.		
17	I can easily create a relaxed atmosphere with my recipients.		
18	I feel exhilarated after working closely with my recipients.		
19	I have accomplished many worthwhile things in this job.		
21	In my work, I deal with emotional problems very calmly.		

APPENDIX TEN

CHILD AND YOUTH CARE WORKER (CAREGIVER) : Site Y EMPOWERMENT

RE-CONFIGURED:HUMAN SERVICES SURVEY

Pre	Post
-----	------

Subscale: Emotional Exhaustion

1	I feel emotionally drained from my work.		
2	I feel used up at the end of the workday.		
3	I feel fatigued when I get up I the morning and have to face another day on the job.		
6	Working with people all day is really a strain for me.		
8	I feel burned out from my work.		
13	I feel frustrated by my job.		
14	I feel I'm working too hard on my job.		
16	Working with people directly puts too much stress on me.		
20	I fee like I'm at the end of my rope.		

Subscale: Depersonalisation

5	I feel I treat some recipients as if they were impersonal objects.		
10	I've become more callouts toward people since I took this job		
11	I worry that this job is hardening me emotionally		
15	I don't really care what happens to some recipients.		
22	I feel recipients blame me for some of their problems.		

Subscale: Personal Accomplishment

4	I can easily understand how my recipients feel about things.		
7	I deal very effectively with the problems of my recipients.		
9	I feel I'm positively influencing other people's lives through my work.		
12	I feel very energetic.		
17	I can easily create a relaxed atmosphere with my recipients.		
18	I feel exhilarated after working closely with my recipients.		
19	I have accomplished many worthwhile things in this job.		
21	In my work, I deal with emotional problems very calmly.		

APPENDIX 11

CHILD AND YOUTH CARE WORKER (CAREGIVER) EMPOWERMENT

INTERVENTION SESSIONS

- **Session 1- General Session**
- **Session 2- Journey of Self Discovery**
- **Session 3- Enhancing Self Esteem**
- **Session 4- Enhancing Self Concept**
- **Session 5- Discipline without Tears**
- **Session 6- Inter-personal relationships**
- **Session 7- Parenting Skills**
- **Session 8- Self Care and Coping with Stress**
- **Session 9-The Fragile Child**
- **Session 10-The School and the Child**
- **Session 11-The Family and the Child**
- **Session 12-The Community and the Child**
- **Session 13- Helping Skills**
- **Session 14- Cultural Diversity**

APPENDIX 12

CHILD AND YOUTH CARE WORKER (CAREGIVER)
EMPOWERMENT

Proposed Schedule of Activities
(Subject to Change and Alteration)

SESSIONS	MONDAY		THURSDAY	
	AM	PM	AM	PM
One	<input type="checkbox"/>			
Two		<input type="checkbox"/>		
Three			<input type="checkbox"/>	
Four				<input type="checkbox"/>
Five	<input type="checkbox"/>			
Six		<input type="checkbox"/>		
Seven			<input type="checkbox"/>	
Eight				<input type="checkbox"/>
Nine	<input type="checkbox"/>			
Ten		<input type="checkbox"/>		
Eleven			<input type="checkbox"/>	
Twelve				<input type="checkbox"/>
Thirteen	<input type="checkbox"/>			
Fourteen		<input type="checkbox"/>		

APPENDIX THIRTEEN

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

THE CEO : SITE X

RE : Confirmation: Ph.D. Research- SITE X

Sincerest greetings! Our telephonic conversation refers.

Thank you for granting me permission to conduct a study at SITE X-

Children's Home.

Kindly be informed that strict ethical principles will be observed.

In the presentation no reference will be made to the research site or the participants. Confidentiality will be maintained at all times.

This study is social-action and empowerment oriented. It is envisaged that the participants will potentially benefit through their involvement.

The institution will be informed of the progress of the study and will be given on completion a summary of the main findings.

Your co-operation is greatly appreciated.

