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EXPLORING PAEDIATRIC BURNS.

Narrative Accounts from Caregivers in Khayelitsha, Cape Town.

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Compulsory Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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Abstract

The incidence of burns and its impact on an individual and his or her family system has received very little attention, despite the fact that burns are noted to be the second biggest contributor to accidental deaths in both adults and children. Historically, burn care has focused on medical issues rather than on psychological problems and corresponding effects on the quality of life. Studies conducted on children suffering from medical conditions, such as severe respiratory syncytial virus, HIV/AIDS, orofacial handicap, traumatic brain injury, or physical disability, show that such conditions have significant psychological consequences for the child, caregiver and the family system. These conditions are often perceived as traumatic, inducing post traumatic stress responses. Dimensions of family functioning are often affected as parents and siblings attempt to meet the demands of caring for the ill child. Primary caregivers are often the worse affected. Feelings of guilt, shame, blame, grief, high levels of anxiety during the hospitalisation and discharge period and concerns about the child's future are often experienced. Studies conducted in the area of burns have recently begun to document the psychological implications of the condition. Burn survivors are often reported to suffer from post-traumatic stress disorder, depression, and social withdrawal. Difficulties in the self-concept domain have also been reported. No study in the country has captured the incidence of burns and its consequences, from the caregivers' perspective. It is this group of people that have been identified as playing a vital role in the child's recovery and adjustment. It is this same group that is also considered to be at high risk for experiencing "caregiver burden" linked with caring for the ill child. This may be so particularly in homes with limited emotional and material support. Caregivers in these cases may also suffer from depression, post-traumatic stress, and anxiety disorders. These conditions may affect the way in which they respond to their child's illness.

The present study aimed to explore the impact of paediatric burns, from the caregivers' perspective. The study positioned itself within the interpretivist paradigm; adopting narrative philosophies in examining caregivers' accounts of their child's burn injury. The sample was composed of four, black, Xhosa speaking female caregivers, residing in Khayelitsha. Children of the selected participants had sustained a thermal injury and received medical intervention from the Burns Unit at the Red Cross Children's Hospital in Cape Town. The child victims in question had been discharged for a period of two months prior to this study taking place. Demographic details were gathered pertaining to the child victim, caregiver and immediate family of the child victim. Semi-structured interviews, one hour in duration, were conducted in Xhosa, and an interviewing schedule consisting of seven open-ended questions was used as a means of generating data. The interview

schedule explored the impact of the burn incident on the child, caregiver and family. Data was recorded via an audiotape. The data was transcribed and the use of narrative analysis was employed to evaluate the data. Apart from exploring the physiological and psychological responses experienced by caregivers and their children, the research specifically aimed at examining caregivers' narrative accounts of the incident and highlighting the personal and interpersonal conflicts or complications experienced; the evaluations that individuals made out of the sets of actions transpiring from the principal situation (the burn incident) and the resolutions taken to achieve a state of equilibrium. Burns can be considered to fundamentally disrupt individuals' lives, resulting in what narrative psychologists call the "narrative wreckage" or points of, "biographical disruption" (Crossley, 2003). In such cases narratives or stories become important in the process of reconfiguring one's life. In the analysis the plots or story lines provided were positioned within the broader societal, cultural, political, economic, and personal dynamics present at the time.

Children in the study were reported to show significant signs of physiological and psychological distress. These children were observed by their caregivers to display loss of appetite, disturbed sleep, frequent crying, clinginess, and separation anxiety. Some of the children were observed as displaying angry and accident-prone behaviours. Caregivers also reported similar experiences such as anxiety, frozenness, nausea, and loss of energy to the extent of not being able to respond to the child. Caregivers also reported a low mood, disturbed sleep and a loss of appetite. Although the burn injuries could be termed unintentional injuries, caregivers nevertheless reported profound feelings of self-blame, blame by others, blame of others, guilt, fear of family and community responses with regards to their mothering and self doubt in terms of their mothering abilities. Caregivers also reported feelings of worry related to their child's future. These concerns centred on issues of normality and their children not being able to fit in. Fear of professionals (doctors, nurses, social workers, and researcher) was reported. Caregivers saw professionals as responsible for monitoring, passing judgement on their ability to mother and could take the child away if they were deemed as incompetent mothers. Though the study comprised a relatively small sample, it however showed common patterns of risk for burn injuries noted in other studies. These were household crowding, household income, educational level of the caregiver, reliance on fossil fuels, cooking implements placed too low on the ground, lack of adequate supervision, and age of the child.

Burn injuries have significant implications for the child, caregiver and family system. Poor living conditions and lack of resources continue to place families at risk. Caregivers continue to be the recipients of blame for such accident. An understanding of the contextual issues is essential in treating and providing support for burn-injured patients and their families.

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Dedication.

To my Grandfather (St John Page Yako)

"Ngemini kaNtsikana eRini kwakunye nembongi u-Manisi"

("Ntsikana Day at Grahamstown with the imbongi Manisi")

. . . we Africans grieve,
grieve at the loss of the great Mqhayi,
who loved the land with all its ailments.
The nation suffers for lack of a comforter,
and the Pleiades mark each passing year;
the land has no-one to bind its wounds
as Mqhayi did in his time.
Old timers groan away
with no-one around to comfort them,
while youngsters rob away
with no-one to stop and correct them.
Hand Mqhayi's weapons to Manisi,
poet to Mhlobo's Daliwonga,
the knotted rod of Rhoda,
poet at Mthikakra's, the bearded puffadder.
When this poet spoke at Grahamstown the sun paused to listen,
the moon came out, Venus rushed back
with the other stars, and all was ablaze;
cars fluttered like dainty birds
keeping their dust from Manisi's face,
planes held to the ground like cows
paying Manisi rapt attention,
the train shunted into its shed
lest the Khundulu poet choke on its fumes.
Ntab'ozuko's bones were shaken,
trembling in rolling thanks
at the wailing of Manisi's son
ripping out "Hail, Vukile! Hail, Vukile!"
sending chills to the hearts of men
who felt urged to lash out with whatever they held,
leaving women to cry, "What's become of our men?"
And the cops continued to nod at their posts, thier handcuffs idly clinking,
as the son of Manisi set the law free. (By Yako, St. J. Page 1976. pp 111-115).

(trans. from the Xhosa)

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Chapter 1: Introduction

1.1 Introduction

According to Hummel (1982), there is no thermal injury to the human body that does not lead to some emotional response. Physically disfiguring traumas, such as burns, can be devastating, with the possibility of human functioning being affected across the biological, psychological, familial and social realms. The disturbance caused to the skin, the physical container, provides opportunities to observe the complexities apparent in the relationship between the phenomenal and objective body.

Burn injuries are a relatively common cause of hospitalisation and may have long-term physiological and psychological consequences. More often than not, it is the younger members of the community that are affected. Burns are noted to be among the most extensive and frightening injuries a person can have (Bosworth, 1997). Extensive injuries caused by burns can be life threatening when homeostatic mechanisms and the interaction between the wound and the host, from a circulatory and metabolic point of view, need to be controlled (Van Loey and Van Sons, 2003). The neuroendocrine system, metabolic functioning, immune system, complement system, coagulation-fibrinolysis complex, and kallikrein system are involved to varying extents. Catecholamine, rennin-angiotensin, serotonin, histamine, interleukins and eicosanoids are released at different sites, including burn wounds. An increase in concentrations of these humoral mediators affects the vital systems, organ functions, membrane permeability and vascular responses (Sette, 1996). Though some of these reactions are considered vital (particularly for circulatory homeostasis) for host defense against infection, or wound healing, they may lead to organ dysfunction or multiple organ failure (Sette, 1996).

The psychological human dimension is intricately interwoven with that of the physiological. Psychological difficulties experienced by burn victims are numerous, including: post-traumatic stress disorder (PTSD), depression, social withdrawal, burn delirium, pain syndromes, sleep disorders and grief (Martyn, 1990). Apart from these psychological disorders, burn scars that remain after deep dermal injury are cosmetically disfiguring and force the scarred person to deal with an alteration in body appearance (Van Loey and Van Sons, 2004). In addition, the traumatic nature of the burn incident, and the painful treatment that follows, may induce psychopathological responses (Van Loey and Van Sons, 2004). Grief and mourning are a common presentation in the

burn population. According to Van Loey and Van Sons (2004), this may be related to the loss of persons or to the destruction of property resulting from a burn incident. A loss of bodily integrity, resulting from a burn incident, is also likely to lead to feelings of grief and despair. Loss of identity, especially in children, is also experienced as a shift from normality to abnormality is perceived to take place. Blankley, Robert and Meyer (1998, p. 196 in Bordlieri, 1985) state that:

Children, who have been physically normal and rendered disfigured by a traumatic injury, must recreate themselves, adapting their previous self-concepts and world views. Cognitively, the demand is to accommodate the altered body image and new life experiences. Such children must develop new interpersonal skills to assist their negotiations as disfigured people in a society in which even very young children place a premium on physical attractiveness”

The ability of child burn victims to explore and learn within their environment may be jeopardised following a burn injury. Children may display constricted and repetitive play, hypervigilance, reckless and accident prone behaviour, fear of body damage, separation anxiety, and loss of developmental milestones (Lieberman, 2004). Injuries sustained during burns may also lead to significant difficulties in ego and self-development. Although most early theorists of personality failed to make the inter-link between body and self, Gorman (1970 in Frost, 1983) asserts that most observers now agree that ego and self development are dynamically linked to the development of body image.

Although the child burn victims are the primary bearers of all physical and psychological pain associated with the burn incident, their caregivers often experience similar feelings of distress. Monahan (1993), states that the pain of a child burn victims’ trauma echoes forcefully in the lives of their parents, brothers, sisters and other loved ones. Parents find themselves reeling with fear and worry following a traumatic event in a child’s life. In this case, burns not only result in alteration or disfigurement of the body, but also in alteration of the family system. Apart from the physical pain, the child burn victim must often deal with the loss of family members, family pets, home and personal treasures. Even in lesser traumatic injuries (partial dermal burns) the intra-psychological and the child’s family system will experience a significant impact. Traumatic events, such as burns, have the capacity to disturb vital functions within the family, such as parenting functions, including: emotional nurturing, education and protection (Lieberman, 2004). Communication, intimacy, expressiveness and role-distribution may also be affected, resulting in a reduced capacity to cope with internal and external demands. The relationship with his or her caregiver and family may be negatively affected. The child’s exposure to trauma can provoke feelings of grief, guilt, anger, anxiety and blame in parents, profoundly affecting family relationships. Infants’ attachment patterns

may be affected as the caregiver may become withdrawn, reducing physical contact. In these cases parental reactions may negatively impact the child more than the direct trauma exposure (Steinberg, 1998, in Lieberman, 2004). Parents may be overwhelmed by the trauma and minimize its effects. This may be accounted for by the parents' past traumatic experiences, or they may feel inadequate in their ability to help their children cope with the trauma (Marans, Berkman and Cohen, 1996, in Lieberman, 2004, p. 5).

1.2 Research Objectives

In recent years, narrative psychology has begun to regain popularity. Narrative psychology believes that people rely on stories, or narrations, to make sense of their lived experiences. This is particularly so in instances of trauma or illness, when major biographical disruptions can occur, and the relations between body, mind and everyday life are threatened (Burry, 1982). The disruption and fragmentation manifest in such experiences serve as useful means of highlighting the sense of unity, meaning and coherence more commonly experienced on an everyday level. When incoherence prevails, as in the case of trauma, narratives are used to rebuild the affected individuals' shattered sense of identity and meaning. Such narratives and account production are dependent on the context within which they are constructed. Such stories, or narratives, not only give meaning to events, but are also seen as constituting an "organising principal" for human action and life. Narratives do not only describe people or events but also play a significant role in the construction of those lives (Crossley, 2003).

The attention directed at burn treatment and understanding its consequences for the child burn victim, caregiver and the family, continues to receive very little support, particularly from a psychological position. Much of the existing knowledge on the subject is drawn from international research, which cannot always be generalized to a South African context. With the high prevalence of burn victims in South Africa, it is clear that there is a dire need for increased research aiming to understand and better inform treatment and preventative strategies.

The present study aimed to explore the impact of paediatric burns on young children and their caregivers. The study positioned itself within the interpretivist paradigm, adopting narrative philosophies in examining caregivers' accounts related to their child's injury. Semi-structured interviews were conducted with four African, Xhosa speaking, female caregivers who represent an enormously under-researched group in the country. The interviews lasted one hour and an interview schedule consisting of seven open-ended questions was used as a means of generating data. The

interview schedule consisted of questions exploring the impact of the burn injury on the child, caregiver and the family. The responses were transcribed and translated. A narrative approach was used in the analysis of the data. The research aimed at examining caregivers' narrative content in order to understand how caregivers and their children are impacted by a paediatric burn injury. The study wished to bring to the fore the sets of *complicating actions*, *evaluations* and *resolutions* witnessed in the course of the injury. It also aimed to highlight the personal and interpersonal exchanges taking place between the caregivers and the involved characters of each plot. The plots were positioned within the broader societal, cultural, political, economic, and personal dynamics present at the time, in the 'meaning-making' process.

Burn injuries can be enormously disruptive. The consequences for caregivers can be profound, resulting in significant points of biographical disruptions in their life narratives.

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Chapter 2: Literature Review

Overview of the chapter:

The chapter begins by reviewing literature relating to the *epidemiology of burns*. The literature reviewed in this section examines studies focusing on causes of burn injuries and associated risk factors. Most of these studies have been conducted in parts of the world with similar conditions to South Africa.

The section on *paediatric burns and its consequences* specifically focuses on the causes of childhood burn injuries. The consequences of these injuries for the child burn victims and their caregivers are examined on a physiological and psychological level. The study also looks at the consequences of paediatric burns for the family system of the child burn victim.

The section on *motherhood and the burden of care*, examines the discursive nature of the concept of motherhood, and how it is constructed and regulated. The aim here is to look at the impact of this on practices such as caring for an ill child.

The section on *narrative and illness* examines how people make sense of an illness as it impacts their lives. According to narrative theory, illness results in points of biographical disruptions in people's lives. This means one's life can be fragmented, resulting in one's identity and sense of self being shattered. Often, in cases of trauma, people find it difficult to locate their experiences within a communicable language. Narrative theory has been found useful in assisting people to "reconfigure" their shattered lives (Crossley, 2003).

2.1 Epidemiology of Burns

The incidence of burns and its impact on individuals and their family system, has historically received very little attention in the South African context, despite the fact that burns are noted to be the second biggest contributor to accidental deaths in both adults and children. Butchart's, (2000) national injury mortality surveillance profile of 1999 indicated that accidental deaths were recorded to account for 5090 (32%) of all 14829 non-natural deaths captured for the periods 1 January to 31 December 1999. The 14829 cases captured in the study made up only 25% of the estimated 60 000 non-accidental deaths that occur in the whole country each year. 77% of the accidental deaths captured from 1 January to 31 December were due to transport collisions. Burns were the second

leading cause of accidental deaths, accounting for 9% of all fatalities. Drowning was the third most frequent cause of accidental death for this period, accounting for 5% of total accidental deaths. However, these figures differed when examined with relation to the reported numbers of accidental deaths of children. The childhood injury deaths statistics for 2000, compiled by The University of South Africa's Injury Prevention Unit, indicated that in South Africa, almost 6500 children, from birth to age fourteen, die due to unintentional injury. Over 5000 children from the age of one to four die due to unintentional injury according to this study. The leading causes of injury death are motor vehicle crashes (44%), followed by fires (21%), drowning (14%), poisoning (4%) and falls (3%). The rate of unintentional injury for children from birth to age 14 was noted to be 44.3 per 100 000. Despite such high rates of unintentional injuries in children, little is being done to document the psychological consequences of such accidents on child burn victims and their family systems.

Historically, burn care has focused on medical issues rather than on psychological problems and quality of life (Van Loey and Van Son, 2003). The psychological impact of burn injuries has become a subject of interest only over the last few decades, as growing insight into the pathophysiology of burn injuries and advances in medical care have made it possible to decrease mortality rates (Martyn, 1990). Van Niekerk, Rode and Laflamme (2004), state that in recent years there has been an increase in the attention directed at the epidemiology of childhood injuries in the country and further a field across other low to middle income countries on the African continent (Ghana, Nigeria, Morocco, Ethiopia) and elsewhere (Brazil, Greece, Bangladesh, India). Studies conducted on the epidemiology of childhood injuries indicate that burns are a significant cause of injury to young children, especially those aged between one and six years, and even infants (Petridou et al., 1998; Rossi et al., 1998, Boukind et al., 1995; Forjuoh et al., 1995; Werneck et al., 1997; Blankley et al., 1998; and Maghsoudi et al., 2005). These studies also indicate similarities in terms of risk factors. Research, conducted in Brazil, Morocco, Ghana, Greece and North America, indicates that burn injuries are environmentally *conditioned* and thus easily preventable.

Similarities regarding burn injuries, and their associated risk factors, are observed in almost every study conducted in recent decades. Werneck and Reichenheim (1997), in a study conducted in Rio de Janeiro, Brazil, found that potential risk factors assumed to be associated with the occurrence of burn injuries in childhood were linked to: low socio-economic status, male gender, low educational level of the mother, history of burn injury in a sibling, sibling death from a burn, psycho-social stressors in the family, multiparity, hyperactivity, adaptive problems, birth order, psychiatric disorders, physical impairment, and chronic disease. The results echoed the findings of a study conducted in Athens, Greece, with a sample of 239 children, where it was found that burns

commonly occurred in low to middle income settings and that children from families of gypsies and recent migrants, who belonged to socially disadvantaged groups, appeared to be at high risk (Petridou et al., 1998). Children of working mothers with limited education made up a large proportion of those at risk, and children living in houses with only one bedroom, or three or more bedrooms, were at substantially higher risk compared to children living in homes with two bedrooms. The likely explanation offered for this bimodal risk pattern was that one-bedroom houses reflect socio-economic strain and unfavorable environmental conditions, whereas larger houses with too many bedrooms reduce the ability of close supervision of children by adult family members (Petridou et al., 1998).

Similar findings were observed in other studies: Rossi, Braga, Barruffini, and Carvalho (1998), investigating the circumstances of occurrences of burns and their prevention in Ribeirao Preto, Brazil, with a sample of 26 children, found that 50% of the injured children were under three years and had suffered a scald. Within this particular study, male children were noted to be more affected by burn accidents than females. These results agree with the studies by Cronin et al. (1996, in Rossi, 1998) conducted in Ireland that indicated that male children are the ones that most frequently suffer from thermal traumas. Unfortunately, reasons behind this were not elaborated. However, one could speculate that male children are placed at greater risk, relative to their female counterparts, by nature of their being more adventurous or clumsy at play.

Results from the above study also showed that a large number of burn accidents affecting children occur in the domestic setting (Rossi et al., 1998). Eighty two percent (82%) of accidents noted in the study, happened near or inside the injured child's house. The kitchen and backyard were identified as the places where the majority of accidents took place. The study also found that at least one parent was present in eighty percent (80%) of the cases. Overheated liquids were the agents causing ninety one percent (91%) of the kitchen accidents affecting children under three. Five of the thirteen children at this stage who had suffered thermal trauma had burns on the scalp, face, arms and hands, and seven were burned on the anterior thorax. With such injuries, hot liquids were spilled on the children in the cephalo-caudal direction, hitting chiefly the scalp, face, thorax and upper extremities (Rossi et al., 1998).

Because burns often occur within the domestic setting, they are preventable. Agents largely responsible for burn accidents are pans whose handles are left projecting out from the front of the cooker, overheated liquids handled carelessly when children are nearby, and containers with overheated contents within reach of children. Children under three years old, very often stay near

their mothers while they cook and are thus more exposed to burn risk (Rossi et al., 1998). In Ghana, a similar trend was observed. In a study by Forjough, Guyer and Smith (1995) investigating the epidemiological characteristics of home-based treatment of burns, it was found that 92% of burns occurred in the home, particularly the kitchen and the outside in the yard (garden). Most of the burn accidents were noted to take place in the late morning and around the evening meal. The main causes of burns were scalds, contact with hot objects, and flame.

The circumstances surrounding burn accidents in South Africa are no different than those of other low socio-economic settings on the continent and elsewhere. It has been estimated that South Africa's burn fatality rate is approximately four times higher than in the industrialized world (Van Niekerk et al., 2004). This is because more than two thirds of burns in South Africa are due to dangerous or inappropriate use of energy sources. Continued reliance on fossil fuels is primarily associated with the lack of access to electricity (Laflamme, Rode, Van Niekerk, 2000). In a study undertaken in Gauteng, it was found that burns were six times more common in informal settlements than in formal residential areas, where burns accounted for the smallest proportion of all household injuries. Incidence rates tend to be elevated in informal settlements because of the reliance on fossil fuels (paraffin, wood, coal) for heating and cooking. With the close proximity of the stove or fire to the ground, the possibility of an adult or a child stumbling into it, or upsetting the cooking pots, is high (Laflamme, Rode, Van Niekerk, 2000). The risk has been noted to increase when children play in cooking areas as, generally speaking, the implements are unstable and the surfaces are uneven. The use of candles for lighting is another significant factor that contributes to house fires and, thereby, burn incidences. A study conducted by Van Niekerk, Rode and Laflamme (2004) in the Western Cape, South Africa, noted that amongst children, toddlers and infants are at a significantly higher risk of burn injuries. The study also highlights the fact that in South Africa, the African group continues to report lower literacy rates, income levels, and overall health status. All of these factors, along with higher levels of household crowding, are variables regarded as significant in terms of contributing to the risk of burn accidents and incidences occurring.

2.2 Paediatric Burns and Their Consequences

The impact of paediatric burns can be severe, affecting physiological and psychological functioning in a child. The physical pain resulting from the injury is often unbearable. The consequences of the thermal injury are: local cell destruction, followed by healing, regeneration, scarring and contraction (Gallagher, Rae, and Kinsella, 2000). The severity of the pain experienced is dependent on the degree of the injury (superficial, superficial partial thickness, deep partial thickness, and full

thickness). Partial burns and superficial partial thickness injuries result in severe pain, as nerve endings are still functional. Pain is absent from full thickness burns as nerve endings are destroyed.

Although rapid wound healing occurs in small and superficial wounds, large, full-thickness burns do not heal spontaneously and need to be treated with excision and grafting (Williams and Phillips, 1992). The destroyed skin must be replaced by uninjured skin that is harvested from another part of the body. Infections, or sepsis, are the greatest enemy of burn patients and become a serious threat in the first week after the burn injury. For this reason, the burn wound is cleaned by hospital staff once or twice a day and then dressed, usually with medication designed to kill germs, and thick dressings. Cleansing the wound includes debridement, which involves removing loose, dead skin and old creams or secretion from the skin. This treatment is very painful and the patient usually receives pain medication beforehand (Munster, 1993). It is understandable that these painful procedures, to which the burn survivor is continuously exposed during the time of hospitalisation and post-discharge, can be experienced as traumatic by a young burn patient.

