AN EXPLORATION OF THE LIFE-EXPERIENCES OF AIDS-ORPHANS IN KINSHIP FOSTER CARE IN SOUTH AFRICA

by

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Declaration

I hereby declare that "An exploration of the life-experiences of AIDS-orphans in kinship foster care in South Africa" is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references. This is a dissertation of limited scope and must be viewed accordingly.

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Abstract

Human Immuno-Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have many devastating impacts, including the growing number of AIDS-orphans left without care. In the study, semi-structured interviews, incomplete sentences and Kinetic family drawings were used to explore the life-experiences and perceptions of AIDS-orphans living in kinship foster care, from a Gestalt perspective. The study revealed that the majority of the AIDS-orphans included were making good contact at the contact boundary and all the respondents were not familiar with the term ‘foster care’. The researcher therefore recommended that children are educated about foster care at school, thus possibly increasing the awareness of foster care in South Africa, thus possibly increasing the provision of homes for the vastly growing numbers of AIDS-orphans in our country and perhaps make a difference in society.

Key Words

HIV/AIDS (Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome), AIDS-orphan, kinship foster care, life-experience, Field Theory, Gestalt Theory.
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Chapter One
Introduction and overview

1.1 Introduction

"South Africa is said to have more people living with the Human Immuno-Deficiency Virus (HIV) than any other country" (UNO in Walker, Reid & Cornell, 2004:14). The estimated number of South African adults infected with HIV/AIDS (Acquired Immune Deficiency Syndrome) in 2010 is 7.5 million, while the estimated life expectancy of South Africans in 2010 is a mere 43 years (Walker et al., 2004:14). Many of the people dying from AIDS are between 15 and 49 years old and often leave children behind (Ghosh & Kalipeni in Kalipeni, Craddock, Oppong & Ghosh, 2004:304). This implies that a large number of adults in South Africa will not reach old age and therefore leave their children, orphaned by AIDS, to grow up without them.

In South Africa, children orphaned by AIDS are either fostered by family members or outsiders, become street children, are placed in children's safe homes or they have to take charge of their parents' households, resulting in child-headed households (Foster, 2000:59). "The responsibility for caring for orphaned children often pushes families beyond their ability to cope and many extended family systems have been completely overwhelmed" (Thiele, 2005:1). The orphaned children who do not stay with family members have slipped through the traditional safety nets and are therefore vulnerable to psychological, social and economic impacts (Sengendo & Nambi, 1997:56).

According to Craddock (in Kalipeni et al., 2004:9) the number of AIDS-orphans in Africa continues to grow at a staggering pace, leaving communities and governments struggling to accommodate so many children in need of food, clothing, housing, school, medical care, and psychological support. African governments also do not usually have the economic resources to adequately address the issue, with the result that orphans frequently suffer mentally, physically, and emotionally (Craddock
in Kalipeni et al., 2004:9). According to Foster, Levine and Williamson (2005:7) the impacts of HIV/AIDS on children include psychosocial distress, death of parents and young children, stigma, problems with inheritance, orphans left without adult care, discrimination, exploitative child labour, sexual exploitation, and withdrawal from school and reduced access to health services. In the opinion of the researcher, foster children who are orphaned by AIDS could carry some of these impacts with them, thus affecting their experience of living in foster care. The researcher was interested in determining which factors were common among AIDS-orphans in foster care and exactly how these influenced the AIDS-orphan's experience of life in a foster family.

Children who are fostered often experience feelings of isolation and feel that they are not treated as well as the other children in the family, especially with regard to household work and access to education (Foster et al., 2005:26). The researcher's interest was firstly in exploring the life-experiences of AIDS-orphans who had been placed in kinship foster care, as they did not have any other form of alternative care, and secondly to gain an understanding of their personal perceptions and how they participated in life events while living in foster care. AIDS-orphans tend to have particular emotional and behavioural problems, which can place great strain on a foster family (Mann in Foster et al., 2005:27). Children orphaned by AIDS may have had to watch their parents die; this results in emotional issues that require emotional support from the foster family to grieve and come to terms with their changed situation (Foster et al., 2005:28). In addition, there is a potential for abuse or exploitation of the foster child in the foster home (Foster et al., 2005:27). The researcher has deducted from the above that AIDS-orphans may have varied view points of kinship foster care and explored this further to identify common experiences and perceptions of foster care among AIDS-orphans.

According to Bradshaw, Johnson, Schneider and Bourne (in Thiele, 2005:1) South Africa's ability to care for these orphaned children will determine the long-term social stability of the country. In addition,
according to De Waal (2006:84), the capacity of African societies for fostering may be more substantial than anticipated. According to this author, this statement, when read in context, means that African societies have a larger ability to foster AIDS-orphans than previously thought. According to Madhavan (in Anderson & Phillips, 2006:12), the increase in HIV/AIDS infection in South Africa could account for increasing fosterage of young children. Thus, it can be hypothesised that the utilization of foster care in South Africa will increase as the number of AIDS-orphans increase. Therefore, an exploration of the AIDS-orphans’ life-experiences in kinship foster care provided valuable insight and recommendations to social workers, which could have lead to possible changes implemented in the system that could have improved foster care in South Africa.

The research was conducted from a Gestalt perspective, where the whole is seen as more than the sum of its parts (Schoeman, 2005:70). In the study, the Gestalt perspective was used only as a theoretical background and not as a form of intervention. The AIDS-orphans were seen as a whole and all the factors in their lives were taken into consideration and no part of the whole was disregarded. According to the Gestalt perspective, each individual has his own field where, in this view, each person is never independent or isolated, but always in contact and connected with everything else in a very real sense (Joyce & Sills, 2001:24). “The experiential field is the field of a person’s awareness; it’s a metaphor for the way they organize their experience; it’s their reality or their phenomenological field and is unique to them” (Joyce & Sills, 2001:24). The larger field is the larger context in which they exist; it includes the physical world of objects (Joyce & Sills, 2001:25). In the research, the AIDS-orphans’ experiential field and larger field were investigated.

Field theory was the main focus in the research where, according to Joyce and Sills (2001:24) each person’s field includes the three areas of phenomenological investigation: the internal world of the child, the external world or environment, and the ever-changing relationship between them. The researcher attempted to gain insight into the internal world
(experiential field) of the AIDS-orphans and explored the way in which they made sense of, experienced and perceived the external world (larger field); which was their world of foster care. Therefore the researcher investigated the relationship between the internal and external world of the chosen AIDS-orphans. “The phenomenological approach means trying to stay as close to the client’s experience as possible, to stay in the here-and-now moment and rather than interpreting the client’s behaviour, to help him explore and become aware of how he makes sense of the world” (Joyce & Sills, 2001:16). In the study, the chosen AIDS-orphans’ fields were looked at in the here-and-now moment. The three areas of phenomenological investigation include: “bracketing, where the counsellor’s beliefs, assumptions and judgements are temporarily suspended in order to see the phenomenon or situation ‘as if for the first time’, description, where the phenomenon is simply described in terms of what is immediately obvious to the senses, and the third is horizontalism, where all aspects of the phenomenon are given potentially equal importance” (Joyce & Sills, 2001:17). The researcher attempted to incorporate these three areas by temporarily suspending her beliefs, simply describing the foster care situation as given by the AIDS-orphans and by viewing all aspects of kinship foster care described by the AIDS-orphans as equally important. The Gestalt perspective and Field theory were chosen by the researcher because they encompass looking at a person as a holistic whole and that each person experiences and perceives their world in away unique to them. The researcher was interested in exploring these various experiences and perceptions of the AIDS-orphan’s world of kinship foster care. Gestalt is discussed further in Section 2.5.1.

1.2 Problem formulation of the study
1.2.1 Motivation and problem formulation
The estimated number of children in South Africa is 16.3 million and growing each day (Walker et al., 2004:57). By 2015 the number of children in this country will have increased dramatically and the estimated percentage of children who will be orphaned by AIDS should reach 12%
(Walker et al., 2004:57). "As more children lose their parents to AIDS they are being taken care of by their grandparents, uncles, and aunts" (Ghosh & Kalipeni in Kalipeni et al., 2004:304). However, according to Kalipeni et al. (2004:24) despite the efforts of many extended families and communities, many are unable to cope. Therefore, the researcher hypothesises that the utilization of foster care by non-family members will need to increase in order to accommodate the growing number of AIDS-orphans in South Africa. The AIDS-orphans' perceptions and life-experiences in kinship foster care could thus warrant further investigation, as it could provide valuable insight regarding the implementation of changes in foster care to improve services, in order to better address the increasing need for foster care.

The annual report for Child Welfare South Africa (2002-2003) confirms that the number of orphaned children on Child Welfare caseloads nationally has reached extreme proportions, with numbers having trebled between the years 1999 and 2002 (Thiele, 2005:15). The fact that the Child Welfare's caseloads have trebled "signals a crisis for service providers who need to find suitable alternative care for what is considered to be a powerless group of children" (Thiele, 2005:15). "The AIDS epidemic has brought fostering into crisis" (Ghosh & Kalipeni in Kalipeni et al., 2004:304). According to Thiele (2005:6), the dramatic increase in foster care applications for placements of orphaned children is an issue that needs to be addressed. "The HIV/AIDS pandemic imposes a significant and potentially crippling burden on the already inadequate health and welfare system" (Thiele, 2005:2). In the South African context, according to Thiele (2005:2), the current social service system cannot cope with the large number of children who are in need of care and support as a result of HIV/AIDS. From these statements, the researcher has deduced that social workers in South Africa cannot cope with the increasing caseloads, which are placing pressure on them to find foster families for these AIDS-orphans at a rapid rate. This thus implies that not much time is spent on exploring the AIDS-orphan's experience and perceptions of foster care in South Africa. In the opinion of the researcher, the investigation of this
problem could provide insight. “Welfare organisations are struggling to cope with the growing number of children who are HIV positive or who have been orphaned by AIDS” (Walker et al., 2004:120).

According to Thiele (2005:2) increasing demands are being placed on welfare organisations for assistance with permanent arrangements for orphaned children. The researcher has deducted from the literature (Anderson & Phillips, 2006; Foster, 2000; Kalipeni, Craddock, Oppong & Ghosh, 2004; Sengendo & Nambi, 1997; Thiele 2005; Walker, Reid & Cornell, 2004) and consultations with social workers in Vryheid, KwaZulu Natal, that social workers of Child Welfare have occasional follow up sessions with these AIDS-orphans, but no time is spent on acquiring the orphan's in-depth account of the experience of being in foster care. In the researcher's opinion this issue needed to be investigated to identify what could be done, changed or improved in the system, in order to render better service to the AIDS-orphans in need.


The researcher searched through all the available databases at UNISA which contain all the registered titles of research dissertations in South Africa and was not able to locate any research that has been conducted
on the AIDS-orphans' life-experience of kinship foster care in South Africa, using a Gestalt approach. There was a study on the experience of foster care in Malawi, but this study did not include the life-experiences of AIDS-orphans and it was not conducted in South Africa. In addition, there was a study on kinship foster care in Vosloorus; however, this study was not conducted with a focus on the life-experiences of AIDS-orphans or from a Gestalt perspective. Therefore, in the opinion of the researcher, there could be a gap in research.

1.2.2 Consultation with experts
The researcher consulted three social workers who deal with foster care on a daily basis, as well as a foster/adoptive mother who started and runs a home for HIV/AIDS orphans and abandoned children. The proposed study was discussed and suggestions were noted.

- Mrs Carol Ellenberger
Carol Ellenberger is a registered social worker and is considered to be an expert as she has 18 years of experience in foster care in Vryheid, KwaZulu Natal. She was informed about how the research was going to be conducted and how AIDS-orphans living in foster care were going to be included. Mrs Ellenberger said that, in her opinion, interviewing the AIDS-orphans was going to be a good method of gathering data. She commended the research idea and offered to assist the researcher in locating AIDS-orphans in kinship foster care in Vryheid, KwaZulu Natal. In the expert's opinion, the proposed research would be valuable to the field as, according to her experience, social workers have insufficient time to investigate the AIDS-orphans' life-experiences in foster care, due to very high caseloads.

- Mrs Hannie Reyneke
Mrs Reyneke is a social worker with an interest in play therapy. She is an expert in dealing with foster care, as she has 20 years of experience in the field. Mrs Reyneke was informed about what the research project entailed, the research methods used and what the aim of the study included. In her opinion the research topic was feasible and the methods chosen could
render valuable information. She suggested that the researcher include a section on the stigma associated with being an AIDS-orphan and the grief experienced. Mrs Reyneke assisted the researcher in locating AIDS-orphans in kinship foster care, which took part in the study.

• Ms Elaine Hanekom

Ms Hanekom has, as a social worker, 6 years of experience with foster care. This expert was also informed about the nature of the research and that the researcher was going to collect data from a few AIDS-orphans in the area and how this was going to be achieved. Ms Hanekom said that the study could be viable as it could uncover problems experienced in foster care, so that professionals could start addressing them. She said that, in her opinion, a lot of the problems experienced in foster care do not always come to the surface and that the study could uncover these problems.

• Mrs Darleen van Tonder

Mrs van Tonder and her husband have fostered a baby and a teenager and have adopted a baby. They started a children's home in Vryheid, KwaZulu Natal, called Inkululeko. Mrs van Tonder was given an overview of the research, the methods used to gain information and the aim of the study. Mrs van Tonder had worked with HIV/AIDS orphans and abandoned children for 5 years and said that in her opinion, the proposed study would provide a valuable understanding of how the orphaned children feel and experience foster care.

The consultation with experts in the field was an important step in the research process and lead to the following step, which included the formulation of a research question.

1.2.3 Research question

A research question can be defined as “a clearly posed question based on a well developed knowledge of previous research and theory, as well as on the scientist’s own ideas and speculations” (Fouché & De Vos in De Vos, Strydom, Fouché & Delport, 2005:100). The research question can
be formulated by determining the unit of analysis, the research goal and the research approach (De Vos et al., 2005:103). “The person from whom the social researcher collects data” could be seen as the unit of analysis (Bless & Higson-Smith in De Vos et al., 2005:104). Therefore, the unit of analysis in the study was the AIDS-orphans who were in kinship foster care.

For the purpose of the study, the research question can be formulated as follows:

**What are the life-experiences and perceptions of AIDS-orphans placed in kinship foster care in South Africa?**

**1.2.4 Aim and objectives**

In order to answer the research question, clear goals and objectives are required. The goal of the research can be defined as, “the end toward which effort or ambition is directed” (Fouché & De Vos in De Vos, Strydom, Fouché & Delport, 2005:104). The word “aim” is defined by WordReference.com [sa] as “intent to move towards a certain goal; target” (2 October 2007). The goal of the research was to explore and describe the life-experiences of AIDS-orphans in kinship foster care, from a Gestalt perspective.

The term objective “denotes the more concrete, measurable conception of such an end toward which effort or ambition is directed” (Fouché & De Vos in De Vos et al., 2005:104). According to WordReference.com [sa], an objective can also be defined as, “the goal intended to be attained” (2 October 2007). For the purpose of the study the objectives include all the aspects in the research that were investigated and explored. The objectives of the study are the following:

- To describe the life-experiences of AIDS-orphans in middle childhood, living in kinship foster care, from a Gestalt perspective.
• To describe the developmental stage of AIDS-orphans in middle childhood.
• To gain information regarding the life-experiences of AIDS-orphans in foster care, from semi-structured interviews, incomplete sentences and Kinetic family drawings.
• To analyse the data gathered.
• To integrate a literature control with the results of the study using a Gestalt approach.
• To provide recommendations and suggestions to social workers for future research.

1.2.5 Paradigm
A paradigm can be defined as, “the way of viewing one’s research material” (De Vos in De Vos et al., 2005:40). A paradigm consists of three aspects - meta-theory, theoretical assumptions and methodology. The meta-theory and theoretical assumptions will be discussed accordingly, whereafter the methodology will be discussed as part of the research approach (see 4.1).

1.2.5.1 Meta-theory
“Meta-theories are integrative approaches that overcome the limitations of adhering to one particular theoretical point of view” (Jordan & Jordan in Berg Bergh in lit list & Theron, 1999:14). According to Allwords.com [sa], a meta-theory can also be defined as, “any theory concerning another theory” (2 October 2007). For the purpose of this study, the meta-theory was grounded on the Gestalt perspective. In the Gestalt perspective the whole is seen as more than the sum of its parts (Schoeman, 2005:70). The researcher concentrated on the ‘whole’ and investigated all the factors in an AIDS-orphan’s life which could have affected his/her life-experiences while residing in foster care.

“The scientific world view that underlies the Gestalt phenomenological perspective is field theory. Field theory is a method of exploring that
describes the whole field of which the event is currently a part rather than analyzing the event in terms of a class to which it belongs by its "nature" (e.g. Aristotelian classification) or a unilinear, historical, cause-effect sequence (e.g. Newtonian mechanics)” (Yontef, 1993:2). Field theory was used in the study to gain an understanding of the life-experience of the AIDS-orphans included. For the purposes of this study the term field was used to describe the aspects in the here-and-now in the child's life at a specific time.

“The field is a whole in which the parts are in immediate relationship and responsive to each other and no part is uninfluenced by what goes on elsewhere in the field. The field replaces the notion of discrete, isolated particles. The person in his or her life space constitutes a field” (Yontef, 1993:2). Each AIDS-orphan included in the study had his/her own field and by examining these different fields, the researcher attempted to gain insight into the various life-experiences and perceptions of these AIDS-orphans in kinship foster care.

1.2.5.2 Theoretical assumptions

Theoretical assumptions “are beliefs that are taken as given and are usually not subject to empirical testing” (Bernard & Whitley 2002:9). The theoretical assumptions will be based on Bronfenbrenner’s Ecological-systems Model of Human Development. According to this model, development is defined as, “a lasting change in the way in which a person perceives and deals with his environment” (Bronfenbrenner, 1979:3). Bronfenbrenner’s (1979) systemic approach will be followed in the investigation, where the Microsystem, Mesosystem, Exosystem and Macrosystem are all different systems, but can still influence and affect each other.

