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**RESILIENCE AMONGST ADOLESCENTS IN A NAMIBIAN
RESIDENTIAL CARE CENTRE: AN EXPLORATORY STUDY OF
WHY SOME YOUTH SUCCEED
DESPITE ADVERSITY**

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SHNSIG002

A dissertation submitted in fulfillment of the requirements for the award of the degree
Master of Social Science in Psychology

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University of 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 according to the APA referencing style 5th edition.

Signature: _____ **Date:** _____

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DEDICATION

Firstly, this research project is dedicated to my mother Sylvi, without whom I would not be who I am today. I admire and respect the resilient strength you carry. Your unconditional love and support has been the foundation for all the accomplishments I have achieved. Thank you for all the considerable sacrifices you have made throughout the years so that I could further my studies.

Secondly, to every child in a residential care facility and to those living without adult control:

"There is always some reason for hope, no matter how desolate one's life may appear"

Chatelaine M.

ABSTRACT

The objective of this mixed-method approach study was to explore and describe key protective factors that contribute to resilience among adolescents in long-term residential care in Namibia. The sample consisted of three caregivers and 61 male and female adolescents between the ages of 11-19 years (mean age=14.45, $SD = 2.26$). Data was collected by means of in-depth interviews and two self-report questionnaires including the Child and Youth Resilience Measure (CYRM) and the Strengths and Difficulties Questionnaire (SDQ). Interviews were conducted with the caregivers and eight adolescents, who were included in the total sample and who were identified by the caregivers to be more-resilient (4 females) and less-resilient (4 males). Additional site-specific questions developed by the researcher based on the qualitative data were incorporated into the CYRM.

Theory-led thematic-content analysis was used to analyse qualitative data under four broad themes, namely: intrapersonal, relational, community and cultural factors. While some themes reflect resilience-promoting factors in vulnerable adolescents as described in the literature, others may be more specific to the Namibian context. The findings suggest that a list of key protective factors contribute to individuals' positive adaptation and adjustment. The results also elucidate a range of barriers to resilience. The quantitative analyses comprised descriptive statistics, correlation and regression analysis.

The overall results showed that significant correlations were found between the CYRM cultural factors, and lower conduct problems, hyperactivity-inattention, and total difficulty scores on the SDQ. These results were only partially consistent with the qualitative results. Possible reasons for this discrepancy are discussed. Findings from the interviewed participants showed that the less-resilient adolescents scored high in the peer- and conduct problem subscales. Scores on the pro-social behaviour subscale were low for a majority of participants, including the more-resilient participants. This suggests a need for intervention. It is also suggested that the resilience construct in adolescents in multi-problem milieus requires further research and context-related interpretation, if appropriate interventions are to be identified.

LIST OF ABBREVIATIONS AND ACRONYMS

BBC	-	British Broadcasting Corporation
BC	-	Before Christ
CBS	-	Central Bureau of Statistics
CHHs	-	Child Headed Households
UN-CRC	-	United Nations Convention on the Rights of a Child
CYRM	-	Child Youth Resilience Measure
HIV/AIDS	-	Human Immune Virus/Acquired Immune Deficiency Syndrome
IRP	-	International Resilience Project
MGECW	-	Ministry of Gender Equality and Child Welfare
MWACW	-	Ministry of Women Affairs and Child Welfare
NAPCP	-	National AIDS Prevention and Control Programme
OAU	-	Organization of African Unity
OHCHR	-	Office of the High Commissioner for Human Rights
OVC	-	Orphans and Vulnerable Children
RCCF	-	Residential Child Care Facilities
SDQ	-	Strengths and Difficulties Questionnaire
SIRCC	-	Scottish Institute of Residential Child Care
TADA	-	Teenagers Against Drug Abuse
UN	-	United Nations
UNAIDS	-	United Nations Global Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Fund for Population Acts
UNICEF	-	United Nations Children's Fund
USSR	-	Union of Soviet Socialist Republics
WCRWC	-	Women's Commission for Refugee Women and Children
WHO	-	World Health Organization

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Overview

The key purpose of this chapter is to introduce the reader to the subject, background and context of the study. Emphasis is placed on identifying key factors that facilitate positive adaptation among adolescents in long-term residential care in spite of having faced multi-problem milieus, such as poverty, parental substance abuse, divorce, abandonment and neglect. The rationale for the study is explained, highlighting the relevance of the research topic. The main research question is also stated. Thereafter, the delimitations, objectives and outline of the study are presented.

1.2 Introduction

For most children, the family is the context within which initial relationships based on love, affection and understanding are developed. The structure and dynamics of families and family life have transformed significantly in recent years. Although the extent of this change has been queried, a diversity of family types exists (Fahey & Russell, 2001). Children are still growing up in two-parent households or with immediate family members, but a number of them are being reared in lone-parent family units and child headed households (CHHs), a situation which is undoubtedly becoming a major national concern.

For a variety of reasons (discussed later in the chapter), an increasing number of children are experiencing separation from their biological families. In Southern Africa, for example, Botswana, Namibia, and South Africa, approximately a quarter of non-orphans live with neither parent (Monasch & Boerman, 2004). Society's interest in their situation is apparent in the number of increasing programme interventions designed to improve their circumstances (Foster, 2002; Ministry of Gender Equality and Child Welfare, 2006; Save the Children, 2003; World Health Organization, 2005). The majority of children

‘without parental care’ and needing ‘alternative care’ are placed in the care and protection of extended family members or non-parental/related adults as often determined by child welfare services. Available literature based on the adverse impacts of diverse family types on children has evidenced that the kind of care a child receives as opposed to the nature of the family unit is of utmost importance, particularly if the child is to develop into a healthy adult. In addition, the economic resources available to the caregiving families are another significant factor taken into account (Hobcraft & Kiernan, 2001). With the sharp increase in the number of vulnerable children, there is widespread local and international concern that responses to childcare provided by non-relational adults is now frequently practised within the settings of what is referred to as ‘institutional’ or ‘residential care’.

Residential care provision for children in need of care and protection constitutes a complex system which varies widely in type, size, management and effectiveness (Subbarao & Coury, 2004). This form of care is guided by different objectives, motivations and perceptions of the needs, nature and roles of children living away from their biological homes. Those providing residential care hold opposing views of how the care system should be organised (Moss, 1999).

The purpose of entering residential care is ultimately to supplant the instability of the adolescents’ home environments considered to constitute a major threat to their safety and development. Residential care is perceived to be a protective mechanism with its potential for full-time supervision and control, and therefore, for containment and influence (Moss, 1999). For some children, it could possibly be a positive life altering model for establishing ones own family in future.

Yet, in many ways, prolonged psychosocial difficulties among children growing up in long-term residential care have been overwhelmingly documented (Bowlby, 1951; Foster, 2003; Pinheiro, 2006; Powell, Chinake, Mudzinga, Maambira & Mukutiri, 2004; Tolfree, 2003). Masten (2002) and Rutter (2000) have observed that residential care denies children the right to a family life. The course of frequently changing residences is

associated with emotional problems such as children sustaining significant loss of connections from usually supportive family and loss of important possessions (Masten, Milliotis, Graham-Bermann, Ramirez, & Neeman, 1993). This acute condition may weaken the protective effect that would otherwise be expected from significant peer relationships. Moreover, residential care has the potential to disturb a child's sense of identity and development of appropriate behaviour. Children growing up in residential care often face social exclusion and rejection by some segments of society (Pinheiro, 2006; Save the Children, 2003). In the vast majority of cases, residential care does not only detach children from their immediate and extended families and their community of origin, but also hinders meaningful interaction with the community in which the care centre is located (Tolfree, 2003).

Social reintegration is another factor that compromises positive adaptation of children. Ultimately, the expectation of residential care is seen to be the prospective return of the child to the family of origin. However, this approach is not a straightforward practice, because biological parents may not be known; they may be strangers to the child or they may not be in a position to have the child back. Lack of access to resources, limited employment opportunities, a threat of returning to high-risk environments, and possibly homelessness, early parenting and substance abuse are other grave factors that youth may be confronted with upon their return into society (Johnson, 1999; Myers, 1992; Save the Children, 2003; UNICEF, 2002). As a result, it has been argued that residential placement should only be utilized when other forms of alternative care such as extended family, community-based, foster care and adoption have failed (Tolfree, 2003).

Despite existing literature suggesting that residential reared children are 'at risk' for developing psychosocial difficulties, their level of functioning varies widely. Even in the harsh realities of their environments, not all of them follow a path of maladjustment and destruction. This study is largely concerned with those adolescents who develop adaptive coping skills and have the ability to convert stressors into opportunities for learning and development (Garmezy, 1993; Masten & Coatsworth, 1998; Werner, 1993). Such adolescents demonstrate 'resilience'. The resilience displayed by such children has given

rise to a pervasive paradox between the evidence of developing vulnerabilities across psychosocial and physical areas of development on one hand, and the evidence of persistence, resourcefulness and creativity on the other (Donald & Swart-Kruger, 1994). Although the processes that contribute to resilience are not well documented and understood, earlier and current studies support the notion that young people are potentially resilient if given the opportunity and that they have the ability to overcome negative experiences in the long-term (Le Roux & Smith, 1998). Literature indicates that children and adolescents' strengths and their ability to overcome adversity may be the result of capacities that are part of their physical and psychological makeup, as well as the existence of supportive environmental variables (Cook & DuToit, 2005; Masten & Coatsworth, 1998). This implies that all adolescents need to experience supportive relationships and be part of an environment that facilitates holistic healthy development and well-being.