Psychological distress has remained problematic, in terms of diagnosing it in infants and young children. Most studies on burn-injured infants and children report relatively few problems (Stoddard, 2006). This can be explained by the lack of observable cognitive and verbal abilities in this group. Terr (1988, in Stoddard, 2006), found that children younger than 28-36 months old at the time of the injury, could not fully verbalise their traumatic experience. At any age, however, behavioural memories (i.e. posttraumatic) remain quite accurate. A study of 32 children with large burns (total body surface area [TBSA] mean = 48%) found significant signs of increased internalising behaviour (Meyer, 1999). These children were found to be socially withdrawn and displayed some degree of depressive behaviour. Another study of 143 children aged six months to six years, with 1%-40% TBSA burns, reported "low normal" ranges of functioning, but with the children's language functioning, marginal for their age (Johnson et al., 1998). These studies also observed signs of traumatic stress, including posttraumatic play, increased startle response, and sleep problems. Lieberman (2004), also reports that infants as young as three months have been observed showing traumatic stress responses following direct exposure to trauma. Though children have a limited understanding of the world which is based on their experiences, observations and developmental and cognitive abilities, they have a capacity to express distress. Rossi (1998), states that children at all developmental stages show emotional reactions to burns that involve disfigurement. According to Herman (1995, in Lieberman), expressions of those reactions are characterized as regressive behaviour, loss of sphincter control and nightmares. Children often "act out" pain and sadness through their behaviour.

Hubbuck (2003) cautions that when considering burn injuries in children, two pertinent issues arise, to which sensitive awareness is essential. The first is family relations and the role that these can have on the way that the thermal injury is dealt with. The second is pre-existing family issues, which may have contributed to the causes of the injury itself. Many children in South Africa are at high risk of sustaining burn injuries because of the level of deprivation faced by their families. Typical situations experienced by families of children admitted with a burn or scald, include: family breakdown, low income, poor housing, mental-health problems, substance abuse, and absence of parental control (Hubbuck, 2003). Under strained resources, families often find it difficult to respond appropriately a child's injury.

Many studies apply the 'stress and coping framework' in order to understand the impact of chronic illness, such as burns, on a family. Paediatric chronic illness is conceptualized as an ongoing stressor for children and their caregivers due to repeated interference with daily role functioning, imposed by disease symptoms and management. The degree of impact caused by chronic illness on children's adjustment depends on a complex interplay of numerous other stress and resistance factors (Soliday, Kool and Lande, 2001). A potential resistance factor for the stress caused by the disease is the child's family environment, characterized in part by family structure, and the quality of the family environment. Family structure varies from traditional i.e. a two parent, intact family, to non-traditional, i.e. one parent families formed by single parenthood, divorce, death of a spouse, or one parent families plus unrelated spouses, or families formed by remarriage. Traditional families typically experience fewer stressful transitions, which would generally put pressure on the psychological, and/or financial resources available to children in one parent or blended families. Traditional families also typically have greater caregiving resources such as time, energy and finances. Another factor, theoretically impacting the effects of ongoing stressors, is the quality of the family environment, with a more positive family environment giving greater buffering force. Positive family environments have been characterised by high cohesion, which is the support family members provide one another. In addition, a high degree of encouragement to express emotions directly, called expressiveness, and low levels of conflict amongst family members also characterise a positive family environment (Soliday, Kool and Lande, 2001).

Caregivers, of children that have suffered burn injuries, also show significant signs of distress. Empirical research indicates that parents of hospitalised infants and children, experience distress, as well as intense emotional reactions, as they observe their young child's physical illness and behavioural and emotional response in an acute care or intensive care environment (Leidy et al.,

2005). These parents show significantly elevated levels of stress, associated with watching their children undergo medical procedures and not being able to take care of the child themselves or respond to the crying child. Steinberg (1998 in Lieberman, 2004), states that a child's exposure to trauma provokes feelings of grief, guilt, anger, anxiety and blame in parents. The reactions displayed by parents are termed *vicarious trauma*, where parents and other loved ones in the family poignantly experience the child's trauma, (Monohou, 1994).

2.3 Motherhood and The Burden of Care

Previous decades have placed mothers under intense public scrutiny. The concept mother has been invested with ideological meaning and cultural significance (Bassin, Honey, and Kaplan, 1994; Braveman, 1989; Glenn, 1994; Parker, 1997). The meanings and significance attached to motherhood is not universal. It functions and operates differently in different settings (Collins, 1994). In contemporary western society, which dominates thinking around this subject, motherhood has acquired a very special significance. Not only is motherhood regarded as the ultimate goal for all women in this society (Llewelyn and Osborn, 1990), but also the role itself has been so rigidly circumscribed and bounded that authors frequently refer to the "myth of motherhood" (Braveman, 1989, p. 244; Glenn, 1994, p. 9; Thurer, 1994). The fantasy of the "perfect mother" (Chodorow and Cotratto, 1982; Price, 1988, p. 17) describes the expectations and requirements that are associated with motherhood. Women are expected to find fulfillment and satisfaction in the role of "ever-bonding, ever-giving, self-sacrificing mother" (Bassin, Honey, and Kaplan, 1994, p. 2).

Feminist researchers have in the last years, set out to collect alternative voices for women – including *voices of motherhood*. Feminist theory has argued, since the 1970s that seeing the mother as subject – a person with her own needs, feelings and interests – is critical to fighting against the devaluation of women (Bassin, 1994). Feminists argue that motherhood is a historical, political, cultural and social construct, rendered visible by systems of imperialism, which are played out in academic and intellectual life (Burman, 1997). The construction and regulation of motherhood in the psycho-medical literature contributes significantly to the functioning and practice of mothering. Macleod, (2001) notes that a number of factors are responsible for this, which include: perceiving mothering as an essentially dyadic activity; viewing mothering as a skill; perceiving motherhood as a pathway to adulthood; and fathering as the absent trace.

Macleod (2001) states that the domestic dyadic activity of mothering has become saturated by what Walkerdine and Lucey (1989) call "Bowlbyism". Bowlby's work on maternal deprivation and

attachment, which served to redefine women's responsibilities (in the post-war period in Britain), is embedded in a history of misogynist discourse (Franzblau, 1999, p. 22). This discourse has been taken up by professional and popular literature, to emphasize the importance of bonding between the mother and infant at birth, as well as the continual presence of the biological mother. This discursive practice underlies the construction of the "good" mother defined as the caregiver who is always available and always attentive. Such a depiction acts as a yardstick, which functions to place the task of mothering on a continuum of good or bad. The skills discourse in psycho-medical literature stands in contradistinction to one of the dominant discourses of motherhood, namely the "natural" discourse, in which mothering is seen as biological and instinctive (Macleod, 2001). The foregrounding of the "skills" discourse and the "natural" discourse are powerful in a number of respects with regards to mothering. Macleod (2001), states that skill implies that a deficient state exists. This understanding opens a space for interventions from professionals through a process of *pedagogisation*. Pedagogisation of mothering does not take place through dictation, instruction or imposition, but rather, the professional facilitates the autonomous, intrinsic process involved in becoming a mother. This regulation takes place in a covert rather than an overt manner. Here the mother is encouraged to be true to herself and the taken-for-granted characteristic of the good mother. Having a child is often seen as the successful accomplishment of womanhood. The underlying, unexamined assumption is that the type of adulthood achieved by women is different from that achieved by men. It is strongly gendered around the conception and bearing of children (Macleod, 2001).

Male partners are largely absent in the literature on child rearing practices, and fathering is mentioned very seldom. This, has until recently been a feature of the developmental psychology literature (Burman, 1997). The rise in interest in fatherhood in Britain has to do, according to Alldred (1996), with the change in family structure, in particular with the increase in single-parent families, a trend in evidence in South Africa as well. Lone mothers have been the subjects of blanket pathologising (Silva, 2000). The lone parents' status is inextricably linked to questions around gender politics: is it acceptable for women to raise children on their own? Should welfare provision support such independence from men? Do mothers have the right to pursue careers? Are the pathologising accounts of single mothers in the media part of a hegemonising discourse to get women back into more traditional roles of housewife and homemaker? Such debates inevitably mean examining the relationship between the family and the state. Silva (2000), offers a critical examination of how economics, welfare and social structures impinge on mothers' everyday lives. Some research surveys have been found to form part of the pathologising discourse, which far too crudely associates such a status (lone mother) with family dysfunction, child delinquency and poor

educational attainment. Making a similar point, Baylies (1998, in Silva, 2000) draws attention to a human development report by the United Nations, which featured single female-parent homes alongside intentional homicides, asylum application and juvenile prisoners under the title weakening social fabric. Smart (1996, in Silva, 2000), in her history of motherhood in Britain, shows how in the context of normalising motherhood, working-class, unmarried mothers are perceived as most disruptive of the norms. They are presumed to be “bad” mothers. Smart (1996) also states that the rise of the “psy” professions led to a range of persuasive policies and professional practices, which were gradually brought to bear on working-class mothers to alter their mothering practices. These strategies were strongly supported by ideologies of motherhood that expressed the natural characteristics of mothers as coinciding with a class-specific, historically located ideal of what a mother should be. In South Africa, this link functions on a racialised level, with the signifier poor mothers, implicitly meaning black mothers (Macleod, 2001).

Caregivers are the most impacted by a child’s trauma in a family system. One of the primary reasons for this is that caregivers take the front line position in nursing, caring and facilitating a child's recovery in the home context. Caregivers are seen to have a central interest in a child’s health and usually take responsibility for monitoring the health of their children, for seeking health care on behalf of their children and participating in decisions concerning the health care of their children. However, as mothers, the behaviours and actions of women are subject to scrutiny in a way that men as fathers are not, and these behaviours and actions are often linked to family and child health outcomes in ways that male activities are not (Jackson and Mannix, 2004).

Caregivers often struggle with feelings of guilt, shame and blame in instances where their child suffers from an illness or injury. In these cases mothers often become the recipients of blame from others in their family and also subtly from broader societal and institutional practices. Fabricius (2004, p. 312), states that “all feelings serve as orientation and refer to an object”. Feelings of guilt and blame are related to a social object or a social relationship and contribute to recognition and regulation. ‘Mother-blaming’ has been called a “serious and pervasive problem” (Jackson, and Mannix, 2004, p. 150). This is a term that describes mothers being held responsible for the actions, behaviours, health and well being of their (even adult) children. The term also describes situations where women are blamed for their own predicaments, such as being abandoned or living in poverty. Phares (1992), adopting a mental health perspective, describes ‘mother-blaming’ as a sexist bias towards studying mothers’ contribution to child and adolescent maladjustment and at the same time ignoring the contributions by fathers. Billing (in Jackson and Mannix, 2004, p. 150) states that this perspective is supported by “bonding doctrine” and other child-rearing theories such as that of

Bowlby's (1969), where the blame for any psychopathology of childhood has been placed firmly on the shoulders of the mother". Theories within psychological literature that serve this function, have been noted to include cognitive developmental theory, learning theory, Freudian theory and attachment theory. These theories serve as the primary reference points, which are institutional and socially relied upon for informing the practice of mothering. From a feminist perspective, there is agreement that these ideas are burdensome to women and do not extend equal responsibility to men (Macleod, 2001).

2.4 Narrative and Illness

People's lives are shaped by the meaning they ascribe to their experiences, by their situations in social structures, and by the language practices and cultural practices of self and of relationships that these lives are recruited into (White, 1992, in Cortazzi, 1993). In the wake of the many atrocities witnessed in recent years, mental health professionals have found themselves consistently confronted by individuals who have been through experiences that are described as traumatic. These people struggle to make sense of what an event means with relation to themselves, those involved in the event and the world in general. Therapists from a variety of theoretical perspectives strive to help their clients examine, evaluate, revise, or create meaning related to these events (Erbes and Harter, 2002 in Erbes, 2004). Therapeutic work with trauma is inherently a work of meaning.

The constructivist and the narrative paradigm have in recent years provided useful ways of working with survivors of trauma. Like other psychotherapeutic enterprises, work with trauma does not occur in a vacuum. It is thus important to attend to the existing meaning systems on a variety of levels when considering such work. Mscolo, Craig-Bray and Neimeyer (1997, in Crossley 2003), talk about the constructions of meaning as existing on several hierarchically arranged and interactive levels: at the broadest level lies the *societal meaning-system*, created and maintained through continuous discourse carried on throughout a socio-cultural system; next follows the *meaning construction systems of interpersonal interactions*; and at the lowest level lies the *individual meaning making* processes, involved as meanings are created through constructions on an intrapersonal level. In considering trauma, it is therefore important to consider the societal and interpersonal systems of meaning, as well as the intrapersonal constructions of a person.

Meaning is obtained through the process of narration. The process itself, referred to as *narrative configuration*, serves to ground experiences in a communicable language by imposing structure on a set of events experienced as fragmented and incoherent. More than that, narrative is considered to

constitute an organizing principle for human action and life (Crossley, 2003). Sarbin (1986, in Crossley, 2003) refers to this as the *narratory principle*. This is an idea that human beings think, perceive, imagine, interact, and make moral choices according to narrative structures Sarbin (1986, in Crossley, 2003). Humans are seen to orient towards the world “with an implicit sense of temporal coherence, connection, order and experiential unity during the course of everyday practical life” (Carr, 1986, in Crossley, 2003, p. 523). It is argued that the reality of human experience can be characterised as one that has a narrative or story-telling character. Carr (1986, in Crossley, 2003) draws on phenomenology, specifically Husserl’s theory of time consciousness, to explain this. The theory depicts the way in which humans experience time. The theory highlights three levels of human experience: passive experience; active experience; and experience of self/life (Carr, 1986, in Crossley, 2003, p.292). At each of these levels, human experience can be characterized by a complex temporal structure similar to the configurations of the storied form. Carr (1986 in Crossley, 2003), states that, according to Husserl, even as humans encounter things at the most passive level, they are charged with the significance they derive from anticipation of the future – what he refers to as *protention*; and our memory of things past – what he calls *retention* (Carr, 1986, in Crossley, 2003, p. 292). The argument is as follows: we cannot experience anything that is happening as present except against the background of what it succeeds and what we anticipate will succeed it. Hence, when we experience time, we have no option but to experience it as an interrelated configuration of past-present-future. The story is seen in the same way – as a symbolised account of the actions of human beings. It is seen to possess a temporal dimension, beginning-middle-ending. The story is held together by recognisable patterns of events called *plots*. Central to the plot structure are human complications and attempted resolutions. Broyard (1992, p. 21) writes:

Always in emergencies we invent narratives. We describe what is happening as if to confine the catastrophe. Storytelling seems to be a natural reaction to illness. People bleed stories and I’ve become the blood bank of them.

Studies of traumatising experiences, such as chronic and life threatening illness, throw into relief our routines and taken-for-granted expectations, highlighting the way in which a lived sense of coherence, unity and meaning normally prevail. When such a sense is disrupted, through traumatisation, the importance of narratives comes into effect as the individual attempts to “reconfigure” a sense of order, meaningfulness and coherence of identity (Crossley, 2000).

Locke (2004) considers narrative psychology a useful tool to examine areas of trauma or illness affecting people. Often, traumatic experiences shift individuals and their families into

psychologically unfamiliar places where the experience encountered is indescribable. The difficulty in locating the experience within a communicable language often leaves those who have experienced it feeling isolated and alone. Thorne (2000) says that many qualitative nurse researchers have discovered the extent to which human experience is shaped, transformed, and understood through linguistic representation. The vague and subjective sensations that characterise cognitively unstructured life experiences take on meaning and order when we try to articulate them in communication. Putting experience into words, whether we do this verbally, in writing, or in thought, transforms the actual experience into a communicable representation of it.

University of Cape Town

Chapter 3: Methodology

3.1 Qualitative Research Approach

The study adopted a qualitative research approach in exploring caregivers' experiences of paediatric burns. This design has been found useful by researchers wishing to investigate attitudes and behaviours as they occur in their natural setting. The study positioned itself within the phenomenological/ interpretivist paradigm, adopting narrative philosophies in examining caregivers' accounts. Within this tradition, the aim of human science is defined as understanding (not explaining) people. People are conceived, not primarily as biological organisms but, first and foremost, as conscious, self-directing, symbolic human beings. All human beings are engaged in the process of making sense of their life within the world.

Narrative psychology can be classified as broadly social constructionist, insofar as it attempts to examine the cultural structuration of individual experience. The basic principle of narrative psychology is that individuals understand themselves through the medium of language, through talking and writing. It is through these processes that individuals are constantly engaged in the process of creating themselves. The focus on meaning is of extreme importance. Serbin (1986, in Crossley, 2003), proposes the *narratory principle*: the idea that human beings think, perceive, imagine, interact, and make moral choices according to narrative structures. In instances of trauma or illness, people rely on narratives in order to establish meaning, coherence and order (imposing the narrative structure). Narratives not only help us to derive meaning, but also function so as to create meaning. Kerby (1991, p. 55, in Crossley, 2003) states that:

The stories we tell are part and parcel of our becoming. They are a mode of vision, plotting what is good and what is bad for us, what is possible and what is not- plotting who we may become.

Narrative forms the basic structure of human meaning-giving (Polkinghorne, 1988). By telling their life story, individuals actively make sense of their life experiences by creating coherence and continuity to face the given complexity and ambivalence of life. Narrative data are not merely an expression of the meaning-giving processes and of the self-presentation of individuals; they are also constitutive of it (Fischer-Rosenthal, 1995, in Crossley, 2003).

The paediatric burn survivors studied in this research are referred to as the *children*, while those responsible for their care are referred to as the *caregivers*.

3.2 Sample

In order to investigate experiences related to paediatric burns in very young children it was thought necessary to explore the narrative accounts of caregivers. The trauma experienced by a child not only affects his or her physical and psychological functioning but also profoundly affects the family system. There is empirical evidence suggesting that parents of hospitalised infants and children experience distress as well, marked by intense emotional reactions as they observe their young child's physical illness and behavioural and emotional responses in an acute care or intensive care environment. No study in the country has captured the consequences of burns, from the caregivers' perspective. It is this group of people that have been identified as playing a significant role in a child's recovery and adjustment. It is this same group that is also considered to be at high risk for developing conditions, which may affect a child's recovery. Caregivers may become withdrawn, minimise contact with the child, doubt their abilities to mother, self-blame and develop depression (Lieberman, 2004).

3.2.1 Sample Criteria

To be considered eligible for participation in the present research, several inclusion criteria were proposed for the participants, relating to: the race of the child and caregiver; geographical location; aetiology; language; age of the child at the time of the burn injury; and the time elapsed since the burn injury was sustained.

In order to qualify as a very young paediatric burn survivor, the child must have sustained a thermal injury before the age of four.

With regards to aetiology of the burn injury, no distinction was drawn between participants who had sustained burns caused by hot liquids (scalds), flame, chemical substances, electricity or contact with a heated surface.

A period of at least two months had to have elapsed between the time of data collection and the time the child was discharged from hospital.

Criteria for caregivers were that sample members were African Xhosa speaking mothers, residing in Khayelitsha, Cape Town. These criteria are pertinent to the study because this group represents an enormously under-researched population. Khayelitsha is a peri-urban settlement on the outskirts of Cape Town. Although some areas of Khayelitsha have privately owned brick and mortar homes, the largest area consists of predominantly informal shelters (shacks). Fewer than one in five of all dwellings are classified as formal houses (Spiegel and Mehlwana, 1997, in Tomlinson, Swartz, Cooper and Molteno, 2004). The informal areas in Khayelitsha are prone to fires, particularly in the winter season, as most residences rely on fossil fuels for heating, which poses a considerable risk factor for the occurrence of accidental fires.

3.2.2 Children

The children were purposively selected from the records of the Burns Unit, Red Cross Children's Hospital. The participants comprised of four (4) paediatric burn survivors ranging in age from one year, two weeks to two years old. The very young children were selected because the early bond (caregiver/child dyad) is often a close and dependent one. This has great significance for the way in which people make sense of the events and the types of conclusions reached. In terms of gender two of the children were boys and the other two were girls. All four participants were African. The initial length of stay in hospital ranged from four (4) days to two (2) weeks. Table 1.1 below provides a summary of each of the children.

3.2.3 Caregivers

The sample of caregivers comprised four biological mothers of the children. Semi-structured interviews lasting one hour were conducted in Xhosa. The interviews were recorded via an audio tape. These were later translated and transcribed for purposes of analysis. Translation of the interviews involved a process of re-listening to the recorded data and capturing each participant's responses, verbatim. However any process of translation inevitably results in loss of meaning of the expressed statement. This is so because translation involves removing the word, phrase or statement from its original context to function and convey a message in another setting. In this case the original intended meaning and performance value of any word may be lost. In such cases, sensitivity was used. This was achieved by applying a number of words or phrases that best approximate the statements, words or phrases. Participants were also given an opportunity to comment on the accuracy of translated words, statement or phrases.

All four caregivers were single mothers. The age ranged from 21 to 29 years old. Their level of education ranged from standard six (grade eight) to standard ten (grade twelve). Two of the participants were unemployed and the other two held jobs as semi-skilled workers. Table 1.2 below provides a brief summary of each of the caregivers.

Table 1.1: Children

	Child A	Child B	Child C	Child D
Age	1 year 2 weeks	1 year 2 weeks	2 years	1.5 months
Gender	Girl	Boy	Girl	Boy
Type of burn	Hot water	Hot water	Hot water	Hot water
Time	10am	7pm	no data	6pm
Area/ Accident	Dinning room	Dinning room	no data	Kitchen
Duration of hospitalization	2 weeks	4 days	2 weeks	1 week

Table 1.2: Caregivers

	Caregiver A	Caregiver B	Caregiver C	Caregiver D
Age	21	29	29	25
Gender	Female	Female	Female	Female
Level of education	Standard 10	Standard 6	Standard 10	Standard 9
Employment	Unemployed	Unemployed	Employed	Employed
Marital status	Single mother	Single mother	Single mother	Single mother
Dwelling	Formal 4 room	Semi-formal 3 room	Informal 1 room	Informal 1 room
N^o of occupants	6	8	2	3
Household income	R0 - R1000	R0 - R1000	R0 - R1000	R1000 - R3000

3.3 Procedure

Data were collected from the medical records of each participant and by conducting semi-structured interviews with each of the four caregivers. A questionnaire eliciting demographic data was also utilised. The medical records provided information relating to the participants' socio-demographic background, the aetiology and size of the burn injury, the participants' hospitalisation and post-discharge period. A demographic data sheet was used to gather participant's demographic information (See Appendix 1). An interview schedule consisting of seven open ended questions was

used as a means of generating data (See Appendix 2). All interviews were conducted by the researcher and at the respective residence of the caregivers. The aims of the interview were explained to caregivers prior to commencement and caregivers were reassured of confidentiality. The interviews took the form of an informal conversation in Xhosa so as to minimize respondents' anxiety. Each interview lasted one hour to one hour thirty minutes. The interviews were recorded on audiotape. They were transcribed and translated for the purposes of analysis. Due to the sensitive nature of the data collected, participants were informed of available psychological services, should they wish to take them up.