According to Bronfenbrenner (1979:22), a Microsystem can be defined as a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics. In the study, the Microsystem included the individual AIDS-
orphaned children in kinship foster care, in middle childhood (6-12 years) and their interactions with the immediate settings.

A Mesosystem can be defined as, “the interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, and neighbourhood peer group)” (Bronfenbrenner, 1979:25). In the research the Mesosystem included the AIDS-orphans’ family settings in the foster home, their neighbourhoods and their schools. An Exosystem can be defined as, “one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person.” (Bronfenbrenner, 1979:25).

In the research the Exosystem included the foster child’s extended family, if any, and the effect of the media. A Macrosystem can be defined as, “consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies.” (Bronfenbrenner, 1979:26). In the study, the Macrosystem would have included the laws in place in South Africa and the values and customs of the AIDS-orphans. It must be noted, however, that these aspects were not investigated in this study. The researcher attempted to investigate how the AIDS-orphans’ experiences of life and perceptions were affected by each system.

1.3 Research approach
1.3.1 Qualitative research approach
Within the context of this study, a qualitative approach was utilized. Qualitative research can be defined as the researcher’s attempts to “understand how people experience and interpret events in their lives” (Bernard & Whitley, 2002:34). According to Meyer, Moore and Viljoen (1997:29) qualitative research describes a phenomenon as it is manifested and its objective is to understand the phenomenon, rather than to explain it in terms of the laws of cause and effect. “The researcher attempts to gain
a first-hand, holistic understanding of phenomena of interest by means of a flexible strategy of problem formulation and data collection, shaped as the investigation proceeds" (Fortune & Reid in De Vos et al., 2005:74). The research was therefore qualitative in nature, as it was directed towards gaining a holistic understanding of the life-experience of AIDS-orphans in kinship foster care.

**1.3.2 Type of research**

The goals of research are “either basic or applied” (Neuman in De Vos et al., 2005:105). “Basic research provides a foundation for knowledge and understanding”, whereas “applied research is focused on solving problems in practice” (Fouché & De Vos in De Vos et al., 2005:1). The research was applied research, as it could be used to solve problems and provide recommendations to people concerned with the foster care of AIDS-orphans in South Africa.

In addition, the research was exploratory, as it was conducted to gain insight into the life-experience of AIDS-orphans in kinship foster care. Exploratory research can be defined as, “research conducted to gain insight into a situation, phenomenon, community or individual” (Bless & Higson-Smith in De Vos et al., 2005:106). The study was also descriptive, as the life-experiences and perceptions of the chosen AIDS-orphans were described. “Descriptive research presents a picture of the specific details of a situation, social setting or relationship” (Neuman in De Vos et al., 2005:106).

**1.4 Research methodology**

**1.4.1 Research strategy**

A qualitative research strategy can be defined as the entire process of research from conceptualising a problem, to writing the narrative (Creswell in De Vos et al., 2005:268). The study incorporated a collective case study research strategy. A case study can be defined as “an exploration or in-depth analysis of a bounded system (bounded by time and or place), or a single or multiple case, over a period of time" (Creswell in De Vos et al.,
A collective case study includes choosing cases so that comparisons can be made between cases and concepts and so that theories can be extended and validated (Mark in De Vos et al., 2005:272).

For the purposes of the study, a collective case study was used, where eight case studies of the chosen AIDS-orphans were compiled, which consisted of information gathered from the semi-structured interviews, incomplete sentences and Kinetic family drawings. All the participants chosen were in the middle childhood years (6-12 years old) and had lived in kinship foster care for a minimum of two years, so that they were settled in their foster family and valuable comparisons could be made.

1.4.2 Data gathering and analysis
The researcher started the research process by consulting literature on foster care and AIDS-orphans in South Africa, in order to formulate a conceptual framework. The next step was to develop questions to be used in the semi-structured interviews and incomplete sentences. The questions utilized in the study were centred on life and experiences in a foster family, personal meanings given to and understandings and perceptions of foster care by the AIDS-orphans included. Semi-structured interviews are defined as interviews “organised around areas of particular interest, while still allowing considerable flexibility in scope and depth” (May in De Vos et al., 2005:292). Burns and Kaufman (1972:2) developed the Kinetic family drawings and said that these drawings could be used to mobilize a child’s feelings related to the self-concept and in the area of interpersonal relations. This method of data gathering was chosen by the researcher, as it could provide information around the AIDS-orphan’s interpersonal relations. The researcher’s aim was to find out how the AIDS-orphans participated in life; how they experienced life events and by exploring aspects of their interpersonal relations, this could be achieved.

The third step included choosing the research participants. Two social workers in Vryheid, KwaZulu Natal offered to help the researcher contact foster parents with AIDS orphans in their care and locate research
participants. The researcher gained written consent from this organisation regarding the use of the facility and its cases. The researcher drew up a letter explaining the proposed research and requested the written consent of the perspective participants, their social workers and their foster parents to take part in the study and to gain consent to record the whole process of data collection. The foster children included in the research remained anonymous. Purposive sampling (paragraph 4.3 below) was used in the study, as AIDS-orphans were specifically chosen to take part. The AIDS-orphans chosen met certain criteria which included being in middle childhood, lost one or both parents to AIDS related illnesses and had been living in a foster home with family members in Vryheid, KwaZulu Natal for a minimum of two years. This step is discussed further in Section 4.3 below.

The next aspect in the process included conducting a pilot study. A pilot study can be defined as, “a preliminary piece of research conducted with a sample of research participants drawn from the study population” (Bernard & Whitley, 2002:403). A pilot study can also be defined as, “a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate” (Bless & Higson-Smith 2000 in De Vos et al., 2005:206). In the study, the researcher conducted a pilot study with five children in the middle childhood years to determine whether the incomplete sentences and questions in the semi-structured interview could be understood by the children.

The fourth step in the procedure was to gather data by interviewing the participants, getting the participants to complete the incomplete sentences and to draw the Kinetic family drawings. A social worker at the Child Welfare Vryheid made individual appointments with the foster parents and AIDS-orphans taking part in the study. The researcher then explained how the data would be collected from the AIDS-orphans (semi-structured interviews, incomplete sentences, Kinetic family drawings) and that a professional outsider would analyse the Kinetic family drawings, and that
she had signed a confidentiality agreement. The foster parents and AIDS-orphants were also informed about what was expected of them and that the whole process of data collection was going to be recorded with a video camera. According to De Vos et al. (2005:334) "the researcher should plan for the recording of data in a systematic manner that is appropriate to the setting, participants, or both, and that will facilitate analysis before data collection commences."

The researcher requested that the foster parent/s wait in the waiting room nearby, while data was collected from the child. However, the foster parent/s were permitted to stay with the child if necessary (if the child did not want the foster parent to leave the room). The researcher, child and interpreter sat on chairs arranged in an informal manner and got to know each other a bit before doing a sensory exercise. The researcher then, with the use of an interpreter, conducted the semi-structured interview and asked the child to complete the incomplete sentences and wrote the answers down for each AIDS-orphan. Finally, the AIDS-orphan was asked to draw his or her foster family doing something.

While the data was collected, a preliminary analysis was done which, according to De Vos et al. (2005:335), involves data analysis at the research site during data collection, as well as data analysis away from the site after the data has been collected. The researcher analysed the data at the research site while it was collected, by taking notes and identifying common themes and ideas expressed by the participants. The data was then analysed away from the site after the process of collection was completed. This was done by comparing answers in the semi-structured interviews and incomplete sentences, making inferences and incorporating the results of the analysis of the Kinetic family drawings by a professional who dealt with them regularly.

The next step was to analyse the data collected. "Qualitative data analysis is a search for general statements about relationships among categories of data; it builds grounded theory" (Marshall & Rossman in De Vos et al.,
For the purpose of the study, the data collected was organised into computer files. "Managing or organising the data involves the organisation of the data into file folders, index cards or computer files" (De Vos in De Vos et al., 2005:336). The researcher read the data thoroughly and took notes. "Reading the data several times and writing memos or transcripts helps in the initial process of exploring the data" (De Vos in De Vos et al., 2005:337). The researcher analysed the data and identified common themes and ideas. "The researcher must identify themes, recurring ideas or language, and patterns of belief that link people and settings" (De Vos in De Vos et al., 2005:338).

The next step in the analysis of data is coding the data. "Coding data is the formal representation of analytic thinking" (Marshall & Rossman in De Vos et al., 2005:338). The researcher applies some coding scheme to the categories and themes identified and marks passages in the data with the specific codes chosen (De Vos in De Vos et al., 2005:338). The researcher used specific codes to represent specific themes and ideas identified in the data. The emergent understandings were then tested. This involves a "search through the data where the researcher challenges the understanding, searches for negative instances of the patterns and incorporates these into larger constructs, as necessary" (De Vos in De Vos et al., 2005:338). In the study the researcher explored and challenged the plausibility of her developing understandings by searching for negative instances of the theme or common idea identified, and by exploring all other feasible explanations or reasons for the occurrence of the specific aspects discovered. In addition, the researcher should search for other plausible explanations for the data and the linkages between them (De Vos in De Vos et al., 2005:339). For the purpose of the study, the researcher analysed the data for alternative explanations. The last step in the analysis of data includes writing the report. This is where the researcher presents what was found in text, tabular or figure form (De Vos in De Vos et al., 2005:339). In the study, the researcher demonstrated what was found in the form of a text.
As the meta-theory used in the research was grounded on the Gestalt perspective, all aspects present in the individual AIDS-orphans’ fields were taken into consideration during the process of data collection and analysis. The researcher investigated and explored the aspects in the AIDS-orphan’s field while gathering the data. This was achieved by exploring the AIDS-orphan’s internal world (lived experiences and perceptions) and external world (foster care), through the use of the questions in the semi-structured interviews and incomplete sentences. A sensory exercise was used in the beginning of the interview to make both the researcher and AIDS-orphan aware. The interview then proceeded where the AIDS-orphan was questioned about foster care and his/her lived experiences and perceptions. The researcher took note of the influencing factors present in each AIDS-orphan’s field and asked each child to describe aspects mentioned in the here-and-now. The aspects present in the AIDS-orphan’s field were explored and described while analysing the data. This was achieved by analysing the data collected as a whole and by including all possible influences present in each AIDS-orphan’s field. Bronfenbrenner’s ecological systems theory was used as a guide as to which areas in the AIDS-orphans’ lives to focus on.

Once the data analysis was completed, Gestalt Field theory was integrated further, where each AIDS-orphan’s individual field was discussed and integrated with the results of the data analysis. From this information, deductions and conclusions were drawn. The last step in the research process included providing recommendations and suggestions for future research.

1.4.3 Universe, population, demarcation of sample and sampling technique

“The term universe refers to all potential subjects who possess the attributes in which the researcher is interested (Arkava & Lane in De Vos et al., 2005:193). In the study, the universe included all the children orphaned by HIV/AIDS in Vryheid, Kwazulu Natal, who were placed in kinship foster care. The study was conducted in Vryheid, KwaZulu Natal,
as the researcher had access to AIDS-orphans in that area and social workers at Child Welfare Vryheid volunteered to assist in locating the research respondents.

The population differs from the universe, as a research population can be defined as, "all the people or phenomena under study, from whom a sample will be selected for research" (Somekh & Lewin, 2005:347). In the study the population included AIDS-orphans in middle childhood that had lived in a foster home with family members in Vryheid, KwaZulu Natal for a minimum of two years.

A sample can be defined as comprising "elements of the population considered for actual inclusion in the study or it can be viewed as a subset of measurements drawn from a population in which we are interested" (Arkava & Lane in De Vos et al., 2005:194). For the purpose of the study, the chosen AIDS-orphans formed the sample. The sampling method used in the study was purposive sampling, as AIDS-orphans in kinship foster care were specifically chosen for the study. "In purposive sampling a particular case is chosen because it illustrates some feature or process that is of interest for a particular study" (Silverman in De Vos et al., 2005:328).

The AIDS-orphans chosen to participate in the research met certain criteria which included: in middle childhood, lost one or both parents to AIDS related illnesses and had been living in a foster home with family members in KwaZulu Natal for a minimum of two years. As the study was conducted in a small town (Vryheid) in KwaZulu Natal, the participants were limited and as a result of this, there was no restriction on the language chosen and where necessary, an interpreter was used. The researcher incorporated participants from both genders and different cultural groups; however, as the number of respondents were limited, there were no gender or cultural specifications. The research was qualitative, which implied that the criteria could have changed as the research progressed.
As there were specific criteria to be met in the sample, the AIDS-orphans were not chosen at random, and this caused the sampling method to be non-probability sampling. Non-probability sampling can be defined as sampling that "is done without randomisation" (Strydom in De Vos et al., 2005:198). For the purposes of this study eight research participants were included in the research, from whom information was gathered.

1.5 Ethical aspects

"Ethical guidelines serve as standards, and a basis upon which each researcher ought to evaluate his own conduct" (Strydom in De Vos et al., 2005:57). There are a number of ethical issues that may arise in research. These will be discussed accordingly.

- Avoidance of harm
The researcher has "an ethical obligation to protect subjects, within reasonable limits, from any form of physical discomfort that may emerge from the research project" (Dane in De Vos et al., 2005:58). According to Bernard and Whitley (2002:63) researchers have the obligation to assess the potential risks to participants in their research and to minimize the risk or not conduct the research if the degree of risk is not justified by the potential benefits of the research. The research respondents must be thoroughly informed about the potential impact of the research before they take part in it. The study did not cause physical harm to the respondents; however it could have brought back memories which might have had an emotional effect on the AIDS-orphans involved in the study. The researcher informed the respondents and their guardians about this possibility and only included those children who were willing to participate.

- Informed consent
"Participants must be legally and psychologically competent to give consent and they must be aware that they would be at liberty to withdraw from the investigation at any time" (Baily in De Vos et al., 2005:59).
According to Neuman (cited in De Vos et al., 2005:59 2003:124) participation must always be voluntary. “The principle of informed consent requires that potential participants receive this information before data about them are collected so that they can make an informed decision about participation” (Bernard & Whitley, 2002:68). The respondents were informed that they could ask questions before and during the research. “Informed consent ensures the full knowledge and co-operation of subjects, while also resolving, or at least relieving, any possible tension, aggression, resistance or insecurity of the subjects” (Strydom in De Vos et al., 2005:60). According to Mrs Ellenberger, who has a Baccalaureus Societatis Scientiae with specialization in Social Work, the AIDS-orphans included in the study have been placed in a foster family under the supervision of a social worker, who is legally responsible for them. Therefore the researcher needed to acquire the permission of the chosen AIDS-orphan’s social workers, to take part in the study. The researcher wrote consent letters, explaining the nature of the research and informed possible participants, their guardians and their social workers that participation in the research was voluntary, that their names would remain anonymous, that a video camera would be used to record the process of data gathering, that only the researcher would have access to the video recordings and that they could withdraw from the research at any time.

• Deception of subjects

“Deception involves withholding information, or offering incorrect information in order to ensure participation of subjects when they would otherwise possibly have refused it” (Corey, Corey & Callanan in De Vos et al., 2005:60). There are two kinds of deception that could be used in research: active deception, where “the researcher provides participants with false information” and passive deception, where “the researcher either withholds information from the participants or observes or records their behaviour without their knowledge” (Schuler in Bernard & Whitley, 2002:73). The study conducted did not include any form of deception (active or passive) of the research respondents and the researcher
maintained open and honest communication with everyone involved in the study.

- Violation of privacy/confidentiality

Privacy can be defined as "that which normally is not intended for others to observe or analyse" (Sieber in De Vos et al., 2005:61). "The right to privacy is the individual's right to decide when, to whom, and to what extent his or her attitudes, beliefs, and behaviour will be revealed" (Singleton, Straits, Straits & McAllister in De Vos et al., 2005:61). Confidentiality is viewed as "a continuation of privacy, which refers to the agreements between persons that limit others' access to private information" (Sieber in De Vos et al., 2005:61). According to Bernard and Whitley (2002:84) research participants have a right to privacy that researchers must safeguard, by keeping the information provided by each individual participant in strict confidence. The respondents' right to privacy was adhered to by means of the confidentiality agreements and the respondents' names remained anonymous.

The researcher used a system where the respondents were given numbers instead of using their names and all information gathered from a particular respondent had the same number on it. Information was gathered from the participants separately, so that they did not know who the other participants were. This information was kept in a safe place during and after the research, where only the researcher and the professional who analysed the Kinetic drawings, had access. The social workers who volunteered to assist the researcher with locating orphans and their foster parents, did not share information with the general public, as they were requested to sign a confidentiality agreement. These social workers are professionals and are well informed about confidentiality, informed consent and ethics. The person who assisted in analysing the Kinetic family drawings was also requested to sign a confidentiality agreement.
- Actions and competence of the researcher

“Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation” (Strydom in De Vos et al., 2005:63). There must also be adequate supervision of the research project to ensure that the research is ethical and that valid results are rendered. “Objectivity and restraint in making value judgements are part of the equipment of a competent researcher” (Strydom in De Vos et al., 2005:63). “The researcher must respect the customs of the particular community in all his actions in order to obtain proper co-operation from the community” (Strydom in De Vos et al., 2005:64). “The ultimate responsibility for the ethical treatment of research participants lies with the person in charge of the research project” (Bernard & Whitley, 2002:59). In the study, the researcher remained objective while conducting the research and refrained from making value judgements. The research participants were treated ethically and the researcher respected the customs of the chosen community. The research project had adequate supervision from an allocated supervisor; therefore the research process was conducted according to the ethical requirements, as the allocated supervisor ensured this.