1.3 Research Problem

1.3.1 Background of the Study

In 1990, Namibia emerged from a century of colonialism and apartheid to celebrate its long sought independence. After years of war for liberation from foreign rule, Namibia, a young country with nearly half (48.2%) of the population under the age of 18, had to struggle with a painful legacy (Ministry of Women Affairs and Child Welfare, 2002). Although the country has enjoyed political stability and a peaceful transfer of power since independence, the nature of the struggle changed.

To this day, Namibia is experiencing enormous impacts on families and communities brought about by political, economic and social transformation. The economy is primarily based on the use of natural resources such as farming, mining, fishing, and tourism. In spite of the significant number of people employed in these industries, the country bears a high unemployment rate of 31% among young females. Even more revealing measures of

inequality are gaps in the empowerment and education for women and girls as well as unequal power relations between men and women (UNDP, 2005).

Income is unequally distributed as revealed by the Gini index of 70.7. More than 50% of the population had a daily income of less than US\$2 between the periods of 1990-2003. In terms of the ratio between the rich and the poor, 78.7% of the income or consumption is produced by the richest 20% of the population (Central Bureau for Statistics, 2003).

The population composition is changing significantly, with a decline in infant and under-five mortality rates, and slowing population growth as a result of lower fertility and life expectancy due to the HIV/AIDS pandemic (CBS, 2003). Hence, many children have become orphaned, while simultaneously, a significant proportion of children are not orphans but require care as orphans and vulnerable children (OVC). The concepts of orphans and vulnerable children are social constructs that vary from one culture to another, and in addition, take on different definitions. Local and international organizations have variously defined OVCs under different age groups encompassing different indicators of vulnerability. For purposes of this study, OVC is defined as a child below the age of 18 years who has lost one or both parents or lives in a household with an adult death. This definition also includes children who are destitute from causes other than HIV/AIDS (MGECW, 2006).

To meet the needs of these OVCs, immediate and extended families have usually been the first line of social care provision and more often responded to family adversity. However, as deepened poverty (the single most important factor contributing to the admission of children in residential care), the HIV/AIDS pandemic, and family conflict spread, the number of OVC is escalating. These factors have emerged as among the greatest threats to positive childhood and adolescent development (Kia-Moon, 2007; Pinheiro, 2006; Save the Children, 2003; UNICEF, 2006). Alcoholism, another recognised social problem in Namibia and the appropriation of family inheritance, in relation to poor families, are also known to increase children's vulnerability (MGECW, 2006). Children's property and inheritance rights are violated when they are denied the

possibility to benefit from the property of their parents or from the property that they have acquired through their own labour. The consequence of these property confiscations and abuses is that thousands of orphans become destitute and vulnerable to mistreatment, including forced labour and prostitution. Other factors include unemployment, imprisonment of parent (s); divorce; single parenting (particularly absent fathers); loss of, or separation from parents and relatives resulting from death (single or double-orphan); physical, sexual, and psychological abuse; neglect or abandonment.

As a result, the extended family is placed under increasing stress as the orphan crisis, street children, child headed households (CHHs), working children and school drop-outs rates unfold. The number of relatives available within any given family is decreasing rapidly as adult mortality increase and numbers of children in need of care and protection become unmanageable (Cook & DuToit, 2005; Foster, 2003; Haihambo, Hayden, Otaala & Zimba, 2004; McDaniel & Zulu, 1996; MGECW, 2006; UNICEF, 1996). This has led to a situation where children are growing up outside their family of origin, creating an overwhelming challenge for the Namibian government as the state's resources and ability to develop a full range of child welfare services is affected. Therefore, alternative forms of residential care arrangements have been established (such as places of safety, shelters, orphanages, children's homes and villages) for children in need of care and protection (Save the Children, 2003; Subbarao & Coury, 2004; UNICEF, 2005). Although a changing society brings about a wealth of new opportunities for development in all sectors of society, it equally brings about various stressors. These transformations are also permeating the lives of adolescents, who are exposed to environments characterised by potential difficulties, in addition to their developmental (physical, cognitive, affective, social, and emotional) challenges (Le Roux, 1992).

In response to the deep-rooted socioeconomic crisis that is affecting the social fabric of the country, the Namibian government, akin to many other African nations, has placed high priority on the well-being of children and youth. To address the legal framework, human rights, growth, well-being, care and protection of Namibian children and young people, the country has established extensive strategies, laws and procedures. These

include the Child Status Act of 2006, the Child Care and Protection Amendment Bill which replaces the Children's Act 33 of 1960, in which a range of new provisions for child welfare functions are regulated (MGECW, 2006). The MGECW also launched a new project in 2009 'the Minimum Standards for Residential Child Care Facilities' (RCCF). These standards of care are approved criteria for measuring and monitoring the management, provision and high quality residential care for Namibian OVC. At an international and regional level, the Namibian government strives to make its responses to the care and protection of children in accordance with the principles of the United Nations Convention on the Rights of the Child (UN-CRC) and the African Charter on the Rights and Welfare of the Child (CRC, 1989; OAU, 1990). These standards are now incorporated into official national OVC policy and services (MGECW, 2006).

The policy accentuates the significance of family and community-based care (as first options) and regards residential care as a last resort for addressing children's care needs. The policy further emphasises that residential care should serve as temporary placement while alternative care that adequately meets the needs of children and youth growing up in disadvantaged environments is being sought. The rationale is based on concerns of the adverse effects of long-term residential care on children's social and psychological development, and the high costs of raising a child in residential care relative to family setting. This has been well documented in some western nations and has led to the deinstitutionalization of this form of care (Rutter, 1982).

Despite longstanding evidence of the detrimental effects of residential care on children and young people, this form of intervention remains the easiest option for child welfare workers (Powell, et al., 2004). The 'mushrooming' of these care facilities, in particular, private organizations is derived from the view that care for OVC in residential care is the ideal course of action. It is also suspected that profit might be the motive. The number of children placed in non-registered child care facilities is unknown. Hence, their services are unmonitored by the government (MGECW, 2006).

1.3.2 Context of the Research Site

This study investigates a family-like residential care setting, where children grow up in conditions comparable to those in 'normal families'. Children of all ages and gender become brothers and sisters, and biological siblings are encouraged to live together. A group of 10-20 houses forms part of this family-like setting and each house is headed by a trained caregiver (mother) who takes care of about 8-10 children. This family-based residential setting adopted a policy that prefers older and mature women who had raised their own families as opposed to employing young, single women with no training or experience in child care. The willingness of women caregivers to care for children is consistent with their general participation in a variety of caregiving roles. The caregivers' biological children and husbands/partners do not live in the home. A possible explanation is that the caregiver might favour her own children. Another concern could be that the husbands/partners might abuse the older female adolescents. Two male role models - the head of the institution and the child/youth project coordinator - were designated to serve as father figures for 120 children. Lack of a father figure could be a concern, especially for the socialization of male adolescents (SOS-Kinderdorf, 2005; Subbarao & Coury, 2004). The caregivers' biological children are often placed in the care of significant others, and are visited by their mothers on their days off (usually 4 days per month) (SOS-Kinderdorf, 2005).

The study is largely concerned with resilience amongst young people who are placed in residential care as a result of their families' inability to care for them as defined by society's agencies of control (for example, the social welfare departments, children's courts, etc.). Moreover, the study examines the difficulties experienced by the adolescents as resiliency does not denote 'invulnerability' to negative outcomes. A wide range of protective factors associated with resilience are examined across four significant aspects of adolescent life (individual/personal traits, family relationships, community and cultural factors). Furthermore, the study evaluates whether key protective factors identified in this sample are unique or similar to those identified in the literature. Both similarities and uniqueness are important: similarities indicate universal human functioning, whereas

unique findings can be used as a guide in designing and promoting specific intervention and prevention strategies for vulnerable children and adolescents. Emphasis is placed on how these factors may interact to influence positive outcomes in individuals developing in 'abnormal' circumstances, within their socio-economic and cultural contexts. Key to this process is to ensure that the rights of children in residential care are guaranteed as guided for by the Convention on the Rights of the Child (CRC). Instead of children being objects of socialization, it is important to actively involve them with their world in efforts to improve their own lives and to learn from adults within their communities and culture. This can help develop their sense of self-esteem, sense of control, self-efficacy and a healthy collective identity.

1.3.3 Rationale for the Study

Motivation to conduct the study occurred on both a personal and professional level. Particularly influential were my personal circumstances and experiences that have significantly impacted on my life. Professionally, as a psychology student (with an interest in working with young people), most of the academic books and articles I have read dealt with adolescent development, health and well-being. Through past and current findings in the literature, I became aware of the extensive focus placed on identifying and treating deficits/pathology. While this remains important, health care paradigms have shifted and began to recognise strengths in individuals (Antonovsky, 1979). While there is information on OVCs in Namibia, focus was on the provision of basic needs. However, in the context of limited resources, I was alarmed at how the government was challenged in meeting the needs of this increasing and potentially vulnerable group; at the same time, facing challenges of poverty reduction, employment creation, as well as the street children and CHHs phenomena.