3.4 Ethical Considerations

The necessary ethical approval to conduct the study was obtained from the research ethics Committee of the Faculty of Health and the Psychology Department at the University of Cape Town. This approval allowed access to both the admission records and the individual medical records. (See Appendix 3).

3.4.1 *Informed Consent*

In order to obtain the necessary informed consent, the nature and purpose of the study was explained to the participant caregivers. Caregivers were informed that interviews were conducted with the aim of exploring the impact of the paediatric burns on the child, caregiver and family. Caregivers were informed that it was possible to withdraw from the research at any time without incurring penalty. Caregivers were then asked to sign a document explaining the above and granting consent to their own and child's participation. (See Appendix 4).

3.4.2 *Confidentiality*

To protect the privacy of the participants under scrutiny, both the participants and their caregivers were assured of the confidentiality of their disclosure. The names of the participants and their caregivers were replaced with pseudonyms.

3.4.3 *Feedback*

Caregivers were informed that feedback regarding the research findings would be available in six months. Contact details were furnished for this purpose.

3.5 Data Analysis

3.5.1 Analysis of Qualitative Data

In recent years numerous studies have looked at how people cope with the disruptive effects of pain, illness and traumatizing events through story telling and processes of narrative reconfiguration (Brody, 1987; Crossley, 1997; Delvecchio-Good, Munakata, Kobayishi, Mattingly, and Good, 1994; Viney and Bousfield, 1991). Such narrative reconfiguration consists of a process through which the individual attempts to re-establish a moderate degree of ontological security and a renewed sense of meaning, order and a connection to his or her life (Davies, 1997; Radley, 1994; Taylor, 1983).

In this section, four case studies are presented and analyzed. Data in each case is organized according to:

- 1) *Context* (the relevant demographic data of each participant),
- 2) *Narrative Plot* (examination of caregiver's narrative under the dimensions of Orientation, Complications, Evaluations, and Results),
- 3) *Narrative Tone* (examined as either pessimistic or optimistic) and
- 4) *Core Narrative* (the underlying meaning in each narrative).

The section marked as *Context* provides the relevant demographic data and background information of each participant and her child. This section provides details of name, surname, age, educational level, employment status, gross monthly household income, type of housing structure (formal/informal), number of residents or occupants, details of parents, siblings and partners, as well as energy sources used in the household. The above data may be useful when thinking about risk factors for burns. However, due to the small nature of the sample in the present research, such results cannot be generalized to a wider audience.

The *Narrative Plot* examines the narrative accounts of caregivers relating to their child's burn injury. This section forms the central point of focus in the research, as it provides rich qualitative data on the impact of paediatric burns on caregivers, children and family relationships. The narratives are examined under the four dimensions provided by Labov (1973, in Cortazzi, 1993), in his *evaluative model of narratives*. The conglomerate of all these dimensions is called the *narrative plot*. These are: *Orientation; Complication; Evaluation, and Results/Resolution* of the plot.

Each of the narratives begins by *orientating* the audience. This section positions the incident by providing details of time of occurrence, characters involved, the place where the incident happened, and the situation. The orientation section gives all the necessary information pertaining to the context. This context is not to be confused with the one already mentioned above where each participant's demographic and background data are given. Here, the focus is narrower and specifically relates to the events associated with the burn incident.

Each narrative proceeds to introduce one or more interrelated *complications*. In all four cases, the burn incident forms the principal situation upon which everything revolves. Leading from this event are a set of *complications*, which are key to the *evaluations* and *results* of the plot. The nature of these in each case is dependent upon the personal, familial, community, societal, economic, and political dynamics present in each context. It is important to offer some clarification of the term *complication* as it is used here. Labov (1973), states that from the situation (in this case the burn incident) must follow a set of complicating actions, or problems, which require a response. This yields results or a possible solution or resolution, which is evaluated positively or negatively before further action is taken. Complication here refers to the entangled and intricately involved sets of human actions and interpersonal exchanges existing between the involved characters. These actions and interpersonal exchanges result in change and, for the most part, an increase in complexity of the situation. To the definition must be added the term '*text*', which encompasses all that is witnessed and forms part of the narrative. The term *text* refers to the spoken utterances, the human actions, and cultural, societal and institutional practices. In the cases presented below, these may be witnessed as the acts of: shouting; blaming of the other; labeling of the other; as careless and negligent; or not good enough; engaging in silencing behaviours; the limited access to an emotionally expressive space; holding on to familiar patterns or routines; and pushing aside thoughts related to the burn incident as a means of self protection and as a means of holding the narrative wreckage or biographical disruption together. These acts, and most importantly the spoken utterances, observed in each narrative, are considered important *actions*, which not only play the role of describing the other's character (caregiver) but also play the role of *identity construction* by providing a sense of self, constructed from the sets of actions that make up the situation. Important in the idea of interpersonal exchanges is the element of internalisation, which is crucial in the *meaning-making process* of the event, affecting the evaluations and resolutions employed in each narrative plot.

From the above, follows an examination of each caregiver's *evaluations*. This section informs us of the reason why the story was told. The term *evaluation* specifically refers to the way narrators

attempt to share their attitudes, beliefs, and values in a given situation (Labov and Polanyi, 1973, in Cortazzi, 1993). Without evaluation, any sequence of events, even a contextualised sequence, is potentially understandable in many ways. In order to make it more likely that the audience will share their view of why the story is reportable, narrators must provide cues as to how the story is to be taken and how it relates to the ongoing conversational and pragmatic situation of which it is a part. In this view, evaluation is one specific mechanism by which narrators convey their 'points'.

Labov (1973 in Cortazzi, 1993), illustrates that narrators have available to them a variety of evaluative devices. These, he says, either function from an external or internal position in relation to the narrative. In external, or overt evaluation, the narrator says more or less directly, by stepping outside the process of recounting, This is it, this is the important part.

Less overtly, the narrator may attribute an evaluative comment or thought to a character, or, less directly still, convey evaluative force by means of an action (e.g. "I screamed"). Even suspension of action can be evaluative, because it heightens the audience's anticipation, making the crucial action, or 'high point', seem even more striking when it does come. In internal evaluations, the evaluation is internal to sentences and thus more embedded in the narrative structure (Labov, 1972, p. 378). In general, Labov considers departures from normal narrative syntax to be evaluative. For Labov, whatever departs from "the unmarked case", that is, whatever is "marked", surprising, or unpredictable, is potentially evaluative.

The results or resolutions stemming from the above follow. They provide details that inform how the character resolved the conflict in the narrative.

Each of the narratives indicate clearly the structural dynamics present in a narrative plot: *temporality* where the events proceed in a chronological manner indicating a beginning, a middle and an end; *causation*, the set of events that mark change in the plot line; and lastly they indicate *human interest*, the reason why the story was told, the element that makes the story reportable, the attitudes and evaluations of the narrator (Scholes and Kellogg, 1966, in Labov 1972). The three are seen by the authors as combining to form a minimum plot structure.

The narrative tone is extracted from the above process. This will inform whether the narrative carries a pessimistic or optimistic tone. The themes that emerge from each narrative are also presented here in detail. The core narrative follows on from this section and provides a statement

conveying the primary underlying meaning in each case. The process, summed together, responds to the question of what impact paediatric burns have, as experienced by the caregiver.

In each case, background data is provided to contextualise the event. This is often followed by an extract from a caregiver.

University of Cape Town

Chapter 4: Data Analysis and Results

A brief note on the interview process.

Before engaging with the material a note must be made about the interview process as a means of gathering data in narrative research. This is important particularly when considering the many-fold dynamics that are part of an interview process and may significantly influence respondents' narratives. Issues of race, class, gender, personal experience, interview setting, length of interview and structure of the interview have been noted to affect how the interviewer and interviewee engage with the subject matter. Wolfson (1976, in Cortazzi, 1993) states that narratives elicited in interviews lack performance features. According to him the features of performed narratives are sound effects, iteration, present deixis, and detailed blow by blow accounts of the action. Those that lack such features are essentially summaries. Interview narratives are seen as a mere shadow of the fully performed conversational narrative. The social situation of an interview has the asymmetrical rights to talk (Silverman, 1973; Kress and Fowler, 1983; Walker, 1985, in Cortazzi, 1993). The interviewer has the unilateral right to ask questions, the respondent has the obligation to provide answers. It is the interviewer that determines, initiates, sequences and closes topics.

Though the interviews were conducted in a conversational style, with the aim of allowing participants to feel comfortable with engaging with the topic, a number of factors affecting the quality of data gathered were observed. Firstly participants displayed a sense of uneasiness and wariness. Initial responses appeared restricted. Participants responded with simple statements, limiting their answers to the questions asked and did not freely offer information. They expressed feelings of fear, this despite having been informed of the aims of the research. These feelings later emerged in their narratives and were linked with the participants' fear of professionals (doctors, nurses, and social workers). These caregivers assumed the interviews to be about checking on whether they were "mothering appropriately". The element of being guarded, suspicious or uneasy in interviews is noted by Bhopal (2000 in Truman, 2000) as a common phenomenon in interviews. Respondent display such behaviours due to a lack of trust between them and the interviewer. Safeguarding ones narrative or life story can be seen here as essentially a process of safeguarding oneself. These observations are useful for a number of reasons. First, for the kinds of data that may be provided in each interview setting. Second for the power, gender, economic and cultural dynamics that exists between the interviewer/ professional and interviewees. Lastly for the potential communicative spaces that may be opened or closed in the process.

Case Studies

4.1 Case A

Context

The first case examines the narrative account of a caregiver who shall be referred to as Nono. Nono is a 29-year-old single mother with two children aged one year and five years. Her highest level of education is standard six (grade eight). She is unemployed and lives with her mother, father, two uncles and their wives, and one younger brother. The family lives in an informal three-room dwelling. The house has running water and electricity, which is relied upon for cooking and heating. The gross household income is estimated between R0 to R1000 a month. The sources of income are identified as a child support grant received for the younger child and an old age pension received by Nono's mother. Ukho is a 1 year, 2 week old boy, born 1 August 2004. He has never suffered from any major illness.

Nono has five siblings. She is the fourth child in the family. Her older siblings live separately in different parts of Khayelitsha. Some of her siblings are employed in semi-skilled work, whilst some do not work at all. Her younger brother is currently serving a sentence at Pollsmor Prison in Cape Town. He has been in and out of prison for numerous criminal activities such as theft. He also has a long-standing history of substance abuse (dagga, mandrax).

Of the five siblings, Nono maintains contact with her older sister who financially assists her with the purchase of goods for her child. Her older sister has her own house in Khayelitsha. In return for the financial assistance, Nono looks after her sister's house while she is at work or away during the weekend. At her sister's house Nono performs chores, such as looking after the younger children in the family (her uncle's children), doing the laundry, cooking and cleaning. Nono's relationship with her sister is sometimes marked by emotional strain. Her older sister shouts and blames her when chores are not done, when appliances break (e.g. a DVD player), when things run out or are used too quickly (groceries). Sometimes the shouting is unjust and unfair, and often her sister does not listen to her explanations. All of this upsets her and leads Nono to lock herself in her room and cry. This often brings her relief. Sometimes she distracts herself by playing with the younger children. Nono sees her task at home as making sure that chores are done since she is unable to contribute financially to the running of the household.

The father of Nono's child is described as "absent and uninvolved in the caring and maintenance of the child". Nono and her child's father have appeared in court as a result of his unwillingness to contribute to the maintenance of the child. Nono stated that she was raising her child on her own with the help of her sister and other family members.

Narrative Plot

Orientation

The elements fulfilling the function of orientating the audience to the sets of events under scrutiny were found present in the case. Elements of time, location, characters involved and the situation were analysed for and identified. Data contextualising the situation was provided.

In this case, the burn incident forms the principal situation. The incident took place at 7 PM, in the evening, at the older sister's house in Khayelitsha. The characters involved in the plot were identified as Nono, Ukho, Nono's older sister, her parents and siblings, a neighbour, as well as the institutions of help that were contacted. However, the principal characters in this plot were identified as Nono, her older sister and Ukho. A rich set of actions and interpersonal exchanges takes place between these characters, particularly between Nono and her older sister. These exchanges, as shall be witnessed below, significantly impact on the evaluations and resolutions employed.

The events that precede the thermal injury are provided along with further help to contextualise the incident. From what follows, emerges an intricate and entangled set of conflicts centering on ideas of motherhood, protection, containment, not only of the child but also of the feelings of guilt and blame elicited, and the idea of responsibility. Both characters engage with these conflicts. These conflicts place the caregiver in a position where she must make meaning of them, and embrace what she is left with, even if that is an identity of the "bad mother" who must be pathologised for her inability to fulfill what is required of her. These conflicts are deeply rooted in institutional, familial, societal and cultural practices, which function to control, regulate and construct the practice and notion of mothering.

A kettle had been placed to boil on the floor in the dining room. The water was to be used for tea. Nono had stepped out of the dining room to the kitchen to prepare to cook. She was alone at the time. She heard a scream coming from the next room and rushed to the baby's aid. Ukho had pulled the kettle via the cord, resulting in the boiling water spilling, not directly on him but on the floor.

He had subsequently placed his hand on the wet patch on the mat, resulting in his hand sustaining a burn injury:

The kettle was boiling on the floor in the dining room round about seven. I was about to make tea for the baby to drink, and I was in the kitchen preparing to cook. Next thing, I just heard screams. The child crawled on the floor, and touched the area on the mat that had the boiled water, and as a result burnt his hand. No, it just spilt on the floor and he touched that area. He pulled the kettle, the kettle plug was very low, since it was one of these that you can put on the floor or put it up on the wall.

Complication

From the above follows a number of complications involving the characters. The reaction of Nono's older sister to the thermal injury is considered a core complicating action, which increases the complexity of the situation. From this *re-action* is witnessed a rich set of difficult actions and interpersonal exchanges. The act of shouting, as a reaction, is the key complicating act in the narrative. The utterances, or words used, are themselves considered *complicating actions*, for their ability not only to describe but also to play a significant role in the creation of a sense of self that, in this case, is viewed as negligent and careless. Here we draw from the social constructionist discourse which states that words are not considered neutral entities that merely point to things or act as signifiers, but play a vital role in the creation of things and identities. Embedded in the utterances are dynamics of blame. The words here function to position the caregiver in a particular manner: that of a mother who is careless, negligent, and who, as a mother and as an adult, must protect the child at all times. This is the task that is given to Nono. What is also witnessed from the reaction or the act of shouting is the element of silencing and closure of any opportunity to hear a different narrative. As presented in the section marked *context*, this dynamic has a history in the characters' relationship. Elements centring on cultural ways of interacting or engaging, particularly between the young and old, and discourses of power and control, poverty and financial dependence, together make up the elements that result in closure of a communicative space. This is also witnessed in the act of responding by becoming silent:

When my sister got back (from work), she shouted at me when my neighbour and I tried explaining what had happened. She shouted repeatedly, calling me irresponsible for letting that happen. I was quiet and listening to her the entire time. She said that I had no care about what had happened. How could a child burn while there is an adult in the house, and how could I not see when the child was burning, and so forth...

The narrative is filled with other complications centering on the practical difficulties experienced with attending to the injury timeously. Problems with transportation and accessing sites of intervention are seen to fall within these difficulties. The hospitalisation period and discharge stage of the child's recovery also presented a number of complications not only for the child but also for the caregiver and the family. These centered on the physiological difficulties encountered by the child as a result of the injury, but also on the psychological stresses experienced by the child and the caregiver. The caregiver reported feelings of shock, frozenness, forgetfulness, poor attention and concentration, constant ruminations and anxiety. Loss of appetite, poor sleep, frequent headaches and nausea were also reportedly experienced:

I couldn't get taxis nor buses to Site B (area where community clinic is), then I went back to the house to run him under tap water, and used it with ice and tied it with a sock. Then, I woke up very early the next morning and took him to Site B. There, I explained to the nurses that I couldn't get any taxis to bring him immediately. They then gave me a referral letter to go to Red Cross.

I had told myself that I was going to stay with him because I just couldn't bare to leave him by himself, therefore I told myself that I would rather stay until he is discharged, then go home.

The changes witnessed in the child and those experienced by the caregiver form the other group of complications witnessed in the narrative plot. The change in temperament is significant for a number of reasons: firstly, for the child's own functioning and post-traumatic stress reactions in the future, and secondly, for the concerns that these may bring for the caregiver. These concerns may be seen to emerge out of the practices that blame women for the mishaps of their children in later life.

Ukho was described as a *laastag* (stubborn) child prior to the burn incident. He had never been a quiet child according to Nono. Nono stated that, since the incident, he had actually become even more *laastag*. She reported significant behavioural changes in her child during the hospitalisation and discharge period. Ukho was described as angry, stubborn, and not wanting to be reprimanded, frequently tearful, clingy and constantly demanding of Nono's attention. She stated that he would not give her a chance to do other things and constantly wanted to be near her. Apart from this, he also displayed a restless and disturbed sleeping pattern:

What I have noticed about this child is that, ever since he got burnt, he seldom sleeps, he cries a lot, he is an angry person, and he does not listen, even when reprimanded for his wrong doings, he does not stop. That is what I have observed about this child, ever since the incident.

He was not a quiet child. He was very *laastag*, but now he's even more.

He never gives me time to do other things around the house, he wants me to play with him all the time, and I end up abandoning whatever I was doing just to sit or play with him until he's tired to play, then I give him his bottle and then he doses off to sleep. Then I resume to my duties.

Some of Ukho's maladaptive behaviour was reported to have improved in the course of the months, most notably his eating and sleeping. However, his mother still regarded him as a challenge in terms of dealing with his maladaptive behaviour:

Apart from the fact that his behaviour has become worse and he is constantly angry, I would say he is fine. Also, he eats properly but he still coughs a lot but I rub his chest with ointment now, but *unenkani* (*stubborn*). He never does what he's told but instead does the extreme opposite of that. Even when the heater is on and is told to get away from it, he goes straight there to play near the fire and then I take him and put him on my back. Sometimes we move the heater and put it far from his reach and then we give him toys and he plays on the floor with them. Sometimes he cries when he is on my back because he wants to go play outside with the other children and I let him, but I always ask them to look after him, but *uyafeketha* (*demanding*) when it's just the two of us.

Evaluation

The evaluations that came out of the complicating actions are seen as complex. They highlight the significant impact of the above statement on the caregiver. What evolves is a complex set of evaluations, largely centering on feelings of self-blame, guilt, and feelings of uncertainty about one's mothering abilities. Feelings of fear are also noted to be strongly experienced. The complicating act leaves the caregiver with the feeling of not being "good enough". This is witnessed in the range of emotions that she experiences. One of the feelings that portrays this dynamic, is her feeling of fear which strongly illustrates the internal conflict experienced. The caregiver experienced fear of being judged as well as a fear of being labeled as incompetent, uncaring, and negligent. She experiences a fear of contact with professional institutions (hospitals, clinics, doctors, nurses, social workers, and psychologists). These institutions regulate the practice of mothering and can thus pass judgment on one's ability to mother. In this way they can contribute to a mother's feelings of inadequacy and incompetence. One's child can be taken away and the mother locked up if she is found to be negligent. Though many would like to believe that mothering is a private affair between the child, the mother and significant others, it is also, however, a practice regulated in the public sphere through institutions:

...that nurses may report me to family members or authorities who might think that I can't look after my child and therefore am unfit to keep him, of course, that is why I always watch his every

move, but when the other children are around I don't worry a lot, but when they are not around I leave whatever I was doing to go sit with him, give him his toys to play with.

When something happens within a household, usually community members are called in to intervene and decide what punishment has to be brought upon that person. Women in the community are only called in if the family cannot solve the problem on its own. If they notice that you care about others in the family then they will also show care towards you but if they see you are a very negligent person then they can refuse you help when you need it. It usually happens when the family no longer knows what to do, and have given up basically, then the last resort is to seek other people for help. The neighborhood also tries by all means to assist but if they're also defeated by the problem and the person is too stubborn and doesn't care they withdraw. They would have been called in to intervene and do something about me, the family would call them in and they would also take it forward to authorities. They can report the matter to social workers, hear what they have to say, and never see my child again if they decide to take him away from me, unless there is a more responsible person within the family.

I was worried. They all crossed my mind and all three made me scared. I thought the Red Cross authorities wanted me in connection with what had happened to the child, since I know that Red Cross does not accept negligence when it comes to children, so I thought they wanted to arrest me, or maybe take away my child. It bothered me quite a lot. And I cannot spend a lot of time without him. It even bothers me when the child is crying and is not happy, even when he had those burn scars, I do wish them upon any child. It would be better if they happened to an adult.

Results

The results or resolutions taken in the narrative, lead strongly from the complications and the evaluations made. In this section the caregiver takes action, which to her, will lead to a resolution of the conflicts experienced. She becomes more watchful over her child, she carries him constantly on her back, and keeps constant guard over him. This is difficult when there are no other people in the house, who would normally help the caregiver with child minding duties, for it prevents her from carrying out her other expected chores. The caregiver reports that watching the child constantly is to protect the child, but it is also to protect herself from further blame and labeling and the possibility of having her child taken away.

The incident has not only resulted in concerns related to the child, but also in a need to maintain good family relationships to appease those in power. The caregiver does this by contributing to the running of the family by performing her expected chores (cooking, cleaning, ironing, laundry, etc.). Such an effort will ensure that her family looks after her and her child:

It's still there (worry). That is why I watch over him all the time.

What I normally fear for him about is the extension cord that he likes pulling and playing with in the rooms so I always keep the doors closed. When we're alone together, I put him on my back and only put him down when the other children are back from school...

It's seeing my child growing nicely without needing anything, being helped by people in my family, and also not needing anything because my family also supports me, and because of the things they provide me with, I make sure that whenever they need help with something, that I try my best to be of help.

I help them with working around the house when they cannot do whatever they need help with. e.g. washing their laundry, or doing their ironing etc.

Narrative Tone

Practices that function to construct a sense of self or identity observed in this narrative occur through actions of blame, and labeling. The narrative illustrates practices that function to regulate and control motherhood as well as practices that silence and limit alternative narratives.