- Analysing the data

“The final responsibility rests with each individual researcher to eventually present a study that fulfils all ethical requirements” (Dane in De Vos et al., 2005:68). This implies that the whole process of research must be conducted ethically and objectively and this includes the analysis of data. The researcher ensured that the data was analysed to reflect a scientific and ethical representation of the study, by comparing information gathered from the different participants and identifying common themes from the semi-structured interviews and incomplete sentences. As mentioned above, the Kinetic family drawings were analysed with the help of a professional, who also had to sign a confidentiality agreement. The various theories were incorporated into the data analysed and inferences were made. Conclusions were drawn from the acquired information only and the
researcher was not biased and remained objective and respected the culture of the respondents involved. The researcher conducted the study under the compliance of the Ethical Code.

- Release or publication of the findings
“Report writing includes doing all you can to make sure your report is as clear as possible and contains all the information necessary for readers to understand what you have written” (Dane in De Vos et al., 2005:65). “An ethical obligation rests upon the researcher to ensure at all times that the investigation proceeds correctly and that no one is deceived by the findings” (Strydom in De Vos et al., 2005:65). The researcher reported only that which was discovered, in a way that the reading community could understand and the researcher remained objective throughout the process of research. In addition, the results of the study could possibly be released in the form of peer-reviewed journals.

- Debriefing of respondents
Debriefing research participants has three functions, namely “educating the participants about the research, explaining any deception that was used, and eliciting the participants’ aid in improving the research” (Greenberg & Folger in Bernard & Whitley, 2002:81). “Debriefing sessions during which subjects get the opportunity, after the study, to work through their experience and its aftermath, are one possible way in which the researcher can assist subjects and minimise harm” (Judd, Smith, & Kidder in De Vos et al., 2005:66). The researcher debriefed all the respondents after the study and offered all the respondents and their guardians the opportunity to ask the researcher questions that they may have had.

1.6 Definitions and main concepts
The following section includes the definitions of the main concepts present in the research.

1.6.1 Child
“A child is defined by the Child Care Act 74 of 1983 as any person under the age of eighteen years” (Thiele, 2005:8). “The period from approximately the sixth to the twelfth year of life is generally known as middle childhood” (Louw, Van Ede & Louw, 1998:322). For the purposes of this study, a child can be defined as a person who is in middle childhood; aged between six and twelve years.

1.6.2 HIV/AIDS
The term ‘HIV’ refers to “Human Immuno-Deficiency Virus” (Tabeisa, 2004:9). HIV is a virus that degenerates the immune system and can lead to AIDS (Tabeisa, 2004:9). ‘AIDS’ refers to “Acquired Immune Deficiency Syndrome” (UNAIDS, 2003:6). People with AIDS have a weakened immune system which makes them more vulnerable to contracting infections that could result in death (Tabeisa, 2004:61). For the purpose of the research these definitions are sufficient.

1.6.3 AIDS-orphan
The term AIDS-orphan is defined as referring to “uninfected children and youth up to the age of eighteen that have lost either or both parents to AIDS” (Thiele, 2005:8). AIDS-orphans can be defined as “those children who are under the age of 15 years and have lost a parent or both parents to AIDS” (UNAIDS in Kalipeni et al., 2004:306). For the purpose of the study, an AIDS-orphan is defined as a child in the middle childhood years (6-12 years old), who has lost one or both parents to AIDS related illnesses.

1.6.4 Foster care
“Refers to the legal placement of children in substitute care as stated in the Child Care Act 74 of 1983” (Thiele, 2005:8). “The intent of foster care is to offer children care within a family environment when their own homes are temporarily unable to do so” (Crosson-Tower, 2007:307). For the purpose of this study, foster care can be defined as the legal placement of 6-12 year old AIDS-orphans in substitute care within a family environment.
1.6.5 Kinship foster care
Blatt (2000:7) defines kinship foster care as, “the placement of a child with relatives”. According to Gleeson, O’Donnel & Bonecutter (in Thiele, 2005:9) kinship foster care refers to the placement of children in state custody with their relatives. For the purpose of the research, kinship foster care can be defined as the placement of children with their relatives.

1.6.6 Foster parent
“Refers to the legal placement of children in substitute care as stated in the Child Care Act 74 of 1983” (Thiele, 2005:8). “A foster parent is an adult who expresses a willingness to protect, nourish, nurture, educate, console, and care for children who are deemed to be in a family situation that potentially is (or has been) dangerous to their well being, have had atypical life-experiences compared with the norm, and may have a sense of who “the adult” is in their lives” (Silver, Amster & Haecker, 1999:280). For the purposes of this study a foster parent is an adult who has been given the legal responsibility of providing substitute care for a child that is not biologically his/her child.

1.6.7 Life-experience
According to the Oxford Dictionary the word ‘experience’ can be defined by, “observation of facts or events, practice in doing something”. Experience is defined by WordReference.com [sa] as, “the accumulation of knowledge or skill that results from direct participation in events or activities” (2 October 2007). For the purpose of this study, life-experience can be defined as the way in which the AIDS-orphan participates in life events while living in a foster family; their perception of living in kinship foster care; the AIDS-orphan’s personal understanding of and meaning given to life in kinship foster care; their lived-experience of kinship foster care.

1.7 Chapter outline
Chapter One - Introduction and overview
In this chapter, the problem formulation, aim and objectives, research approach and methodology and ethical aspects are discussed.

**Chapter Two – Literature review**
This chapter is focused around HIV/AIDS and the levels of impact thereof, orphanhood, foster care and the context of the research: the Child Welfare Vryheid is discussed. Finally, the developmental stage of the AIDS-orphans in the study (middle childhood) and the developmental theories applicable to the study are discussed.

**Chapter Three – An integration of the research methodology and the findings**
In this chapter, an overview of the research methodology is given and Bronfenbrenner’s Ecological Systems Theory is used as a guide as to which areas in the AIDS-orphans’ lives to focus on. The findings of the research are focused on, where information gathered from the semi-structured interviews, incomplete sentences and Kinetic family drawings is used. Finally, a literature control is incorporated, where the Gestalt perspective is integrated with the findings of the study.

**Chapter Four – An integration of the conclusions and recommendations of the study**
This chapter is focused around the goal and objectives of the study, and the limitations, recommendations and suggestions for future research.

**1.8 Conclusion**
In conclusion, an introduction and overview of the study was given, where the problem formulation, research question and aim and objectives were highlighted. The research approach, methodology and ethical aspects were focused on and the definitions and main concepts were given. Finally, the chapter outline was included.
Chapter Two
Literature review

2.1 Introduction
In South Africa by 2001, about 10% of the population or 4.2 million people were living with HIV (Centre for Policy Studies, 2001:23). However, Richter, Manegold and Pather (2004:5) stated that in Southern Africa (South Africa and surrounding countries within the African continent) the HIV/AIDS epidemic is not expected to peak until 2010-2020, after which it is anticipated that incidence and prevalence will begin to decline.

The HIV/AIDS epidemic has many impacts on children, which, according to Pharoah (2004:65), can include malnutrition, migration, homelessness, reduced access to education and health care, depression, guilt, fear, increased vulnerability to HIV infection, illiteracy, poverty, child labour, exploitation and the prospect of unemployment. These statements provide a brief introduction to the broader context of the research which will be elaborated upon in this chapter. This chapter aims to focus on HIV/AIDS and the impact thereof on individuals, communities and society in general. Orphanhood as an outcome of HIV/AIDS and the multiple losses associated with orphanhood are discussed, whereafter foster care (with a focus on kinship foster care) and its implications are introduced. The Child Welfare Vryheid is then focused on briefly, as it provided the context of the study. Finally, in an attempt to provide a theoretical grounding, the developmental theories of Erikson and Piaget are incorporated.

2.2 HIV and AIDS
In Barnett and Whiteside (2006:3), it is stated that HIV/AIDS is predominantly a sexually transmitted disease which causes illness and death among people, especially between the ages of 15 and 50 years old and these people are the most productive people in any society. “The disease affects people in their most productive years and also in their childbearing and –rearing years” (Centre for Policy Studies, 2001:11).
A similar statement was made by Pharoah (2004:1), where she said that people were likely to contract HIV in their late adolescence and young adulthood, but only become ill and die in mid-adulthood. Barnett and Whiteside (2006:174) established that the AIDS epidemic is now probably approaching its thirteenth year worldwide. According to Pharoah (2004:1), HIV/AIDS has implications for the well-being of individuals, households, communities and states. "There has been a full measure of denial, where politicians, policy makers, community leaders and academics all denied what was patently obvious - that the epidemic of HIV/AIDS would affect not only the health of individuals, but also the welfare and well being of households, communities and, in the end, entire societies" (Barnett & Whiteside, 2006:5). In the opinion of the researcher, HIV/AIDS is a worldwide plague that is affecting every person in some way or another and can no longer be ignored.

The outcomes of HIV/AIDS include dying people, orphaned children, the elderly left uncared for and heightened levels of poverty (Barnett & Whiteside, 2006:6). HIV/AIDS is a global epidemic; it has been reported from every inhabited continent and from every country (Barnett & Whiteside, 2006:8). The AIDS epidemic is at its worst in Africa and does not end with the death of the sufferer, but continues throughout the lives of a whole generation of children who are orphaned by AIDS (Guest, 2003:1). Foster, Levine and Williamson (2005:4) agree with this statement and added that the HIV/AIDS epidemic is most severe where it emerged earliest - in sub-Saharan Africa, which includes 42 African countries south of the Sahara desert, of which South Africa is one.

In addition the Centre for Policy Studies (2001:23) states that 95 % of the world's orphans live in sub-Saharan Africa, which corresponds with the statements made above. Guest (2003:1) states that about 70 % of the world's 42 million HIV-positive people live south of the Sahara desert (sub-Saharan Africa) and about 80 % of the world's AIDS-orphans are in Africa. South Africa is seen as the area with the highest number of people living with HIV in the world, with 6.29 million infected people (Barnett &
Whiteside, 2006:131). Pharoah (2004:66) asserts that it is estimated that almost three-quarters of orphans in the world will be from Africa. Guest (2003:10) claims that there is an AIDS-orphan crisis in Africa because Africans like to have big families as it offers status and acts as an insurance policy, as children will look after their parents in old age. Therefore, as AIDS is killing a large number of adults, even larger numbers of children are left without care. In addition, HIV-positive Africans tend to die faster than HIV-positive Westemers, as they cannot always afford enough food, clean drinking water, antiretroviral drugs and drugs to treat opportunistic infections (Guest, 2003:10).

Barnett and Whiteside (2006:25) state that many HIV infected children survive beyond their first birthdays only to die before the age of five. The development of HIV/AIDS in the world can be seen in four waves: first, the wave of HIV infection; second, the wave of tuberculosis (the most common opportunistic infection); third, the wave of AIDS illness and death, and fourth, the wave of impact (including poverty, orphaning and many more effects) (Barnett & Whiteside, 2006:26). The HIV/AIDS infection has an impact on population dynamics, which are being altered by unusual levels of death (Barnett & Whiteside, 2006:179). It has been predicted that populations will grow more slowly and their overall structures will change and there will be fewer births (Barnett & Whiteside, 2006:187). The epidemic increases morbidity (sickness) and mortality (death) in populations at precisely those ages where normal levels of morbidity and mortality are low (Barnett & Whiteside, 2006:172).

2.2.1 The different levels of impact of HIV/AIDS

Guest (2003:157) explains that AIDS sets off a vicious spiral – as adults die, families grow poorer, as families grow poorer, children go hungry. When children are hungry, they grow weak and vulnerable to infectious diseases and grow up with stunted bodies and minds. More children will drop out of school to care for dying parents, earn a living, do household chores or raise younger siblings. When children miss out on schooling, they will be less employable and more ignorant about sex, AIDS and
condoms. In addition, more children will be abused because they lack shelter and protection, or because selling sex is their only means of survival. More and more children will end up on the streets and crime will escalate as more children steal to survive or join gangs in search of a surrogate family (Guest, 2003:158). The researcher agrees with this statement as, in her opinion, the number of street children has increased and this could be a direct impact of HIV/AIDS in South Africa. This whole generation of AIDS-orphans will carry sadness from their childhood into their adult years, thus making them susceptible to depression and perhaps vulnerable to exploitation (Guest, 2003:160). Pharoah (2004:2) made similar statements which emphasised that in South Africa, people will experience growing socio-economic problems where there will be a decline in wealth, assets and economic productivity and this in turn will cause the breakdown of families which will affect households, communities and societies in a variety of ways.

Guest (2003:157) points out that AIDS will affect children in many ways, such as an increase in child mortality, as children will die from HIV or perhaps neglect after their mothers’ deaths; an increase in the levels of child abuse, malnutrition and illiteracy would also occur. The number of children living on the street, committing violent crime, joining gangs and abusing alcohol and drugs will also rise. Many babies will be abandoned as people believe that children born to HIV-positive mothers will be infected too. Other potential impacts of HIV/AIDS on children include reduced well-being and failure to immunize or provide health care (Hunter and Williamson in Richter et al., 2004:8). The impact of the AIDS epidemic on children follows the adult epidemic (Foster et al., 2005:5). The researcher is of the opinion that the number of children orphaned by HIV/AIDS is rapidly increasing as the number of adults dying from AIDS-related illnesses is increasing. According to Foster et al. (2005:6), HIV/AIDS is a dynamic pandemic and its impacts on children, families and households unfold gradually and in many directions. In the opinion of the researcher, HIV/AIDS has many different, yet integrated, levels of impact which are explored further below.
2.2.1 (a) The individual impact

The impact of HIV/AIDS on individuals ripples into other levels of impact as they are all interrelated. The individuals who are infected with HIV/AIDS confront an impact on their health (Barnett & Whiteside, 2006:198). In the opinion of the researcher this impact on a person's health can be deducted from the research (above and below) and includes sickness, pain, discomfort, eventual loss of independence and loss of mobility. Other individual impacts include the loss of loved ones, orphaning (an individual impact on children), stigma, guilt, fear and depression, the loss of employment and thus loss of income, food, sufficient clothing, and schooling and perhaps loss of shelter. “Direct impacts of HIV/AIDS on children occur in the domains of material problems affecting poverty, food security, education and health, as well as non-material problems related to welfare, protection and emotional health” (Richter et al., 2004:9).

The individual impact of HIV/AIDS shares some aspects with the psychosocial impacts, which will now be explored.

(b) The psychosocial impact

The psychosocial impact of HIV/AIDS on children includes the pain and suffering associated with the death of a parent, serving as a caregiver to ill parents, seeking employment to support the family financially, raising younger siblings in place of their parents and depending on the resources and goodwill of extended family, friends and neighbours to take them in when they are finally orphaned by AIDS (Foster et al., 2005:93).

According to Richter et al. (2004:9) other psychosocial impacts of HIV/AIDS on children include decreased affection and encouragement, harsh treatment, stigma and social isolation, sexual abuse and exploitation, abandonment, institutionalisation, grief, depression and antisocial and difficult behaviour. Foster et al. (2005:94) describe similar psychosocial impacts on children, such as anxiety, mistrust, fear, depression, anger and guilt and the impact of the stigma of HIV/AIDS and how it encompasses
their lives. In addition, Pharoah (2004:12) includes exhaustion and stress from work and worry, and separation from friends as psychosocial impacts of HIV/AIDS. Children worry about sick parents and this often results in fear of abandonment and chronic insecurity (Foster et al., 2005:98). These children, according to Foster et al. (2005:94), often carry this burden alone and in isolation, without adult guidance and they lack the skills and emotional maturity to cope.

The psychosocial impact given above, is integrated with and therefore leads to the discussion of the economic impacts below.

(c) The economic impact
The economic impact of HIV/AIDS, as described by Foster et al. (2005:39), includes enormous amounts of stress placed on households as they care for sick family members, take in orphans and experience the loss of productive adults. This loss of the family income causes AIDS-afflicted households to sink further into poverty (Guest, 2003:7). Pharoah (2004:10) declared that the selling of family assets to pay for health care, funeral costs and the loss of income by breadwinners may deplete all household reserves. The high cost of treatment and the need to assist sick family members has the greatest economic impact on the family (Foster et al., 2005:39).

Richter et al. (2004:9) state that economic impacts of HIV/AIDS include increased poverty, loss of property and inheritance, loss of food security and loss of shelter, withdrawal from school to care for others and to save costs, increased skipping of school and premature termination of education. Foster et al. (2005:39) concur with this and emphasise that the economic impacts on children include the loss of educational opportunities due to children being kept out of school to help care for sick family members, or to leave the home in search of work to provide an income for the family. Mutangadura (in Foster et al., 2005:39), affirms that some children leave school simply because their families can no longer afford schooling due to reduced household incomes as a result of HIV/AIDS.
Foster et al. (2005:39) states that other children leave school because they are too worried about a parent’s condition or because they feel stigmatized by the nature of a parent’s illness. In addition, these economic impacts of HIV/AIDS on children are evident through the reduced capacity of their mothers to care for them (Foster et al., 2005:40). Traditionally, women care for the children and the sick, and work for an income. However, in some cases, these women had to leave work in order to care for the increasing number of sick people in the family, therefore leaving little or no time to spend with the children. Ultimately, the children are neglected and their needs left unsatisfied. According to Pharoah (2004:10), migration has been identified as an important coping mechanism, as many people go home to die, move closer to relatives who can assist them or move to places where there are more jobs available. This all implies that children in these situations are often relocated and have to adjust to yet another change.

(d) Household and community level impact

The household impact of HIV/AIDS includes clusters of households of infected people as the HIV virus is sexually transmitted (Barnett & Whiteside, 2006:198). Community level impact of HIV/AIDS can be seen as HIV/AIDS infected individuals make up households, households make up communities and communities make up nations (Barnett & Whiteside, 2006:207). “Indirect impacts on children include changes in the population structure, household support and livelihood activities, poverty and insecurity, quality and availability of health and education services, and in the morale of the communities in which they live” (Richter et al., 2004:9). Hunter and Williamson (in Richter et al., 2004:8) describe the inability to maintain infrastructure, loss of skilled labour and psychological stress and breakdown as potential impacts of HIV/AIDS on communities. As for the rural impact, Barnett and Whiteside (2006:245) state that each season of cultivating will see a small, significant and usually negative change in farming, household relationships and the social fabric of the community. In
addition, property disputes may arise when opportunities surface to contest inheritance.