The study was further motivated by the fact that available literature in this field of study focused on children and adolescents in the USA and European societies, and therefore, offers perspectives that may be specific to those societies. While useful as a starting point, study findings generated from these developed nations may not systematically

describe, analyse and document the resilience and residential care phenomenon of most African or Namibian adolescents in residential care. This leaves little more than an anecdotal picture of how this phenomenon manifests in practice, generally, and in particular, among adolescents. Many African youth have to deal with the severity of HIV/AIDS, coupled with mounting socio-economic problems that have a profoundly negative impact on the well-being of young people growing up in the midst of this crisis (Chigunta, 2002; Save the Children, 2003). Taking into account the paucity of information on this topic, this form of family setting is still rather peculiar and an uncommon research phenomenon in Namibia. In addition to contributing to the country's child welfare policy system and the designing of interventions, providing an outlet for children's concerns, hopes and dreams was a definite motivation.

The zeal for this growing awareness has led to my asking the main question in this research study: Why are certain adolescents able to rise above significant duress while others are not able to manifest this level of functioning?

1.4 Delimitations of the Study

The intent of this study is not to:

- evaluate causes or changes within individuals' contexts,
- attempt to develop a hypothesis by which all experiences of adolescents in residential care facilities may be explained or
- develop a resilience-building-intervention programme

This research study makes a contribution to our understanding of the resilience concept and key factors that contribute to or promote resilience in adolescents living in residential care, while involving children and their caregivers in the production of knowledge and solutions. The examination of resilience can assist child welfare workers to put as much effort in assessing and recognizing strengths and promoting competence as they have traditionally focused on the detection of deficits and the 'fixing' of problems. Given that this phenomenon has received limited attention in the literature, particularly across

Southern Africa, an in-depth understanding should precede taking action. The findings can offer an important opportunity for guiding prevention and intervention strategies aimed at improving children's lives. The findings of this study can also provide information that can enhance the psychological health and well-being of as wide a population of young people as possible to aid the cultivation of productive adults.

Failure to care for, and protect this vulnerable group would undermine existing national policies, and further contravene the CRC. It is also hoped that the study findings would benefit other residential care centres and schools, as it could serve as the basis for further research in this field.

1.5 Objectives of the Study

The study primarily aimed to:

- Gain a deeper understanding of the resilience phenomenon, generally and within a residential institution in the Namibian context.
- Demonstrate that some children who live under conditions of poverty or hardship have the capacity to develop healthy coping strategies, supportive networks and competencies.
- Identify protective factors - qualities that are influential in shaping adaptive passageways for young people, subsequently contributing to resilience.
- Ascertain what challenges children in residential care face, which have the potential to inhibit their ability to adapt well in the face of life stressors.

1.6 Outline of the Dissertation

This dissertation is a work in five chapters. This chapter has presented a description of the background and rationale of the study. Chapter Two, the foundation on which the study is based, provides an in-depth review of significant literature related to the contextual framework of this study. Chapter Three discusses the research design, and gives details of the methods employed for data collection. Data analysis procedures are

also presented. In chapter four, the findings of the qualitative and quantitative analyses are reported. Finally, chapter five provides an interpretation and discussion of the results presented in chapter four in relation to existing research and theory. The findings and conclusions reflect how the researcher attained the objectives of the investigation, as outlined in chapter three. Thereafter, limitations of the current study are discussed. This chapter concludes with a summary of recommendations for future research.

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CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.1 Overview

This chapter attempts to integrate, summarise and evaluate early and recent literature on resilience and adolescents living in residential care. It begins with an in-depth discussion on the resilience concept, and the protective factors identified (based on the ecological framework) that enable adaptive functioning. Following this discussion is an introduction to adolescence and adolescent development. Central themes relating to adolescent development are also presented. This includes critical theories of adolescent development; developmental changes during adolescence; and developmental tasks of adolescence. The review then explores experiences of adolescence as shaped by the African context. The residential care setting – the history of residential care, its nature and extent- and why children grow up outside family environments are examined. Theoretical arguments and empirical studies explaining the impacts of long-term residential care on child and adolescent are also presented. The chapter concludes with a summary of the main themes relating to resilience and adolescents in residential care. Finally, key limitations of past research on resilience are outlined.

2.2 Resilience

2.2.1 The Concept of Resilience

The roots of the resilience concept can be found in two bodies of literature: the psychological aspects of coping and the physiological aspects of stress (Tusaie & Dyer, 2004). Like most psychological constructs, the resilience construct is difficult to define because it cannot be observed or measured directly. Attempts to understand this concept have been hampered by a lack of consistency in its basic definition, the non-comparability of sample groups across research settings, the ad hoc nature of risk and protective factors, and the discrepancy that exists between individuals who view resilience as an outcome, a personal attribute, or a transactional process (Freitas & Downey, 1998; Luthar, Cicchetti & Becker, 2000; Rutter, 1993). While there

is no universally accepted definition of resilience, it is widely agreed upon that a working definition includes two common markers:

- Exposure to a significant threat or severe adversity
- Achievement of successful adaptation despite significant odds or debilitating adversity (Garmezy, 1985; Luther & Zigler, 1991; Masten, Best & Garmezy, 1990; Rutter, 2007; Werner & Smith, 1982; 1992).

Researchers adhere to this 'health-despite-adversity' definition as it is considered both functional and dynamic. It implies the successful performance of developmental tasks by virtue of a complex interaction between risk and protective factors (Luthar et al., 2000; Masten & Coatsworth, 1998; Minnard, 2001). Children are not immune to continual risks and their reactions to stressful events in adulthood are not definite (Higgins, 1994; Garbarino, 2000; Werner & Smith, 1992). Nonetheless, several studies have deemed some children as 'resilient' in the face of adversity and they emerge from childhood as psychologically healthy and socially competent (Anthony, 1987; Grotberg, 1995; Masten, Best & Garmezy, 1990; Rutter, 2007; Ungar, 2004; Werner & Smith, 1982). Equally important is that children have the capacity to unremittingly amend their responses to stress (Rutter, 1989). Masten and Reed (2002) found that if the development of the child is healthy and the systems surrounding the child are protected (even in the face of severe adversity and risk), the risk for developmental problems may be reduced and normal development may be robust. However, if the systems are impaired, and risk experiences are intensified by subsequent experiences, the child may succumb to maladaptive functioning.

Although early research characterised resilience under the 'coping' phenomenon, current research places greater emphasis on identifying cognitive and behavioural efforts children employ in order to manage stressful situations (Curtis & Cicchetti, 2003). Accordingly, even within comparable conditions and environments, individuals display a diversity of responses to events (Masten, Best, & Garmezy, 1990). However, the outcomes vary in terms of an individual's vulnerability to risk and in terms of protective factors which may reduce risk

(Kolvin et al., 1990; Masten, 1994; Rutter, 1985). Heller, Larrieu, D'Imperio and Boris (1999) add that there is no single risk factor which predicts a specific outcome. Yet, the occurrence of multiple risk factors to which an individual is exposed appears to be an important factor related to outcomes. Rutter's (1979) study found that the presence of two or three risk factors resulted in an increase in the rate of psychiatric disorders by fourfold while exposure to four stressors increased distress by tenfold (Rutter, 1979; Turner & Lloyd, 1995).

Further analysis of study findings revealed that a relatively small portion of individuals display competence in all indices of human functioning. For most, resilience is observed in specific areas. Characteristics associated with resilience may not necessarily be 'positive' traits, and may be maladaptive in other contexts or other periods of the life span (Garmezy, 1987; Luthar & Zigler, 1991; Werner, 1992).

For purposes of this study, the following criteria identified by Luthar, et al., (2000) and Ungar (2006) are used to define resilience: Firstly, it is the capacity of the individual to navigate resources that sustain well-being and the ability of the individual's family, community and culture to provide and negotiate these resources in culturally meaningful ways. Secondly, it includes an interrelated dynamic process of internal and external adaptation. Thirdly, average functioning is accepted as sufficient for the less-resilient and superior functioning qualifying for the more-resilient. Lastly, resilience is assessed on multiple outcomes rather than on a single outcome. Emphasis is not only placed on identifying stable characteristics of the child or the environment in the face of adversity but also on the individual's ability to recover or adapt after a period of disorganization. It is this process of navigating and negotiating resources that connects individuals and their ecosystems in a dynamic process of human adaptation and well-being.

2.2.2 A Historical Perspective on Resilience

Displeased with the traditional approach of focusing on why things go wrong, researchers seeking to promote youth development based on a healthy developmental approach began asking "why is it that some children raised in miserable conditions make it, while others do not?" "What

is right with these children?" "How can we help others to become less vulnerable in the face of life's adversities?" (Werner, 1999 p. 569-570). These kinds of questions led to an attitude shift away from pathogenesis to salutogenesis which recognizes strengths rather than deficits (Antonovsky, 1979; Fergus, & Zimmermann, 2004).