The following narrative themes, tones and imagery were observed: themes of psychological and physiological difficulties experienced by the caregiver, child and family. Parts of the central themes that run across the narrative are those of strain, limit, loss, and control. These are experienced relationally and materially. On a relational level, these are witnessed in the relationships between caregiver and older sister and between caregiver and the father's child. Materially these are witnessed in the form of lack of resources, support and financial independence. Loss on a physiological level is witnessed as loss of appetite and loss of functioning of a limb. On a psychological level, this is experienced as loss of a sense of self. Themes of fear are also observed: fear of being judged and labeled as incompetent, uncaring, and negligent; fear of contact with institutions (doctors, nurses, social workers, community) is also observed as part of the themes. As noted above, these fears stem from an idea that institutions possess power, control and the ability to regulate the practice of mothering. Themes of hope and recovery are also witnessed in the narrative, as well as themes centering on the need to be a better mother.

The tone of the narrative appears to be one that could be described as hopeless, silencing, and disempowering. It can be said to be pessimistic. However, themes of hope and recovery do emerge.

Core Narrative

A one year two month old baby sustains a thermal injury by pulling a kettle cord. The family (older sister) reacts by shouting and blaming the mother, labeling her irresponsible for allowing the incident to happen. The mother experiences a range of feelings such as self-blame, worry, fear, and guilt. The incident leaves her feeling she must protect her child more by watching him and guarding him.

4.2 Case B

Context

The second narrative examines the accounts of a caregiver who shall be referred to as Akhona. Akhona is a 21-year-old, unemployed, single mother. Her highest level of education is standard ten (grade twelve), with an additional qualification in home care. She lives in a formal three-room dwelling with her mother, father and two younger siblings (16 and 19). The house has running water and electricity. The gross household income is estimated between R0 - R1000 a month. Both parents work in semi-skilled employment and are the primary breadwinners. The father of Akhona's child was described as involved in the maintenance and caring of the child. However, the parents are not in a relationship.

Zonke is a one year, two week old girl. She was born on 28 July 2004. She is the first-born. She has never suffered from any major illness. Zonke's grandmother was the primary caregiver in the initial months after her birth.

Narrative Plot

Orientation

The narrative provides a rich set of details that orientate the audience to the events. Elements of time, place, characters involved and the situation are captured. Data contextualizing the situation were provided.

The burn incident, identified as the principal situation, took place at about 10 AM on a Saturday morning. The characters involved in the plot were Akhona and her parents, Zonke and her father,

Akhona's younger sister, an aunt that helps around the house, a neighbour, community members and friends, and the institutions of help contacted. The key characters, however, were identified as Akhona, Zonke, Akhona's father and the father of Akhona's child.

The events that precede the thermal injury are provided and further help to contextualise the incident. The key conflict that emerges from the sets of events below, is a sense of reflecting and questioning one's identity as a mother. The narrative illustrates how a thermal injury results in a "narrative disruption" that requires the actors to reflect upon themselves, to question their identities as mothers and suddenly jolt the individual into a position of needing to become "100% of a mother in the mothering department". The term *suddenly* may be incorrect to use here, for it may imply that this need has emerged out of the blue, without the actor's prior knowledge of its existence or presence. What I am attempting to convey here is that nothing emerges or exists without our knowing it. Consciously these needs or feelings may be absent, but an examination of the unconscious may reveal that such things have been part of us for an extended period. Here, I am referring to the need to mother when one's own mothering abilities have not been afforded the space to do so. Within this need is also a sense of competition between the caregiver and her own mother, as well as an idealisation of the caregiver's mother's abilities. These are used as the yardstick that defines the "100% mother".

Present in the house, at the time of the burn incident, was Akhona, her younger sister and an aunt who assisted with cleaning. The parents were out at the time, visiting the informal structure in an old neighbourhood where the family used to live. Akhona was meant to have gone with them, but she was running late and it was agreed that she would join them later. She placed a kettle on a chair to boil, in the dining room. The water was to be used to bathe Zonke. Akhona had stepped into the bedroom to look for a receipt. She was not sure where her sister was at the time, but thought that she was somewhere around the house. The aunt was in the bathroom. Akhona and the aunt came running from the separate rooms in response to the screams of the child. Zonke had pulled the kettle and was found on her knees in the area where the water had spilt:

The thing is, the wall unit was in a different place at that time because the electricity in the building was not yet installed on to the walls and the kettle was within reach, on the chairs, and what happened is that we were all in the room not noticing the child crawling to where the kettle was, and she pulled it that day, it was a Saturday around 10 AM. Both my parents were going to Site C and I was also supposed to go with them but since I was running late, they left me behind. I had put on water in the kettle to wash the baby.

We used to stay there before so the house that we used to live in was supposed to be rebuilt.

...I just felt like going there since I used to live there, and I like going there on Saturdays, so they left me behind with another auntie that helps around the house. I was in the room at the time looking for a receipt and the auntie was in the bathroom. A while after I was in the room I just heard the baby crying and ran to see what had happened. It seems like she had pulled the kettle because when I found her she was on the floor with her knees on the area where the water had spilt. I quickly removed her from the floor and ran with her to the bathroom. I took off the tracksuit that she was wearing, and while I was doing this I noticed that the skin on her knees had come off. After that, Andiswa, who stays here took her to the woman who lives next door and after that we took her to Site B. There, I was transferred to Red Cross.

Complication

A number of complications ensued as a result of the incident. These were diffusely spread across the home context, right through to the hospitalisation setting. They involved physiological and psychological reactions profoundly experienced by the caregiver and her child. Complications in interpersonal relationships were experienced between the caregiver and her father, as well as between the caregiver and the child's father. The latter two remain central in this case as they are seen to contribute significantly to the caregiver's evaluation and resolution. The initial physiological reactions experienced by the caregiver form part of the sets of complications witnessed. The incident brought with it feelings of nausea, followed by sensations of shock, loss of energy and a state of frozenness – all resulting in the caregiver not feeling 'right' and not being able to respond to her child:

I wasn't feeling right at the time because when I took her to the bathroom I had planned on putting her on the bath and run cold water but I was shocked by the knees that had no skin, so I had no energy to do anything at the time, so my younger sister took her next door and I followed after them.

The key sets of complications arise out of the caregiver's father's reaction, as well as the child's father's reaction to the thermal injury. Both of these result in blame and labeling which have a profound effect on the caregiver's sense of self as a mother. The effects of these are strongly witnessed in the sets of evaluations and resolutions taken. The caregiver's father reacted by saying "all sorts of things" that made the caregiver feel hurt, and labeled her as "careless". The interactions with the child's father also left her feeling that she was a careless and negligent mother. However, what is interesting to observe in this narrative, with regards to evaluations, is that the caregiver fluctuates between an acceptance and a rejection of these complicating actions. This is illustrated in

the quoted text, taken from an interview with the caregiver, below, where it is indicated that the acts of labeling strongly affect her and yet, at some points, they are rejected through a process of rationalising the incident as an accident and also through talking to other caregivers, friends and family members about the incident:

My dad said all sorts of things that hurt me at the time; that I was careless and that hurt me but I was okay again. But I felt really bad at first.

...he (child's father) came on the Sunday, and even though he didn't say it, I felt that he was blaming me inside. I explained to him that it wasn't my fault, that she pulled the kettle

When a person wants to say something to you, you can sense it through their words. He said things like, "how could you let a child play alone, why didn't you do this, and why was the kettle put in that place and why didn't you put the child in the room with you and leave her alone instead". I told him that since we had recently moved into the place we didn't have plugs that were far from the child's reach, so then he understood. But he also mentioned that had the child been at his house she wouldn't have burnt and I told him that if it was meant to happen it would have.

Evaluation

The impact of the complicating actions is examined here in the form of evaluations that the caregiver engages in. From the above comes a set of complex and difficult emotions which play a significant role in identity creation, particularly an identity of a young 21-year-old mother who has a poor perception of herself as a mother. She does this by comparing herself to her own mother, whom she perceives as a far more capable mother, because of her ability to be attuned to the baby. This again, as noted in the previous case, reflects the regulation and control of mothering which takes place via institutions that serve the purpose of instructing individuals on the "correct processes" responsible for good mothering. The regulation of mothering through the psycho-medical literature may be seen to be responsible here. Linked to this is the caregiver's sense of difficulty around making sense of, and defining, the burn incident, which centers on distinguishing whether the incident was an accident or an attempt to kill the child. The incident clearly illustrates a sense of distress in the caregiver, a sense of not coping because of the blame and labeling and because this is all new to her as a young mother. Her opening remark in the narrative illustrates the use of a comparator as an evaluative device. Here she brings out alternative scenarios that could have happened to prevent the burn injury from taking place:

I wasn't coping at the hospital because I felt as though she wouldn't have burnt if I had put her on my back.

This woman came up to me in the hospital and she also asked me how I was feeling, after I told her she said I shouldn't blame myself because it wouldn't make sense to want to burn and kill my child after raising her for two years. She reassured me not to blame myself. After what she had told me, I stopped blaming myself because it was an accident.

My heart was always sore when she was in hospital and I would cry all the time. The pain that she was going through, I felt it too, whenever I looked at her I would have plenty of 'what ifs' in my head but then would think of what the woman in hospital told me and that would make me feel better.

Akhona stated that she was not used to being in hospital and sleeping on a chair. Despite the discomforts she experienced it was better than being at home and not having a clue what was happening to her child. Her parents also encouraged her to stay in hospital and be with her child. She cried frequently. She could feel the pain that her child was experiencing. Looking at the child was difficult as it filled her with "what ifs". She felt like taking her child's pain away and feeling it for her, as Zonke was too young to be enduring such pain. Though these can be termed 'normal' maternal reactions to a stressful situation, it is observed that the dynamics go beyond a mother's grief related to her child, to broader issues of becoming a mother to a child. These are deeply rooted in ideas of control and surveillance of mothering, from a familial, community, societal and professional level (hospitals, social workers, doctors, political):

It was hard at the beginning. The food couldn't even go in. I would really worry when the nurses came to take her to the dressing room in the mornings and would really be touched when I heard her screaming from there, but would console myself by saying that they were also doing that to help her.

...others called me in hospital and my friends would call and tell me to be strong, that she was going to be fine. My parents asked me not to get tired of being in hospital that I should stay there until the child was fine. So I was determined to stay and see her recover.

...it wasn't hard because I was doing something that I wanted to see happen

Well in the beginning there were a bit because I was doing something that I wasn't used to because staying in hospital and sleeping on a chair is not an easy thing, but I just thought rather than staying at home and not having a clue of what is done to the child I should rather stay.

The feelings that she experienced, particularly those associated with loving her child and not wanting to kill her, were more than her own internal anxieties or self doubt about the meaning of the incident. Akhona's community, particularly from the old section that her family used to live in, would have been more likely to think that she wanted to kill her child and thereby instill such thoughts in her:

Interviewer: Were the feelings inside you that other people or doctors would think that you wanted to kill your child?

Akhona: No, I wasn't thinking that but there are people that do not understand who would've thought like that.

Interviewer: Are these people from your area?

Akhona: No, it's the people from where I used to live, in Site C, that would say such things.

Interviewer: I understand that this was merely what you were thinking but in reality were there people that looked at you in that kind of way?

Akhona: No, these were my thoughts. They didn't say such things in my presence but I don't know what they said when I wasn't there. They would feel sorry whenever they saw me.

The narrative also illustrates instances of engaging and adopting different sets of evaluations, which is achieved with support, through talking to others about the experience:

This woman came up to me in the hospital and she also asked me how I was feeling, after I told her she said I shouldn't blame myself because it wouldn't make sense to want to burn and kill my child after raising her for two years. She reassured me not to blame myself, after what she had told me, I stopped blaming myself because it was an accident

...I started telling people about it and I felt better. I told myself that I love my child and would never want to harm her, if I wanted to kill her I would have aborted her and she would not be here, but seeing that I love her I kept her and gave birth to her. It wasn't my fault it was merely an accident that is what I told myself.

Results

The incident resulted in two key dynamics;

1. A need to be a better mother and
2. Worry about the impact of the burn on her child's future, indicating concerns of difference and fitting in.

Akhona became more careful as a mother. She always carried her child on her back if she was busy with something. She now lived with the fear that another accident might happen, as her child was still young and could not distinguish between what was dangerous and what was not. Her alertness around her child was more acute as a result of the fear of being labeled, judged or blamed by family members and community members. The incident has made her want to be more of a parent to her child. This need is seen to come from the complications that transpired leaving her with a feeling of inadequacy. She draws from her own mother's ability to mother and uses this as a yardstick for her own mothering ability:

I now think I should be more of a parent; even though I get support from my family I should really be the only one looking after my child and not ask anyone else to do my job for me.

My mother helped a lot. I did not know a lot of things about parenting since she did most of the things on my behalf.

...almost everything about babies because my mother did everything for her (baby). She washed her, bathed her and fed her. She wouldn't let me do anything. She wasn't working at the time, but now I am planning to be 100% excellent in the parenting department because I do the job alone now since my mother goes to work. I want to be able to do all the things that she does with the baby: be able to tell when she is hungry, when she needs sleep and when she needs to take her medication.

Though things improved, Akhona experienced feelings of fear related to her child's burn scars. She expressed concerns about the marks that the burn injury would leave on her child and the possible impact that might have on her relations with other children. She also felt worried at having to explain the incident to her child when she was older. She feared that her child might label her as a negligent mother:

I do not think that she will be able to wear short skirts when she is old because of her scars, even now I do not dress her up in short clothing, if I happen to do that I always make sure that she has socks to hide the ugly wounds. Also, when she grows up she will want to know what happened to her because she will be different from other children, and I know that I'm going to have to explain to her what had happened.

Kids talk a lot, I'm just scared of what they will say about her, or ask her what happened to her, or say things that might hurt her.

Yes, but sometimes I think that maybe by the time she is able to play with other kids her scars would've vanished – that is what I'm hoping for.

Narrative Tone

The narrative illustrates a struggle around an identity centering on motherhood. Though this theme runs through all the narratives, it is particularly significant here where we observe that this is the central conflict for the character, particularly when she has not had the opportunity to be a mother to her child.

This particular transcript presented themes that were in some ways similar to the above case, centering on physiological and psychological distress. The physiological complications such as shock, frozenness, nausea, and loss of energy could be connected to a theme of not being able to respond to the child. They broadly relate to the central theme of the narrative, of not being able to mother or be available to the child. The dynamics of self-blame, doubt, guilt, and difficulty with defining or making sense of the incident are all connected to the broader theme of control and regulation of the practice of mothering.

The narrative tone has some elements of pessimism, dread, and sadness. However, positive statements centering on hope were also identified.

Core Narrative

A 21-year-old, unemployed, single mother is blamed when her child sustains a thermal injury. The mother experiences feelings of self-blame, and feels like a careless and negligent mother. The incident results in the caregiver wanting to be a better mother to her child by acquiring the mothering skills that her own mother has.

4.3 Case C

Context

The following narrative examines the account of a caregiver referred to as Noluntu. Noluntu is a 29-year-old single mother. She is employed as a till-packer. Her highest level of education is standard ten (grade twelve). She lives in a one room, informal dwelling with her child. The house has no running water or electricity. She relies on fossil fuels, such as paraffin, for cooking and lighting. The gross household income is estimated between R0-R1000 a month. Noluntu has five siblings, most of who reside in the Eastern Cape with her unemployed parents. She has an older, married sister who lives in Khayelitsha. The two have a good relationship. Questions relating to the father of the child were discouraged.

Sihle is a two-year-old girl. She was born on 3 July 2003 and is the first born. She currently attends a day care centre in Khayelitsha. She has never suffered from any serious illness.

Narrative Plot

Orientation

The elements fulfilling the function of orientating the audience to the sets of events under scrutiny were found present in the case. Elements of time, place, characters involved and the situation were identified.

The burn incident, as the principal situation, took place at the child's day care centre in the afternoon. The characters involved in the narrative are Noluntu, Sihle, the day care mother, Noluntu's employers, her family and the institutions of help contacted. The analysis, however, identified Noluntu, Sihle and the day care mother as the principal actors.

The events that precede the thermal injury are provided and further help to contextualise the incident. The central conflict illustrated in the narrative is that of dealing with the consequences of paediatric burns under strained material and emotional resources, where support is scant. It is a narrative of the employment of defences such as suppression as a means of coping with the child's

trauma. The narrative illustrates the need to hold the “narrative wreckage”, or points of biographical disruption, together in instances where support is limited.

The day care has five children who are looked after by a day care mother. No one knows exactly how the accident took place but the day care mother stated that Sihle must have fallen into a water basin filled with hot water. The basin was placed on the floor and the water was prepared for washing the children. Noluntu was at work at the time. At around 4 PM a man came to her and asked if she could purchase items such as bandages. He informed her that her child had sustained a burn injury but said it was not so bad. He gave her R100 to purchase the goods. She informed her supervisor about what had happened and asked if she could be excused from work. When she arrived home, she found her child in a playful mood. She showed her the blister, saying: “look mommy I got burnt”.

Noluntu did not think that the injury was serious at that point. However, Sihle did not eat that night and seemed to have lost her appetite. The following morning Noluntu noticed that there was a change in her child. According to Noluntu’s account, Sihle was not the same as the previous day. She was taken to the Community Day Hospital in Khayelitsha, where she was treated and referred to the Burns Unit at the Red Cross Children’s Hospital. Sihle was admitted for two weeks. It was only upon hearing how long she would remain in hospital that Noluntu began to worry.

Complication

The primary complicating action in this narrative revolves around the caregiver’s reaction to the incident. This relates to the adoption of a defensive position, which allows the caregiver to push aside thoughts associated with the incident, and to close off opportunities of reflecting and engaging with the events of the burn. Under limited resources, emotionally and materially, such a defensive stance may be seen to serve the function of protecting the individual.

The initial reaction to the incident was to regard it as a minor event. This perception was largely fed by the child’s presentation (playful and did not initially show distress). However, the more complex the physiological state of the child became, the more the perceptions and reactions of the caregiver changed. With the child showing significant changes through loss of appetite, disrupted sleep and the development of blisters and other conditions, the caregiver’s state and perception also changed. The caregiver experienced strong feelings of anxiety, fear, and shock. These were also accompanied by feelings of ‘closing up’ and adopting a defensive position that allowed the caregiver not to

reflect on the incident, and not to experience feelings of worry or anxiety associated with the incident and all that it demanded. The narrative clearly illustrates a way of coping with a situation under strained resources. A lack of emotional support, combined with difficulties in finding employment and missing workdays, is further aggravated by the limited possibility of finding suitable alternative arrangements with regards to child minding:

At the time I was there, I didn't really have any fears because I thought it was a minor injury. I only started panicking when we were transferred and she started having these blisters, and she got sick on top of the burns. She developed these things that I did not know on her body, and when the Professor came up to me and asked if I had taken any Aids tests when I was pregnant I panicked a lot. I thought she might be HIV-Positive.

Whilst in hospital, Noluntu struggled with sleeping and eating. She stated that she was not able to do either because the child was also not sleeping or eating well:

I wasn't able to because the child was also not eating

Sihle showed changes in her behaviour after discharge. She displayed behaviour that her mother had to excuse in the presence of others. Sihle did not want to be around other people, including family members. She constantly demanded her attention, became needy, and cried frequently, particularly when people looked at her:

...when I came back, it was difficult because she did not want other people, she wanted me only. I would have to come to her after work.

...she did not want any of my sisters, and not any other person for that matter. I just excused her behaviour with the fact that we were together at Red Cross all the time. She would cry if people looked at her.

Despite this, Sihle displayed no anxieties about returning back to the day care centre:

She was "full of tricks", as she got on well at the day care with everyone. However, she started acting up whenever she saw me coming to fetch her.

Evaluation

One of the key sets of evaluations that the caregiver engages in, in this narrative, is that of perceiving the incident as an accident. From this process, emerges the idea that no one is to be

blamed, for the incident was an accident. Within this lies a deeper process to the evaluation, which has already been alluded to above. The defensive position engaged by the caregiver is seen as central here. It is a tool that is used to deal with the situation, by minimising and pushing the reality aside, and avoiding the strain and stress that a confrontation would evoke. The caregiver herself, acknowledges this when she states that, “to think about the incident is to bring stress, misery and unhappiness on oneself”:

... she was very worried because she said that of all the children she'd ever looked after before, none of them got burnt, including her daughter's children.

I did not think of blaming myself, I took it simply as that it could happen to any child even when you think you were carefully watching him or her.

I had to work and I knew that she would have to go back to where she is nursed and, had I worried, I wouldn't have been able to go back to work and therefore I couldn't put myself through that kind of stress, misery and unhappiness. As long as I knew she was happy there.

I was forced to put them aside (worries) because I had to leave her behind and go to work. I did not even want to hire someone else because that new person could also do something else accidentally. Therefore, it was better staying with the one I already had who would take care of her better because she wasn't going to go through the same mistake.

...It's hard, but not so hard, because I had no option to make things any better because either way, things would have required other options such as hiring someone else or even taking the child to a crèche.

Putting those worries aside means that I don't have to think about them while I am at work.

...I do not allow myself to think about such things I would rather face it when it happens.

Results

After the burn incident had occurred, Noluntu's sisters in the Eastern Cape offered to take the child and help her look after it. Noluntu stated that they felt that she was too busy to give adequate attention to the child. She refused the offer and stated that they would need to find a baby-sitter there as well. These results strongly illustrate the trend adopted in the narrative:

...they were worried because they kept calling all the time to find out how she was doing when I was at Red Cross, until she got better. That is when they opted that she go down to live with them.

...they said that I did not have time for her because of my work obligations, but then it wasn't going to make much of a difference because even if I had taken the offer, they would also have to hire a baby-sitter who could also make the same mistake, so it was the same thing.

Narrative Tone

One of the key themes that runs through this narrative is that of limitations, or lack of support, materially and emotionally. This is witnessed in the defensive position that the caregiver adopts in dealing with the incident. Without family support or financial support one must hold the familiar narrative together, even if that is a *narrative of wreckage*. The narrative illustrates the emotional burden of burns under strained conditions. It shows the employment of defences as a means of coping with a child's trauma.

The narrative tone may be seen as optimistic on the surface, in the sense that the caregiver does not display the same difficulties that caregivers in the previous studies showed. This may, superficially at least, suggest that she is coping. However, her actions can be seen as suppressing or restricting of emotional material. This element was strongly witnessed in the manner she engaged in the interview. It must be said, however, that what is witnessed here may be seen as a necessary way of coping, particularly under strained resources (being a single mother with no financial support, having to go to work to support herself and the child).

Core Narrative

29-year-old, single mother feels that she has no option other than not to think about the thermal injury sustained by her child. To think about the injury is to bring "stress, misery and unhappiness" upon oneself.