A variety of interrelated impacts were given above, which provides a background to the following section, the long-term impacts of HIV/AIDS.

(e) Potential long-term impacts
Pharoah (2004:95) highlights potential long-term impacts of poor psychosocial support systems, due to HIV/AIDS: reduced literacy, high unemployment, segregation, discrimination, teenage pregnancy, child prostitution, crime, violence, family disintegration, and the erosion of the extended family safety net, lack of parenting skills and mentors and chronically traumatised adults.

A long-term psychological effect of emotional deprivation due to HIV/AIDS infection, as emphasised by Wild (in Pharoah, 2004:12), includes children at a higher risk of developing psychological problems due to growing up without the love and care of adults devoted to their well-being. The long term consequences of AIDS and orphaning, according to Thiele (2005:24), include children who are unlikely to become fully functioning members of society as a result of their lack of education, reduced literacy, inadequate parental supervision, food shortages and poor social and economic skills. In addition, according to Smidt (2006:87), HIV/AIDS will have an impact on the passing on of culture, as in Southern Africa the ability of the family to nurture children and socialise them into the culture is being deeply damaged by the HIV/AIDS epidemic. Richter et al. (2004:9) concur with this and state that an impact of HIV/AIDS is that traditional knowledge will not be passed on.

A devastating consequence of HIV/AIDS is the creation of growing numbers of AIDS-orphans; therefore an exploration of orphanhood will follow to provide a broader context to the research.

2.3 Orphanhood as an outcome of HIV/AIDS
Barnett and Whiteside (2006:195), are of the opinion that one of the worst consequences of the AIDS epidemic is the creation of orphans and that the projected total number of AIDS-orphans by 2010 is 25 million (Barnett & Whiteside, 2006:9). It is estimated that by 2010 there will be 500 000 AIDS-orphans in KwaZulu Natal alone (Guest, 2003:59). In the opinion of the researcher there seems to be a larger number of AIDS-orphans in KwaZulu Natal, the province where the research was conducted.

Barnett and Whiteside (2006:211) state that, in poorer countries, families routinely took in children from the wider family, whereas in rich countries, institutions were available to care for these children. However, the scale of AIDS orphaning is such that these coping mechanisms are collapsing in the poor world. The child’s family structure and role will change as the epidemic progresses, with more and more children being fostered or adopted and overcrowding and high levels of stress can negatively affect everyone in the household (Thiele, 2005:20). When people take in AIDS-orphans, they are placing increasing demands on their household resources and many of these families already have to care for a number of children of their own, therefore all children in the household suffer the same economic and other deprivations resulting from the spreading of resources more thinly as a coping response to the epidemic (Barnett & Whiteside, 2006:222).

In Barnett and Whiteside (2006:226), it is proclaimed that, although the government in Africa offers some additional support for orphans, carers are sometimes reluctant to accept this assistance, as this acceptance may identify the dead parent as having died from AIDS, or it may suggest that the family cannot cope, which is another stigma.

The process of becoming an AIDS-orphan is a slow and very painful process for the child, who has to deal with the loss of a parent or parents along with the responsibility of long term care that the parents failing health may require (Barnett & Whiteside, 2006:223). Thiele (2005:19) states that the stigma attached to HIV/AIDS often results in silence about
the impending death of a parent and is a barrier to the child's future planning and that orphaned children often carry the sadness of their childhood into adulthood. Guest (2003:2) agrees with this statement and emphasised that the stigma associated with HIV and AIDS causes some people to keep silent about the virus. This tact may save some families from extra pain, but ultimately it obscures the truth (Guest, 2003:2).

According to Foster et al. (2005:106), the stigma of HIV/AIDS affects children's adjustment as distress and social isolation are common among children whose parent is HIV-infected. Kelly (in Barnett & Whiteside, 2006:229) claims that an aspect of orphanhood includes the AIDS-orphans' struggle with the stigma and discrimination that is often associated with AIDS, which often deprives them of basic social services and education. The researcher is of the opinion that the stigma around HIV/AIDS is still very prevalent in South Africa, in spite of many educational programmes aimed at reducing this stigma.

Children who have witnessed their parent's illness over a period of time usually experience severe trauma, uncertainties about the future and are often emotionally withdrawn (Thiele, 2005:19). "Children also become uncommonly familiar with death" (Barnett & Whiteside, 2006:223). Foster et al. (2005:98) emphasise that children of parents with HIV/AIDS are more likely to be depressed and anxious and have more behaviour and conduct problems, poor social competence and less ability to pay attention. "Depressed children may bully a sibling, pick a fight at school, or suffer frequent, unexplained aches and pains" (Foster et al., 2005:113). Foster et al. (2005:98) state that children sometimes resent their parent's illness and this resentment leads to feelings of guilt, anger and a low tolerance for frustration. According to Foster et al. (2005:101), when parents die, older children may take on the parental role and care for siblings and maintain the household. Children of single parents with HIV/AIDS express fear that can result in generalized or separation anxiety, which includes refusing to attend school (Foster et al., 2005:100). Foster et al. (2005:103) stipulate that parents who are ill cannot be emotionally and physically available for
their children and this may result in children being less supervised and left alone more often. This parental unavailability may mean that younger children fail to develop cognitive, academic, emotional and social skills, while adolescents’ risk for involvement in early sexual activity, cigarette use, alcohol and drug use, or involvement in gangs increases (Foster et al., 2005:103).

Pharoah (2004:11) postulates that children who are affected by HIV/AIDS may receive poorer care and supervision at home and may suffer from malnutrition. Children who have suffered the long-term psychological effects of emotional deprivation have experienced a lack of positive emotional care which is associated with a lack of empathy with others and these children may develop antisocial behaviours (Pharoah, 2004:12). Makame, Ani and Grantham-McGregor (in Pharoah, 2004:75) conclude that orphanhood is associated with increased child labour.

When the parents in a family die from AIDS-related causes, the sibling group are often split up between aunts and uncles in order to share the cost. However, the older generation seems to be taking on more children. “In all heavily affected countries, there is now an army of grandmothers, aunts and older sisters struggling to care for exploding numbers of orphans. But as the pressure on them grows, they are going to need help in order to feed those extra mouths” (Guest, 2003:11). “Orphans and the elderly are not only AIDS affected, some will also be infected” (Barnett & Whiteside, 2006:211). When an orphan goes to grandparents or to another relative, the relative they go to may also die from AIDS-related illnesses, thus causing the child to undergo successive orphaning and the child will again have to move on to some other relative’s house (Barnett & Whiteside, 2006:223). Many of these AIDS-orphans living with their grandparents will end up looking after the aging and perhaps infirm grandparents, thus exerting more pressure on the children concerned (Barnett & Whiteside, 2006:223). Many grandparents looking after AIDS-orphans said that they had problems with discipline (Barnett & Whiteside, 2006:235). This could place further strain on the family. In addition,
according to Barnett and Blaikie (in Barnett & Whiteside, 2006:224), children were likely to be disinherited on the death of a parent or parents, thus causing extra damage to the family system. Some AIDS-orphans’ inheritances are stolen by their relatives in desperate cases (Guest, 2003:11).

Wild (in Thiele 2005:22), emphasised that children who are orphaned are at risk of dropping out of school prematurely, to either go out to work, look after the home, care for siblings or an ill person, or because the family cannot afford schooling costs. Children may receive a low standard of education due to the under-resourced public schools and the death of teachers as a result of the AIDS epidemic (Barnett & Whiteside, 2006:220). The researcher is of the opinion that this low standard of education received by AIDS-orphans adds to the negative experiences of orphanhood. Barnett and Whiteside (2006:223) have established that for the orphaned child there is often a premature entrance to burdens of adulthood, all without the rights and privileges associated with adult status. “AIDS has increased the number of households headed by children” (Centre for Policy Studies, 2001:79). Pharoah (2004:75) also states that children affected by HIV/AIDS are increasingly taking on adult roles at a young age, where children are providing care for a sick parent and taking on extra household responsibilities. In addition, Barnett and Whiteside (2006:228) confirmed that orphanhood threatens many aspects of children’s lives. HIV/AIDS increases the chances of children’s rights being violated. According to section 28 of the Bill of Rights, every child has the right to the following: a name and nationality from birth; family or parental care or to appropriate alternative care where the child is removed from his or her family environment; to basic nutrition, shelter, basic health care and social services; to be protected from maltreatment, neglect, abuse or degradation and to be protected from exploitative labour practices (South African Human Rights Commission, 2002:12). Therefore it can be hypothesised that children’s rights will be violated by the consequences and impacts of HIV/AIDS.
AIDS-orphans are a generation of children deprived of their childhood (Barnett & Whiteside, 2006:212). When comparing AIDS-orphans and children who have parents, AIDS-orphans run greater risks of social exclusion and abuse and exploitation than do non-orphans (Barnett & Whiteside, 2006:212). According to Pharoah (2004:41) psychosocial risks of HIV/AIDS which affect children include growing up in war-torn communities or in families with mentally ill, alcoholic, abusive or criminal parents, child abuse and neglect, a lack of secure attachments, parental death and a lack of stability and routine. In Barnett and Whiteside (2006:219), it is stated that AIDS-affected households tend to be poorer, consume less food and have smaller disposable incomes, thus causing children in these households to be less well-nourished and have a greater chance of being stunted. “Unknown numbers of children will go hungry, starve and suffer stunted physical and mental growth” (Pharoah, 2004:21). Guest (2003:157) concurs with this statement and says that many children will grow up with stunted bodies and minds. Stunting results from an extended period of poor nutrition and orphanhood exacerbates the pathways to stunting. The long-term effects of stunting, according to Barnett and Whiteside (2006:219), include poor physical condition, compromised immune systems and mental functioning - these will affect the ability of children to benefit from education and to function socially and economically later in their lives.

AIDS-orphans who are not taken in by relatives often end up on the streets of the cities, while others are drawn into soldiering (Barnett & Whiteside, 2006:227). Those AIDS-orphans who turn to the street, have physical needs and their financial desperation makes them vulnerable to crime, substance abuse and sexual exploitation. This places a number of these children at risk of contracting HIV through income-generating prostitution (Barnett & Whiteside, 2006:229). Guest (2003:158) agrees with this as she emphasised that more children will be abused, because they lack shelter and protection, or because selling sex is their only means of survival. “AIDS-orphans are at greater risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes” (Barnett & Whiteside,
Migration is another factor present in a large number of AIDS-orphans' lives. Pharoah (2004:10) states that many orphans are frequently relocated and the Centre for Policy Studies (2001:25) backs this up by saying that HIV/AIDS causes forced migration, as children are often sent away to live with relatives following the death of their parents. The manner in which AIDS-orphans may respond to the stressors in their lives may vary according to the age, developmental level, circumstances and personality of the particular child and their varied responses may include hopelessness, depression, anger, loneliness, anxiety, fear of abandonment and confusion (Wild in Thiele, 2005:16). In addition, Wild (in Thiele, 2005:17) states that children who are orphaned by AIDS, may, in addition to the normal grief process, experience survivor guilt and this could worsen the child's feelings of isolation.

Orphanhood is associated with a number of losses; therefore the next section will focus on the multiple losses of orphanhood.

2.3.1 Multiple losses of orphanhood
As the parent's illness progresses, the parent will become less able to influence the child's behaviour and therefore offer diminished support and guidance for the child (Thiele, 2005:18). Thiele (2005:17) postulates that the eventual death of a parent is regarded as a crisis for any child, involving the loss of love, care, support, security and adult guidance that parents should provide, as well as the loss of the link both with the past and shared future. According to the Centre of Policy Studies (2001:53), orphans are stressed even before their parents die and the death of their parents exacerbates their feelings of depression, anger, resentment and confusion. In addition, Corr (in Pharoah, 2004:23) states that the loss of parents is associated with internalising psychological conditions including anxiety, rumination, depression, social isolation, survivor guilt and low self-esteem.

AIDS-orphans are often unsocialised, uneducated and unloved children who are struggling into adulthood (Barnett & Whiteside, 2006:226).
According to Schöneich (in Barnett & Whiteside, 2006:227), during the next decade there will be a boom in South Africa's orphan population and, with children growing up without parents and being badly supervised by relatives and welfare organisations, this growing pool of orphans will be at greater than average risk to engage in criminal activity. A similar statement was made by Pharoah (2004:2), that it is feared that the epidemic may create generations of disenfranchised and potentially dysfunctional young people who lack the socialisation necessary for constructive social engagement. In the opinion of the researcher, the levels of crime committed by youths in South Africa have already risen with the increase in orphaning of children by AIDS.

AIDS is accelerating the breakdown of the traditional African family. AIDS-orphans are going to raise their own children without the help of grandmothers that used to provide a source of love and support and free child care while the mothers were at work (Guest, 2003:27). In the researcher's opinion this is yet another loss related to orphanhood and adds to the negative experiences associated with orphanhood. Foster et al. (2005:100) conclude that children of HIV/AIDS infected parents may have suffered losses other than the loss of one parent. Many children have had to watch one parent deteriorate for months or even years and this creates insecurity and personal vulnerability in children. They may doubt their ability to go through and cope with all that for a second time with their other parent (Foster et al., 2005:100).

Children may have lost their homes and assets due to the sale of livestock and land for survival, as well as asset stripping by relatives (Pharoah, 2004:11). According to Straker (in Pharoah, 2004:94) the multiple losses experienced by children due to HIV/AIDS include the loss of several family members, siblings, friends, familiar surroundings, nurturing, family stability, social connectivity, schooling opportunities, and even their childhood and hope in the future. In addition, according to Hunter and Williamson (in Richter et al., 2004:8) one impact of HIV/AIDS on children is a loss of identity. Orphans and foster children may additionally be disadvantaged by
their pre-existing low socio-economic status at the time of their parents' deaths (Richter et al., 2004:11).

The AIDS-orphans in the study were in kinship foster care; therefore an exploration of foster care will follow.

2.4 An exploration of foster care

Guest (2003:11) asserts that if a child is deprived of a family, the state must ensure that there is alternative care such as foster placement, adoption, or, if necessary, placement in suitable institutions. Blatt (2000:1) describes foster care as the provision of substitute homes for children who have been removed from their own homes. Pharoah (2004:83) states that fostering is a less permanent form of substitute care which does not involve the transfer of parental rights and responsibilities. Askeland (2006:65) established that the AIDS crisis has devastated the adult populations to such an extent that thousands of AIDS-orphans have been left without any family care. These children could benefit from placement in foster homes. The best place for a child is in a family; if this is not possible, the next best thing is to provide some form of care within the child's original community. The last resort, according to Guest (2003:12), should be in residential care (which is another name for an orphanage). In the past, children without homes were placed in orphanages. However, it is now considered more appropriate to place these children in private homes (Blatt, 2000:1). The reason for this change is that children placed in orphanages became institutionalised and did not learn how to be part of a family (Blatt, 2000:5). Barber and Delfabbro (2004:3) state that foster care is as close as you can get to the way most of us live. The goal of foster care, in most cases, is to temporarily remove the child from the home, so that the problems present in the home can be addressed and then the child is reunited with the biological family (Blatt, 2000:1). However, sometimes children are placed in foster care and then it becomes apparent that they cannot return to their biological families, so these children are then offered for adoption (Blatt, 2000:1). Adoption is considered to be the best option for AIDS-orphans, because it offers
security as it permanently transfers legal guardianship to the new parents. Fostering is seen as a short-term fix, usually with a view of returning the child to the family, or as an interim measure whilst finding an adoptive family (Guest, 2003:41).

In Blatt (2000:6) it is stated that people generally become foster parents because they feel that they have something to offer to these children. Blatt (2000:7) describes kinship foster care as the placement of a child with relatives. This is a common phenomenon in South Africa due to the large numbers of parents dying from AIDS related illnesses. Pharoah (2004:67) states that even in the absence of parental death, children are fostered, and this includes the practice whereby natural parents allow their children to be reared by adults other than themselves. Harber (in Thiele, 2005:37), considers foster care to be the most widely utilised form of substitute care in the world, with the most common form of fostering in Africa being foster care by family members (kinship foster care). According to Thiele (2005:37), the HIV/AIDS crisis has changed foster care in South Africa and permanent foster care placements of orphaned children with their relatives (kin) is becoming commonplace. Kinship foster care has positive features such as the availability of additional placement resources, a setting which is likely to be familiar to the child, a stronger commitment of carers to the child and the added likelihood that children may feel the pain of separation from biological parents less acutely (Barber & Delfabbro, 2004:23). In 2000, it was estimated that about a third of South Africa’s 250000 AIDS-orphans were in foster care and almost two thirds were being cared for by their families or communities (Guest, 2003:41). According to Barber and Delfabbro (2004:37) kinship foster care is associated with fewer placement moves and lower levels of access to support systems. The AIDS-orphans in the study were all placed in kinship foster care and were therefore living with relatives.

Blatt (2000:2) states that children are placed in foster care for various reasons, such as abuse or neglect and living in a home that is considered to be unsafe; children who are considered unmanageable; and children
who have been abandoned, or whose parents cannot care for them. In Barber and Delfabbro (2004:37) it is stated that most foster children prefer sibling co-placement. When a child is placed in foster care, they are afforded the opportunity to learn new behaviours, new attitudes and know the pleasures and challenges of family life (Blatt, 2000:9). Blatt (2000:10) established that a foster home does not have to be a perfect home, but a home with love and strong bonds.