The salutogenesis paradigm which is rooted in clinical literature: psychiatry, psychology and social work departed from problem-focused practices and research with children at-risk to positive outcomes of children who, against expectations, develop well within the context of life's adversities (Masten & Reed, 2002; Werner & Smith, 1982; 1992). Meanwhile, the pathogenesis paradigm is concerned with determining factors which cause abnormality in people and does not take into account individual healing processes. The fundamental question asked by this traditional approach is limited to "why do people fall ill and why do they develop specific illness entities?" (Strumpfer, 2001 p. 3).

Factors that result in adaptive outcomes in the presence of adversity were initially studied in the early 1970's when researchers in the area of child psychopathology were primarily concerned with children of schizophrenic mothers at risk of serious psychopathology (Masten et al., 1990). Researchers discovered that schizophrenic mothers with the least severe causes of illness were characterized by a premorbid history of relative competence at home; work, social setting and the capacity to fulfil responsibilities. Studies of children of schizophrenic mothers who thrived despite their being at measurable risk led to an increase in efforts to understand individual variations in human behavioural responses to challenges (Garmezy, 1974; Luthar et al., 2000; Masten et al, 1990).

Following Werner, Bierman and French's (1971) and Werner and Smith's (1977) groundbreaking longitudinal studies on children in Hawaii, research on resilience expanded to take into account multiple adverse circumstances. Such risks encompass environmental factors (e.g., family instability, poverty and community violence, low maternal education, low socioeconomic status, delinquency and criminality, substance abuse, teenage pregnancy); biological factors (e.g., genetic disabilities, parental mental illness, chronic illness, prenatal

complications) (Masten & Coatsworth, 1998); and traumatic or catastrophic life events (e.g., maltreatment, natural disasters, war, homelessness, sudden loss of a significant other) (Luthar et al., 2000; O'Dougherty-Wright, Masten, Northwood, and Hubbard, 1997). These studies served the purpose of systematically identifying protective factors - those forces which differentiated children who attain healthy adjustment profiles from those who do not (Luthar et al., 2000).

Early research was essentially focused on personal or 'innate' qualities (intelligence and sociability) of children who appeared particularly stress-resistant and demonstrated successful adaptation despite exposure to adversity. This research implied that there was something extraordinary about these children. They were described as "*resilient kids*", "*thrivers*" "*super and invincible*", "*invulnerable*", "*stress-resistant or resilient children*" or "*simply beating the odds*" (Masten, 2001 p.221; Werner & Smith, 1982). These notions inferred invulnerability to risks as fixed and absolute across most life situations. As research evolved, the concept of resilience has changed over the years from an absolute or global construct to a relative construct. It became clear that positive adaptation despite adversity involves new vulnerabilities and strengths which often emerge throughout a person's life (Werner & Smith, 1982). As noted earlier, researchers acknowledge that certain characteristic that foster resilience may derive from factors within the broader ecological system. These multiple systems interact and operate across time at a level of ordinary human development to prevent, minimise and overcome severe adversity (Garmezy, 1993; Masten & Reed, 2002; Werner & Smith, 1982). Characteristics of these systems are detailed in the following section.

2.3 Protective Factors Associated with Resilience

While risk factors hinder resilience, protective factors foster the development of resilience. Protective factors are factors within the child, in the child's environment and the interaction between these factors that give the child strength, skills and motivation to cope in difficult situations and re-establish a normal life (Gunnestad, 2006). The defining feature of protective factors is that they moderate relationships that exist between stressors and psychological well-being such that the individual can manifest competency or healthy adaptation (D'Imperio,

Dubow & Ippolito, 2000). Losel and Bliesener (1990) note that the effects of protective factors as shown in their interaction with risk, do not in themselves yield resilience. For example, efforts by a parent or significant other to foster adjustment may not be sufficient if the vulnerability of the individual or the severity of the adversity is too great to overcome (Masten et al., 1990).

A number of studies have identified a triad of key protective processes or mechanisms that decide how much resilience a child will develop (Govender & Killian, 2001; Luthar, 1999; Mampane, 2004; Masten, et al., 1990; Werner & Smith 1992). These are: (i) internal predictors - those factors intrinsic to the adolescent; (ii) interpersonal factors - family relationships; and (iii) external factors, those from the environment (such as the school, church and community) which youth might be connected to, that reinforce and support positive efforts made by the child (Masten et al., 1990; Werner & Smith, 1982). Gunnestad (2006) has grouped the sources of resilience into three groups: 1) Network factors – external support; 2) Abilities and skills – internal support; 3) Meaning, values, and faith – existential support, meanings and understanding that a child attaches to his/her faith and values. Regardless of how the protective factors are categorised, there appears to be a consensus as to which protective factors are most important (Grotberg, 1995; Gunnestad, 2006; Masten & Coatsworth, 1998). Depending on the individual and situation confronted, the protective factors operate together in different ways and they affect each other.

2.3.1 The Ecological Model

Bronfenbrenner's (1979) bio-ecological model provides a useful framework for understanding these protective factors. The model conceptualises adolescent development as a process which takes place within the micro-, meso-, exo-, and macrosystems. Microsystems are the immediate social contexts of everyday life, such as the family, peers, school and recently noted by Wachs (1996) is the adolescent workplace. The mesosystem links the relationships between different microsystems that the child inhabits, for instance, how what goes on at home affects the child's school performance and vice versa. The exosystems refers to features of the environment that affect a child's development but that are not directly encountered by the child; for example, a

parent's work place and the mass media. The macrosystems include the broader social context such as cultures, subcultures, and social institutions involved in child upbringing. Bronfenbrenner included a fifth system to this model – the chronosystem, which adds the dimension of time, change and constancy across history and the life course. A sixth level – the physical ecology system (e.g. climate) was added to the ecological model by Wachs (2000). The latter system considers the effects of the physical environment on psychological development. The roles and relationships between these multiple levels are interdependent and interacting, and they form the basis of daily interactions between the adolescent and the social environment, which over time, shape individual development (Donald et al., 2002; Wachs, 1996). Furthermore, because these contexts are embedded in a multilevel environmental structure, this suggests that changes in family, societal and cultural patterns can greatly influence adolescent development in multiple ways.

2.3.1.1 Internal Factors

Masten et al., (1990) identified individual protective factors that include self-esteem and internal locus of control - feeling confident that one's own efforts will produce desired effects (Werner & Smith, 1998). Such attributes have been shown to help children and adolescents hope, self-regulate, plan ahead and set personal goals. The authors reported that the most consistently identified positive factor impacting adaptation at all ages is an internal locus of control. Moreover, the presence of planful competence (which refers to a sense of making conscious, future-oriented decisions about life's events) distinguishes children and youth with healthy adaptation profiles from those who succumb to life's circumstances (Rutter, 1989). Werner and Smith (1982) documented the results of their highly regarded longitudinal study investigating the long-term effects of risk factors such as poverty, parental psychopathology, and perinatal stress. The findings pointed to strong personal skills such as an easygoing, sociable temperament and cognitive skills as commonly associated with competence, especially in an academic environment. The link between cognitive abilities, social competence and school performance appears to be especially important as it relates to furthering self-confidence and self-esteem (Heller et al., 1999; Masten, 2001). The capacity to think critically and reflectively has been

shown to help guard adolescents from simplistic face-value interpretations or self-defeating reasoning (Garbarino, Kostelnly & Dubrow, 1991). Other protective factors include a sense of coherence and humour. Rutter (1990) and Luthar and Zigler (1991) noted that resilient children use humour to generate comic relief and reduce stress. Domain activities (such as hobbies, participation in sports activities, and interests in religious faith or spirituality) further serve as potential protective factors. In essence, internal resources (temperamental factors and cognitive abilities) enable a child to receive positive reinforcement and successfully transit into subsequent developmental stages.

2.3.1.2 Interpersonal Factors

Social relationships among family members are perhaps the best documented factors associated with positive behaviour change in children and adolescents (Masten, 2002). Secure attachment in infancy, along with good quality parent/adult-child relationships in early childhood contributes enormously to shaping a stable internal representation of the self and in creating a resilient developmental trajectory. For instance, research has established that parental support decreases the risk of depression in early adolescence, while depression is more likely to wear away supportive relations with peers during this period (Franz, McClelland & Weinberger, 1991; Masten, 1994; Turner, S. 2000; Werner & Smith, 1982).

In today's society however, the mother has become one of several caregivers, consequentially, the child's attachment bond has become dispersed (Mann, 2001). Turner, S. (2000) argues that adolescents raised by responsive adults, who set clear rules and consequences for rule violation, assist the child in developing healthy social functioning. Similarly, children of parents or adult caregivers who exercise appropriate authority and monitoring, communicate high expectations and facilitate school attendance and academic achievement, as well as engage in joint decision-making, are more likely to be well adjusted (Miliotis, Sesma, & Masten, 1999). Moreover, the literature has demonstrated that resilient children feel unconditional acceptance and approval from family and friends and are continually provided with new opportunities to explore (Boyden & Mann, 2005).