4.4 Case D

Context

The present narrative examines the accounts of a caregiver, who shall be referred to as Zimkhitha. Zimkhitha is a 25-year-old, single mother. She is self-employed and makes a living by selling shoes. Her highest level of education is standard nine (grade eleven). She lives with her maternal aunt and child in an informal one-room dwelling. Zimkhitha's aunt works as a cleaner at Century City. The two have been living together for the past three years. Previously, Zimkhitha lived by herself in an informal dwelling in Khayelitsha. The residence has electricity but no running water. The gross household income is estimated between R1000 and R3000 a month. Zimkhitha's parents both live in the Eastern Cape and are unemployed. Zimkhitha had one brother who passed away in 2003. He was reported to have committed suicide (the precipitating factors leading to the act are unknown). The father of Zimkhitha's child is a 33-year-old, unemployed man. He is uninvolved in the caring and maintenance of the child.

Odwa is Zimkhitha's only child. He is a one year, five months old boy. He was born on 28 March 2004. Odwa was born with a twisted right foot and has received corrective surgery at Red Cross Children's Hospital, Cape Town. Zimkhitha looks after the child. Her aunt assists her when she has time. The two have a good relationship.

Narrative Plot.

Orientation

The elements fulfilling the function of orientating the audience to the sets of events under scrutiny were found present in the case. Elements of time, location, characters involved and the situation were identified. Data contextualizing the situation were provided.

The burn incident, identified as the principal situation, took place at 6 PM in the area designated as the kitchen. In this narrative, the characters involved are Zimkhitha, Odwa, Zimkhitha's aunt, a neighbour and the institutions of help encountered. The principal characters are Zimkhitha, her aunt and Odwa.

The events that precede the thermal injury are provided and further help to contextualise the incident. The narrative illustrates conflicts, with blame and labeling experienced by the caregiver towards her aunt, who was charged with minding the child. The narrative illustrates the struggle of not being able to share her feelings with the aunt in a manner that may help to resolve the internal conflicts experienced by the caregiver. This is also a narrative that centers strongly on ideas of the “mother as protector”. It is a narrative of taking responsibility and facing feelings of self-blame, even when one was not present at the time of the incident, and about containing the feelings of guilt experienced.

Present in the house at the time of the burn incident, were Zimkhitha’s aunt and Odwa. Zimkhitha had gone to a shop nearby to purchase goods for supper. Her aunt had plugged in a kettle to boil water and placed it on a table. The cord of the kettle was left hanging and Odwa pulled it. The contents of the kettle spilt on him. The child was placed under a tap of cold running water:

...It happened in a short space of time. Because I left for a short while to get something from the shops and I come back and the baby has already burnt. I tried keeping him quiet but he was crying and wouldn’t stop and that also made me cry.

...another lady that lives next door who came to see what was going on since she was alarmed by the child’s cries. I quickly took the child from them and went to run him under tap water.

Odwa was taken to the Community Day Hospital, where he was attended to and referred to the Burns Unit at Red Cross Children’s Hospital for further treatment. Odwa was admitted for one week. Zimkhitha remained in hospital with him for the full duration of his stay.

Complication

The key complicating action takes place between Zimkhitha and her aunt. The incident leaves Zimkhitha experiencing feelings of blame towards her aunt. She perceives her as negligent and careless. However, what is interesting to observe, is that these feelings never become externalised and shared with the aunt. The above alludes to closure in terms of communication in the character’s relationship. There are a number of reasons that could lead to this situation. One of these may relate to cultural ways of engaging, where clear lines of respect are maintained between the older and younger generations and where communication lines between the two may seem open but are actually fairly restricted.

Her mistake (aunt) was to leave the cord hanging in the air and the child crawled and pulled it.

...she (aunt) felt sorry that the child burnt because of her, even though it was just an accident.

I had those feelings inside of me that she was negligent but then I told myself that it was an accident, and I could've been the cause of it myself.

It wasn't anger, as such, but the fact that I thought she was just negligent – period.

Zimkhitha experienced the period she spent in hospital with her child as difficult. Her sleep was disturbed; she had loss of appetite and frequently cried, particularly when her child cried. She constantly wished she could take her child's pain away and feel it for him. Looking at the child made her think about a lot of things. She consoled herself by seeing that other children in the unit were making progress and thought that her child would also recover quickly:

It was hard for me to get any sleep, and I couldn't even eat; I would just lose my appetite whenever I attempted to eat.

I was crying because my heart was sore because I was just imagining his pain on me, since I've been burnt before and know how it feels like to be burnt.

I consoled myself by seeing other kids that were also burnt. Others were worse and others were in the same condition as him and others were better already and I just thought that she would also get better.

I wished that I could be able to take away his pain because I'm not a person of too many words but I would just look at him and think about a lot of things.

Odwa displayed changes in his behaviour. He initially could not play, showing difficulties with motor movement. This improved after three days in hospital. He was afraid to be touched, especially around the area of the burn wounds. His body shook as if he was shivering from a cold, and he cried frequently. Odwa also presented with a loss of appetite and had difficulty sleeping. However, he gradually improved during his time in hospital.

After Odwa was discharged, Zimkhitha still experienced feelings of fear related to the safety of her child. She became more cautious around him and also, initially, could not trust her aunt with looking after Odwa:

I would not enjoy myself and would be unhappy whenever I left the child with her (aunt) because of fearing she might burn him again.

Evaluation

The evaluations indicate an internalised sense of not being a good caregiver, and of perceiving oneself as negligent and careless. These evaluations reveal an interesting phenomenon, where the caregiver claims responsibility for the incident, even when she was absent. The reactions are similar to those experienced in the previous narrative and may easily be termed as “the normal” mode of reacting to a child’s trauma. However, a deeper analysis of the narrative reveals that such a process results from positioning mothers in a particular way. It results from ideas of mothers as protectors, who are omnipotent and omnipresent. To draw this to the present narrative, it is thought that the child’s birth defect formed part of the complications or part of these internalised feelings. It lays the foundation for feelings of negligence and carelessness. These feelings can be seen to be further connected to a phenomenon of mothers whose children are born with defects, who internalise a sense of guilt and engage in self-blame for the child’s deformity. The process reveals the need to find cause in every challenge encountered. These feelings do not simply transpire out of nowhere, but are fed to people via societal, institutional and cultural practices that dictate what is acceptable and what is not acceptable. Deformity of a leg, and permanent burn scars form, in our societies, the “things of difference”, to be ostracised and judged as ‘outside of the norm’. These complications reveal the burden of mothering:

...I felt that if I was there next to her he wouldn't have burnt

I thought of myself as negligent and I blamed myself for leaving him behind because maybe if I had taken him with me then he wouldn't have burnt.

I perceived myself as a negligent mother, but then thought to myself again that I wasn't there; maybe things would've been otherwise if I was.

I was scared. What I feared the most was that doctors were going to tell me that I'm very negligent because he sustained the injury on the same leg that was recently broken and treated at Red Cross.

...since he burnt on his operated foot, I thought that they might say I'm very careless and report me to social welfare authorities.

...the nurses didn't say much, they just asked how it happened and then they removed his clothes and took him away.

...my fears of being shouted at were slowly decreasing at that point, but I was just heart-broken because of the pain my child was going through.

Results

The incident leaves the caregiver with very strong concerns for herself and her child. The sets of complications and evaluations engaged in are strongly witnessed here. Feelings of self-blame, and self-doubt around one's ability to mother are witnessed here. A sense of mistrust around her aunt is also evident. This is observed in the unease that the caregiver experiences when her child is with her aunt. However, feelings of acceptance and of perceiving the incident as an accident are also present. This is achieved through talking and drawing support from other caregivers in the unit.

... what bothered me the most was that I was worried about the belief that a burnt child is stubborn and never listens, and I was also worried about the marks that he would have for a very long time.

...my cousin was told at Red Cross that she must not be surprised if her child is inattentive and very stubborn because children that are burnt are likely to turn out like that.

...firstly, his skin complexion won't be even because of the marks, and he will ask me what happened to him and when I tell him what happened he might be hurt because he might think that I neglected him.

...another thing that bothered me is the fact that he might take a lot of time to walk or not be able to walk at all since he burnt on the same leg that was limping since it broke.

I was scared of him questioning me once he was older, thinking that I neglected him as a child, and the fact that his skin might be permanently damaged.

I will just have to explain to him how he got them, and then all will be up to him to say if he thinks I'm a negligent mother or not.

I don't have too many concerns because the scars are in hidden places so I don't think they'll notice them easy.

Narrative Tone.

The narrative, similar to that of the first case study, highlighted a theme of silence and closure of a communicative space. A theme of 'mother as protector' was also observed in this narrative, which

resulted in the dynamics of self-blame, an internalised sense of guilt and feelings of not being ‘good enough’ as a mother. The tone in this narrative initially presents as pessimistic, changing as the story continues and a sense of hopefulness is introduced to the plot.

Core Narrative

A 25-year-old caregiver’s child sustains a thermal injury while being looked after by her aunt. The caregiver initially experiences feelings of blame towards the aunt and herself. These feelings change as she perceives the incident as an accident.

University of Cape Town

Chapter 5:

Discussion

The data gathered in the present study was considered useful for highlighting the challenges that caregivers and their children face in the wake of a thermal injury. However a number of factors were considered to influence the quality of data gathered. These are important particularly for highlighting the variables impacting on the research.

One of the fundamental aspects affecting the quality of the data lies with the interviewing process. Interviews in research are regarded as a useful tool for gathering data. However a number of challenges observed in the study exist with the process. It may be argued that interviews when considered as a methodological tool for data gathering, may be limiting. They may be silencing, marginalising and disempowering both for the interviewer and interviewee. They may only extricate certain data, leaving out other. A number of dynamics sometimes beyond the control of the researcher may be responsible for this. In the present study the dynamic of power was seen to play a pivotal role in terms of responses provided. Nunkoosing (2005) states that power is always present in the transactions of the interview, as it is in all human interactions. Power present in any setting may lead to an unavoidable imbalance. Such an imbalance may be useful for highlighting points of disjuncture in the interviewer-interviewee relationship. It may be useful for pin-pointing those aspects that may lead to what can be referred to as “awkwardness of engagement”. Awkwardness of engagement here refers to the points of disruption in the normal or expected patterns of engaging between two people in a communicative act. Issues of class, gender, personal experience, socio-economic positions and professional positioning may be seen in the study to act as the points of disjuncture in the interviewer-interviewee relationship. These aspects may contribute to the initial reserved and restricted nature of the participants’ responses. Restricted engagement is often associated with a lack of trust and rapport between the interviewer and interviewee. Bhopal (2000 in Truman, 2000) states that subjects may be highly suspicious of a researcher’s motives. The researcher may be regarded as a kind of secret investigator. This aspect in the present research was linked to caregivers’ fears of being judged, labeled and even possibly having their child taken away. The aspect forms part of the central theme that runs across each narrative. An interpretation of it needs to be placed within the broader societal, cultural and institutional positions that both the interviewer and interviewee occupy.

What may also be added to the above is the highly structured nature of interviews. This may play a significant role in terms of the power dynamics and communicative spaces afforded in the process. According to Nunkoosing (2005) *structure* implies the degree of control that the interviewer exercises over the transaction of the interview. Within the interview process it is the interviewer that determines, initiates, sequences, and closes topics. The pragmatic aspects of the process such as the setting, the duration of the interview and the frequency of the interview process may be seen to influence the type of data that may be gathered. Conducting the interviews at the residence of the caregivers may be one aspect that may contribute to minimising anxieties associated with the process. However the duration of the interview (1 hr to 1 ½) and frequency (1 session) may have impacted on aspects such as the establishment of rapport. This may have limited opportunities for exploring certain aspects of the caregiver's narratives further. Despite this it is believed that the data gathered provide useful and valuable findings that may help us understand not only the impact of paediatric burn injuries on caregivers and their children but also on the manifold aspect that influence the type of data gathered.

Burn injuries are a serious form of trauma to children and their families. Physiological and psychological functioning can be affected, impacting significantly on the child. The study observed critical incidents of behavioural and psychological distress, as reported by the caregivers. Though the reactions differed across all four cases, similar signs of distress were reported during the hospitalisation and discharge period. These observations support studies that indicate that infants have been observed showing traumatic stress responses following direct exposure to trauma (Lieberman, 2004). All four children presented with a loss of appetite or reluctance to eat; disturbed sleep; frequent crying and refusal to be comforted; raised levels of anxiety; fear of being touched; pain syndrome; startled responses, and situation specific anxiety. In two cases, caregivers noted: restless and angry-prone behaviours; clinginess; stubbornness and refusal to be reprimanded; a constant demand for the caregiver's attention; fear of other people, and separation anxiety. Two children who were badly burnt around the hands, and one on his foot, were noted to present with partial loss of motor functioning in these areas. The above reactions are noted in several studies, where children are observed to present with fear of body damage; display reckless and accident prone behaviours; constricted and repetitive play; hypervigilance or startle responses; separation anxiety and loss of developmental milestones (Cicchetti, 1995; Paynoos, 1990; Scheeringa and Gaensbauer, 2000 in Lieberman, 2004). Children are noted to act out their distress through their behaviour. This results from their limited capacity to verbalise distress. Behavioural memories associated with a traumatic event remain intact, even in infants and young children (Terr, 1988, in

Stoddard, 2006). These memories manifest in the behaviours that children display, such as post-traumatic play (re-enactment of the events).

The physical pain resulting from the injury was noted as 'unbearable' for the affected children. This was marked by frequent and intense crying, a fear of being touched, fear of body damage and reluctance to part from the caregiver. The procedures that the children underwent, such as dressing changes, sometimes twice a day, placed them in a vulnerable position. Munster (1993) states that it is understandable that these painful procedures, which the burn survivor is exposed to during the time of hospitalisation and post-discharge, can be experienced as painful and traumatic by a young burn patient.

...I would really worry when the nurses came to take her to the dressing room in the mornings and would really be touched when I heard her screaming from there, but would console myself by saying that they were also doing that to help her. (Case B)

I was crying because my heart was sore because I was just imagining his pain on me since I've been burnt before and know how it feels like to be burnt. (Case C)

...I wished that I could be able to take away her pain because I'm not a person of too many words but I would just look at her and think about a lot of things. (Case D)

Linked to the idea of body damage is the idea of *difference and disfigurement*. Burns can be distressing for a child, as they may become an object of curiosity amongst siblings and friends. In Case C, of the case studies, the child experienced distress associated with being around people and being looked at. According to Magrouther (1997, in Blankley, Robert and Meyer, 1998), the pressure in society to conform to an idealised appearance lies at the root of the distress. The obsession with appearance devalues those who do not match the perceived ideal and stigmatises those with visible disfigurement. This is the case even in young children who do not place a premium on physical attractiveness (Blankley, Robert and Meyer, 1998).

...She would cry if people looked at her. (Case C)

Disturbed sleep, nightmares, day napping, talking, shouting, crying and shivering during the sleep process, are noted to be common sequelae of paediatric burns (Liebowitz, 2001). As noted above, all four children were reported to present with some disturbance in their sleep. This was marked by restless behaviour, frequent waking during the night, and refusal to sleep. Most research links the disturbance experience in burn-injured children to the physical pain experienced as a result of the

burn injury, as well as to post traumatic memories associated with the injury (Stoddard, Saxe, Ronfeldt, Drake, Burns, Edgren, and Sheridan, 2006). Kravits' (1993) study of the dream content of children's nightmares, related to the actual burn, revealed that sleep is a coping mechanism during which cognitive processing of emotional stressors occurs.

Eating difficulties experienced by burn-injured children are seen to result in cases where depressive symptoms are observed, or where emotional reactivity is reduced (Liebowitz, 2001). The caregivers' own psychological state may contribute to feeding difficulties. Researchers have for a long time made associations between maternal mood and feeding problems experienced in infancy, particularly in times of trauma (Coulthard and Harris, 2003). The physical strain and the psychological difficulties associated with the traumatic event contribute to the experience of both the caregiver and the child. Caregivers' reactions to their child's pain may result in reduced interaction, as they may find the process of caring for the child difficult and they may struggle with feeling like they are not able to help the child. Furthermore, caregivers, in these cases, may be struggling with their own post-traumatic stress reactions.

Most burn-injured children show anxiety associated with the incident. Children in the initial phases of their recovery show an elevated fear of fire, electricity and substances or objects associated with the incident. This was reported in the study, where children initially showed fear of objects linked to the incident (kettles, hot water, and bath). These fears, however, subsided post-discharge. In two cases, however, the children were reported to display accident-prone behaviours, where they frequently played near the fire and refused to be reprimanded. In younger children such behaviours may be associated with a lack of awareness of the injurious stimuli. The angry and aggressive behaviours reported in the study, may be linked to the idea that children younger than 28-36 months old cannot fully verbalise their traumatic experiences (Terr, 1988 in Stoddard, 2006). This preverbal group lacks the capacity to vocalize distress. These children often "act out" pain and sadness through their behaviour. Meyer's (1999), study of 32 burn-injured children supports this. The study found significant signs of increased internalising behaviours were the children were found to be socially withdrawn and had some depressive symptoms.

Children that have sustained a thermal injury often present with separation anxiety, manifesting in the form of a reluctance to part from the caregiver, for example, in a situation such as being cared for by others. These children demand their mother's attention and presence continually, which is concurrent with what was reported in the cases examined. The children showed high levels of distress whenever they separated from their caregivers during dressing change of the burn injury. In

one case (Case C), the child showed symptoms of separation anxiety and reluctance to part from her caregiver whenever she was left at the day care center. In another case (Case B), the child continually demanded her mother's attention and feared being left with others in the family. These children cried and became angry when parting from their respective caregiver. These behaviours are often linked to the child's need for security, protection, and reassurance from their attachment figure. In the case of burns, the presentation of separation anxiety symptoms may be more than the fear of not knowing that separation is temporary. This fear may be strongly linked to post-traumatic memories, associated with the accident and a fear of the accident recurring. In the above cases, the caregivers reported that their children displayed what they termed as "acting out behaviours" in their presence, by continually demanding their attention and crying. However, in their absence, these children interacted well with others and showed no signs of distress. Again, this may be linked to a child's need for reassurance and comfort from their attachment figure.

Caregivers in the study reported a range of responses associated with their child's injury. Leidy (2005) states that parents of hospitalised infants, and children, experience distress, as well as intense emotional reactions, as they observe their young child's physical illness and behavioural and emotional responses in an acute care, or intensive care, environment. The parents show elevated levels of stress, associated with watching their children undergo medical procedures and not being able to take care of the child themselves. The reactions of the caregivers in the study were characterized by feelings of nausea; loss of physical energy; elevated levels of anxiety; hyper-alertness; frequent headaches; poor or disturbed sleep; loss of appetite, and low mood. Caregivers also reported intense feelings of anxiety, guilt and self-blame. Steinberg, (1998 in Lieberman, 2004) states that a child's exposure to trauma provokes grief, guilt, anger, anxiety and blame in parents.

I wasn't feeling right at the time because when I took her to the bathroom I had planned on putting her on the bath and run cold water but I was shocked by the knees that had no skin, so I had no energy to do anything at the time, so my younger sister took her next door and I followed after them. (Case B)

It was hard for me to get any sleep, and I couldn't even eat, I would just lose my appetite whenever I attempted to eat.

I was crying because my heart was sore because I was just imagining his pain on me since I've been burnt before and know how it feels like to be burnt. (Case D)

The reactions experienced by these caregivers are reported in most studies on childhood illness. Smith (2004), states that in incidents where a child suffers a trauma, mothers blame themselves for

not being able to protect the child. The burden of blame is often internalised and the mothers become self-critical, experience feelings of inadequacy and become angry. These feelings are often worsened in unsupportive, conflictual family relationships. In the majority of cases, these experiences are found to be mother-bound, excluding male figures. This is because caregivers are seen to have a central interest in their child's health and usually take responsibility for monitoring the health of their children, for seeking health care on behalf of their children, and participating in decisions concerning the health care of their children. This locks caregivers in a mother-child, dyadic relationship, viewed as necessary for the child's development. However, what is questioned here is that, as mothers, the behaviours and actions of women are subject to scrutiny in a way that men as fathers are not, and these behaviours and actions are often linked to family and child health outcomes in ways that male activities are not (Jackson and Mannix, 2004).

The experiences of the caregivers in this research exist within this frame. The feelings of blame (by self and others), guilt, anxiety, inadequacy, and the actions of labeling, stigmatisation, and silencing, serve as orientation and refer to an object. Fabricius (2004) states that feelings of guilt and blame are related to a social object, or a social relationship, and contribute to recognition and regulation. Mother blaming has been called a "serious pervasive problem" and is a term that describes mothers being held responsible for the actions, behaviours, health and well being of their (even adult) children. The central argument here, is that if we take the position that motherhood is a historical, political, cultural and social construct, then we must agree that the dynamics emergent in the practice of motherhood are more than just a reflection of the personal, but are also a reflection of the broader systems responsible for the construction and regulation of mothering. In the examined cases, for instance, psycho-medical discourses of childhood and innocence are at play. The idea of perceiving young children as innocent, and not fully cognisant of their actions, and in need of guidance and supervision from more competent others in their family or society, can be witnessed in all of the cases in this study. None of the children in the research are the recipients of blame, even in cases where the caregivers were absent when the incident took place. The idea exonerates children from blame, and functions to place caregivers as containers of these feelings, and assist in locating cause in the sets of events. In an age of positivist rationality, attribution is necessary. Gall (1984), states that the assignment of blame in adults is strongly influenced by outcome-foreseeability, that is, adults assigned blame on the basis of perceiving the other as being able to foresee the outcomes of their actions. In their respective studies, actors who caused foreseeable injury were blamed more than actors with positive motives and those causing unforeseeable injury. The victim was perceived to be less blameworthy than the one who caused the injury. However, victims were blamed more if the actors' motives were seen to be negative, and the

injury was caused unintentionally. What is missing, even from the narrative, is a reflection of the impact of the broader systems that contribute fundamentally to what is witnessed. Factors associated with poverty, structural problems linked to housing difficulties, such as insufficient living space, lack of material resources, such as tables to place electric appliances on and plugs fixed too low on the ground, are absent in the narratives.

These elements act as fundamental tools that position caregivers in marginalised and oppressed positions. They draw on historically, culturally and socially sanctioned practices that view mothers as bearers of the burden of child rearing, while excusing male figures from such a task. In three cases, we witness absent male figures. This positioned them outside of the scope of blame for “faulty parenting”. Only in one case was a male figure present and yet, even in this case, experiences of blame, leveled at the mother, were observed. Xhosa culture, because of its strongly patriarchal nature, supports these ideas that position women in child rearing activities, while excusing the male figure. The status of the absent father has remained unquestioned in the pertaining literature for a long time. Change in the traditional family structure (nuclear family) has resulted in the emergence of single-parent households, which have not been favorably received by institutions of governance. Single-mothers have been labeled as “bad” mothers. This group is often marginalised and fundamentally pathologised for any incidences of faulty parenting. Lone mothers have been considered a problem and in need of professional intervention, via welfare services and through the psycho-medical professions, with the aim of correcting their parenting. Silva (2000), states that the lone parent’s status is inextricably linked to questions around gender politics: is it acceptable for women to raise children on their own? Should welfare provision support such independence from men? Do mothers have the right to pursue careers? The struggle that exists around single mothers and employment was observed in one of the cases in the current study (Case C). In this case, the caregiver was found to be too busy to look after her child due to her work commitments. Marginalisation of women, and an associated lack of financial freedom, positions them in a dependency relationship, whether with the state or their family. This inevitably places these women in power relations, where they occupy the subordinate positions. Case A highlights this, where exchanges for services are rewarded via financial support for the child. Power and dependency dynamics are at play here. These may be difficult to manage under additional family strain, such as a lack of finances, overcrowded living conditions, and existing family problems (for example, a brother in jail).