When a child is placed in foster care, he or she is separated from the family and this is almost always a traumatic experience where the child will need assistance in adjusting (Barber & Delfabbro, 2004:23). According to Sinclair, Wilson and Gibbs (2005:251) foster care is an impressive system to which both carers and children are committed. However, in the authors’ opinion there are three problems associated with foster care: the fact that it rarely offers permanence, its placements are too liable to break down and it does not have proven ways for enabling its children to change.

According to Blatt (2000:4), many foster children act older than might be expected and they may seem stubborn and opinionated and may not be willing to listen to foster parents. On the other hand, other foster children may seem immature and problems like bedwetting and temper tantrums are quite common. Foster children are also often not committed to telling the truth and sometimes make up elaborate stories that represent the way they wish things were (Blatt, 2000:5). Barber and Delfabbro (2004:94) stated that when a child is placed in foster care, friendships are sometimes disrupted and this is likely to cause considerable psychological distress in many children and a loss of interest in school; it may also contribute to tension and placement breakdowns when children fail to complete homework or attend school (Barber & Delfabbro, 2004:93). In addition, many foster children may show anger and may express aggression towards siblings, pets, teachers or foster parents (Blatt, 2000:5). Therefore it could be concluded that foster care is not always easy. Barber and Delfabbro (2004:91) established that children in foster care tend to obtain lower scores on most measures of psychosocial and physical well-being.
compared with normative populations of a similar age. In addition it was found that foster children are at significant disadvantage compared with other children. Adolescents are at greater risk of placement instability, which is moving from foster family to foster family. When this happens, the development of stable attachments are compromised (Barber & Delfabbro, 2004:93). The researcher is therefore of the opinion that foster children display a variety of problem behaviours and these behaviours could contribute to the AIDS-orphans experience of foster care.

Sinclair et al. (2005:240) established that foster placements are more likely to be unsuccessful when children appear to have difficulties with attachment or appear to be disturbed. However, foster placements seem to be more successful when children helped others, saw tasks through to the end and showed other admirable traits. Children may be removed from foster care by a judge for a number of reasons which, according to Blatt (2000:12), include the following: a child returning to the biological family if the judge determines that the child will be safe and comfortable there; the child moving to another foster home (to be closer to the biological family, siblings or relatives); or the placement is not working out well and the foster parents have requested that the child be placed with another, more suitable foster family.

The AIDS-orphans included in the study all lived in and around Vryheid, KwaZulu Natal and were selected from the Child Welfare Vryheid's cases. The following section will focus on the context of the research, which was the Child Welfare Vryheid.

2.5 Context of the research: the Child Welfare Vryheid
The Child Welfare Vryheid, hereafter referred to as the Vryheid Child Welfare, has been in existence since 1925 and is affiliated to Child Welfare South Africa. According to the Child Welfare South Africa (Annual Report, 2006), the organisation in Vryheid renders a variety of services, such as casework, group work and community work. The casework services rendered include assistance with child care related problems,
financial related intakes, foster care, family conflict, drug and alcohol abuse and other problems (rape, grief counselling, depression, disabilities and volunteers). The community and group work services that the Vryheid Child Welfare renders include the protection of children (through crèches, a toy library, foster care support groups, Christmas parties, child protection week, children’s day, golf day, May fair, life skills course, blanket and food collection and feed-a-baby fund) and efforts at poverty alleviation such as a sewing club, a beadwork project, boreholes, a vegetable garden and a bake-for-profit initiative. The impact of HIV/AIDS has seriously affected the clients of the organisation, therefore service delivery has been focused on counselling, prevention and statutory placements. Finally, in regard to services aimed at substance abuse, the Vryheid Child Welfare has implemented a Teenagers Against Drug Abuse (TADA) programme at one of the high schools in the area.

There are currently three full-time and one part-time social workers employed by the Vryheid Child Welfare. According to the Vryheid Child Welfare’s 2006 annual report, one of the primary functions of the social workers at the Vryheid Child Welfare is the provision of efficient casework services. Thiele (2005:3) states that there has been a steady increase in the amount of statutory intervention done by the Vryheid Child Welfare and that the majority of the statutory cases are foster care and children’s home placements. The Vryheid Child Welfare’s combined statistics for March 2004 indicated that out of 301 clients, 198 were foster care supervision cases. There was a 44% increase in the number of foster care placements between April 2003 and March 2004 (Thiele, 2005:3). Thiele (2005:4) found that there was an increasing trend towards kinship foster care at the Vryheid Child Welfare, where 97% of the children in foster care were in kinship placements with members of their extended families. The intakes from April 2005 to March 2006 reflected 273 new intakes, of which 65 were child care related problems (which included, among other things, orphans and HIV/AIDS) and 51 cases of foster care (screening, placement and supervision).
The AIDS-orphans included in the study were from the Vryheid Child Welfare's cases and were between the ages of six and twelve years old and therefore in middle childhood. According to Blatt (2000:75), children between the ages of six and twelve generally develop a personality and a sense of right and wrong, and it is during this time that individual strengths and weaknesses can be identified. Under normal circumstances, children living with their biological families are strongly influenced and guided by their families; however when children grow up in foster care, the foster families and caseworkers must provide guidance for this type of development (Blatt, 2000:75). An exploration of middle childhood was therefore necessary to provide a background for the research and to determine what milestones are reached at certain ages, so that the AIDS-orphans' development could be explored.

2.6 Developmental stage of the AIDS-orphans

Development can be defined as “an increase in complexity; a change from the relatively simple to the more complicated and detailed; an orderly progression along a continuum or pathway” (Allen & Marotz, 2007:22). Allen and Marotz (2007:22) stipulated that the sequence in child development is basically the same for all children; however, the rate of development varies from child to child.

The AIDS-orphans in the study were in middle childhood, aged from six to twelve years. Therefore this stage of development is the focus in this section. Blume and Zembar (2007:34), define middle childhood as, “the developmental period between early childhood and adolescence, from approximately age eight to twelve”. Six, seven and eight year olds are in control of themselves and their immediate world and they are ready and eager to go to school, where reading would be the most complex perceptual task in this stage of development that the child encounters (Allen & Marotz, 2007:164). These children are of school going age and are likely to be developing new skills and making new friends (Blume & Zembar, 2007:34).
During this stage, growth occurs slowly but steadily, height and weight increases, co-ordination improves, energy levels fluctuate, there is greater control over fine and gross motor skills, the child's attention span increases and they start to understand concepts, speech and language develop, the child becomes more and more independent and they develop socially through the formation of friendships (Allen & Marotz, 2007:167-185). Blume and Zembar (2007:34) state that at the age of six or seven, new cognitive capacities emerge that enable these children to handle more complex intellectual problem solving and more intimate friendships than in early childhood. Nine, ten, eleven and twelve year olds show more goal directed effort and language usage becomes more sophisticated (Allen & Marotz, 2007:198). According to Blume and Zembar (2007:34), twelve year olds display greater self-regulation and the consolidation of problem solving skills allows these children to extend their abilities to tasks requiring flexible, abstract thinking and the maintenance of social relationships. Allen and Marotz (2007:198) support this statement and claim that children in this stage develop an increasingly complex ability to think in the abstract, understand cause and effect and use logic for solving problems and figuring out how things work. This stage is marked by slow and irregular growth rate, an increase in the size of the brain, height and weight increases, refinement of motor development, increased cognitive development, and children in this age group can express feelings and emotions effectively (Allen & Marotz, 2007:198-202). Katz and McClellan (in Allen & Marotz, 2007:203) claim that this is the stage when the child begins to develop moral reasoning. Eleven and twelve year olds, according to Allen and Marotz (2007:207), display smoother emotional stability and see themselves as invincible. Their height and weight vary and girls are the first to experience a pre-puberty growth spurt, bodily changes occur and these children begin thinking in more abstract terms (Allen & Marotz, 2007:207-209). "School-age children's social and moral development allows relationships built during middle childhood to pave the way for adolescent dating experiences and social identity" (Blume & Zembar, 2007:164).
A brief explanation of two developmental theories will follow, as the stages in these theories provided a valuable guideline for exploring the AIDS-orphans’ development and thus broadened the context of the research.

2.6.1 Developmental theories
2.6.1.1. Erikson’s theory of psychosocial development
It has been shown above (paragraph 2.2.1 (b)) that HIV/AIDS has a psychosocial impact on children. Therefore Erikson’s theory of psychosocial development has been included in this section to provide a background. Erikson (in Louw, van Ede & Louw, 1998:51) emphasises that the life span is divided into eight stages, where each stage is characterised by a crisis. Solving the crisis is a synthesis which results in a new life situation. The researcher has given a brief overview of the life stages applicable to middle childhood, as it provides a reference of what the child has achieved and what is still to come, for if the child is unsuccessful at one stage, it may affect the next stage of development. According to Erikson, the stages in the lifespan around middle childhood include the following.

2.6.1.1 (a) Initiative versus guilt (synthesis: purpose)
This stage lasts from three to six years of age and is characterised by the child learning to show initiative while overcoming a feeling of guilt. Erikson (1959:74) claims that this is the stage where the child must find out what kind of person he is going to be, and from this the child develops a sense of purpose. The researcher included this stage in this section as it could have been applicable to some of the younger participants in the study.

(b) Industry versus inferiority (synthesis: competence)
This stage of development lasts from the age of six years until the beginning of puberty (twelve years old). According to Erikson (1959:82), this is the time when children watch how things are done and then try doing them and this is the time when children go to school. During the middle childhood years, “the child’s primary psychosocial task is to acquire a sense of industry, or the ability to work on a skill or project and to follow
through over an extended period of time” (Blume & Zembar, 2007:133). When the child achieves success in his school work, he avoids feelings of inferiority and develops a feeling of competence (Erikson in Louw et al., 1998:53). According to Blume and Zembar (2007:133), the child requires a sense of industry and appropriate guidance from others to acquire the basic skills needed in the wider culture in school settings. “The industry stage in middle childhood contributes to the development of adolescents’ emergent sense of identity” (Blume & Zembar, 2007:133). This stage of development will be an area of focus in the following chapters as it concerns the age group of the AIDS-orphans in the study.

(c) Identity versus role confusion (synthesis: reliability)

During this stage, the child is an adolescent (twelve to nineteen years old) who experiences an identity crisis; overcoming this crisis results in reliability, where the adolescent is sure of his or her identity. This stage has been included in this section, as the researcher is of the opinion that the older children in the study could be entering this stage of development.

The second theory included in the study to provide a framework of reference is Piaget’s cognitive-structural theory. This theory was selected as it focuses on cognitive development and was useful in the study as a basis for the sequence of normative cognitive development to ascertain whether the AIDS-orphans in the study were on similar levels of cognitive development as non-orphans.

2.6.1.2 Piaget’s cognitive-structural theory

There are four stages in Piaget’s cognitive structural theory: the sensori-motor, the pre-operational, the concrete operational and the formal operational stage (Piaget, 1972:54). The research was focused on middle childhood, therefore only the relevant stages of Piaget’s theory were included below.

2.6.1.2 (a) Pre-operational stage
The period between two and seven years old is referred to as the pre-operational period, as there is no operational thinking as yet. This stage will be focused on in the following chapters, as it concerns the AIDS-orphans in the study. According to Piaget (1972:57) this is where the symbolic function appears in language and play.

Thought is intuitive and is not based on logic, but on perceptions from which conclusions are drawn. According to Blume and Zembar (2007:99), children in middle childhood are transitioning from pre-operational thought to concrete thought and then preparing to move on to formal operational thinking. “This pattern of development reflects the change from a dependency in early childhood on rigid, self-centred thought that relies heavily on how things appear at that moment to a dependency on operations” (Blume & Zembar, 2007:99).

(b) The concrete operational stage
This stage occurs from the age of seven to the age of eleven or twelve (Piaget, 1972:58). During this stage, the child is capable of operational thinking; however, this thinking is concrete and not abstract. According to Blume and Zembar (2007:99), this is the stage where children develop the ability to apply logical thought to concrete problems. Therefore this stage will also be focused on in the following chapters.

(c) The formal operational stage
This stage occurs during adolescence (twelve to nineteen years old) and involves the highest level of cognitive development. The child develops the ability to carry out formal operations during this stage and learns to reason, think in an abstract and logical way and this is also the stage where the child uses scientific thinking (Piaget, 1972:59). This stage is included in this section, as the older children could have been affected by it.

2.7 Conclusion
In conclusion, the context of the research was explored by examining HIV/AIDS and the impact thereof. The individual, psychosocial, economic,
household and community level and potential long-term impacts of HIV/AIDS were the main areas of focus in this section. Orphanhood as an outcome of HIV/AIDS was then investigated and included aspects such as risks of orphans, stunting, prostitution, migration and the stigma attached to HIV/AIDS. The multiple losses associated with orphanhood were then looked at, and included the death of parents, orphans growing up unsocialised and alternative care. Foster care was then explored where kinship foster care was described as a focal point of the research, and foster children and foster parents were also investigated. The context of the research was then briefly explored by looking at the Vryheid Child Welfare and its services rendered. Finally, the developmental theories of Erikson and Piaget were briefly explored by focusing on the specific age group of the respondents in the research (six to twelve years).

The following chapter contains the research methodology and findings of the semi-structured interviews, incomplete sentences and Kinetic family drawings that were conducted and documented, and the results thereof will be discussed.
Chapter Three
An integration of the research methodology and findings

3.1 Introduction
This chapter focuses on the methods used to conduct the research and on the findings of the research. An overview of the research methodology was given and the process of data gathering was focused on. The analysis of data gathered and documentation of the whole process was then included and the research question was re-visited. Bronfenbrenner's Ecological Systems Theory was then used as a guide as to which areas in the AIDS-orphans' lives to focus on. The findings of the semi-structured interviews, incomplete sentences and Kinetic family drawings were then discussed and integrated with the Gestalt perspective.

An overview of the research methodology will be focused on in the following section.

3.2 An overview of the research methodology
3.2.1 Research strategy
A qualitative research strategy was used in the study as qualitative research, according to Bernard and Whitley (2002:34), is defined as the researcher's attempts to understand how people experience and interpret events in their lives. Fortune and Reid (in De Vos et al., 2005:74) state that, "in qualitative research the researcher attempts to gain a first hand, holistic understanding of phenomena, by means of a flexible strategy of problem formulation and data collection, shaped as the investigation proceeds". The researcher attempted to understand how the AIDS-orphans experienced living in foster care, through the use of semi-structured interviews, incomplete sentences and Kinetic family drawings.

As mentioned in Chapter One, the universe in the study included all the children orphaned by HIV/AIDS in Vryheid, KwaZulu Natal who were placed in foster care. The population included AIDS-orphans in middle childhood, that had lived in a foster home with family members in Vryheid,
KwaZulu Natal for a minimum of two years, whereas the AIDS-orphans that were specifically chosen to take part in the study formed the sample. The researcher incorporated a collective case study that contained all the information obtained from the research participants. A collective case study, as stated by Mark (in De Vos, et al., 2005:272), can be defined as the selection of cases so that comparisons can be made between cases and concepts, and so that theories can be extended and validated. In this study, eight case studies of the chosen AIDS-orphans were compiled which consisted of background information (obtained from the Vryheid Child Welfare) and information gathered from the semi-structured interviews, incomplete sentences and Kinetic family drawings.

As the research was conducted to gain insight into the life-experience of AIDS-orphans in foster care, it could be described as exploratory research. Bless and Higson-Smith (in De Vos, et al., 2005:106), describe exploratory research as research conducted to gain insight into a situation, phenomenon, community or individual. The study was also considered to be descriptive, as the perceptions and life-experiences of the chosen AIDS-orphans were described. According to Neuman (in De Vos, et al., 2005:106), descriptive research can be said to present a picture of the specific details of a situation, social setting or relationship. In addition, as previously mentioned, the research was applied research, as it was used to identify and perhaps solve problems in the system and provide recommendations to people concerned with the foster care of AIDS-orphans in South Africa. Applied research is defined by Bernard and Whitley (2002:30) as, “research conducted to find a solution to a problem that is affecting some aspect of society, and its results are intended to be immediately useful in solving the problem, thereby improving the condition of society”.

The next step in the research included preparation for the gathering of data, which will be focused on in the following section.

3.2.2 Preparation for the gathering of data
A social worker of Vryheid Child Welfare in Northern KwaZulu Natal assisted the researcher and contacted foster parents with AIDS-orphans in their care and made individual appointments with them. The researcher gained written consent from the Vryheid Child Welfare regarding the use of the facility and its cases. The researcher had access to the AIDS-orphans' files and obtained valuable background information on each. The researcher then gained the written consent of the perspective participants, their social workers and their foster parents to take part in the study and to record the whole process of data collection with a video camera. The foster children included in the research remained anonymous.

As mentioned in Chapter One (paragraph 1.4.3, p. 19) *purposive sampling* was used in the study, as the AIDS-orphans were specifically chosen to take part. Silverman (in De Vos, et al., 2005:328), describes purposive sampling as choosing a particular case because it illustrates some feature or process that is of interest for a particular study. The AIDS-orphans in the study were specifically chosen and they met certain criteria, which included being in middle childhood, lost one or both parents to AIDS related illnesses and had been living in a foster home with family members in and around Vryheid, KwaZulu Natal for a minimum of two years.

### 3.2.2.1 Pilot study

The next step in preparing for the data gathering process was conducting a pilot study. A pilot study, according to Bless and Higson-Smith (in De Vos et al., 2005:206), can be defined as a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The researcher conducted a pilot study with five children in the middle childhood years to determine whether the incomplete sentences and questions in the semi-structured interview could be understood by the children. The pilot study was conducted on four boys aged nine and ten, two eleven-year olds and one girl that was eight years old. The same process was used in both the pilot and the actual study which included the sensory exercise, followed by the semi-structured interview, incomplete
sentences and then the Kinetic family drawing. The researcher changed the phrasing of the questions slightly after the pilot study; some AIDS-orphans had difficulty understanding certain words, therefore the researcher elaborated and explained the questions more in the actual study.