In families with very few advantages, parents or caring caregivers who limit children's exposure to high-risk surroundings create a protective environment against perilous stressors and the child's personal strength is likely to emerge (Scudder, Sullivan & Copeland-Linder, 2008). Greef and Le Roux (1999) and Killian (2005) argue that there is sufficient evidence to suggest that families living in economic destitution can serve as role models for their children, if good inter- and intrapersonal relationships exist. Such families play a vital role in helping the at-risk youth population to interpret, process, adjust and overcome complex life circumstances (Dawes, 1992; Richman & Bowen, 1997). As adolescents move towards adulthood, nurturing and maintaining meaningful relationships become salient predictors of their functioning (Scudder, Sullivan & Copeland-Linder, 2008).

2.3.1.3 Support Factors

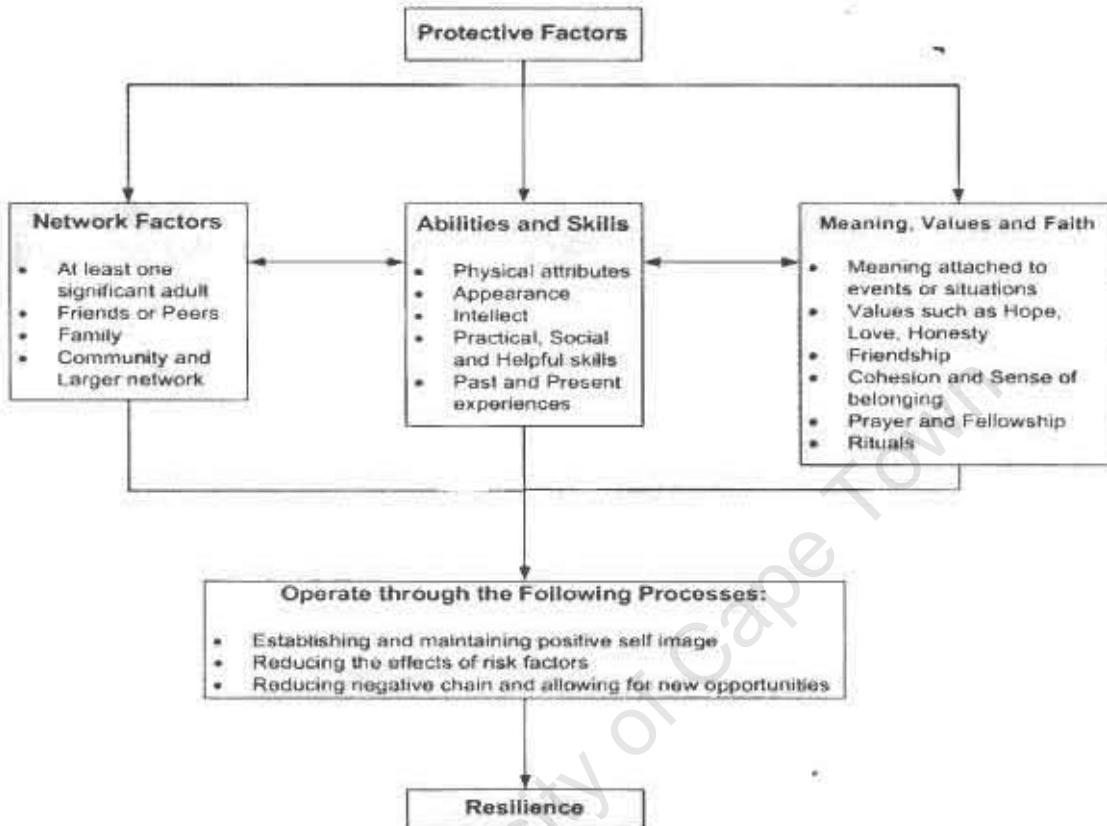
Research has shown that a social support network beyond the family generally plays an important role in limiting children's vulnerability to risks and in helping to build and support their resilience (Turner, M. 2000). These support systems may come from a variety of sources (Werner, 1990). Support from peers and teachers have been shown to enhance children's self-esteem. Positive peer relationships provide adolescents with opportunities to be themselves and to feel a sense of belonging, whilst teachers facilitate an arena of support characterised by praise, motivation and developmental opportunities (Cauce, Felner & Primavera, 1982; Werner, 1990). Hayes and Kernan (2001) and Garmezy (1987) note that educational success is a determining turning point in individuals' lives. However, low academic achievement does not in itself lead to a negative self-concept. It is the adolescent's external networks that can help foster protection or increase risk. Research has further documented the positive role of neighbourhoods and organised community groups and programmes in supplementing protective factors at the individual level by providing a supportive context (Boyden & Mann, 2000).

There is also considerable evidence that the social settings and the moral environment provided by churches and religious organizations help to protect children from the negative effects of stressful situations (Gunnestad, 2006; Masten, 1994; Turner, S. 2000). These findings provide

substantial consistency with a cross-cultural study conducted in Southern Africa and Norway by Gunnestad (2006). The study found that faith/prayer appeared to be a common protective factor in Southern African families. The study further reported that existential support does not only influence the values and faith beliefs a child adheres to or whom a child will identify themselves with, but is also likely to influence a child's choice of people with whom to interact.

While the above factors may be necessary, they are not sufficient to fully understand resilience and they do not produce resilience in all high-risk contexts whatever their characteristics (Cicchetti & Toth, 1997; Gunnestad, 2006). The role of risk and protective factors requires a complex system of not only understanding the contexts in which the individual lives, but of how the identified protective factors initiate the processes through which resilience is created. Rutter (1990) proposed three such processes: (1) Building and sustaining a positive self-image, for instance, a child can feel good about him/herself when they successfully carry out tasks through the use of their skills, abilities and talents; (2) reducing the impact of the risk factors, either by changing the meaning of the risk for the child or changing exposure to the risk. For example, having a good relationship with a significant adult; (3) reducing negative change reactions and allowing for new opportunities. For example, establishing intervention strategies that support children's competencies, as well as providing information networks that can serve as models that respond to children's challenges. Although it was beyond the scope of this study to detail these processes, figure 1 below contributes to our understanding of how resilience can be created and enhanced.

Figure 1: Model Process for Developing Resilience (Adapted from Gunnestad 2003)



Culture is what links the three main groupings of protective factors, particularly the third group of protective factors – meaning, values, and faith. Culture is a way of life. It encompasses values, norms, rules, and ideas that are passed on from generation to generation. Every generation interprets, adapts and applies these diverse ways of living to their own lives and society. Due to the globalisation process, changes in culture are accelerating (Gunnestad, 2006).

In this world of cultural change, we need to understand how culture can foster well-being and survival of individuals. Therefore, in efforts to understand and promote resilience across cultures, there is a need for studies in diverse populations (Ungar et al., 2007). Wyman (2003, p.314) cautioned that “processes that are beneficial to children in one context may be neutral, or even deleterious, in another”. However, few studies have systematically investigated resilience as culture-dependent. Where studies do exist, it is suggested that planful efforts be made to

develop measures which include ethnic considerations, but which are directed at common features of coping among the youth, families, and communities across population groups (Gunnestad, 2006; McCubbin, Thompson, Thompson, & Fromer, 1998; Werner & Smith, 1982; Ungar et al., 2007). This demonstrates that resilience develops as per the contextual needs and experiences of people. However, some cultural practises and a dissolving culture can lead to increased vulnerability or less resiliency. In Southern Africa, cultural practices such as witchcraft can lead to increased vulnerability or decreased resilience. It generates a sense of fear and confusion in both children and adults (Gunnestad, 2006).

2.4 Adolescence: A Critical Phase of Life

Adolescence has been considered a separate phase of development since the 19th century (Graham, 2004). This period of life is largely viewed as a unique and critical phase influenced by a variety of factors, many of which are predictable and uncontrollable (Moos, 1979). The word 'adolescence' began to be used as early as the twentieth century (Graham, 2004) and several definitions of this term have been coined within different societies. It is generally used to refer to a transitional period of rapid growth between childhood and adulthood (Atwater, 1983) in which individuals experience major physical, cognitive and socio-affective changes (Dumont & Provost, 1999). There are no precise universal age boundaries which mark either the beginning or exit point of adolescence (Gouws, Kruger, & Burger, 2000). The WHO (1998) identifies adolescence as the period of life between the ages of 10 and 19 years. Chaplin (1985), on the other hand, defines the approximate age span as 12 to 20 years for girls and 13 to 22 years for boys, with physical changes occurring almost two years earlier in girls than in boys (Tanner, 1962). One of the reasons for this variation is that adolescence has as much to do with socio-cultural conditions as with biological changes (WHO, 1998; Gouws, et al., 2000). For the purposes of this research study, adolescence is defined according to the above-mentioned definition by the WHO.

This crucial developmental phase has been traced as far back as the years of Plato and Aristotle who characterised adolescence as a developmental stage when many are prone to endless

arguments and exaggeration, lacking in sexual self-restraint, erratic in their desires, passionate and impulsive, and fonder of honour and victory than of money (Aristotle, 1941 in R. McKeon; Plato, 1953). It is during this life stage so profoundly experienced and so wide open to choices that adolescents become sexually active, begin to assert themselves socially, and engage in negative behaviours and negative role identities (such as involvement with delinquent groups and school malingering) (Resnick, & Burt, 1996). Other major changes that occur at varying rates include intellectual development, changes in self-concept and body image, career opportunities, new recreational activities, and the adoption of several role identities before making a conscious commitment to a set of values and abiding by them (Burt, 2002; Coates, Petersen, & Perry, 1982).