A thermal injury leaves caregivers questioning and examining their identities as mothers, whose primary task is to protect, contain, nurture and facilitate physical and emotional development in the

child. The *skills discourse* in psycho-medical literature is at the centre of the deliberations here (Macleod, 2001). The dynamic of self-doubt of one's mothering abilities, witnessed in the cases, can be brought in here. Caregivers reported feelings of not being "good enough" as mothers and also reported a need to improve their mothering. In one case the caregiver felt that she needed to be "100% in the mothering department". These caregivers blamed themselves for the thermal injury and perceived themselves as negligent and careless. The skills discourse, specifically the passing on of maternal skills from mother to daughter, is observed here, where the caregiver aspires to nurture her child in the same manner that she has observed her own mother doing. The maternal skill of attunement is highlighted as primary, where the caregiver knows when the child is hungry, knows when to feed the child, knows when the child needs changing and knows when the child needs medical intervention. Women are encouraged at every level to bond with their children in the effort of developing and nurturing such skills. Failure to achieve these skills may lead being social perceived as a "bad" mother.

The constellation of the above cannot be viewed lightly. The personal and interpersonal exchanges that take place, fundamentally threaten individual's life worlds and their identities. An examination of these conflicts is essentially a process of empowering women and the institutions that serve them. It is argued that the conflicts experienced, emerge out of the process of positioning mothers as the omnipotent and omnipresent domestic god. These conflicts accrue from the disputed status of the concept of motherhood and the discourse within which such a concept functions. Motherhood is a historical, political, cultural and social construct. Thus, an examination of the conflicts experienced by the caregivers must be a process of examining the manifold enterprises and institutions within which such feelings emerge, and locating the experiences of these caregivers within these collectives.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

The purpose of this study was to provide insight into the consequences of paediatric burns, by exploring the narrative accounts of caregivers. No research conducted on the local population exists. Thus, most of the literature examined was internationally based and this called for caution in the interpretation of results. Studies, examined in the literature, show that burns are environmentally conditioned and frequently occur in low socio-economic settings. Children, particularly those below the age of five are significantly at risk of sustaining injuries. Such an injury may have significant physiological and psychological consequences for the child. In these instances, caregivers as well as family systems may be strongly impacted by the child's injury. Caregivers of injured children have been observed to show significantly raised levels of stress associated with the burden of caring for the ill child. These caregivers often also find themselves reeling with feelings of fear and helplessness.

The study yielded important information about the impact of paediatric burns on a small group of caregivers, their burn-injured children and the family. The study highlighted the challenges that they face during the different stages of the incident.

The children that participated in the study were reported to have shown significant reactions to the burn injury. These children were observed by their caregivers to display angry or aggressive behaviour; clinginess; frequent crying; loss of appetite; poor or disturbed sleep; fear of separation from caregivers, and stubbornness. These reactions were observed during the hospitalisation and discharge period of the child's injury. In some cases, the child's functioning, such as problems with eating and sleeping, improved.

Caregivers also reported significant psychological distress, such as: poor appetite; disturbed sleep; headaches; nausea and elevated levels of anxiety. These reactions were experienced during the child's hospitalisation period. Hypervigilance, hyperalertness and fear of the injury recurring were also reported. These feelings were experienced strongly during the discharge period of the child's recovery.

Caregivers in the research study highlighted the arousal of significant emotional distress in response to the burn-injury traumatic event. These caregivers experienced personal and interpersonal conflicts. Dynamics of guilt; labeling; blame by self and by others, as well as feelings of not being a 'good enough' mother were experienced by the caregivers in the current research study. The injury brought with it conflict that strongly challenged the caregivers' sense of self and identities as mothers.

The findings of the study are interesting in that they illustrate the significant impact that an injury can have on a caregiver. Such conflicts in this study are argued to be the consequence of the social, political, and societal institutions charged with the construction and regulation of motherhood.

6.2 Limitations of the study

This research project can be considered a small scale, exploratory pilot study, as no other study covering the same topic exists in South Africa. The results of the study are fairly general, which suggests that there is a need for further research in the area of paediatric burns.

Limitations with existing research in the South African contexts placed the study in a position of not being able to expand on any previously observed dynamics.

Methodological issues related to the analysis of data presented as a linguistic challenge. The process of translating data from its original context, in order to make it visible to those outside of that language practice, inevitably results in a loss of meaning. The richness of the communicable expressions may not present themselves in the same way as they would in their original context. Nevertheless, sensitivity was taken in this regard. Also the interview process may have been enhanced by conducted interviews over two sessions to allow the researcher and subject to further explore emergent themes.

6.3 Recommendations

The Xhosa speaking population of our society is significantly under-researched. Their experiences are not captured at length in existing literature and yet their functioning is subject to regulations by principals foreign to their context. It is important that their experiences be captured to assist with practices of intervention in the medical and home settings. Such research is necessary to fulfill the task of highlighting caregivers' struggle and thereby assisting them in the process of emancipation.

Thus, the key recommendation made here is for further research exploring the experiences of caregivers in instances of paediatric illness.

It is also clear that South Africa lags behind in the focus on burns. Preventative strategies are needed to help the injured child burn victims and their families cope with the psychosocial sequelae of burns.

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University of Cape Town

Appendices

Appendix 1.

Confidential Demographic Sheet.

Red Cross Children's Hospital Private Bag Rondebosch 7701 Cape Town	RED CROSS CHILDREN'S HOSPITAL, BURNS UNIT EXPLORING PAEDIATRIC BURNS. Narrative Accounts from Caregivers in Khayelitsha, Cape Town.	Tel 021-658 5155 658 5055
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Name/ Surname		Gender	
DOB		Age	
Language		Schooling/ Grade	
Hospital Number		Residential Address	
Burn Injury Type			
Cause of Burn Injury			
Date of Injury			
Hospitalization : Admission & Discharge			
Treatment Program			
Duration of Treatment			
Parent/s Mo			
Age			
Occupation			
Highest Level of Education			
		Household area in which Burn Injury Occurred	
Parent/s Fa		Gross Household Monthly Income in Rands	0-1000; 1000-3000; 3000-6000; 6000-9000; 9000-12000; 12000-15000; 15000+
Age			
Occupation		Caregiver/s	
Highest Level of Education		Caregiver Type/s	Type 1: Type 2: Type 3: Type 4:
Family Hx of Illness		Age	
		Highest level of Education	
Family Resources		Occupation	

Appendix 2.

Qualitative Interview Schedule (Caregiver Questionnaire)

A set of seven open ended questions have been prepared to explore the impact of burns on the family. The open ended questions will be administered on the primary caregivers of a child that has sustained a burn injury.

1. Please tell me who makes up your family?
2. Please tell me everything about the accident
3. How was the/ your child before the accident? How do you feel about the/ your child now? Are things different?
4. Please tell me how things have been in the family after the accident? How, if so, is the family different from before? Are there things that you have noticed that have changed (communication, arrangement or composition of family structure, parent & sibling relationships, employment etc)? If not how do you understand this?
5. How is the family coping now? Who looks after the child? Who is the child closest to?
6. What fears do you have with regards to your family's functioning in the future? How do you see your family functioning in the future?
7. Is there anything else you would like to share?

Thank you.

Appendix 3.
Ethical Consideration

UNIVERSITY OF CAPE TOWN



Research Ethics Committee
E52 Room 24, Old Main Building Groot
Schoor Hospital, Observatory, 7925
Queries : Lamees Emjedi
Tel : (021) 406-6338 Fax: 406-6411
E-mail : lemjedi@curie.uct.ac.za

08 July 2005

REC REF: 270/2005

Prof. S Swartz
Dept. of Psychology
Humanities

Dear Prof. Swartz

**EXPLORING THE PSYCHOLOGICAL CONSEQUENCES OF PEDIATRIC
BURNS ON FAMILY FUNCTIONING. A CAREGIVER PERSPECTIVE**

Thank you for submitting your study to the Research Ethics Committee. It is a pleasure to inform you that the Ethics Committee has formally approved the above mentioned study.

Please quote the REC. REF in all your correspondence.

Yours sincerely

Signed by candidate

PROF T. YAKO
CHAIRPERSON

CC: MR JPW Yako

Appendix 4.

Participants Consent Form

Aim of the study.

The research study aims to explore the psychological consequences of burn injuries on the child, caregiver and family, adopting the caregiver's perspective. The study is conducted under the University of Cape Town, Department of Psychology and is in partial fulfillment of the requirements for the degree of Master of Arts in Psychology. The research thesis is undertaken by Mr. Jon Piko Wycliffe Yako under the supervision of Professor Sally Swartz. Four caregivers attending the outpatients department of the Burns Unit at Red Cross Children's Hospital will form the participants of the study.

Procedure.

Data will be gathered by means of administering a semi-structured interviews schedule. All interviews will be conducted by the researcher and in the language of the participants (IsiXhosa). The interview guide will comprise of a set of seven open-ended questions. The interview will be conducted for a duration of 1 ½ hours at the residence of the participants. An alternative interviewing venue will be arranged should the need arise. Participants may be requested to participate in a second set of follow up interviews aiming to explore the initial responses further. The interviews will be recorded by means of an audiotape and the data will be translated and transcribed for purposes of analysis.

Confidentiality.

Participant's information will be treated as confidential and data gathered will only be used for the purposes of the study. Use of pseudo-names will be employed as a means of protecting the study's participants. All research material will be stored in a secure venue after the research (University of Cape Town, Department of Psychology).

Withdrawal.

Participants are not compelled to undergo the study's process if for any reason they feel disempowered in the process. For this reason if participants wish to withdraw from the research study at any point, permission to do so will be granted with out question. Withdrawal from the study will not in any way prejudice the participants.

Containment and Provision of Psychological Services.

The process of providing narratives related to a burn injury sustained by a child can be a challenging experience as it evokes traumatic memories. For this reason the study will link participants and their families with existing psychological services.

Feedback.

A copy of the research findings will be made available to participants within six months of the completion of the project.

Thank you for participating in this study. Your contribution is valued.

Sign.....

Date.....

Appendix 5.
Translated Transcripts

Case Study A- Nono & Akhona

Interviewer: What is the name?

Respondent: Ukho.

Interviewer: Ukho How old is she?

Respondent: A year old. He actually finished a year on the 1st week of August.

Interviewer: When is the child's date of birth?

Respondent: 01/08/2004

Interviewer: Boy or girl?

Respondent: It is a boy.

Interviewer: (Isalambisa in Xhosa) *NgowesUkhophi?*

Respondent: He is the second born.

Interviewer: How did the accident occur? Was it water or was it the stove?

Respondent: It was from boiling water in the kettle, in the kitchen but the fell.

Interviewer: When did the accident happen? Was it during August? What month was it?
And what time was it?

Respondent: He was eight months old when he got the burns.

Interviewer: You're saying he is finishing a year now. So, this probably happened round
May/June. (May). How long did he stay in hospital for?

Respondent: He was admitted on the 23rd and discharged on the 27th.

Interviewer: (4 days, okay). I am now going to ask for all the details. The name of the
Mother?

Respondent: Nono.

Interviewer: What is your age?

Respondent: 20/ 09/ 1975.

Interviewer: So you will be turning 30 this year. Were you working? What do you do?

Respondent: I was working.

Interviewer: At school, what is the highest standard that you competed?

Respondent: Standard 6 (grade 8).

Interviewer: What is the home address?

Respondent: 35137 Boopanga Street, KwaLanga.

Interviewer: Who do you live with at home?

Respondent: I live with my grandmother, my 2 uncles, my uncle's wife, and my brother.

Interviewer: How old is your brother? Is he older than you?

Respondent: His name is Mncedisi, he follows right after me.

Interviewer: The house that you live in, there are these terms called formal somethings...meaning it's a brick house. How would you describe it?

Respondent: the child did not sustain the burn injuries at my house, she got them at my Sister's place and she lives in a brick house.

Interviewer: Okay, you're saying that you live here and the accident happened at your sister's. Alright, so do you have electricity where you live?

Respondent: Yes, there is electricity.

Interviewer: What about water? Does the one that your sister live in have water and Electricity?

Respondent: Yes, there is water and electricity, and its a brick -house.

Interviewer: So the child pulled the kettle?

Respondent: He pulled the kettle, the kettle plug was very low, since it was one of these that you can put on the floor or put it up on the wall.

Interviewer: Where did this happen? Was it in the kitchen? Dining room?

Respondent: In the dining room.

Interviewer: Was the water for washing, or was it tea water?

Respondent: It was tea water.

Interviewer: The time that this all happened?

Respondent: Half past seven .

Interviewer: Late in the evening? The question that I'm going to ask you *sisi*, I want you to estimate, what I want to establish the amount of money or income that household gets every month. Could you perhaps have money from 0-1000? 1000-3000? 3000-6000 per month?

Respondent: It is difficult to explain the monetary issue. The only money that comes in is R780,00 From the child's grandmother, plus her child's grant money, plus her other child's grant money. Actually, there is a single grant payout. Social workers took away the elder child's grant since he's staying with me.

Interviewer: Who looks after the child? Who looks after him most of the times?

Respondent: This one? She is the one that looks after him because she does not work.

Interviewer: Are there other people that sometimes help in looking after him?

Respondent: Its usually the other children but she looks after him most of the time.

Interviewer: Are there illnesses that Ukho occasionally suffered from? Was he a child that

usually got sick?

Respondent: No, but he usually coughs.

Interviewer: Are there any members of the family that suffer from sicknesses such as sugar-diabetes, arthritis?

Respondent: I'm the one who is diabetic, has arthritis and high blood pressure.

Interviewer: Where do you get your treatment from mama?

Respondent: At Stellenbosch.

Interviewer: Can you tell me how he was after the incident?

Respondent: What I have noticed about this child is that, ever since he got burnt he seldom sleeps, he cries a lot, he is an angry person, and he does not listen, even when reprimanded from his wrong doings, he does not stop.

That is what I have observed about this child, ever since the incident

Interviewer: Do you still remember when he was discharged? I just want the month.

Respondent: He came out hospital in that same month. He did not stay very long.

Interviewer: So what really happened? In terms of the accident?

Respondent: The kettle was boiling on the floor in the dining room round about seven. I was about to make tea for the baby to drink, and I was in the kitchen preparing to cook. Next thing, I just heard screams. The child crawled on the floor, and touched the area on the map that had the boiled water, and as a result burnt his hand.

Interviewer: So the water never spilled on his body?

Respondent: No it just spilt on the floor and he touched that area.

Interviewer: What kind of a child was he previously? How would you describe him? Was he a quite child?

Respondent: No, he was not a quite child. He was very *laastag* but now he's even more.

Interviewer: After he touched the mat, what happened?

Respondent: I couldn't get taxis nor buses to Side B, then I went back to the house to run him under tap water, and used it with ice and tied it with a sock. Then, I woke up very early the next morning and took him to Side B. There, I explained to the nurses that I couldn't get any taxis to take bring him immediately. They then gave me a referral letter to go to Red Cross.

Interviewer: How did the doctors and nurses there treat him?

Respondent: Their treatment towards him was very good, they went to check up on him regularly, they also gave him pills and continued with their regular rounds.

Interviewer: Did you spend the entire 4 days there, or did you go home?

Respondent: No, I spent the entire 4 days there at Red Cross. My sister and my mother would come and visit to check how the child was doing.

Interviewer: How were things after you came back from the hospital?

Respondent: There was not much that changed, except that I always kept the child under extra guard and caution.

Interviewer: How were you feeling when all of these things were happening? Please tell me about what you mean when you say you were not worried.

Respondent: I was worried about the fact that he got burnt because I always tried to watch him, especially if there were plugs around.

Interviewer: I'm trying to understand what you mean when you say you were not happy, what other things were you experiencing, and the things that were going on your mind at that time.

Respondent: When my sister got back, she shouted at me when my neighbor and I tried explaining what had happened. She shouted repeatedly, calling me irresponsible for letting that happen.

Interviewer: How were you feeling at that point in time, when she was shouting at you?

Respondent: I was quite and listening to her the entire time.

Interviewer: What were some of the things that she was saying to you?

Respondent: She said that I had no care about what had happened. How could a child burn while there is an adult in the house, and how could I not see when the child was burning, and so forth...

Interviewer: When you were going to the hospital, was she there or not?

Respondent: Yes, she accompanied me.

Interviewer: Was the atmosphere tense? How would you describe it?

Respondent: I wanted to go to the hospital alone, but she came with me only because she was still upset about what had happened to the child, and also the fact that there weren't anymore taxis. However, she came back home and I stayed behind till the discharge date (Red Cross).

Interviewer: How was your sister after that?

Respondent: She was fine when she saw that the child had recovered.

Interviewer: Did she trust you enough to leave the child with you again? Did anything change or was she still mutual?

Respondent: No. She did keep encouraging me to keep a watchful eye over the baby at all times, she would sometimes relieve me and take the child if I was busy.

Interviewer: Can you please tell me about your experience in hospital. How were you

feeling inside?

Respondent: I had told myself that I was going to stay with him because I just couldn't bare to leave him by himself, therefore I told myself that I would rather stay until he is discharged, then go home. The nurses were caring, and would ask us all the time when they came to change the bandages if all was still okay. My sister and my mother kept visiting, and sometimes were unable because they would not have petrol money for the car. When I was told we could go home, I had no money. I asked this random lady, a colored nurse for a rand to make a phone call and I called my house and told them that were discharged but I had no taxi fare.

They then sent a child to come give me taxi fare to go home and were happy on his return, and the fact his hand was working properly again.

Interviewer: The house where all of this happened, is it a 2 bed roomed house or what?

Respondent: No, it's a 3 bed roomed house. There is a sitting room, bathroom, and kitchen and a room.

Interviewer: You said that she started helping you after that. Did she usually do this, or was it something new.

Respondent: She would normally help me, so it wasn't anything new. Even my mother would help if she saw that I had other things to do. I'm now staying at my sister's place at Ekuphumleni, near Greece land. My home is in Harare.

Interviewer: Please tell me how he is now and what other new things are noticing about him?

Respondent: Apart from the fact that his behaviour has become worse and he is constantly angry, I would say he is fine. Also, he eats properly but he still coughs a lot but I rub his chest with ointment now, but *unenkani*. He never does what he's told but instead does the extreme opposite of that. Even when the heater is on and is told to get way from it, he goes straight there to play near the fire and then I take him and put him on my back. Sometimes we move the heater and put it far from his reach and then we give him toys and he plays on the floor with them. Sometimes he cries when he is on my back because he wants to go play outside with the other children and I let him, but I always ask them to look after him, but *uyafeketha* when its just the two of us.

Interviewer: What do you mean when you say *uyafeketha*? Please elaborate on that.

Respondent: he never gives me time to do other things around the house, he wants me to play with him all the time, and I end up abandoning whatever I was doing

just to sit or play with him until he's tired to play, then I give him his bottle and then he doses off to sleep. Then I resume to my duties.

Interviewer: Are there any other things that you have notice in the child?

Respondent: There hasn't been anything.

Interviewer: How are you feeling the parent? Do you sometimes feel scared for him?

Respondent: What I normally fear for him about is the extension cord that he likes pulling and playing with in the rooms so I always keep the doors closed. When were alone together, I put him on my back and only put him down when the other children are back from school. When we are at my grandmother's place he plays with my uncles child and my sister's child. Sometimes my brother comes over to and he takes the child with him for a walk.

Interviewer: So you still have that element of fear within you?

Respondent: Yes, its still there. That is why I watch over him all the time.

Interviewer: Does the fact that you were labeled uncaring bother you the most? What seems to bother you the most?

Respondent: That nurses may report me to family members or authorities who might think that I can't look after my child and therefore am unfit to keep him.

Interviewer: So you fear being labeled an uncaring mother.

Respondent: Of course, that is why I always watch his every move, but when the other Children are around I don't worry a lot, but when they are not around I leave whatever I was doing to go sit with him, give him his toys to play with.

Interviewer: You mentioned that one of your fears is being reported by nurses to social welfare, apart from that, what else do you fear? Could it be other women in the community or perhaps, other females within the family?

Respondent: when something happens within a household, usually community members are called in to intervene and decide what punishment has to be brought upon that person. Women in the community are only called in if the family cannot solve the problem on its own.

Interviewer: can you provide me with an example of the kind of punishment that is likely to be given to a person?

Respondent: if they notice that you do not care about others in the family then they will also show care towards you but if they see you are a very negligent person then they can refuse you help when you need it.

Interviewer: is this a family thing, to call other people for intervention?

Respondent: it usually happens when the family no longer knows what to do, and have given up basically, then last resort is to seek other people for help. The neighborhood also tries by all means to assist but if they're also defeated by the problem and the person is too stubborn and doesn't care they withdraw.

Interviewer: could this happen in Ukho's case? (community coming in to help). If the child was not well taken care of after his burn injuries and if his hand was swollen. Would the family have called the women in community to address the matter?

Respondent: yes, they would have been called in to intervene and do something about me. The family would call them in and they would also take it forward to authorities.

Interviewer: when you talk about authorities, who are you referring to?

Respondent: they can report the matter to social workers, hear what they have to say and never see my child again if they decide to take him away from me unless there is a more responsible person within the family.

Interviewer: when you look at yourself, do you think of yourself as a good mother? How would you rate your parenting skills?

Respondent: I love children, even sometimes when the kids are playing outside, I join them sometimes. Sometimes when my sister is upset about something, I go and cry in the room by myself and then find myself playing with the kids.

Interviewer: it also hurts you when she's upset. What could the reason of that be?

Respondent: It prevents me from doing things that I was supposed to do as I forget mainly because my mind still dwells on what she shouted about earlier. I get better if I cry in the room alone or lock myself in the bathroom.

Interviewer: are there any other things that you can think of in your experiences?

Interviewer: when the DVD player wasn't working and I informed her that Abongile was playing with it, but we were not sure if there were cockroaches inside but my sister just shouted at me, but I just went to the bathroom to cry so that she wouldn't see me.

Interviewer: so when the DVD player broke, you felt as though all the blame was dumped on you?

Respondent: yes, since I am the only one that's always in the house.

Interviewer: How old is your sister? How big is the age gap between the two of you?

Respondent: she was born in 1968, then there is another one that follows after her, then there is the one who was born in 1970, and then me in 1975, and my other

brother who is in jail.