3.2.3 Data gathering
The fourth step in the research process was to gather data by interviewing the participants, getting the participants to complete the incomplete sentences and to draw the Kinetic family drawings. The researcher first met with both the foster parent and the AIDS-orphan and explained everything about the study. Once the consent letters were signed by the foster parents and AIDS-orphans, the researcher requested that the foster parent/s wait in the waiting room nearby, while data was collected from the child. The researcher, child and interpreter sat on chairs arranged in an informal manner and got to know each other a bit before doing a sensory exercise. The sensory exercise was a feeling exercise, which was included to increase the AIDS-orphans and researcher's awareness and it made the children more relaxed to share their experiences of foster care. The sensory exercise conducted included four objects that were placed in a bag and the child was asked to close his/her eyes and take one object out at a time, feel the object and describe how it felt. The AIDS-orphans all expressed their enjoyment of this sensory exercise.

As mentioned in Chapter One (paragraph 1.2.5.1, p. 10) the meta-theory used in the research was grounded on the Gestalt perspective, therefore all the aspects present in the individual AIDS-orphans' fields were noted and taken into consideration during the process of data collection and analysis. In addition, Bronfenbrenner's Ecological Systems Theory was used as a guide as to which areas in the AIDS-orphans' lives to focus on in the semi-structured interviews and incomplete sentences.

The researcher then proceeded with the semi-structured interviews, incomplete sentences and Kinetic family drawings discussed below.
3.2.3.1 (a) Semi-structured interviews

The researcher, with the use of an interpreter, conducted the semi-structured interview with the AIDS-orphans. Saunders, Lewis and Thornhill (1997:212) are of the opinion that, "in semi-structured interviews the researcher will have a list of themes and questions to be covered, although these may vary from interview to interview." The researcher had a list of questions to be covered in the interview and ensured that all the AIDS-orphans understood the questions, through the use of the interpreter, and that they were all given the opportunity to answer all the questions asked. According to Bernard and Whitley (2002:323), a semi-structured interview follows an interview guide that specifies the topics and issues to be covered and may include some specific questions, but there is no specified order in which the topics must be covered.

Gillham (2000:6) emphasises that semi-structured interviews have both open and closed questions. The researcher made use of both open and closed questions in the semi-structured interviews conducted. Koshy (2005:92) states that semi-structured interviews allow you to probe further during the interview. The researcher incorporated the use of probes and asked the AIDS-orphans questions about what they think foster care is, what the best and worst thing about foster care is and questions relating to their home and school life. Most of the AIDS-orphans could answer all of the questions without any problems and valuable information was obtained. The questions used in the semi-structured interview can be found in Appendix 2, at the end of the dissertation.

(b) Incomplete sentences

The AIDS-orphans were then asked to provide answers for the incomplete sentences. Carne (1949:93) states that "the incomplete sentence test is a device in which the subject is asked to read to himself the forepart of a sentence, and write anything he wishes to complete it". Schoeman (2005:98), states that incomplete sentences can be used as an open projection, where the child can express himself. The incomplete sentences
were included in the study as a method for the AIDS-orphans to express their views and opinions regarding life in foster care.

The incomplete sentences used in the study were focused around the AIDS-orphans' feelings and experiences associated with living in foster care, the different members of their foster families and their schools, churches and neighbourhoods. The incomplete sentences were read to the AIDS-orphans by the researcher, translated by the interpreter, and then completed by the respondents, through the use of the interpreter, and the researcher wrote down the answers given by each. A copy of the incomplete sentence used in the study can be found in Appendix 2, at the end of the dissertation.

(c) Kinetic family drawings
The data gathering process ended with the AIDS-orphans drawing the Kinetic family drawings. Burns and Kaufman (1972:2) developed the Kinetic family drawings and emphasised that these drawings could be used to mobilize a child's feelings related to the self-concept and in the area of interpersonal relations. According to Burns and Kaufman (1972:2), Kinetic family drawings often reflect primary disturbances much more quickly and adequately than interviews or other probing techniques. The researcher chose this method of data gathering as it could provide information around the AIDS-orphan's interpersonal relations. The aim of the research was to explore and describe how the AIDS-orphans participated in life; how they experienced life events and by exploring aspects of their interpersonal relations, this could be achieved.

Burns and Kaufman (1972:5) state that the procedure for obtaining Kinetic family drawings includes asking a child to seat himself, placing a plain white piece of paper and pencil in front of him and asking him to draw a picture of everyone in his family, including himself, doing something. The AIDS-orphans were each given a blank piece of paper and a pencil and asked to draw all the members of their foster families, including themselves, not just standing still, but all doing something. The AIDS-
orphans in the study enjoyed this part of the research and took time and care in their drawings. According to Burns (1982:64), "a number of studies and reports have suggested the usefulness and applicability of the Kinetic family drawings to many cultures". The applicability of the Kinetic family drawings to different cultures is important as the AIDS-orphans in the study were from different cultures and they were from different cultures from the researcher.

In the beginning of the data gathering process, the researcher informed the AIDS-orphans and their foster parents that a professional outsider would analyse the Kinetic family drawings, and that she had signed a confidentiality agreement. Therefore, once the researcher had completed the empirical aspect of the study, the Kinetic family drawings were given to a registered psychometrist who analysed them and provided the researcher with feedback.

3.2.3.2 Additional information collected
While the data was being collected from the AIDS-orphans, the researcher noted that the majority of the respondents' mothers were the primary caregiver and had passed away, whereas the majority of the AIDS-orphans fathers' whereabouts were unknown. According to the background information of each case, given to the researcher by the Vryheid Child Welfare, three out of the eight AIDS-orphans' mothers had neglected their children, while one mother abandoned her child years before she was assumed dead. There were no restrictions on the gender of the AIDS-orphans included in the study; however, the respondents had to meet the criteria mentioned above. There were four boys in the study aged seven, eight, nine and eleven years and four girls, two nine-year olds and two eleven-year olds. Seven children were Zulu speaking and one child was English, therefore it was necessary to make use of an interpreter.

The next step in the research process included analysing the data, which is focused on in the next section.
3.2.4 Data analysis

A preliminary analysis of the data collected was done at the research site as the researcher took notes and identified common themes and ideas expressed by the participants, and noted common aspects in the AIDS-orphans' background information, while at the Vryheid Child Welfare. The data was then analysed away from the site after the process of collection was completed. This was done by comparing answers in the semi-structured interviews and incomplete sentences, making inferences and incorporating the results of the analysis of the Kinetic family drawings by a psychometrist. The results thereof will be elaborated upon in the following chapter.

The next step was to analyse the data collected. For the purpose of the study, the data collected was organised into computer files. The researcher read the data thoroughly and took notes. The researcher analysed the data and identified common themes and ideas expressed by the AIDS-orphans in the study and included these in the case studies that were compiled. The aspects present in the AIDS-orphan's field were explored and described while analysing the data. This was achieved by analysing the data collected as a whole and by including all possible influences present in each AIDS-orphan's field.

The next step in the analysis of data is coding the data. The researcher used specific codes to represent specific themes and ideas identified in the data. According to De Vos (in De Vos et al., 2005:338), the emergent understandings should then be tested by searching through the data and challenging the understandings that have developed, and then searching for negative instances of the patterns identified. In the study, the researcher analysed the data for alternative explanations and took note of these. De Vos (in De Vos et al., 2005:339), explains that the last step in the analysis of data includes writing the report, where the researcher presents what was found in text, tabular or figure form. In this study, the researcher demonstrated what was found in the form of a text, which is
focused on in Section 3.3, below.

In order for the researcher to demonstrate the findings of the study, the research question was re-visited, as discussed in the following section.

3.2.5 Research question
As mentioned in Chapter One (paragraph 1.2.3 p. 9), the study was focused around the research question, which reads:

What are the life-experiences and perceptions of AIDS-orphans placed in kinship foster care in South Africa?

The researcher attempted to answer this question in the study and began the process by including Bronfenbrenner's Ecological Systems Theory as a guide as to which areas in the AIDS-orphans' lives to focus on.

3.2.6 Bronfenbrenner's Ecological Systems Theory as a guide
As mentioned in Chapter One (paragraph 1.2.5.2, p. 11) the theoretical assumptions of the study were based on Bronfenbrenner's Ecological systems Model of Human Development, where the Microsystem, Mesosystem, Exosystem and Macrosystem are all different systems, but can still influence and affect each other.

Bronfenbrenner (1979:22) states that a Microsystem can be defined as a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics. In the study, the Microsystem included the individual AIDS-orphaned children in foster care, in middle childhood (6- 12 years) and their interactions with the immediate settings.

The researcher took note of how each AIDS-orphan in the study interacted with the immediate setting, which included the foster mother, researcher and interpreter. Most of the respondents were very quiet and shy when they first entered the interview setting. The researcher noticed that all the
AIDS-orphans showed great respect towards their foster mothers, by carefully listening to them, doing exactly what was asked of them and by avoiding eye contact with their foster mothers. This respect towards their foster mothers was also revealed in the answers in the semi-structured interviews and incomplete sentence. When their foster mothers left the room, they opened up and did not seem to have a problem with answering the questions. One AIDS-orphan was very nervous; however, he was told that there was no right or wrong answer and then was more relaxed and able to participate in the research. Most of the AIDS-orphans thought carefully about their answers and took care in drawing the Kinetic family drawings.

A Mesosystem, according to Bronfenbrenner (1979:25), can be defined as the interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, and neighbourhood peer group). In the research the Mesosystem included the AIDS-orphans' family settings in the foster home, their neighbourhoods and their schools. The researcher first spoke to the foster mothers and gained background information regarding the family setting. Questions were included in the semi-structured interview and incomplete sentences that had to do with each respondent's school, church and neighbourhood.

Bronfenbrenner (1979:25) defines an Exosystem as one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person. In the research the Exosystem included the foster child's extended family, if any, and the effect of the media. Four of the AIDS-orphans included in the study were fostered by their grandmothers, and the other four were fostered by their aunts, therefore all their extended families were involved in the lives of the AIDS-orphans.
A Macrosystem, according to Bronfenbrenner (1979:26), can be defined as the consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-), that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies. In the study, the Macrosystem included the laws in place in South Africa and the values and customs of the AIDS-orphans investigated. All the respondents had been legally placed in foster care and were living with family members. Most of the AIDS-orphans included in the study valued material aspects, while at the same time they valued positive connections within the family setting. The customs of the AIDS-orphans were not included in the study.

The researcher attempted to investigate how the AIDS-orphans’ experiences of life and perceptions of foster care were affected by each system, as discussed in the following sections below.

The findings of the research are focused on in the following section.

3.3 Findings of the research

The researcher attempted to answer the research question, “What are the life-experiences and perceptions of AIDS-orphans placed in kinship foster care in South Africa?” Thus the researcher focused on the AIDS-orphans’ experiences in foster care. Perls, Hefferline and Goodman (1951:227) emphasise that “experience occurs at the boundary between the organism and its environment, primarily the skin surface and the outer organs of sensory and motor response. Experience is the function of this boundary, and psychologically what is real are the ‘whole’ configurations of this functioning, some meaning being achieved, some action completed.” Therefore the researcher attempted to look at each AIDS-orphan as a ‘whole’ and in context, as in the Gestalt perspective the whole is seen as more than the sum of its parts (Schoeman, 2005:70). Each AIDS-orphan’s internal world was focused on and included how he or she interacted and made contact at the contact boundary; his or her external world was focused on as well and included how he or she satisfied his or her needs.
through the interaction with the environment. Therefore each AIDS-orphan’s field was focused on. According to Yontef (1993:2), “the field is a whole in which the parts are in immediate relationship and responsive to each other and no part is uninfluenced by what goes on elsewhere in the field. The field replaces the notion of discrete, isolated particles. The person in his or her life space constitutes a field”. The researcher attempted to include everything that the AIDS-orphans experienced in foster care, as each AIDS-orphan included in the study had his/her own field. By examining these different fields, the researcher attempted to gain insight into the various life-experiences and perceptions of these AIDS-orphans in kinship foster care.

While conducting the research, the researcher attempted to increase the AIDS-orphans’ awareness, by including a sensory exercise in the beginning of the data collection process, before the semi-structured interview began (p. 58, above). The AIDS-orphans thoroughly enjoyed the feeling exercise and were more relaxed and aware afterwards. The researcher then attempted to make the children aware of what foster care meant and entailed. The researcher also emphasised to the AIDS-orphans that they were living in foster care, and thus attempted to increase their awareness of their own situations in the here and now.

Once the sensory exercise was complete, the researcher proceeded with the semi-structured interview; the findings thereof are discussed in the following section.

3.3.1 Semi-structured interviews

3.3.1.1 The AIDS-orphans’ perceptions of foster care

The first question that the AIDS-orphans were asked was “Do you know what foster care is?” The researcher found that none of the AIDS-orphans knew what foster care was, therefore it was explained to each respondent and then they were asked again in the incomplete sentences to see whether they would remember. In the Gestalt perspective, a person must be aware of their behaviour and surroundings in order for change to occur.
The AIDS-orphans in the study were aware that they were living with family members because they could not stay with their biological parents, as they had passed away. However, they were not aware of the term ‘foster care’. Therefore the researcher attempted to make the AIDS-orphans aware of the term ‘foster care’ and explained what it entailed.

When asked whether foster care is a good thing, seven AIDS-orphans stated that foster care is a good thing as they have families that take good care of them, they do not have to live on the streets and they are taught what is right and wrong by their foster parents (“It is good, they take care of me”; “It is good because I don’t have to live on the streets and grandmother teaches me right and wrong”). Three AIDS-orphans indicated that the best thing about living in foster care is that their foster parents buy them new clothes, shoes and food. Another three stated that the best thing is that their foster parents take good care of them (“grandmother buys me food and clothes”; “they take good care of me”). One AIDS-orphan described the best thing about foster care as having fun with her family and laughing, while another stated that going to school was the best thing (“I go to school”).

When asked what the worst thing about living in foster care was, one AIDS-orphan stated that the worst thing was that he could not live with his biological mother, as she had passed away and that he had to live with his aunty (“that I can’t live with my mom, but must stay with my aunty”). Three AIDS-orphans stated that there was nothing that they did not like about living in foster care, while two respondents indicated that the worst thing about foster care is that they have to help clean the house and do chores (“working, cleaning the house”; “on Saturdays and Sundays we have to clean the house”). Another AIDS-orphan indicated that the worst thing for him was waking up early to go to school, while another stated that the worst thing for her was that her grandmother shouts at her when she’s done something wrong.
When asked what they would change about foster care, one AIDS-orphan stated that she would change the fact that people in her family are dying, while two respondents indicated that they would change the material aspects (furniture, clothes and bicycle) in their foster homes ("that no one must ever die in my family"; "my clothes and bicycle"; "buy new furniture"). One respondent stated that he would move away from his foster mother (grandmother) and go live with his other grandmother and little sister in Durban, as he misses them and only sees them over the December holidays. Another AIDS-orphan indicated that he would like to spend more time with his foster mother ("go shopping with grandmother more"), whereas three respondents stated that they would not change anything about foster care.

3.3.1.2 The AIDS-orphans' feelings regarding foster care
The researcher found that four AIDS-orphans had been living with their foster families since they were infants, whereas the remaining four moved in with their foster families after one or both of their biological parents had passed away. Only three AIDS-orphans remembered the day that they moved into their foster homes, two of which were happy to be moving in ("yes, I was happy"), while one respondent indicated that she was unhappy and wanted to move in with her grandmother and not her aunty ("I cried because I wanted to go to my granny in Piet Retief").

When asked what makes them happy in their foster homes, two AIDS-orphans indicated that spending quality time with the members of their foster families makes them happy ("when I watch comedies on TV with my family"; "sometimes I go to work with my grandmother"), while two other respondents indicated that they are happy that they have good family relations with the members of their foster families ("they miss me when I'm not at home"; "I'm happy that I live with grandmother"). The remaining four AIDS-orphans stated that their toys make them happy in their foster homes. In the opinion of the researcher, these AIDS-orphans were happy because they were able to satisfy their needs through the foster families and thus regulate themselves.
One AIDS-orphan indicated that she gets sad when she hears a song that reminds her of her biological mother, while another respondent gets sad when his foster mother punishes him for bad behaviour ("sometimes they hit me and shout at me when I'm naughty"). Two respondents stated that they are sad when they do not receive attention from their foster families ("when they don't buy me toys"; "I'm sad when I must stay in the car and grandmother and sister go shopping"); one respondent said that the other children in her house tease her and that makes her sad, while three other respondents indicated that nothing at home makes them sad. In the opinion of the researcher, the AIDS-orphans are sad in instances when they cannot satisfy their own needs, therefore they are left with incomplete Gestalten that will press until completed, thus causing the AIDS-orphans to feel sad and unsatisfied.

Six AIDS-orphans indicated that they talk to their foster mothers when they are sad ("I cry and talk to granny"; “Grandmother hugs me and makes me feel better"), whereas one respondent said that he talks to his aunty when he is upset and another respondent indicated that he prefers to talk to his friends when he’s upset ("I play with my friends, they make me feel better"). These are examples of how the AIDS-orphans regulate themselves; they talk to their foster mothers or friends when they are feeling down and this cheers them up and thus satisfies their need for emotional support and comfort.

3.3.1.3 Systems present in the AIDS-orphans’ lives
Seven of the AIDS-orphans interviewed lived with other children whom they played with ("there are four other children at home"; “two children”; “six children at home, we all play together"), while one respondent had an older sister (adolescent), who only played with him occasionally, therefore he indicated that he was lonely at home. All the respondents indicated that there were at least two adults living in the foster home with them ("two grown-ups"; “three”; “eight adults”). When asked whether all the children in the home were treated the same by the foster parents, five AIDS-orphans
indicated that all the children were indeed treated equally. One respondent stated that some of the children in his house have to do chores and clean, while other children do not have to. Another respondent indicated that his foster sister never gets smacked for doing something wrong; whereas he gets punished for bad behaviour (“my sister doesn’t get smacked when she’s naughty, but I do”). A different respondent indicated that her foster brother is treated differently from the rest of the children as he is very naughty and is always in trouble.