In the past, the adolescent phase of development was perceived as inherently a time of storm and stress. The turmoil theory of adolescent development was accepted as universal and inevitable to the extent that its absence signified psychopathology (Freud, 1958). Until approximately the 1980s, research on the innumerable stress factors and stereotypical portrayals of this age group supported some of the contentions of earlier adolescent researchers (Petersen, & Hamburg, 1986). However, social construction and views of adolescence have changed to a certain extent in recent years. These changes are discussed below.

2.4.1 Re-assessing Adolescent Development

The theoretical perception of turmoil perceived as inherent to adolescent development has evidently and consistently been modified by taking into account individual differences and cultural variations (Arnett, 1999; Hall, 1904). Petersen and Hamburg (1986 p.481) point out that in order to understand why some adolescents seem to be “disruptive, unruly and out of control”, it is essential to view them within diverse developmental contexts because in all but a few dimensions, they are “simply coming to be like the group they are growing towards - adults”.

It is now recognized that major turmoil and turbulence is more likely during adolescence than other life periods (Arnett, 1999; Coleman & Hendry, 1990; Petersen, 1988). Recent research

presents a reconsidered view of adolescence as a period of transition which demands new forms of adjustment; new specific problems faced and new coping requirements (Coleman & Hendry, 1990; Olbrich, 1990). Beside troubles at school and failure to cope with developmental tasks, other problems are located in the adolescents' social relationships and interpersonal activities. Adolescence brings an increase in parent-adolescent conflict evident in early adolescence and mood disruptions during mid-adolescence (Paikoff & Brooks-Gunn, 1991). Research has shown that adolescents experience more volatile and negative emotions than their parents or younger peers (Larson & Richards, 1994). Studies have also shown that adolescent involvement in various risky behaviours such as irresponsible sexual activities, substance abuse, reckless driving, and suicide peak during late adolescence and early adulthood (Arnett, 1992; 1999). It is usually in combination that the above mentioned key issues create a discernable view of adolescence as a difficult time. Nevertheless, there is also evidence that many adolescents cope well during this life transition. They delight in many aspects of their lives and they are optimistically expectant and hopeful about the future (Graham, 2004).

The adolescent stage of development is stereotypically characterised as a universal time involving a great deal of change – change in every facet of growth and in every social context within which an individual functions. One cannot begin to understand any developmental aspects of this age group without insightful information on the key theories of adolescence from different disciplines; developmental tasks or expectations and developmental changes of adolescents. These changes tend to be sporadic and relatively rapid, as opposed to smooth or synchronous (Petersen and Hamburg, 1986). Each area of developmental change is inextricably interconnected to other areas in a number of ways. Hence, these aspects are discussed in subsequent sections below:

2.4.2 Theories of Adolescent Development

Theories of adolescence are diverse. Each discipline describes and understands adolescents differently. It should however be noted that there is no single theory that captures all the developmental aspects of adolescence. With the discovery of new information, many theories are

modified accordingly. The **Biological theorists** believe that positive or negative negotiating through adolescent development into adulthood is hereditary or genetically determined (Atwater, 1983). The **psychoanalytic theorists** see adolescent development as a period ruled and determined by driving forces of personality - the id - "the unconscious reservoir of psychic energy derived from biological instincts which are primarily sexual and aggressive in nature", the ego and superego. The dynamics of personality development in adolescents largely depend on how these sexual instincts have been shaped during the formative years of childhood (Atwater, 1983 p.23; Burns, 1988). The **Psychosocial theorists** give prominence to the social, environmental and interpersonal relationships between the adolescent and his/her environment (Erikson, 1963). Erikson's ego-development theory characterises development through eight major life stages and at each stage conflicts between needs or feelings and the environment must be successfully resolved for healthy development. Of particular relevance to adolescence is the period of identity formation versus role confusion. Erikson believed that adolescence is a critical period in the lifelong process of achieving an identity. Erikson does take into account the danger of identity and role confusion, sexually or occupationally. Csikszentmihalyi and Larson (1984 p.8) noted that "when identity is achieved, it is a stable feeling of confidence that one knows who they are". Because of individual differences and cultural diversification, some adolescents are unable to integrate the different role identities into one distinctive identity, resulting in difficulties of defining 'who one really is'. The **Anthropological theorists'** principal argument on adolescence is focused on the way societies prepare and initiate the transition from childhood into adulthood through culturally defined processes (Rice & Dolgin, 2005).

2.4.3 Developmental Changes during Adolescence

Adolescent development can be broadly categorized into three stages, namely, early, middle and late adolescence. The age at which each stage is reached varies greatly from child to child. The different rates of growth/maturation are connected to physical, psychological and social changes that form part of this developmental transition. These periods of change that mark the adolescent years are discussed next:

Early adolescence extends roughly from age 10 to 14 years. During this phase, adolescents are well adapted to childhood, yet not mature. This stage is characterised by the plea for self-independence in an attempt to control the physical changes which are a constant irritation, while parents do not give ample freedom. This is the time when even studies are getting more difficult. *Middle adolescence* coincides with the majority of time spent in high school, between the ages 15 through 17 years. This stage is marked by increased self-awareness, sexual stirrings, risk taking and independence in decision making and increased time away from home and bonding with peers. Many more changes occur physically, mentally, cognitively and sexually. Depending on the way both parents and adolescents cope and relate with each other during this phase, the road of transformation can proceed relatively smoothly or there might be a great deal of emotional wounding by parents and rebellious behaviour on the part of the adolescent. *Late adolescence* comprises the final years of the adolescent period – ages 18 to 22 years. This stage of development is marked by separation from one's parents and gaining independence. But because many individuals enter college or higher tertiary institutions, they remain financially dependent on parents, hence, their separation from parents and significant others may be delayed. In this phase the adolescents come close to having a well developed and firm sense of identity and stable interests, as well as greater emotional stability. For instance, when there is a delay in gratification of desires, they are able to maintain patience (Burt, 2002).

2.4.3.1 Biological/Physical Changes

The journey through adolescence is regarded as developmentally unique because during no other period of life except infancy do as many biological changes occur in a given period of time (Montemayor, Adams & Gullota, 1990). Adolescent years are not only marked by growth spurts in height and weight, but also involve other physical changes such as the development of bones, muscles, and organs. The reproductive system reaches maturation together with physiological characteristics. The physical changes are dramatic and often said to instigate the period of adolescence. These changes are said to last for about 4-5 years with variations in time and progression (Petersen, & Taylor, 1980). Shaffer (1999) further noted that the ability to reproduce becomes highly probable.

A prominent change is the onset of puberty in both males and females. Puberty is also thought to mark the completion of brain development, and this possibly continues until the age of 25 years (Park, 2004; Petersen, 1985). Contrary to the above statement, Yakolev and Lecours (1967) are of the opinion that changes in the brain occur over the life span of an individual. Nevertheless, these authors identified two brain processes that do seem to be completed during late adolescence: the development of neural pathways and the process integrating the two hemispheres.

2.4.3.2 Psychological Development

Emotional, moral and intellectual development are some of the changes occurring during the period of adolescence (Park, 2004). According to Piaget's theory, the final phase of cognitive development – the phase of formal operational thinking - takes place during adolescence. It is during this life stage that adolescents are first able to think abstractly, even about issues of religion, politics, and the meaning of life. As development progresses adolescents begin to think about not only what is but also what might be. They develop abilities to reason theoretically, plan in advance, and create and think through tentative ideas and outcomes. Furthermore, a positive self image and self-esteem are also evidenced to increase over the adolescent years (Inhelder, & Piaget, 1958 in Keating, 1980).

According to Elkind (1974), however, many adolescents and adults as assessed by standard measures of formal operational thinking never manifest the capability to think abstractly. Linked to cognitive development are what Loevinger (1976) and Josselson (1980) term ego development. Cognitive changes have a great bearing on the emotional development of adolescents. What are perceived as normative changes experienced by an average adolescent are likely to inevitably challenge, if not stress, atypical adolescents causing maladaptive functioning in emotional and other salient development aspects (Petersen & Spiga, 1982).

Moral reasoning in adolescents has been reported to improve over the adolescent developmental period from the conventional to the post-conventional levels (Hofman, 1980). According to

Kohlberg's (1969) rule oriented model, an increase in conventional moral reasoning improves adolescents' ability to understand reasons for behaviour, compliance to rules and social order. The post-conventional stage increases an adolescent's sympathy for others and enables development of a greater sense of personal guilt and social justice. In contrast to Kohlberg's model which best characterises moral development in males, is Gilligan's (1982) interpersonal model which focuses on female moral development. In this model, moralistic reasoning develops from understanding personal behaviour through to understanding shared norms, expectations and responsibilities. Although both theories have raised contentious issues and criticism with regard to the methodology used (Coleman & Hendry, 1999; Skoe & Diessner, 1994), a review of the specific arguments is beyond the scope of this study.