Thank you

Warm regards

N CHETTY

APPENDIX FOURTEEN

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

TO : The Principal

RE : Ph.D Research- SITE X Children's Home

MADAM

Our telephonic conversation refers.

Kindly note that the CEO, has approved your site for the purpose of conducting a study.

I will liaise with you closely throughout this process.

Kindly be informed that ethical principles will be observed.

In the presentation no reference will be made to the research site or the participants. Strict confidentiality will be maintained at all times.

This study is social-action and empowerment oriented.

I look forward to working with you in this project.

Thank you

Warm regards

N CHETTY

APPENDIX FIFTEEN

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

TO : The Child and Youth Careworker : Site X
RE : Invitation:Research at your Children's Home

Dear Caregiver

Sincerest greetings!

Kindly be informed that you are invited to participate in a Community study concerning your most critical responsibility as a caregiver.

As a child and youth care worker you are an extremely important person in the lives of children who are most in need of care.

Your involvement in this study will possibly help you and colleagues in the same demanding role as you to cope better in their daily work. Please note you will fill in some forms under my guidance. You will not disclose any identifying details and all information will be treated in the strictest of confidence.

As an acknowledgement for your participation, on conclusion of the project we will jointly negotiate a programme of activities at your convenience.

I look forward to working with you for our mutual benefit.

Thank You
Warm Regards

N CHETTY

APPENDIX SIXTEEN

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

TO : The Caregiver : Site X

RE : Voluntary Participation:Research at your Children's Home

Dear Caregiver

Sincerest greetings!

Kindly be informed that your consent as a voluntary participant in my research project is sought. Your privacy will be respected at all times.

The purpose of this study is to empower you and colleagues to cope better in your demanding daily work.

In the course of our work, there will be :

- Group sessions**
- Individual consultations**
- Completion of Questionnaires**
- Maintenance of Journals**

We will jointly negotiate a schedule of activities at your convenience.

Thank You

N CHETTY

APPENDIX SEVENTEEN

CAREGIVER EMPOWERMENT RESEARCH

CONSENT: Site-X

TO : Mr N Chetty

FROM : Caregiver: Number.....

Dear Mr Chetty

An invitation to participate in your Empowerment Research project dated August 28,2006 refers.

Kindly note that :

- **I consent to participate in your study.**
- **I understand that my privacy will be respected at all times.**
- **I will be informed of the outcome of the studies.**

I am participating in the hope that I will be empowered as a Child Care Worker which will help me in my own growth and also to make a greater difference in the lives of the children that I worked with.

Thank You

NUMBER : _____

CHILD CARE WORKER AT SITE X

APPENDIX EIGHTEEN

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

THE DIRECTOR : SITE Y

RE : Invitation- Ph.D. Research- SITE Y

Sincerest greetings! Our telephonic conversation refers.

Thank you for granting me permission to conduct a study at SITE Y.

Children's Home.

Kindly be informed that strict ethical principles will be observed.

In the presentation no reference will be made to the research site or the participants. Confidentiality will be maintained at all times.

This study is social-action and empowerment oriented. It is envisaged that the participants will potentially benefit through their involvement.

The institution will be informed of the progress of the study and will be given on completion a summary of the main findings.

Your co-operation is greatly appreciated.

**Thank you
Warm regards**

**-----
N CHETTY**

APPENDIX NINETEEN

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

TO : Manager

RE : Ph.D Research- SITE Y Children's Home

MADAM

Our telephonic conversation refers.

Kindly note that the Director, has approved your site for the purpose of conducting a study.

I will liaise with you closely throughout this process.

Kindly be informed that ethical principles will be observed.

In the presentation no reference will be made to the research site or the participants. Strict confidentiality will be maintained at all times.

This study is social-action and empowerment oriented.

I look forward to working with you in this project.