Two AIDS-orphans indicated that they had no trouble with their schoolwork (“it’s easy”; “I get high marks”), while four stated that they are having difficulties in their schoolwork (“Zulu is very difficult”; “tests are difficult”; “school is difficult”). Two other respondents indicated that sometimes the schoolwork is easy while other times they need assistance. It was found from the background information that three AIDS-orphans were struggling with their schoolwork and had reports which read unsatisfactory or poor progress. Two AIDS-orphans displayed average progress in their schoolwork, whereas two others displayed good progress and one had above average school progress.

All the AIDS-orphans interviewed stated that they had friends and even named them (“one friend”; “three”; “I have six....”). When asked whether they knew any other foster children, three respondents indicated that they did know of other foster children (“two other foster children live with me”; “I know one at school”), while the remaining five AIDS-orphans did not know of any. Three respondents stated that they regularly visited their social workers at the Vryheid Child Welfare and that their social workers spoke directly to them and that they told the social workers the truth (“we come visit her here, I’m sometimes shy to tell the truth”; “I’ve been here before”). Four respondents indicated that they do come visit their social workers; however their social workers only speak to their foster mothers and do not speak to them (“she only speaks to grandmother”). The researcher is of the opinion that this is true as not all the social workers at the Vryheid Child Welfare are able to speak the language of the AIDS-
orphans. The researcher had to use an interpreter for most of the interviews conducted, as not many AIDS-orphans could speak or understand English.

The researcher included questions around the various systems in the AIDS-orphans' lives, so that aspects present in each child's field could come to the foreground and taken note of by the researcher.

A discussion of the findings of the incomplete sentences follows.

3.3.2 Incomplete sentences
3.3.2.1 The AIDS-orphans' feelings regarding foster care
It was found that two out of the eight AIDS-orphans in the study remembered what foster care was when asked for the second time in the incomplete sentences, while the other six did not know what foster care was. Two AIDS-orphans said that foster children are happy children (foster children are.... “happy”; “happy because they remember their parents”). While another two respondents indicated that foster children are sad because they miss their parents (foster children are.... “sad because it hurts their hearts that they don't have parents”). In the opinion of the researcher, these AIDS-orphans were projecting what originates in the self on the environment. Thus it was possible for these respondents to deny and disown those aspects of their personalities which they found difficult to handle.

Three respondents said that foster care sometimes makes them sad, because they “miss their parents”, “have no one to play with sometimes” and “the other children sometimes hit me when we fight”. Three other respondents said that foster care sometimes makes them feel happy. One respondent said that foster care sometimes makes him feel angry, because “the other children in my house hit me and granny hits me when I'm naughty".
Four AIDS-orphans said that there was nothing that they did not like about living in foster care, while one said he did not like being punished (hit) for being naughty and another said he would like to move to Durban to live with his biological sister, as mentioned above. When asked what worries them the most, one AIDS-orphan said, “that I will live alone”, while another, who was abandoned (and his mother assumed dead) said, “I’m worried because I think that my mom is dead or has been in a car accident”. One girl was worried that she might be receiving preferential treatment (the thing that worries me the most is.... “that when I did something wrong, I didn’t get punished, I’m worried why not’). One boy said that the thing that worries him the most is “children at home bite me”. Another child worries the most about fights that she has with friends. When asked what they wish for in foster care, two AIDS-orphans indicated that they wished to get good jobs when they grow up (“to get a job as a nurse”; “to get a job-electrician”) while the boy who was abandoned wished that “foster care was a place to find my mom”. This is an example of unfinished business in this child’s life, as his dominant need (to know what happened to his mother) wants to be satisfied and the Gestalt completed (hierarchy of needs). However, the Gestalt was not completed, thus the AIDS-orphan was left with unfinished business, which will press and press and want to be completed and therefore continue to worry him. Perls et al. (1951:140) state that unfinished business must be returned to in therapy, as it was left unfinished in the past because it was too painful for the human organism to deal with, and he therefore avoids the situation.

When the researcher asked the respondents, through the use of the incomplete sentences, what they liked about living in foster care, seven respondents said that they liked receiving love and attention from their caregivers (“Granny loves me”; “Grandmother takes good care of me”; “I stay nicely”; “Aunty takes care of me”; “they buy me nice things”), while one AIDS-orphan indicated that she had fun living with her foster family (“we have fun, we talk and laugh”). This shows that these AIDS-orphans
were making contact at the contact boundary, as they were satisfying their needs for love and affection received from the foster parents.

Two AIDS-orphans indicated that the **worst thing** about living in foster care was doing chores ("cleaning the house - washing the dishes and vacuuming" and "sweeping"), while another indicated that she does not like it "when grandmother shouts at me". Another indicated that the worst thing about foster care was that, "I must stay with aunty and not with mommy", as she had passed away.

### 3.3.2.2 The AIDS-orphans' connections with members of their foster families

Six AIDS-orphans indicated that they had positive connections with their **foster brothers and sisters** and described playing together, joking and talking, as activities which they enjoyed sharing with siblings in the home (my foster brothers or sisters.... “love me”; “plays nicely with me”; “defend me from others at school and home”). One said that her foster siblings sometimes fight with her, while another said that they “respect each other”.

It was found that four of the AIDS-orphans’ **foster mothers** were their grandmothers and the other four were the AIDS-orphans’ aunties. All the respondents indicated positive connections with their foster mothers and said that they provided well for them and took good care of them (my foster mother.... “looks after me”; “takes good care of me and loves me”; “makes sure there’s food to eat”; “plays with me sometimes”). Seven respondents indicated that they had **male role models** at home, some of these being grandfathers, uncles or even older brothers; however, not all the AIDS-orphans in the study had foster fathers. Five respondents indicated that they had positive connections with their foster fathers and generally indicated a deep respect toward these foster fathers (my foster father.... “takes me to school”; “I like him, he sometimes buys me sweets”; “is a good man, he does not drink or smoke”; “sometimes buys toys for me”).
3.3.2.3 Systems present in the AIDS-orphans' lives

Three out of eight AIDS-orphans indicated that their social workers only talk to their foster mothers and not directly to them, while the remaining five respondents were of the opinion that their social workers were good ladies who take good care of them and help foster children (my social worker... “only speaks to my mom”; “takes good care of me”; “is a good lady”; “I like her because she helps foster children,”; “is a nice aunty”).

Four AIDS-orphans indicated that they enjoy learning new things at school and have good relationships with their teachers, while three respondents stated that they had formed good friendships at school (at school.... “I do art”; “I'm happy because I learn new things”; “I have a good teacher and I understand the work”; “I play nicely with friends” “I like my teacher”). One AIDS-orphan informed the researcher that he was being bullied by older children in his school (“the grade sevens sometimes bully me”). All the research respondents indicated that they attended church, some more regularly than others, and that they all enjoyed it (at church.... “we pray”; “we sing”; “it's nice”; “we pray and play”; “teaches us about Jesus”). Seven AIDS-orphans indicated that they have good relationships with the people in their neighbourhoods, whereas one respondent stated that he lives in a very noisy neighbourhood and that his foster family does not have a good relationship with the neighbours (my neighbourhood.... “I like talking to my neighbours”; “is good and I have friends there”; “I talk and play with friends there”; “always make a noise” “they look after our house when we are not there”).

The researcher included these systems again in the incomplete sentences to confirm aspects that were present in the AIDS-orphans’ fields, as mentioned above (p. 66).

The results of the Kinetic family drawings will be the focus of the following section.

3.3.3 Kinetic family drawings
The researcher feels that it must be noted that one of the AIDS-orphans included in this study did not want to draw his foster family; however, he eventually drew the faces only, but he did not draw any authority figures. The analysis of this child’s drawing is included below.

The analysis of the eight kinetic family drawings identified various themes expressed by the AIDS-orphans in the study. Six AIDS-orphans indicated that their foster mothers were the dominant figure to them in the foster family. This is indicated by placing the figure above the rest, or as the largest figure drawn. One respondent indicated that his foster sister was the dominant figure to him, while another drew herself as the dominant figure. Three AIDS-orphans indicated absent male authority figures and one respondent indicated a total lack of authority figures. Three AIDS-orphans indicated in their drawings that their need for nurturing was being met by the foster mothers. This was achieved by drawing their foster mothers cooking a meal. This is an example of good contact at the contact boundary, as these respondents were able to satisfy their need for nurturing and thus were able to maintain a certain level of equilibrium, and thus could regulate themselves and maintain homeostasis. According to Perls et al. (1951:274) "the spontaneous consciousness of the dominant need and its organisation of the functions of contact is the psychological form of organismic self-regulation".

In five of the AIDS-orphans' drawings, feelings of inadequacy in dealing with the environment or circumstances emerged. This indicated that these respondents could have difficulties in satisfying their needs through the interaction with the environment, and would thus, in the opinion of the researcher, cause them to show disturbances at their contact boundaries in the future.

Six drawings revealed feelings of helplessness expressed by the AIDS-orphans. This was indicated by the absence of hands and arms of the figures drawn, which could also indicate a denial of their function. Six of the drawings revealed conflicts in the foster families, whereas seven
AIDS-orphans indicated problems with impulse control, which is related to the conflict theme identified. Conflict was identified by shading, absence of arms and 'X's found within the drawings. Shading could have also indicated anxiety experienced by the AIDS-orphan concerned. It was found that in four drawings a theme of aggression emerged, where repressed and outward aggression was identified. Aggression was identified in drawings where the respondent drew dark lines (applied pressure while drawing) and dark eyes (shaded), and aggression was also identified by the way in which the mouths were drawn. These themes of conflict and aggression which emerged, could, in the opinion of the researcher, be seen as examples of deflection, as the AIDS-orphans concerned could deflect their true feelings of living in an unstable and stressful world, by displaying outward aggression (hitting, kicking and striking out). This statement is further strengthened by the findings in seven of the AIDS-orphans' drawings which indicated problems with impulse control, as mentioned above, which is also related to outward aggression.

Two AIDS-orphans isolated themselves from the rest of the foster family, which indicated a withdrawal of the respondents from the family. This was done by compartmentalising the drawing and placing barriers between the 'self' (AIDS-orphan) and the other members of the foster families. In four of the AIDS-orphans' drawings, a lack of emotion was identified by the depiction of shallow or empty eyes. Six respondents indicated possible affectional problems in their drawings by expressing a need for love, warmth and acceptance from their foster families. One of these AIDS-orphans expressed a feeling of rejection, by placing himself far away from the sun in his drawing and by placing a barrier between himself and the sun and his foster family. Two out of these six respondents with possible affectional problems indicated an inability to express their love naturally or openly towards family members. This was indicated by the AIDS-orphans encapsulating members of the foster families. These themes of withdrawal, lack of emotion and possible affectional problems expressed a need for love, warmth and acceptance from the AIDS-orphans' foster families and could, in the opinion of the researcher, be examples of introjection. These
respondents could have ingested the fact that they had to live with family members in a foster home; however, they have not digested it and made it their own as of yet, as they isolated themselves from the foster families and showed lack of emotion and possible affectional problems and therefore did not see themselves as part of the foster family yet. However, these AIDS-orphans were acting as though they were part of the family, by drawing all the members of the foster family together on one page. These AIDS-orphans did not, in the opinion of the researcher, feel part of the foster family yet, even though it may look as if they were.

Four respondents indicated a strong dependency on the members of the foster families by including long necks, leaves and buttoned noses in their drawings. These instances, in the opinion of the researcher, could be seen as examples of confluence as these AIDS-orphans could not satisfy their own needs, as they were overly dependent on their foster parents for the satisfaction of their needs. These children were thus unaware of the boundary between themselves and their foster parents, and therefore could not make good contact with them, nor satisfy their own needs.

Five of the AIDS-orphans included balls in their drawings, which could indicate the 'force' between family members or competition. One respondent emphasised the importance of academic achievement in the foster family by including 'A's in her drawing. Three AIDS-orphans drew figures without ears which could have indicated a refusal to listen to the criticism of others, while three respondents emphasised the ears in the drawings which could have indicated sensitivity to the outside world. One AIDS-orphan indicated that he is experiencing an unstable world, as he attempted to stabilize the picture by placing a firm foundation at the bottom of it. Possible depression was identified in three of the drawings as the respondents included a bed (depressive or sexual theme), lined foreheads or water in their drawings.

One AIDS-orphan drew a flower on her skirt, which indicated identification with femininity. One respondent drew his big brother vacuuming, which
could have indicated a domineering, controlling and powerful person, in the eyes of the respondent. In addition, the vacuum cleaner could have been seen as an extension of the brother’s arm which could have indicated controlling the environment. One respondent drew her baby sister in a crib above the ‘self’; this could have indicated that the well-being of the baby was important to the AIDS-orphan concerned.

The researcher has included a table (Table 1 below), highlighting the findings of the research.

<table>
<thead>
<tr>
<th>Highlights of the findings of the research</th>
<th>Number of AIDS-orphans in the study (total=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially did not know what foster care was</td>
<td>8</td>
</tr>
<tr>
<td>Had been living with the foster family since infancy</td>
<td>4</td>
</tr>
<tr>
<td>Indicated that they had someone to talk to when they were feeling down</td>
<td>8</td>
</tr>
<tr>
<td>Indicated that there were at least two adults living in the foster home</td>
<td>8</td>
</tr>
<tr>
<td>Stated that they received love and attention from their foster families</td>
<td>7</td>
</tr>
<tr>
<td>Indicated positive connections with foster siblings</td>
<td>6</td>
</tr>
<tr>
<td>Indicated positive relationships with their foster mothers</td>
<td>8</td>
</tr>
<tr>
<td>Indicated positive connections with their foster fathers</td>
<td>5</td>
</tr>
<tr>
<td>Indicated absent male authority figures</td>
<td>4</td>
</tr>
<tr>
<td>Expressed feelings of helplessness</td>
<td>6</td>
</tr>
</tbody>
</table>
Table 1: Highlights of the research findings

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revealed possible conflict within the foster families</td>
<td>6</td>
</tr>
<tr>
<td>Revealed possible affectional problems</td>
<td>6</td>
</tr>
<tr>
<td>Knew of other foster children</td>
<td>3</td>
</tr>
<tr>
<td>Indicated that they visited their social workers</td>
<td>7</td>
</tr>
</tbody>
</table>

In the opinion of the researcher, it can be concluded from the above (paragraph 3.3 and Table 1), that most of the AIDS-orphans in the study experienced living in foster care positively and that they received support from their foster families. The majority of the AIDS-orphans indicated that they had positive relationships with their foster mothers and foster siblings, whereas just over half of the sample (five AIDS-orphans) indicated positive connections with their foster fathers.

3.4 Conclusion

In conclusion, an overview of the research methodology was given, and the research strategy was elaborated upon. The preparation for the gathering of data was focused on and included the pilot study. The data gathering process was focused on, and the sensory exercise, semi-structured interviews, incomplete sentences and Kinetic family drawings were highlighted and discussed. The analysis of data was then emphasised, and the research question was re-visited. Finally, the findings of the research were focused upon, and the findings of the semi-structured interviews, incomplete sentences and Kinetic family drawings were discussed and integrated with the Gestalt perspective.

The last step in the research process included deductions and conclusions that were drawn by the researcher, and the recommendations and suggestions for future research, which is focused on in the following chapter.
Chapter Four
An integration of the conclusions and recommendations of the study

4.1 Introduction
This chapter focuses on the conclusions and recommendations of the study. The goal and objectives of the study are re-visited and their achievement is discussed. Limitations of the study are highlighted and recommendations and suggestions are given.

A discussion of the goal and objectives of the research follows.

4.2 Goal and objectives of the study
The goal of the research was to explore and describe the life-experiences of AIDS-orphans in kinship foster care, from a Gestalt perspective.

As mentioned in Chapter One (paragraph 1.2.4 p. 10), the research objectives included all the aspects in the research that were investigated and explored.

The objectives of the research conducted were as follows:

(1) To describe the life-experiences of AIDS-orphans in middle childhood, living in kinship foster care, from a Gestalt perspective.

(2) To describe the developmental stage of AIDS-orphans in middle childhood.

(3) To gain information regarding the life-experiences of AIDS-orphans in foster care from semi-structured interviews, incomplete sentences and Kinetic family drawings.

(4) To analyse the data gathered.
To integrate a literature control with the results of the study, using a Gestalt approach.

To provide recommendations and suggestions to social workers for future research.

In the opinion of the researcher, the **first objective** was achieved by the study, as the life-experiences and perceptions of AIDS-orphans in middle childhood were described from a Gestalt perspective. The researcher conducted an extensive literature review which focused on various areas relevant to the study, some of which included HIV/AIDS and the impact thereof, orphanhood and foster care. The research respondents were selected through purposive sampling, as AIDS-orphans in foster care were specifically chosen for the study. There were specific criteria to be met in the sample, therefore the AIDS-orphans were not chosen at random and the sampling method was therefore non-probability sampling. The criteria that had to be met by the AIDS-orphans in the study included being in middle childhood, lost one or both parents to AIDS related illnesses and had been living in a foster home with family members in and around Vryheid, KwaZulu Natal for a minimum of two years. The AIDS-orphans' perceptions and life-experiences of kinship foster care were obtained through the incorporation of semi-structured interviews, incomplete sentences and Kinetic family drawings. The findings of the study were then integrated with Gestalt (Chapter Three).