2.4.3.3 Social Development

Social change is characterised by the way adolescents interact with and relate to others. It is through social interactions that adolescents define themselves and achieve their autonomy from parents and families without removing themselves to the extent of complete isolation. Peer group involvement become increasingly important as friendship forms the basis where thoughts and feelings are shared and life decisions are made. Conformity to the peer group peaks particularly during early adolescence (Burt, 2002). Anxiety about friendships intensifies in middle adolescence while emphasis on romantic relationships and even raising children becomes apparent during late adolescence. There is probably no single factor in an adolescent's life as influential as being socially accepted into a peer group (Berndt, 1982; Constanzo and Shaw, 1966).

2.4.4 Developmental Tasks of Adolescence

All stages of life involve key developmental tasks that build on previous successes of earlier tasks. These tasks are all related to life's transitional periods. Because adolescence is generally seen as a period when involvement with peer groups takes on new meaning and when new patterns of relationships are formed, coping with developmental tasks has been shown to be

greatly dependent on the sort of relationships developed by the adolescent with parents and peers. It is the nature of the relationship which has significant implications for the developmental process (Seiffge-Krenke, & Shulman, 1993).

The major task of adolescence that Erikson (1968) described with regard to personality development is a positive and coherent attainment of a sense of identity. Although identity formation is a life-long process, it is an intense struggle during the adolescent phase. Most adolescents struggle to develop a sense of identity, failing to work out their own individual uniqueness and to disconnect themselves from other people's expectations. An adolescent's interpersonal relationships within and beyond the family environment are vital settings during the process of identity formation, and adolescent development more generally. It is usually within the adolescent's family environment that he/she is able to draw from personal and family resources in order to develop and maintain an adequate level of functioning, psychologically (becoming emotionally independent of parents and significant figures; developing cognitive skills necessary for social competence), behaviourally and socially (Hawkins-Rodgers, 2007). Other salient developmental tasks that need to be achieved during adolescence include: (a) accepting one's physical make-up and sexual maturation; (b) learning to deal with sexual maturity in responsible ways; (c) developing appropriate relations with age mates of both sexes; (d) developing the capacity for economic viability for instance in career development, relevant skills training, attitude and habits; (e) challenging rules and testing limits and understanding consequences of actions; (f) acquiring values and healthy belief systems that form the basis of one's behaviour and ideology; and (g) in some instances preparing for marriage or a family (UNICEF, 2004).

In addition, the family environment is where adolescents can receive help to successfully complete primary developmental tasks and navigate through risk behaviour. It is where they learn how to survive and cope with a series of life's stressful and traumatic experiences and/or fail to adjust to the challenging changes of adolescent development. Hence, learning and building resilient behaviours to adjust to major life stressors is another important adolescent developmental task (Hawkins-Rodgers, 2007).

It has been hypothesised that positive developmental outcomes, in particular a positive sense of identity, can lead to a more cohesive, integrated personality and greater probability of success with future tasks, whereas failure may lead to unhappiness, societal disapproval and difficulties with later developmental tasks (Erikson, 1968).

Adolescents' inability to overcome developmental changes that are taking place in their families, peer groups, school environment, and the wider society have been noted to pose significant challenges (Petersen, & Hamburg, 1986). The *family* for instance may change in structure as a result of divorce, separation or remarriage; death, disappearance of one or both parents; abuse and neglect. Moreover, the family change may occur in function, for example, developmental challenges experienced during the adolescent phase, the powerlessness of parents to deal with the change and parental difficulties in providing the necessary support during these trying times (Petersen, & Hamburg, 1986; Save the Children, 2003).

By middle adolescence, the *peer group* becomes extremely complex as more time is spent with teenagers of both sexes, and romantic relationships increase (Berndt, 1982; Dunphy, 1963). Association with different friends, groups and organizations outside of school allows for contact with the wider society. Research has demonstrated that transition to different school settings challenges early adolescents' coping mechanisms (Blyth, Simmons, & Carlton-Ford, 1983).

In *school settings* where the nature of peer group interactions is affected and where the phenomenon of top-dog/bottom-dog exists, norms for maladaptive behaviour such as physical violence, substance abuse, and sexual misconduct are established by the older adolescents. The younger adolescents are easily influenced by, and often become victims of the older ones, resulting in related decreases in the self-esteem of early adolescents (Blyth, Hill, & Smith, 1981).

Very little has been documented on research focusing on impacts of the *wider society* on adolescents (Petersen, & Hamburg, 1986). Various messages transmitted via the media (such as television, magazines, newspapers, movies or the Internet) to adolescents claim to portray the ideal body image. These images promote thinness, the type of clothes to wear, and sexuality.

Evidence for the destructive nature of such messages has been noted in a number of studies investigating the effects of promoted body images on boys and girls' perception of their bodies (Faust, 1983). Studies show that media consumption has a great impact on how individuals view themselves and how they are perceived by others, thus affecting the important task of identity formation. Early on in life girls begin to view their bodies as objects and boys begin to view their bodies as power (Gentry & Martin, 1997). Consequently, girls consciously and subconsciously compare their own bodies and physical traits to those of models and actresses who they believe represent social and cultural ideals (Frost, 2001). Typically, they begin to view physical beauty as the most important aspect of how they value themselves as individuals (Gentry & Martin, 1997). The tendency of increasing body image dissatisfaction has been found to be frightening as it can lead to serious disorders, such as eating and anxiety disorders, drug use and depression, particularly after a realization that the portrayed ideal image is difficult to maintain. Moreover, body dissatisfaction can lead to excessive dieting and a distorted self-esteem (Groesz, Levine & Murnen, 2002).

2.5 Adolescence in Africa

Today's generation of young people is the largest in human history, with nearly half of the world's population (more than 3 billion people) under the age of 25 years. About 85% of these live in developing countries (UN, 2004). When compared to other nations of the world, Africa has the largest segment of young people in its population (Curtain, 2000). Many of them are growing up in the face of deepening poverty and the perils of HIV/AIDS. Almost 45% of all youth survive on \$1 a day. The demographic significance of young people is causing grave concern as African states are challenged to provide for this future generation in terms of education, health, employment and other social services in a context of economic decline and family restructuring (Chigunta, 2002).

2.5.1 Understanding Adolescent and Youth Development within the African Context

The concept of 'youth' has been understood and applied differently by governments and organizations depending on the country's political, economic and socio-cultural context. As such, the value societies place on youth-adulthood development is immensely diverse. In much of Africa, the transition to adulthood is defined in legal terms. For instance, adulthood commences at the age of 21 years - the age at which many of the activities and responsibilities are assumed. This applies to countries such as Cameroon, Cote'd Voire, Egypt, Guinea, Lesotho, Madagascar, Namibia, and Swaziland. This number however, has now been lowered to 18 years (Curtain, 2000; Mkandawire, 1996). In countries like South Africa, the spectrum of 'youth' has been defined as ranging from 11-35 years. In Namibia, the youth age category ranges from 15-30 years.

International organizations such as the UN and the Commonwealth have standardised specific age categories to define 'youth'. The UN for instance, uses the age category 15-24 years, while the Commonwealth uses the age category 15-29 years (Chigunta, 2002). The WHO (2005) defines 'youth' as any person under the age of 25 years. Many African countries (especially in rural Africa), often define adolescence or youth and adulthood by socio-cultural norms in relation to gender, rather than by chronological age (Abdullah, 1998; WCRWC, 2004). For example, getting a job and getting married is used to signify the passage into adulthood. Such a practice is known to exist in the countries of Mali, Burkina Faso, Ivory Coast, Guinea-Conakry, Senegal, Sierra Leone, Gambia, rural Ghana and Niger (Mkandawire, 1996; (WCRWC, 2004). Those not married or who have failed to sustain a marriage for whatever reasons and regardless of their age are considered to be children. It is common to define a 12 year old as an adult by virtue of marriage, while a 40 year old unmarried man still economically dependent on parents is likely to be considered a youth (Mkandawire, 1996). The adolescent-adulthood passage has been especially impossible for war veterans, for instance in Sierra Leone, such that men in their 40s and 50s are still believed to be "youth" (WCRWC, 2004, p.15).

The phase of adolescence has now lengthened, both at the beginning and at the end. Entry into the labour force takes longer, and occurs at a later age than was the case ten or twenty years ago. Young people remain in parental homes for a longer period, frequently continuing to be economically dependent until their late twenties. In Sierra Leone, for instance, Abdullah (1998) observed that young people refer to themselves as 'young man', a term used to describe anyone who has gone beyond the customary age associated with youth. In other words, this is a metaphor for Africa's poverty crisis. "It is a reflection of the inability of many young people to pursue independent or sustainable economic livelihoods in contemporary Africa" (Chigunta, 2002, p.3).