**Thank you
Warm regards**

**-----
N CHETTY**

APPENDIX TWENTY

NARAINSAMI CHETTY

P O Box 56870

Chatsworth

4030

TO : The Child and Youth Careworker: Site Y
RE : Invitation- Research at your Children's Home

Dear Caregiver

Sincerest greetings!

Kindly be informed that you are invited to participate in a Community study concerning your most critical responsibility as a caregiver.

As a child and youth care worker you are an extremely important person in the lives of children who are most in need of care.

Your involvement in this study will possibly help you and colleagues in the same demanding role as you to cope better in their daily work. Please note you will fill in some forms under my guidance. You will not disclose any identifying details and all information will be treated in the strictest of confidence.

As an acknowledgement for your participation, on conclusion of the project we will jointly negotiate a programme of activities at your convenience.

I look forward to working with you for our mutual benefit.

Thank You
Warm Regards

N CHETTY

ANNEXURE ONE

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION ONE

SESSION : Monday

TIME : 09h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Data Questionnaire
- Programme of Activities
- Negotiating Schedule of Activities
- Summary

**N CHETTY
(Presenter)**

ANNEXURE TWO

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION TWO

SESSION : Monday

TIME : 14h30

VENUE : Boardroom

AGENDA

- ❑ Prayer
- ❑ Welcome
- ❑ Feedback
- ❑ Journey of Self Discovery
- ❑ Summary

EMPOWERMENT

Session : 2A

NOTE: *'The journey begins'.*

My work as a Caregiver

- 1. What qualities do I bring into my work?*
- 2. What qualities do I need to work on to better myself as a caregiver?*
- 3. Why do I like my work?*
- 4. Why do I not like my work?*
- 5. What needs to be done to improve child and youth care work?*

THANK YOU

ANNEXURE THREE

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION THREE

SESSION : Thursday

TIME : 14h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Enhancing Self Esteem
- Summary

**N CHETTY
(Presenter)**

ANNEXURE FOUR

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION FOUR

SESSION : Thursday

TIME : 14h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Enhancing Self Concept
- Summary

N CHETTY
(Presenter)

ANNEXURE FIVE

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION FIVE

SESSION : Monday

TIME : 09h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Discipline without tears
- Summary

N CHETTY
(Presenter)

ANNEXURE SIX

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION SIX

SESSION : Monday
TIME : 14h30
VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Inter- personal relationships
- Summary

**N CHETTY
(Presenter)**

ANNEXURE SEVEN

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION SEVEN

SESSION : THURSADY

TIME : 09h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Parenting Skills
- Summary

N CHETTY
(Presenter)

ANNEXURE EIGHT

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION EIGHT

SESSION : Thursday

TIME : 14h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Self care and coping with stress
- Summary

**N CHETTY
(Presenter)**

ANNEXURE NINE

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION NINE

SESSION : Monday

TIME : 09h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- The fragile child
- Summary

N CHETTY
(Presenter)

ANNEXURE TEN

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION TEN

SESSION : Monday

TIME : 14h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- The school and the child
- Summary

N CHETTY
(Presenter)

ANNEXURE ELEVEN

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION ELEVEN

SESSION : Thursday
TIME : 09h30
VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- The family and the child
- Summary

N CHETTY
(Presenter)

ANNEXURE TWELVE

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION TWELVE

SESSION : Thursady
TIME : 14h30
VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- The community and the child
- Summary

N CHETTY
(Presenter)

ANNEXURE THIRTEEN

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION THIRTEEN

SESSION : Monday

TIME : 09h30

VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Basic Helping Skills
- Summary

**N CHETTY
(Presenter)**

ANNEXURE FOURTEEN

CHILD AND YOUTH CARE WORKER (CAREGIVER)

EMPOWERMENT

SESSION FOURTEEN

SESSION : Monday
TIME : 14h30
VENUE : Boardroom

AGENDA

- Prayer
- Welcome
- Feedback
- Cultural Diversity
- Summary

N CHETTY
(Presenter)

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