The **second objective** of the study was to describe the developmental stage of AIDS-orphans in middle childhood (aged six to twelve years old). In the opinion of the researcher, this objective was attained, as the developmental stage of the AIDS-orphans was described and integrated with the developmental theories chosen, which included Erikson's theory of psychosocial development and Piaget's cognitive-structural theory (Chapter Two).
The third objective was to gather information regarding the life-experiences of AIDS-orphans in kinship foster care from semi-structured interviews, incomplete sentences and Kinetic family drawings. In the opinion of the researcher, this objective was accomplished as information was gathered from the AIDS-orphans. The researcher travelled to Vryheid, KwaZulu Natal and through the use of the Vryheid Child Welfare, made individual appointments with five AIDS-orphans and conducted the pilot study. After that, further individual appointments were made with eight other AIDS-orphans, from whom valuable information was gained through the use of semi-structured interviews, incomplete sentences and Kinetic family drawings. An interpreter was used in the whole process of data gathering, as most of the AIDS-orphans who took part in the study, could not understand or speak English (Chapter Three).

The fourth objective of the research was to analyse the data which was gathered from the AIDS-orphans in the study. In the opinion of the researcher this objective was achieved, as the information gathered was analysed by the researcher. The researcher compared the AIDS-orphans’ answers in the semi-structured interviews and incomplete sentences, made inferences and incorporated the results of the analysis of the Kinetic family drawings by a psychometrist. Common themes and ideas expressed by the AIDS-orphans were then highlighted by the researcher (Chapter Three).

The fifth objective was to integrate a literature control with the results of the study, using a Gestalt approach. In the opinion of the researcher, this objective was accomplished, as the researcher integrated the findings of the semi-structured interviews, incomplete sentences and Kinetic family drawings with Gestalt, and highlighted various Gestalt concepts by providing examples of these concepts from the findings of the research (Chapter Three).

The sixth objective of the study was to provide recommendations and suggestions to social workers for future research. In the opinion of the
researcher, this objective was attained and discussed in the following section below.

In the opinion of the researcher, all the objectives of the study were achieved and the goal accomplished, as the study described and explored the life-experiences of AIDS-orphans in kinship foster care, from a Gestalt perspective. The accomplishment of the goal and objectives of the research led to the formulation of the limitations of the study, which is focused on in the following section.

4.3 Limitations of the study
In the opinion of the researcher, the limitations of the study included the following:

- The fact that the AIDS-orphans included in this study did not know what the term 'foster care' meant, could have limited the impact of the study, as the main aim of the study was to obtain the perceptions and life-experiences of AIDS-orphans living in kinship foster care. However, the AIDS-orphans were made aware of what foster care meant and they did understand the concept of foster care, just not the specific word used.

- As there were specific criteria to be met in the sample, the AIDS-orphans that took part in the study were not chosen at random, thus non-probability sampling was used. The researcher could not control the racial groups included in the study, as cases that met the criteria were chosen by the social workers at the Vryheid Child Welfare. It was noted that a large majority of the AIDS-orphans (seven) in the sample were from the same racial group (Zulu), therefore the results of the study cannot be applied to all racial groups in South Africa. In addition, the sample used in the study was very small, and consisted of eight AIDS-orphans, therefore the results of the study cannot be generalised to the whole population.

The recommendations for the limitations of the study are included in the following section.
4.4 Recommendations
The researcher conducted the study and became aware of a number of aspects which were noted and formulated into recommendations for social workers and the general public. A discussion of these recommendations follows.

4.4.1 Education regarding foster care
The researcher was very interested to note that initially, all of the AIDS-orphans included in the study did not have any knowledge regarding foster care. They did not know what foster care was or what it was used for, even though they were living in foster care themselves. This was a limitation in the study (as mentioned above) and could have influenced the impact of the study, as the aim of the study was to obtain the perceptions and life-experiences of AIDS-orphans living in kinship foster care.

In the opinion of the researcher, children should be educated about foster care in schools, as this could raise awareness of foster care and thus cause the AIDS-orphans in foster care to gain additional support from teachers and learners, and it could ultimately assist the children living in foster care. From the literature review (Chapter Two) the researcher concluded that AIDS-orphans living in foster care have usually experienced hardships in their lives and this education and increased awareness of foster care could provide the extra encouragement and emotional support that these children so desperately need. According to Blatt (2000:2) children are placed in foster care for various reasons, such as abuse and/or neglect and living in a home that is considered to be unsafe; children who are considered unmanageable; and children who have been abandoned, or whose parents cannot care for them. In the opinion of the researcher, this statement shows that foster children have usually lived through traumatic experiences leading up to their placement in foster care, and that the extra emotional support mentioned above could make the world of difference to these foster children.

4.4.2 Sampling method
As mentioned above (under limitations), the AIDS-orphans were not chosen at random and a small sample was used. This could have limited the study as the majority of the sample came from the same racial group (Zulu), therefore the results cannot be applied to all racial groups or generalised to the whole population. The researcher therefore recommends that future research be conducted with a larger sample, where the respondents are chosen from all racial groups at random.

4.4.3 Feedback for foster parents included in the study
In the opinion of the researcher, it was necessary to provide feedback to the foster parents of the AIDS-orphans included in the study. This feedback was provided to the foster parents in the form of personalised letters, which highlighted the findings of the research and included a summary of the analysis of the data obtained from their foster child. These letters were given to the foster parents once the dissertation was completed.

4.4.4 Gestalt play therapy
According to the background information obtained from the Vryheid Child Welfare and as far as the researcher could perceive, none of the AIDS-orphans placed in kinship foster care received any form of counselling. All the AIDS-orphans had experienced the loss of at least one parent and therefore could benefit from receiving Gestalt play therapy, as a means of dealing with the grief and trauma experienced. As mentioned in Chapter One (paragraph 1.1 p. 3) Gestalt follows a phenomenological approach which, as stated by Joyce and Sills (2001:16), means “trying to stay as close to the client’s experience as possible, to stay in the here and now moment and rather than interpreting the client’s behaviour, to help him explore and become aware of how he makes sense of the world”. Thus, in the opinion of the researcher, Gestalt play therapy could benefit the AIDS-orphans, as they would be empowered to make sense of their own worlds and learn how to satisfy their own needs. Therefore, the AIDS-orphans would become aware of how to solve their own problems, and thus become self-regulating individuals.
Gestalt play therapy could also be used to assist the AIDS-orphans to deal with unfinished business in their lives. Unfinished business, as mentioned in Chapter Three (p. 72) is when there is a dominant need that wants to be satisfied; the Gestalt wants to be completed. However the Gestalt is not completed and the person is left with unfinished situations, which press and press and want to be completed (Perls, 1973:119). Gestalt play therapy could be used to bring the dominant need to the fore, in the here and now moment, to be satisfied through the discussion and selection of viable alternatives, as depicted and chosen by the AIDS-orphan through a dialogue with the therapist.

In addition, Gestalt play therapy could be used to assist the AIDS-orphans’ expression and release of aggression. As mentioned in Chapter Three (p. 76), aggression was identified in a number of the AIDS-orphans’ Kinetic family drawings. Gestalt play therapy provides a safe place for the AIDS-orphan to express his or her anger and 'get it out' through aggression play.

As mentioned in Chapter Three (p. 75), possible contact boundary disturbances were identified in the findings of the research. It was indicated that some AIDS-orphans could have had difficulties in satisfying their needs through interaction with the environment. Examples of possible contact boundary disturbances that were identified in the findings of the research included introjection, projection, confluence and deflection. Gestalt play therapy could be used to assist these AIDS-orphans to make improved contact with the environment at the contact boundary and thus to increase the satisfaction of needs, thereby decreasing the disturbances at the contact boundary.

4.4.5 Support groups for foster children in schools
It was revealed in the semi-structured interviews that only three of the eight AIDS-orphans in the study knew of other foster children (Chapter Three, p. 70). In the opinion of the researcher, the provision of support groups for foster children in the school environment could provide
additional social support for these AIDS-orphans in foster care, and serve as a means of developing relationships with other foster children with similar experiences, thus providing a supportive social network. In addition, these support groups could be used for the development of coping skills in the lives of the AIDS-orphans, thus equipping them for the challenges and obstacles of adolescence and even adulthood.

A discussion of the suggestions follows.

4.5. Suggestions

In the opinion of the researcher, the following suggestions, formulated from the findings of the research, could improve the life-experiences of AIDS-orphans living in foster care.

4.5.1 A voice for foster children

It was noted in the research (Chapter Three, p. 70) that the majority of the AIDS-orphans in the study were not spoken to directly by the social workers assigned to their cases. This was largely due to the language barrier between the AIDS-orphans in foster care and the social workers. However, some of the older AIDS-orphans in the study could understand the basics in English. In the opinion of the researcher, the AIDS-orphans living in kinship foster care could benefit from the formulation of a system where they too are spoken to and their opinion included in the cases at the Vryheid Child Welfare. This could be achieved by social workers incorporating a few sentences aimed at the AIDS-orphan during the regular follow-up meetings with the foster parents and foster child (in the cases where the foster child could understand some English). The provision of a voice for foster children could also be accomplished by increasing the number of Zulu-speaking social workers at the Vryheid Child Welfare, or by including the use of interpreters for occasional follow-up meetings. The researcher agrees with Thiele (2005:107), who conducted research on the feasibility of foster care as a primary permanency option for orphans in the Vryheid area, and who stated that
we need to give our local orphans a voice and create a child-centred, child-valuing culture, which goes beyond leaders and into our homes.

4.5.2 Positive regard for foster children
The Kinetic family drawings (Chapter Three) revealed that some AIDS-orphans withdrew from their foster families, while others felt helpless in their present situations. In the opinion of the researcher, when children are given positive regard and they are loved unconditionally and totally accepted for who they are, they begin to value themselves more, feel more accepted and feel more part of the foster families concerned. In the opinion of the researcher, when AIDS-orphans in kinship foster care receive unconditional positive regard from their foster families, they could regain some control over their lives, which could have previously felt to be unstable, and this control regained could reduce feelings of helplessness and increase the empowerment of the AIDS-orphans concerned. This could be achieved by informing the foster parents at the Vryheid Child Welfare about the benefits of unconditional positive regard and by providing examples of how to give unconditional positive regard to the AIDS-orphans in their care.

4.5.3 Future research
In the opinion of the researcher, future research could focus around the implementation and outcomes of Gestalt play therapy with AIDS-orphans living in kinship foster care, as this was identified as a need through the analysis of the data gathered.

4.6 Conclusion
In conclusion, the goal and objectives of the study were accomplished, in the opinion of the researcher. The limitations of the study were then discussed, which led to the formulation of the recommendations, which focused around education regarding foster care, sampling method, feedback provided to foster parents included in the study, Gestalt play therapy, and the provision of support groups for foster children in schools. The researcher then provided suggestions on providing a voice for foster
children, unconditional positive regard for foster children and future research.

It can be concluded from the study that most of the AIDS-orphans included had positive life-experiences of kinship foster care. As the study was conducted from a Gestalt perspective, it was indicated that the majority of the AIDS-orphans included were making good contact at the contact boundary, as they were satisfying their needs for love and affection received from their foster parents. All the AIDS-orphans had experienced the loss of at least one parent and therefore it was recommended that they receive Gestalt play therapy to assist them in dealing with the associated grief and possible trauma experienced.

In the opinion of the researcher, if children are educated about foster care at school, they will inform their parents about foster care and its benefits, thus increasing the awareness of foster care in South Africa and perhaps making more people open to the idea and willing to become foster parents in the future. This would provide more homes and loving environments for the vastly growing numbers of AIDS-orphans in our country and perhaps make a difference in society.
Bibliography


the feasibility of foster care as a primary permanency option for orphans.


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Appendix 1: Consent Forms
Dear Child Welfare

My name is Lindy Tissiman and I'm studying my Masters degree in Play Therapy through Huguenote College (UNISA). The title of my research is "An exploration of the life experiences of AIDS-orphans in foster care in South Africa".

I am requesting your permission for the use of your facilities for my research. I am making individual appointments with the different families. I am going to do a feeling exercise with the child, then I'm going to ask the child some questions about his/her life in foster care and then ask him/her to complete some sentences, finally I'm going to ask the child to draw a picture of their foster family. This picture is going to be analysed by a professional who is an expert in this field. He will not know any details about the child and will also sign a confidentiality agreement.

All the names will remain anonymous, the personal details confidential and only children who are willing to participate will be included in the research. There are no right or wrong answers to the questions asked.

I need to record the whole process of the research with a video camera however, these videos will be kept confidential and only used for gaining information for the research. The videos will be deleted once the research is completed.

Thank you
Lindy Tissiman

..........................................................give permission for Lindy Tissiman to use the Child Welfare's facilities and cases for the research.

Sign: [Signature]

VRYHEID KINDER- EN GESINNOSP.VERENIGING
VRYHEID CHILD AND FAMILY WELFARE SOCIETY
06 603144 0005
P. O. BOX: POSTBUS 421, VRYHEID 3100
TEL.: (034) 982 1197 / 8
FAX: (034) 982 1198
Dear Foster parent (Guardian)

My name is Lindy Tissiman and I’m studying my Masters degree in Play Therapy through Huguenote College (UNISA). The title of my research is “An exploration of the life experiences of AIDS-orphans in foster care in South Africa”.

I am requesting your permission for your foster child to participate in the research. I am making individual appointments with the different families. I would like to ask you a few questions regarding your foster child’s background, then I am going to do a feeling exercise with the child, then I’m going to ask the child some questions about his/her life in foster care and then ask him/her to complete some sentences, finally I’m going to ask the child to draw a picture of their foster family. This picture is going to be analysed by a professional who is an expert in this field. He will not know any details about the child and will also sign a confidentiality agreement.

All the names will remain anonymous, the personal details confidential and only children who are willing to participate will be included in the research. There are no right or wrong answers to the questions asked.

I need to record the whole process of the research with a video camera however, these videos will be kept confidential and only used for gaining information for the research. The videos will be deleted once the research is completed.

Thank you
Lindy Tissiman

I ............................................foster parent of ............................................ (code: ) give permission for my foster child to take part in the research and for the process to be video taped.
Sign:

I ............................................Social Worker of ............................................ (code: ) give permission for this child to take part in the research and for the process to be video taped.
Sign:

I (code: ) want to take part in the research and give permission for the process to be video taped.
Sign:
Dear Thembe

My name is Lindy Tissiman and I’m studying my Masters degree in Play Therapy through Huguenote College (UNISA). The title of my research is “An exploration of the life experiences of AIDS-orphans in foster care in South Africa”.

I am requesting a confidentiality agreement with you regarding the interpretation of my research to the respondents. I am making individual appointments with the different families. I am going to do a feeling exercise with the child, then I’m going to ask the child some questions about his/her life in foster care and then ask him/her to complete some sentences, finally I’m going to ask the child to draw a picture of their foster family. This picture is going to be analysed by a professional who is an expert in this field. He will not know any details about the child and will also sign a confidentiality agreement.

All the names will remain anonymous, the personal details confidential and only children who are willing to participate will be included in the research. There are no right or wrong answers to the questions asked.

I need to record the whole process of the research with a video camera however, these videos will be kept confidential and only used for gaining information for the research. The videos will be deleted once the research is completed.

Thank you
Lindy Tissiman

[Signature]

I agree that I will not share the personal details of the research respondents and that I will maintain this confidentiality agreement.

Sign: [Signature]
Appendix 2: Semi-structured interview, questions to parents and incomplete sentences
Introduction

Hello, my name is Lindy and I'm with you here today to find out more about how you feel about foster care. I'm going to do a feeling exercise with you, then ask you some questions and then ask you to fill in some sentences for me and then I'm going to ask you to draw me a picture. Is that alright with you? Do you have any questions?

How are your holidays so far? What do you do this week? Did anything interesting happen? What's the best thing that happened this week? Worst thing?

a) Sensory exercise: feeling things hidden in a bag. What thing did you like the most? What thing didn't you like feeling?

You live in foster care and your experiences and opinion are important to me and I'd like you to answer some questions about your life in foster care. There is no right or wrong answer; I just want to hear what you think.

b) Semi-structured interview:
(Describe things in here-and-now eg. it's happening now, today)

1. Do you know what foster care is? What do you think foster care is? What is it used for?

2. What do you think about foster care? Is it a good thing?

3. What do you think the best thing about foster care is?

4. What do you think the worst thing about foster care is?

5. If you could change anything in foster care what would you make different?

6. Do you remember the day that you moved into your new foster home? How did you feel that day? (Scared, sad, happy, angry?) (here-and-now)

7. Is there someone in your house that you can talk to if you are feeling sad? Who?

8. What makes you feel sad? What makes you feel happy?
9. How many children are living in your house? What do you like about them? What don’t you like about them?

10. Do you think that all the children in your house are treated the same? How/why?

11. Do you go to school? What grade are you in? How do you find the school work? (difficult/easy?)

12. Do you play with anyone at school? (friends) How many?

13. Do you know any other foster children? Where do you know them from?

14. Does your Social Worker visit you sometimes? Do you always tell her the truth when she asks you something?

Thank you for answering these questions, you are helping me a lot! Now I have some other sentences for you to complete for me please.
Questions for parents:

1. What relation are you to the child?
2. How many adults and children live in the house with the foster child?
3. How well do you think the child has adjusted to living with you?
### Incomplete sentences

<table>
<thead>
<tr>
<th>Code: Boy/Girl</th>
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<tbody>
<tr>
<td>Age:</td>
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1. Foster care is
   (explain)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

2. Foster children are
   (how)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

3. Foster care sometimes makes me feel
   (how)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

4. The thing I don’t like about foster care is
   (what)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

5. The thing that worries me the most is
   (what)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

6. I wish foster care was
   (how)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

7. My favourite memory of living in foster care is
   (what)
   .................................................................................. 
   .................................................................................. 
   .................................................................................. 

8. The worst thing that happened to me while living in foster care was
   (what)
   .................................................................................. 
   .................................................................................. 
   ..................................................................................
9. The best thing about living with other family members is (what).

10. My foster brothers or sisters (what).


12. My foster father (what).


15. At church (what).