Interviewer: how old is the one in prison? Is he older than you?

Respondent: no, he's the last born.

Interviewer: what is he arrested for?

Respondent: it's a long story.

Interviewer: was it theft? What was it?

Respondent: it was the second time he'd done something like this. First time he was sent back to Polsmoore he had done something wrong somewhere. The second time he jacked some woman's earrings. Then he was given a 6 months sentence. My mother and a church member went to plead with the authorities to let him do his time on the outside.

Our plea was granted but it was conditional and was therefore given rules and regulations to follow. He then again failed to honor that agreement and broke it by jacking another girl's cell phone. All he ever does is ask for money to buy pills.

Interviewer: what pills are we talking about?

Respondent: these pills that you can smoke, since he also uses drugs.

Interviewer: lets go back to the child. Who is the father of this child?

Respondent: the father of this child has never taken any action with regard to this child. I'm raising her on my own and with the help of my sister and my other family members.

Interviewer: what is his name? What does he do? And where does he live?

Respondent: his name is Boysie, he also lives *ko35*, and we've been to court already because of his unwillingness to pay maintenance.

Interviewer: how old is he?

Respondent: he was born in 1965

Interviewer: does he work? What does he do?

Respondent: I do not know because we don't even see each other. Even in court I only saw him for that moment.

Interviewer: do you know which level of school he completed.

Respondent: no, I don't know.

Interviewer: are there things that concern your child's future of yours that could be at home maybe out of all the things we've talked about?

Respondent: its seeing my child growing nicely without needing anything, being helped by people in my family, and also not needing anything because my family

also supports me, and because of the things they provide me with, I make sure that whenever they need help with something, that I try my best to be of help.

Interviewer: what are these things that you help them with? Do you help them by performing chores around the house?

Respondent: I help them with working around the house when they cannot do whatever they need help with. E.g. washing their laundry, or doing their ironing etc.

Interviewer: so you have no problems since your family supports you, you are happy, as long as they don't turn their backs on you.

Respondent: no, there is nothing else.

Interviewer: is there anything else that you want to share with me that I may have left out?

Respondent: there aren't any complaints on my side because he's showing good progress even at the clinic, he eats well, has the perfect weight.

Interviewer: so how do you feel now after this interview?

Respondent: I was worried.

Interviewer: tell me, what were you worried about? Being arrested? Accused?

Respondent: they all crossed my mind and all three made me scared. I thought the Red Cross authorities wanted me. In connection with what had happened to the child, since I know that Red Cross does not accept negligence when it comes to children, so I thought they wanted to arrest me. Or maybe take away my child.

Interviewer: how did all of this make you feel as a parent?

Respondent: it bothered me quite a lot. And I cannot spend a lot of time without him. It even bothers me when the child is crying and is not happy, even when he had those burn scars, I do wish them upon any child. It would be better if they happened to an adult.

Interviewer: is there anything that you would like to ask me?

Respondent: no.

Interviewer: have you ever worked before?

Respondent: I use to hold a job in Killarney, working as a domestic there.

Interviewer: thank you very much *sisi* for your time and your support, and for taking the time out to be here.

Interviewer: do you have a phone? How can I get hold of you if I want to contact you? I want to check if you will get your children's grant money. I want to check if

you will get the money on that date for both children, the one that is 5 yrs old and Ukho. Lets talk about it again around the 16th.

******The end******

University of Cape Town

Case Study B- Akhona & Zonke

Interviewer: may I please have the child's name?

Respondent: Zonke

Interviewer: and the surname is?

Interviewer:

Interviewer: is it a boy or a girl?

Respondent: a girl

Interviewer: how old is she?

Respondent: she is a year and 2 weeks old

Interviewer: has she started school yet?

Respondent: no she hasn't

Interviewer: is your home language Xhosa?

Respondent: yes, it is

Interviewer: what's her date of birth?

Respondent: 28/07/2004

Interviewer: is she the first?

Respondent: she is my first born child

Interviewer: how did she burn? Was it fire? Was it water?

Respondent: she pulled water from the kettle

Interviewer: when did the accident occur? Do you still remember the date, month?

Respondent: I do not remember the date but it was during May

Interviewer: how long did she stay in hospital for?

Respondent: she stayed for 2 weeks

Interviewer: are you her mother?

Respondent: yes

Interviewer: how old are you?

Respondent: I'm 21 years old

Interviewer: are you employed or not?

Respondent: I'm unemployed

Interviewer: what level of education did you complete?

Respondent: matric

Interviewer: did you pass your standard 10?

Respondent: yes

Interviewer: did you have any qualifications after matric?

Respondent: yes, I did a course in home –care

Interviewer: do you have any information on the father?

Respondent: yes

Interviewer: what's his name?

Respondent: Phillip

Interviewer: how old is?

Respondent: he's 27 years old

Interviewer: what does he do?

Respondent: he is working

Interviewer: What kind of job does he do?

Respondent: he is a painter, he paints people's houses

Interviewer: do you know the level of education that he completed?

Respondent: no, I do not know

Interviewer: what's your address?

Respondent:

Interviewer: did the accident take place here?

Respondent: yes

Interviewer: who else lives in this house with you?

Respondent: my mom, and my dad

Interviewer: hoe old is your mother?

Respondent: she was born in May 1967

Interviewer: and your father?

Respondent: my father was born in 1960

Interviewer: who else follows after you?

Respondent: it's me, and my other two siblings

Interviewer: how old are they?

Respondent: one is 16 and the other one is 19 years old

Interviewer: is it only the 3 of you?

Respondent: yes

Interviewer: where did the accident take place?

Respondent: here at home. The thing is the wall unit was in a different place at that time because the electricity in the building was not yet installed on to the walls and the kettle was within reach, on the chairs, and what happened is that we were all in the room not noticing the child crawling to where the kettle was, and she pulled it

Interviewer: The question that I'm going to ask you *sisi*, I want you

to estimate, what I want to establish the amount of money or income that household gets every month. Could you perhaps have money from 0-1000? 1000-3000? 3000-6000 per month?

Respondent: I would say it's a 0-100

Interviewer: who is your child's caregiver around the house?

Respondent: they all go to work, so I take care of the child

Interviewer: did Zonke suffer from any kinds of illnesses before the accident?

Respondent: no

Interviewer: so she never gets sick. are there people in the family that often get sick? from any sort of diseases/ illnesses?

Respondent: yes, my mother has sugar diabetes

Interviewer: so you say she is not a child that often gets sick.

Respondent: yes she hardly ever gets sick

Interviewer: now Nosipho I would like you to tell me in detail about the day of the accident. What time was it, when was it and what was happening?

Respondent: I think it happened around 10 in the morning

Interviewer: what happened?

Respondent: that day, it was a Saturday around 10 am. Both my parents were going to Side C and I was also supposed to go with them but since I was running late, they left me behind. I had put on water in the kettle to wash the baby.

Interviewer: what was happening in Side C?

Respondent: we used to stay there before so the house that we used to live in was supposed to be rebuilt.

Interviewer: so were you going there to help rebuild the place?

Respondent: no, I just felt like going there since I used to live there, and I like going there on Saturdays, so they left me behind with another auntie that helps around the house. I was in the room at the time looking for a receipt and the auntie was in the bathroom. A while after I was in the room I just heard the baby crying and ran to see what had happened. It seems like she had pulled the kettle cause when I found her she was on the floor with her knees on the area where the water had spilt. I quickly removed her from the floor and ran with her to the bathroom. I took off the tracksuit that she was wearing, and while I was doing this I noticed that the skin on her knees had come off. After that, Andiswa, who stays

here took her to the woman who lives next door and after that we took her to Side B. there, I was transferred to Red Cross.

Interviewer: you say that, Andiswa who is your sister took her to the house next door, where were you when all of this was happening?

Respondent: I wasn't feeling right at the time because when I took her to the bathroom, I planned on putting her on the bath and run her cold water but I was shocked by the knees that had no skin so I had no energy to do anything at the time, so Andiswa took her next door and I followed after them.

Interviewer: what did they say at Red Cross, in fact, what did they do at Side B first?

Respondent: at Side B, they gave her this white ointment, I think its phlamazoiec, and then they bandaged her. Then we had to wait for an ambulance to Red Cross. At Red Cross, I was sent to the trauma unit. The doctor arrived and examined the baby. They removed the bandages, the hand was the worst part that was badly burnt and the back, and we were then told we'd have to sleep over.

Interviewer: so the knees were not that bad compared to the hand. Okay, again I would like to know about your experiences, how were you feeling?

Respondent: I wasn't coping at the hospital because I felt as though she wouldn't have burnt if I had put her on my back. This woman came up to me in the hospital and she also asked me how I was feeling, after I told her she said I shouldn't blame myself because it wouldn't make sense to want to burn and kill my child after raising her for 2 years. She reassured me not to blame myself, after what she had told me, I stopped blaming myself because it was an accident

Interviewer: but did that take time?

Respondent: yes it took time

Interviewer: what were other feelings that you were experiencing?

Respondent: my dad said all sorts of things that hurt me at the time that I was careless and that hurt me but I was okay again. But I felt really bad at first

Interviewer: can you tell me about the feelings that you had when you say that you felt bad.

Respondent: my heart was always sore when she was in hospital and I would cry all the time. I was the pain that she was going through and I felt it too, whenever I looked at her I would have plenty of what ifs in my head but then would think of what the woman in hospital told me and that would make me feel better

Interviewer: these pains that you say you saw her feeling, what did you feel should happen?

Respondent: I wish I could take the pain away from her and feel it for her because she was too young to be enduring such pain.

Interviewer: let's go back to your parents now. You say that they were not there when all of this happened. When did you meet and how did they know about the accident?

Respondent: Andiswa left the baby next door and rushed off to the public phones to call my father, my dad then came back and we met with him on our way to the hospital and my mother rushed to Side C. when we got there, my mother was already there and she saw what had happened. When I got into the ambulance they left to go meet with me at Red Cross

Interviewer: how were you feeling in front of your parents

Respondent: I was scared at what my father was saying because he usually warned us not to plug the kettle where the child could reach it. I was scared of him the most.

Interviewer: what scared you the most about your father?

Respondent: I was scared that he was going to shout at me

Interviewer: what were the other things that he said to you?

Interviewer: nothing else, he only said that I was careless on that Saturday after the accident and he didn't say anything else. The following day when he went to see her he didn't say much. He was just hurt when he was her

Interviewer: how was your mother?

Respondent: my mother didn't say anything. She didn't say negative things that indicate that she blamed me for what had happened.

Interviewer: can you please tell me about the 2 weeks in which the child was hospitalized. Did you stay there or you would come check up on the child everyday?

Respondent: I stayed the entire 2 weeks

Interviewer: how was it?

Respondent: it was really hard in the beginning. The food couldn't even go in. I would really worry when the nurses came to take her to the dressing room in the mornings and would really be touched when I heard her screaming from there, but would console myself by saying that they were also doing that to help her. Things got better, I would even have conversations with some of the women that were there also with burnt children.

Interviewer: what were the things that you spoke about?

Respondent: we would talk about how our children burnt, how we felt at the time and how we are feeling now, and I saw that they were feeling better and that their children were also healing and therefore my child would also be helped at Red Cross.

Interviewer: you mentioned that during that week it was even hard for you to eat. What were the other things that you were experiencing? Was it worry?

Respondent: yes It was worry and pity for the child. I couldn't eat, just looking at her and witnessing the pain that she felt really affected me

Interviewer: you already said that you experienced self-blame. From the things that your father was saying to you, what kind of a parent did you perceive yourself to be?

Respondent: at the beginning, I felt careless as I've stated that I blame d myself but as I started telling people about it, I felt better. I told myself that I love my child and would never want to harm her, if I wanted to kill her I would have aborted her and she would not be here but seeing that I loved her I kept her and gave birth to her. It wasn't my fault it was merely an accident that is what I told myself.

Interviewer: I'm interested in what you've just said that after giving birth to your child and raising her it just wouldn't make sense to want to kill her. Were there people that said these things or you felt that that is what people would think or say?

Respondent: yes, that is what I thought because she could've died if the water had spilled on her head.

Interviewer: were here feelings inside you that other people or doctors would think that you wanted to kill your child?

Respondent: no, I wasn't thinking that but there are people that do not understand who would've thought like that.

Interviewer: are these people from your neighborhood?

Respondent: no, it's the people from where I used to live in Side C that I thought would say such things.

Interviewer: I understand that this was merely what you were thinking but in reality were there people that looked at you in that kind of way?

Respondent: no, these were my thoughts. They did not say such things in my presence but I do not know what they said when I wasn't there. They would feel sorry whenever they saw her.

Interviewer: did you feel they were supporting you?

Respondent: yes, others called me in hospital and my friends would call and tell me to be strong, that she was going to be fine. My parents asked me not to get tired of being in hospital, that is should stay there until the child was fine. So I was determined to stay and see her recover

Interviewer: was that a hard thing to do?

Respondent: no it wasn't hard because It was something that I wanted to see happen

Interviewer: I'm trying to follow up on your previous statement that your parents asked you not to get tired of being in hospital. Were there such feelings of being tired?

Respondent: well in the beginning there were a bit because I was doing something that I wasn't used to because staying in hospital and sleeping on a chair is not an easy thing, but I just thought rather than staying at home and not having a clue of what is done to the child I should rather stay.

Interviewer: was the father of the child also a part of what was happening?

Respondent: yes, he would come to see her

Interviewer: how was he, how did he take it?

Respondent: at the beginning he was also hurt. He was informed by telephone on Sunday.

Interviewer: who called him?

Respondent: It was my mother because I couldn't call him myself.

Interviewer: why couldn't you call him yourself?

Respondent: I couldn't on the Saturday, and another thing is that the phoned are too far at Side C, in order to make a phone call one has to go to Side B. he came on the Sunday, and even though he didn't say it, I felt that he was blaming me inside. I explained to him that it wasn't my fault, that she pulled the kettle

Interviewer: when you say that he didn't spit it out that he blames you directly, what then, were the things he said to you?

Respondent: when a person wants to say something to you, you can sense it through their words. He said things like, " how could you let a child play alone", " why didn't you do this", and "why was the kettle put in that place "and" why didn't you put the child in the room with you and leave her alone instead. I told him that since we had recently moved into the place, we didn't have plugs that were far from the child's reach, so then he understood. But he also mentioned that had the child been at his house she wouldn't have burnt, and I told him that if it was meant to happen it would've.

Interviewer: was he hurt?

Respondent: yes gathering from the questions that he asked me I would say he was.

Interviewer: after you came back from hospital, how were things around the house?

Respondent: there were no changes, everything was okay

Interviewer: what were your experiences as a parent who had a burnt child?

Respondent: I'm very careful now, if I'm doing something else, I prefer to put her on my back. I do not want her anywhere near electric appliances now.

Interviewer: do you still fear that another accident might happen?

Respondent: yes, because children do not listen. She won't be scared to go near the thing that burnt her again. That's how children are.

Interviewer: throughout everything that was said to you after the child was burnt by your own father and of course, the baby's father, do you think that you're now carefulness is somehow guided by what you fear they might say to you?

Respondent: yes and it would be much worse if she were to burn for the second time.

Interviewer: so this is not only about protecting her but protecting yourself as well from the accusations of not caring for your child.

Respondent: yes

Interviewer: how does that make you feel as a parent?

Respondent: I now think that I should become more of a parent, even though I get support from my family I should really be the only one looking after my child and not ask anyone else to do my job for me.

Interviewer: does that mean that there was another person playing that mother-role to your child?

Respondent: yes, my mother did a lot

Interviewer: now you wish to be the only one who fulfils that role?

Respondent: yes

Interviewer: what does parenting mean to you?

Respondent: as I've said that my mother helped a lot, I did not know a lot of things about parenting since she did most things on my behalf

Interviewer: what sort of things didn't you know?

Respondent: almost everything about babies because my mother did everything for her. She washed her, bathed her, and fed her, she wouldn't let me do anything. She wasn't working at the time, but now I'm planning to be 100% excellent in the parenting department because I do the job alone now since my mother goes to work. I want to be able to do all the things that she does with the baby. Be able to tell when she is hungry, when she needs to sleep and when she needs to take her medication.

Interviewer: I would think that is a very difficult job to do. Wouldn't you say it's challenging?

Respondent: yes I would say that but it's not a really tough challenge

Interviewer: in relation to everything that I have asked you about the baby and the accident, what do you think the future will be like for you and your baby?

Respondent: I do not think that she will be able to wear short skirts when she is old because of her scars, even now I do not dress her up in short clothing, if I happen to do that I always make sure that she has socks to hide the ugly wounds. Also, when she grows up she will want to know what happened to her because she will be different from other children, and I know that I'm going to have to explain to her what had happened.

Interviewer: so you still fear for her in terms of what people will say?

Respondent: kids talk a lot, I'm just scared of what they will say about her or ask her what happened to her, or say things that might hurt her.

Interviewer: does that hurt you?

Respondent: yes, but sometimes I think that maybe by the time she is able to play with other kids her the scars would've vanished, that is what I'm hoping for.

Interviewer: what did the doctors say to you about the scars?

Respondent: they told me that she was still very young and that they will fade away as she gets older.

Interviewer: where are they to be exact?

Respondent: on her knees, her right hand side, and her left foot.

Interviewer: are someone who is constantly worried about this?

Respondent: not a lot because I tell myself that she might be fine again. Other people also give me hope by telling me that she will be okay.

Interviewer: do you have any worries of what your family might say or think of you in the future?

Respondent: my whole family is supportive, I don't think anyone from my family would have such things.

Interviewer: who performs the household chores around the house?

Respondent: if other people are not around I do the cleaning around the house

Interviewer: since the accident occurred, has there been any changes in the household in terms of them lending an extra hand?

Respondent: well, I clean during the day and look after the child when the other children are gone to school but the minute they get back, it becomes their responsibility. Then I cook, but late in the evening, my parents look after him and I wash the dishes.

Interviewer: is there anything that I haven't asked you maybe?

Respondent: no

Interviewer: thank you very much for your support, if there is anything I might have left out then I will just contact you telephonically. How do you feel now after this interview?

Respondent: I'm very happy to have spoken about it.

Interviewer: were there feelings of fear about this interview at the beginning?

Respondent: no because you had briefed me about the interview at the beginning

Interviewer: we will have a feedback session around November, since most people go on holiday, if it's impossible do conduct it then, then I will give you the feedback in January

******The end******

Case Study C- Noluntu & Sihle

Interviewer: what is the child's name?

Respondent: Sihle

Interviewer: is it a boy or girl?

Respondent: a girl

Interviewer: how old is she?

Respondent: 2 years.

Interviewer: she hasn't started school, has she?

Respondent: no she hasn't

Interviewer: what is her date of birth?

Respondent: 3/07/2003

Interviewer: what language does she speak?

Respondent: isiXhosa

Interviewer: *ngowesingaphi?*

Respondent: she is my first child.

Interviewer: how did he burn? Was it water?

Respondent: she burned from water that was in a washing tub

Interviewer: when did the accident happen?

Respondent: in June

Interviewer: how long did he stay in hospital for?

Respondent: 2 weeks to be specific

Interviewer: as the child's mother, what is your name?

Respondent: Noluntu

Interviewer: your age?

Respondent: I'm 29 years old

Interviewer: do you work?"

Respondent: I work at PicknPay

Interviewer: what do you do there?

Respondent: as a till packer

Interviewer: what's your highest level of education that you have completed?

Respondent: standard 10

Interviewer: the father of the child? What are his details?

Respondent: I do not wish to talk about him.

Interviewer: that's okay then.

Interviewer: what's your home address?

Respondent:

Interviewer: who do you stay with?

Respondent: I live with my child only, I also have a sister but she is married.

Interviewer: is your sister older than you?

Respondent: yes, she is.

Interviewer: any brothers and sisters?

Respondent: yes, but they do not live here, they live in the Eastern Cape

Interviewer: how many are they?

Respondent: there is 6 of us.

Interviewer: are they all in the Eastern Cape?

Respondent: yes, they all there, my other brother is in P.E and my other sister is in KWT

Interviewer: where did the accident take place?

Respondent: it took place here in Cape Town.

Interviewer: The question that I'm going to ask you *sisi*, I want you

To estimate, what I want to establish the amount of money or income that household gets every month. Could you perhaps have money from 0-1000? 1000-3000? 3000-6000 per month?

Respondent: 0-1000.

Interviewer: are you the child's care giver?

Respondent: yes I am.

Interviewer: did Sihle suffer from any kinds of illnesses before the accident?

Respondent: she's never suffered from anything

Interviewer: are there any members of the family who suffered from diseases like cancer?

Respondent: No

Interviewer: can you please tell me in detail about the day of the accident?

Respondent: I was at work that day. Around about 4pm a man came to me at work and asked me to buy items like bandages at Link pharmacy and other stuff. He informed me that my child had been burnt but said it was not so bad. He gave me a R100 to buy the things, and I told the supervisor what this man was telling me and I asked if I could be excused from work and the supervisor gave me permission. We went to buy the stuff and I went home, when I got there, she was the one that showed me her blister, saying: "look mommy I got burnt". I then did not think it was serious at all from the mere fact that she could report the incident herself. She did not eat that

night and went to bed, cause she had no appetite. The following morning I noticed that there was a change, she was not the same as yesterday. So I decided to take her to hospital in side B because she was just losing her appetite I hadn't noticed how badly the wounds were at that time.

Interviewer: so you are saying that you hadn't looked carefully at the child's wounds?

Respondent: not that I did not pay attention to the child but it's just that I did not notice how serious it was. I just thought it was small and she would be alright because I did look at the wound and I applied ointment to it and then I took her to side B. From there we were transferred to Red Cross. That's where I realized just how serious this whole thing was from the length of our time there.

Interviewer: How were you feeling when all of these things happening?

Respondent: I only started grasping the seriousness of the situation when the Professor told me that the child would be admitted because they needed to examine her. that was a Saturday.

Interviewer: while you were at Red Cross, what were some of the feelings that you were experiencing at that time? Things that you feared? The extent of the harm?

Respondent: I was just scared.

Interviewer: who was the child's supervisor in hospital when you were not around?

Respondent: it was her nanny

Interviewer: after you realized that this could be serious, and the child was admitted how did the child's nanny react?

Respondent: at the time I got there she was very worried because she said that of all the children she'd ever looked after before, none of them got burnt, including her daughter's children. She would even come around for at times.

Interviewer: going back to the question I asked earlier, what were the feelings/ emotions that you were experiencing when you were at the hospital with her? Some parents fear that the child might lose their life so on since they may not know much information about the accident. Some parents tend to blame themselves, by saying if only they were there. What were your fears?

Respondent: at the time I was there, I didn't really have any fears because I thought it was a minor injury. I only started panicking when we were transferred and she started having these blisters, and she got sick on top of the burns. She developed these things that I did not know on her body, and when the Professor came up to me and asked if I had taken any Aids tests when I

was pregnant I panicked a lot. I thought she might be HIV-Positive

Interviewer: did you sleep and eat well?

Respondent: no I wasn't able to because the child was also not eating.

Interviewer: throughout this period, did you get any support?

Respondent: yes, I got lots of support from my sisters, people that knew me, my friends and even at work they would call me.

Interviewer: do you still get that support

Respondent: yes, my colleagues still continue asking how she is doing.

Interviewer: what were some of the thoughts that were going through your mind?

Respondent: I did not think of blaming myself, I took it simply as that it could happen to any child even when you think you were carefully watching him/her

interviewer: what were your reactions, feelings and attitude after you were discharged?

Respondent: when I came back, it was difficult because she did not want other people, she wanted me only. I would have to come to her after work. What lifted my spirits is that unlike other kids, she ate well.

Interviewer: going back to the point you made about her not wanting other people? Can you tell me about these people and her attitude towards them?

Respondent: she did not want any of my sisters, and not any other person for that matter I just excused her behaviour with the fact that we were together at Red Cross all the time. She would cry if people looked at her

Interviewer: how long did that happen for? (the crying and stuff)

Respondent: approximately 2 weeks but then I was forced to go back to work after that because I had taken almost two weeks leave from work. The information I got was very good. She had no problem with people when I wasn't around but once I got back she would go back to her stunts.

Interviewer: how did you respond to the nanny when you got back?

Respondent: she had no problem with her nanny, I would take her to where the nanny lives before I go to work. She still wanted to be there but would be upset if I leave her, she still wanted to be there but with me present as well.

Interviewer: did the accident happen here, at your house?

Respondent: no, not here. It happened at the house where she is nursed during the day

Interviewer: was the water intended to be used for cooking?

Respondent: no, it was water that was in the tub which was going to be used to wash items of a child that had returned from an initiates hut (ibhoma).

Interviewer: did the water spill on her?

Respondent: no one is quite sure of the way it happened because that house is big but we suspected that she might have tripped onto the water. The washing tub was put on the floor, we are not sure if she went to it or she just tripped.

Interviewer: was this an open area with no kitchen or something?

Respondent: no, it's an open area combined with the sitting room

Interviewer: is this a day care centre or what?

Respondent: no. it's not a day care, it just person who has space in her house to look after other children.

Interviewer: how many children does she have under her care?

Respondent: I think that she looks after almost 5 children

Interviewer: you say she (child) was there for 2 weeks. After she was discharged, did you notice any changes in the baby or yourself?

Respondent: I haven't noticed any changes with the child, before she went there she Even had allergies, but she was alright when she came back.

Interviewer: were there things troubling you as the mother when she got back?

Respondent: no, because I had to work and I knew she would have to go back to where she is nursed and had I worried I wouldn't have been able to go to work and therefore I couldn't put myself through that kind of stress misery and unhappiness. As long I knew she was happy there.

Interviewer: if I understand you correctly, you are saying that you had no choice but To put those thoughts aside?

Respondent: yes, I was forced to put them aside because I had to leave her behind and go to work. I did not even want to hire someone else because, that new person could also do something else accidentally therefore it was better staying with the one I already had who would take of her better because she wasn't going to go through the same mistake.

Interviewer: your decision of not accommodating worrying thoughts in your head, could it be a hard thing to do?

Respondent: its hard, but then not so hard because I had no option to make things any better because either way, things would have required other options such as hiring someone else or even taking the child to crèche.

Interviewer: so you chose to put the option of worrying aside. Do you think that decision help you of taking the child to crèche?

Respondent: yes, because now I don't have to have worrying thoughts at work

Interviewer: are there any worries or concerns that you have about her future or yours?

Respondent: no, I don't have any

Interviewer: aren't you worried that someone else might come and report a similar incident while you're in the line of duty?

Respondent: I would rather say no, I do not allow myself to think about such things I would rather face it when it happens.

Interviewer: I just want to go back, both of you live alone in this house, and when do you fetch her?

Respondent: around 7pm because that place close late in the evening.

Interviewer: then you come home, also have to prepare for dinner, and bath her?

Respondent: yes, I fix everything, then I take her there again in the mornings

Interviewer: does your sister play any role in helping you?

Respondent: yes, she does play a role now that she is working cause during weekends she looks after her or take her to her place and stay with her when I have to do overtime at work.

Interviewer: I do not think there is anything else that I want to ask you, I would like you to know that this interview was of great help because we wanted you to share with us your experience during the time the accident happened, and the child's experience, so that I may also tell you that:

- Number 1, there might have been something else right at the beginning, even before the child burnt and you just did not understand its depth, and then later on it shocked you when you got at the hospital the moment you were told that you were going to be admitted that it's serious. Other things started showing, which resulted in you having more worries, such as things of other things the child could have been suffering from, such as HIV and other things, and to me it seems that it was even difficult when you were discharged because there were other decisions that you had to take, and they weren't easy but were necessary. Also, you staying at home and worrying wasn't a choice for you because you had to go back to work and she had to be looked after, and you decided that she should go back to the very same place where the incident happened because at least, then they would be more alert now when it comes to the child.

Interviewer: is there anything else that I have left behind *sisi*?

Respondent: no

Interviewer: how do you feel about this interview now that it's over?

Respondent: no, I'm okay. And I'm glad to have shared what happened with others.

Interviewer: then, if there is anything else that I want to communicate with you, then I will just phone. Your support is highly appreciated. If there's anything else that I've forgotten then I will just make a phone call.

Interviewer: just this last question *sisi*. I'm not sure if I asked this question but I will ask Nonetheless. Are there any future concerns that you have with the child?

Respondent: no, I'm not worried because after Sihle burnt my sisters recommended that she go stay with them and I refused the offer because it wasn't something that I couldn't handle myself.

Interviewer: where did you say your sisters were in the Eastern Cape?

Respondent: my 2 sisters are in Port Elizabeth and my brother is in King.

Interviewer: could it be that they were also trying to express their concerns?

Respondent: they were worried because they kept calling all the time to find out how he was doing when I was at Red Cross until he got better, that is when they opted that she go down to live with them.

Interviewer: how did you take that request?

Respondent: they said that I did not have time for her because of my work obligations, but then it wasn't going to make much of a difference because even if I had taken the offer, they would also have to hire a baby-sitter who could also make the same mistake so it was the same thing.

Interviewer: how did they respond to you turning their offer down?

Respondent: they were okay with it, and I haven't spoken to them ever since but they said that if I wanted to change my mind then I should tell them

Interviewer: thank you very much. If there is anything else, as said earlier I will call.

*****the end*****

Case Study D. Zimkhitha & Odwa

Interviewer: I'm going to ask you to please tell me about the day of the accident. How Did it happen?

Respondent: my aunt had plugged water and the water was on the table. Her mistake was to leave the plug hanging in the air and the child crawled to the plug and Odwa pulled it, and the water fell on her. Then we ran her under tap water and then we took her to the clinic and she was admitted

Interviewer: do you still remember the date of the accident?

Respondent: no, I'm not sure but it was around April

Interviewer: so your aunt was going to work and she was making eggs for herself and on the table was the kettle, right? So tell me, is the kettle usually put on top of the cupboard or on top of the table?

Respondent: no, it's on top of the table, but Odwa managed to crawled to it and pulled the kettle plug, and the water just fell on her.

Interviewer: is the house that you are staying in an informal or a formal house? Is it made of bricks or not?

Respondent: no, it's an informal house

Interviewer: is it a one bed-roomed house or just a one roomed house?

Respondent: it's a one roomed house

Interviewer: so is there electricity?

Respondent: yes there is electricity

Interviewer: what do you cook with?

Respondent: we cook with an electricity stove

Interviewer: so you say you put her in cold water and then took her to the clinic. Then what happened at Red Cross?

Respondent: they cleaned her wounds and they bandaged her and she was admitted

Interviewer: how long did she stay there for?

Respondent: she stayed for a week

Interviewer: what happened during the week that you were there for? Did you stay there or did you go home?

Respondent: no, I stayed for the entire week

Interviewer: how was the child during this time?

Respondent: the first few days she couldn't even play but after three day she got better

Interviewer: were there other things that you started noticing about the child?

Respondent: she was scared to be touched especially in her legs and her arms

Interviewer: did this take a toll on your work?

Respondent: I wasn't working at the time

Interviewer: how is the child now?

Respondent: there is absolutely nothing wrong with the child now, he even plays happily

Interviewer: so you haven't noticed anything different about the child. Does she not get frightened to go to the kitchen?

Respondent: no she is not even afraid of fire because usually when we go back to the rural areas in the Eastern Cape, she sometimes wants to pull the fire wood when the fire is lit.

interviewer: when this accident happened was the father of the child informed?

Respondent: yes I did inform him that the child was burnt, so he was very upset.

Interviewer: what about you? How were you feeling?

Respondent: I was also very hurt but then I consoled myself

Interviewer: how?

Respondent: my cousin's child also got burnt when she was little and she told me how it was for her and that she was going to be fine, and when I went to hospital I found that there were plenty of other kids that were severely burnt, so my child was also going to be okay

interviewer: how was your relationship with your aunt around the house after the accident?

Respondent: my aunt always took me to hospital and she felt sorry that the child burnt because of her even though it was just an accident

Interviewer: what were your feelings towards her?

Respondent: I had those feelings inside of me that she was negligent but then I told myself that it was an accident, and I could've been the cause of it myself.

Interviewer: let's go back to the question of how you were feeling after the accident. How ere you feeling immediately after the accident? Were there feelings of blaming yourself as in to say, if only you had been there?

Respondent: yes I had such feelings. I felt that if I was there next to her she wouldn't have burnt

interviewer: could there have been other things that you felt at the time? Were there feelings of fear

Respondent: yes I was scared. What I feared the most was that doctors were going to tell me that I'm very negligent because she burnt on the leg that was recently broken, and just had the plaster removed.

Interviewer: so you feared doctors scolding at you?

Respondent: yes

Interviewer: other things that you were experiencing? Was it difficult to sleep perhaps?

Respondent: it was hard for me to get any sleep, and I couldn't even eat, I would just lose my appetite whenever I attempted to eat.

Interviewer: so you say you consoled yourself?

Respondent: yes I consoled myself by seeing other kids that were also burnt. Others were worse and others were in the same condition as him and others were better already and I just thought that she would also get better.

Interviewer: how long did it take for you to fully accept that?

Respondent: it took me two weeks

Interviewer: was this after she was discharged?

Respondent: yes

Interviewer: after she was discharged did you fear for her around other dangerous things

respondent: yes, I was always cautious around her and didn't want her anywhere near the table and most of the times would carry her on my back

interviewer: how about now? Do you still insist on putting her on your back, not wanting her anywhere near the table?

Respondent: yes

Interviewer: so you still have those fears within you?

Respondent: yes I still get very scared, that I even asked my mother to stop making fire because she will want to pull the wood and she might get burnt again

interviewer: do you ever go to the Eastern Cape

respondent: the last time I went down was when I took the baby there but then I make it a point that I call them

interviewer: how long were you there for?

Respondent: I stayed for two weeks

Interviewer: can you please tell me how things were around the house before the accident? How were things between your aunt, Odwa and you

Respondent: we were extremely happy together. Odwa got along very well with her aunt

interviewer: who looked after Odwa the most?

Respondent: it was me

Interviewer: when did your aunt help out?

Respondent: when she was around, after work or during weekends

Interviewer: after the accident did you notice anything that was different with the baby?

Respondent: No. I didn't notice anything different

Interviewer: as you've said that you looked after her and your aunt would relieve you on weekends. Did that pattern remain as it was or did it change?

Respondent: no it didn't change

Interviewer: was the child scared of going to her aunt or going to the kitchen after she was discharged?

Respondent: no she wasn't scared of any of those things

Interviewer: how is the family coping now after the accident?

Respondent: it's still the same as before

Interviewer: the accident happened, and there were fears you had for the child, and there was a period whereby your aunt blamed herself, and you also wished that you could've been there, and you also blamed your aunt of her negligence and you were scared of what the doctors might say to you. And you say that all these feelings changed after you saw other children who were worse than her. Did that take time for you to get used to the idea because even after she was discharged, you did not want her near plugs, fire and the table. To me, it seems as if you still have those fears because you don't want her anywhere near fire even in the Eastern Cape.

Respondent: well, I suppose there is still that fear inside of me

Interviewer: are you saying there is nothing changed about the fear that it is still Greater?

Respondent: yes

Interviewer: how do you see the family coping in terms of the future? Is there any difference in the way you are coping now and the way you were coping before or is it still the same?

Respondent: no, it's still the same. Nothing's changed

Interviewer: how do you see the family coping now, in terms of the future? Maybe after the child's grown up? Are there things that you think might change according to how you're living in the house when the child is back from the Eastern Cape?

Respondent: no

Interviewer: is there anything that I might have forgotten to ask you?

Respondent: no

Interviewer: do both you and your aunt work?

Respondent: yes

Interviewer: what time do you get back from work?

Respondent: past six to seven

Interviewer: and your aunt?

Respondent: past six

Interviewer: who takes care of the cooking?

Respondent: my aunt takes care of the cooking because she gets back before me. I get to cook on Sundays

Interviewer: you mentioned that you look after the baby most of the times, what happens to her when you're at work? Or do you go to work with her?

Respondent: she is now in the Eastern Cape

Interviewer: what did you do when she was still here?

Respondent: I wasn't working at the time

Interviewer: so you only sent her after you got the job?

Respondent: yes I sent her there after I got a job since I had to go to work

Interviewer: so when you were not yet working, it wasn't a problem because you were with her all day?

Respondent: no it wasn't

Interviewer: how is your relationship with your aunt? Are you able to talk to her about things?

Respondent: yes I'm able to talk to her about anything that I want to talk about.

Interviewer: and what type of person is she?

Respondent: she also talks about anything that she wants to talk to me about

Interviewer: how is your relationship with the father of the child?

Respondent: we get along, there is no problem

Interviewer: I know that I might have asked you this question in the beginning but I'm going to repeat it again because I would like to understand how you

were emotionally, due to the accident? Some parents that I've worked with at Red Cross went through a lot of different emotions, some went through stress, some can't cope, some can't eat, and some blame themselves of what might have happened. Some just wish that they could just take away the pain that the child is going through and feel it for them. What I would like to know is, were these also your experiences?

Respondent: yes, I wished that I could be able to take away her pain because I'm not a person of too many words but I would just look at her and think about a lot of things.

Interviewer: what were some of the things that you would think about? Did these things bother you, were they related to her future?

Respondent: what bothered me the most is that, I was worried about the belief that a burnt child is stubborn and never listens, and I was also worried about the marks that she would have for a very long time.

Interviewer: where did you get this belief from?

Respondent: my cousin was told at Red Cross that she must not be surprised if her child is inattentive and very stubborn because children that are burnt are likely to turn out like that.

Interviewer: what bothers you about her scars?

Respondent: firstly, her skin complexion won't be even because of the marks, and she will ask me what happened to her and when I tell her what happened she might be hurt because she might think that I neglected her

interviewer: so you were afraid that your child might also turn against you and say you were a negligent mother?

Respondent: yes

Interviewer: what were other things?

Respondent: another thing that bothered me is the fact that she might take a lot of time to walk or not be able to walk at all since she burnt in the same leg that was limping since it broke.

Interviewer: did you have other thoughts, like wonder if she was going to fine or not?

Respondent: yes I did have those thoughts, especially on the first day because her whole body started shaking as if she was shivering from a cold and I even thought that she might die.

Interviewer: who was supporting you when you were thinking about all these things?

Respondent: no, there wasn't anybody. there was another lady in the ward who I

Might have chatted with if I wasn't too much of an introvert

Interviewer: how often did your aunt visit you?

Respondent: I think she visited about 3 times

Interviewer: were there other feelings or thoughts that you were experiencing?

Respondent: there weren't any

Interviewer: was it a difficult time?

Respondent: yes it was a very difficult period indeed.

Interviewer: what do you mean by "very difficult"?

Respondent: it was a very difficult time compared to the period she was in hospital for her operation. She experienced a lot of pain when she was burnt

Interviewer: were you worried about the pain she was feeling all that time?

Respondent: yes

Interviewer: was it easier talking to your aunt at that time?

Respondent: yes, there wasn't anything that had changed.

Interviewer: did the child cry a lot during this time in hospital?

Respondent: she cried a lot during the first few days because she did not even want to be touched.

Interviewer: was it because of the pain she was feeling?

Respondent: yes, she didn't even want food then, all she wanted was her bottle only

Interviewer: as a family (you and your aunt), how do you deal with difficulties such as the operation?

Respondent: I think we put our faith in God

Interviewer: is it only the two of you that make decisions such as having the operation?

Respondent: we were told at Groote Schuur Hospital when I took her there that she had to be operated on her leg and then my aunt and I both agreed that she should be operated.

Interviewer: on this recent incident, who made the decision?

Respondent: we both agreed that she should be taken to the hospital

Interviewer: exactly at the time the incident occurred, where were you?

Respondent: I went to get something at the shop and when I came back the baby was crying and they were undressing her.

Interviewer: who else was there?

Respondent: another lady that lives next door who came to see what was going on since she was alarmed by the child's cries. I quickly took the child from

them and went to run her under tap water

Interviewer: what happened after you put her in cold water?

Respondent: I dressed her in other clothes so that I could take her to the hospital

Interviewer: where was your aunt all this time you were trying to keep the baby quiet?

Respondent: she was next to me

Interviewer: were you shocked?

Respondent: yes because It happened in a short space of time. Because I left a for a short while to get something from the shops and I come back and the baby has already burnt. I tried keeping her quiet but she was crying and wouldn't stop and that also made me cry.

Interviewer: I know you already told me that you not a person of many words, but I will ask you anyway. At the time that you were crying, what were you thinking about that made you cry?

Respondent: I was crying because my heart was sore because I was just imagining the her pain on me since I've been burnt before and know how it feels like to be burnt.

Interviewer: what are other things that you were experiencing? Was your mind clouded by many thoughts?

Respondent: no it wasn't. I just wanted to get to hospital immediately so that she could get something to ease the pain

interviewer: what was your aunt feeling when she was just standing next to you?

Respondent: I wasn't thinking at that time. I was just thinking about the baby so its hard to tell.

Interviewer: what happened after you got to the Day Hospital?

Respondent: we got there and they questioned us about how it happened and the nurses gave her something and called the ambulance.

Interviewer: did both you and your aunt get on the ambulance?

Respondent: no, I got in alone and she followed

Interviewer: were you attended to when you got there?

Respondent: yes they attended to us and they made a new card because I had forgotten her clinic card, but they looked into the computer system and saw that it wasn't our first time there and so they did not ask us more questions. She was then taken to the doctor's unit to wait for the doctor

Interviewer: how long did she wait for the doctor for?

Respondent: about 30 minutes or so

Interviewer: how were you feeling all this time from the point you left Day Hospital, being in an ambulance alone. What were you thinking?

Respondent: I wasn't thinking a lot at the time except that I was going to be scolded by doctors and nurses once I got there.

Interviewer: Did you fear for the child at that point?

Respondent: no, I hadn't started thinking that she might die at that time

Interviewer: was there a stage whereby you felt anger towards your aunt?

Respondent: it wasn't anger as such but the fact that I thought she was just negligent period!

Interviewer: did you tell her about it?

Respondent: no I didn't

Interviewer: was it something that you kept inside yourself?

Respondent: yes

Interviewer: do you still fear for your child when you leave her alone with her?

Respondent: after the accident I used to a lot, but now I'm not scared of leaving the child with her

interviewer: did she notice that?

Respondent: no she did not pick it up?

Interviewer: how would you feel after you've left her in charge of the baby?

Respondent: I would not enjoy myself and would be unhappy wherever I was
Because of fearing she might burn again

Interviewer: when did these feelings go away?

Respondent: they disappeared a lot with time and the months because I came to realize that mistakes happen to everyone and she might burn even when I'm around.

Interviewer: was this something that people told you?

Respondent: no it's something that I told myself

Interviewer: you said that you were scared of nurses shouting at you. What were these fears based on?

Respondent: since she burnt on her operated foot, I thought that they might say I'm very careless and report me to social welfare authorities

interviewer: how did you perceive yourself as a parent?

Respondent: I perceived myself as a negligent mother, but then thought to myself again that I wasn't there, maybe things would've been otherwise if I was

Interviewer: could you please repeat what you've just said?

Respondent: I thought of myself as negligent and I blamed myself for leaving her behind because if maybe if I had taken her with me then she wouldn't have burnt.

Interviewer: how did you feel when the nurses took her away from you at Red Cross?

Respondent: the nurse didn't say much, they just asked how it happened and then they removed her clothes and took her away.

Interviewer: how did you feel after that?

Respondent: my fears of being shouted at were slowly decreasing at that point, but I was just heart broken because of the pain my child was going through

Interviewer: how long was your heart shattered for?

Respondent: for about 2 weeks

Interviewer: after those established fears, what were your other fears?

respondent: I was scared of her questioning me once she was older, thinking that I neglected her as a child, and the fact that her skin might be permanently damaged.

Interviewer: is there hope that these marks will go fade away eventually?

Respondent: yes there is, because doctors said they might

Interviewer: what if they don't fade off?

Respondent: I will just have to explain to her how she got them, and then all will be up to her to say if she thinks I'm a negligent mother or not

interviewer: seeing that she will be starting school soon, do you have concerns of the things that other kids might say to her?

Respondent: I don't have too many concerns because the scars are in hidden places so I don't think they'll notice them easy

interviewer: so that doesn't really bother you?

Respondent: not that much

Interviewer: is there anything that you want to say that I might have forgotten?

Respondent: no

Interviewer: you mentioned that your aunt takes care of the cooking, what about the Cleaning?

Respondent: we share the responsibility

Interviewer: are you the caregiver?

Respondent: yes

Interviewer: who disciplines the child?

Respondent: both of us share that right

Interviewer: when the accident happened, were you scared of what people in your neighborhood might say to you?

Respondent: yes I was scared that they might judge me and say that I'm an irresponsible person. How could I let my child burn and so on

interviewer: did that happen?

Respondent: no because the people were empathizing with me

Interviewer: how are you feeling now, after this interview

Respondent: a lot relieved because yesterday I was just wondering what sort of questions was I going to be asked and other concerns about the interview

interviewer: so you feel a bit of relief, what could still be bothering you then?

Respondent: maybe its still fear because I've never been interviewed before

Interviewer: relax, an interview is nothing to be scared about. I would like to extend My great gratitude for all your support throughout this interview, it has helped a lot. As I've said before, if there is anything that I might have forgotten to mention, then I will just call you. You will be given a report of this interview, sort of like feedback once everything has been finalized

******the end******

University of Cape Town