Each generation experiences its adolescence phase differently with new sets of challenges and possibilities. The experiences are time and context specific. As children grow up and as they come into contact with external influences, their knowledge and horizons expand, and they encounter beliefs and practises that contradict their own (Chigunta, 2002). Their sexual mores are now being redefined. Adolescents' conversations on sexuality and intimacy seem to contradict adult norms and values. These discourses are thus seen as creating an intergenerational conflict between different generations. Basic traditional values once received from elders are now lost. It also appears as if "the culture, norms and values that parents hope to pass on to their adolescents are perceived as outdated and irrelevant by young people" (Hailonga, 2005, p.8). Adolescents in both urban and rural areas resist information because they claim to be adopting modern values, which are seen as a threat to society's moral integrity. It is likely that adolescent development in traditional cultures will become stormier and stressful as a result of the global economy increasingly integrating traditional cultures (Arnett, 1999; Barber, 1995).

Adding to the above challenges, Africa's adolescents are confronted by multiple life stressors and social changes. Of particular importance is the economic impact of HIV/AIDS on households, which has created a CHHs phenomenon which equally has its own problems and risks. While older children may care for their younger siblings and ailing family members, they may be unable to cope with household responsibilities and decision-making power. Hence, they may have to make enormous personal sacrifices that can threaten their own development. Their

chances of staying in school and receiving an education are jeopardized. The economic crisis in Africa has deprived adolescents of much needed recreation and participation in activities that concern their well-being (UNICEF, 2005). Furthermore, in urban areas, the severely depressed economic situation and shortage of basic social amenities has forced many young people to survive living on the streets. In armed conflict situations, adolescents are now at the forefront of all the major wars in Africa's armed rebel forces where they are recruited as soldiers, domestic and sexual slaves. African adolescents also deal with issues of migration and apartheid. For the millions of girls who marry young, the adolescence phase comes to a sudden halt (Abdullah, 1999; Chigunta, 2002; OAU, 1990; UNFPA, 2005).

Often, internalised and externalised behaviours such as depression, anxiety, low self-esteem, hopelessness; behavioural and learning disorders, developmental delays and psychosomatic illnesses are noted as common responses to adolescents' extreme circumstances that need urgent special attention and protection measures (Foster, 2002).

Changes in the African family and societal patterns have caused a growing concern. A combination of these multifaceted causal factors has reduced the ability of parents to fend and provide for their children (Pinheiro, 2006). In response to such situations, the number of OVC in need of care and protection of their families is increasing at an alarming rate (Pinheiro, 2006; UNICEF, 2006). The placement into substitute or alternative care away from the supervision of their natural parents or extended families has become an option for families and children in difficult circumstances (McPherson, 1987). The more children are placed at risk of potential abnormal development, the higher the number of children likely to be placed in alternative care.

Institutional care, an alternative care model, is a generic term referring to a variety of *residential care* facilities (Tizard, Sinclair, & Clarke, 1975). The two terms discussed next will be used interchangeably in the current study, although the preferred term is residential care. It appears to promote less stigma and discrimination from society.

2.6 Children and Adolescents in Residential Care

It is estimated that over 8 million children and adolescents who lose the care and protection of their families grow up for substantial periods under the control and supervision of child welfare authorities. This number is expected to grow, most commonly as a result of the calamitous effects of the HIV/AIDS pandemic, increasing global poverty, changing of social patterns associated with rapid urbanisation, family breakdowns, and armed conflict. The reasons for the provision of substitute care for OVC and the personal circumstances that lead them there for care and protection are numerous and complex. Total destitution appears to be the major cause, although disparities between different countries seem to exist in the ratio of children placed in residential care and their length of stay (Save the Children, 2003).

Regardless of the operating factors and circumstances, children deprived of a family environment and growing up outside of family care have rights as stipulated by the United Nations Convention on the Rights of a Child (UN-CRC) (Articles 19, 20). The CRC guides and protects four important general children's rights: (1) The principle of non-discrimination (Article 2); (2) the best interests of the child (Article 3); (3) the child's right to survival and development (Article 6); and (4) the child's right to participation and influence (Article 12) (UN-CRC, 1989). The CRC requires that these rights must be scrupulously applied equally to all children. However, many residential institutions fail to meet these requirements (Save the Children, 2003). In seeking "the best interests of the child" as recognised in Article 3 of the UN-CRC (1989), the questions of at *what* point and *how* can the child be removed from undesirable influences of their homes, as well as *where* and *when* to displace the child, all need to be critically taken into consideration. In addition, the African Charter on the rights and welfare of the child and the Namibian constitution give effect to certain rights of children (OAU, 1990; UNICEF, 1997).

Ideally, growing up within a 'supportive biological' family environment is generally seen to be in the best interest of the child, because stability and continuity of care is maintained and biological and psychological bonding simultaneously develops (Winnicott, 1965). But if this is an impossible or unsafe practice, the decision of whether or not to place a child in alternative care

needs to be made. Alternative care may be identified in the form of family fostering/foster care, crisis fostering; adoption; community-based care; boarding school and institutional/residential care. Residential form of care includes orphanages, children's homes, children's care homes; children's villages, group homes, place of safety, shelters, juvenile detention/correctional facilities, reform schools, etc.) (Foster, et al., 1995; Powell, Chinake, Mudzinga, Maambira & Mukutiri, 2004; Save the Children, 2003; UNICEF, 2004). Foster care and adoption remain the preferred form of care for abused, deprived and abandoned children in order that a child may have a chance to form long-term affectionate relationships that are now generally seen as important for normal social development (Tolfree, 2003). Foster care and adoption form of care are however not prevalent in African society. The cultural taboos limit the options and social relations available for families to foster or adopt a child who is not blood-related. Crisis fostering, an inappropriate form of care, is becoming a pronounced form of care in Southern African countries whereby families, neighbours or other custodians feel obligated to take in orphaned and displaced children, without willingly choosing to do so (Foster, et al., 1995). All these forms of childcare interventions function differently and are run by different organizations and individuals. Whatever their name, type, or size, they oversee the day-to-day lives, activities, personal development, and future lives of a very large number of children. For the purposes of this study, concern is largely on children placed in long-term residential care through Social and Child Welfare Service Departments. While there is no universal definition of childcare institutions, the following definition of institutional or residential care will be used in the current study: "a group living arrangement for children in need of care and protection provided by remunerated adults who would not be regarded as neither family nor traditional carers of the children within the wider society" (Tolfree, 1995 p.9). This definition refers to round the clock care in which a group of often unrelated children live together in the care of a group of unrelated adults in organised and structured living arrangements. The structuring and organising of residential institutions help in providing limits to children's behaviours and consequences for rule violation (Tolfree, 1995).

2.6.1 A Historical Perspective on Residential Care

The placement of children in alternative care is an old practice recorded in Biblical scriptures as far back as the 12th century BC. Scripture gives evidence of baby Moses who was intentionally hidden in an ark of bulrushes by the river's bank. Baby Moses was found and rescued by a non-parental woman, to whom he became a son (Exodus 2: 1-10 New King James Version). Scripture also makes reference to the needs of orphans, the fatherless and widows; as well as to societies' responsibilities towards them (Exodus 22:22; Job 29:12, 31:17).

The earliest institutional care centres were founded during the 3rd century AD, in the years of Constantinople (Carter, 2005; UNICEF, 2006). They were established as repositories for unwanted children, otherwise relegated as society's outcasts and misfits, and such centres were also used as a means of reducing infanticide. During the 14th century in the middle Ages, foundling homes (orphanages) for abandoned and neglected children were set up by churches in Italy, and the practice spread across Europe, America and later to the rest of the world. The orphanages were also seen as a way of keeping abandoned and neglected children off the streets (Carter, 2005; UNICEF, 2006). In later centuries, the mortality rate in such institutions in Europe increased consistently due to the spread of infections in these crowded residential settings (Boswell, 1988). In Australia and Canada, generations of children were removed from their families, placed in residential schools, and denied their own culture, clothing and language. This pattern was continued in many communist countries, notably the USSR after 1945 (Pinheiro, 2006).

Initially, these large, closed repository facilities were concerned with only providing shelter and food to destitute children, disregarding effective care for each child and their individual needs. Providing clothing was later recognized as a need but no personal relationships were formed between children and the caregivers. The existing relationship was observed to be regimented, uncongenial, unhealthy, depersonalised and very isolating. In addition, the staff lacked the necessary training and skills (Pinheiro, 2006).

By the 18th century, more homely children's homes and foster care establishments developed with closer contact between children and the caregivers. Elements of moral principles and education were acknowledged and supplemented to children's almost non-existent developmental programs. Caretakers also began to receive remuneration for their work. In the late 19th and early 20th century, juvenile systems for adolescents accused and convicted of crimes were also introduced as residential confinements. It was during this time that child welfare authorities recognised that large, closed institutions could not support physical, social, emotional and cognitive developmental needs of children in any way comparable to a family setting (UNICEF, 2003).

Further development of institutional care led to a complete shift in environmental focus. Harsh, derivative and sterile environments were replaced by environments characterised by personal relationships, connectedness and responses to the emotional needs of children. Claims on the effectiveness of some forms of residential care treatment programs, for instance, the type of residential treatment, need-based or individual based; duration of the treatment; treatment target and the effects of the treatment on each individual child, are yet to be established in research studies. Overtime, however, there has been increasing awareness that residential treatment should respond to children's social and emotional needs in addition to providing them with basic physical care (Pinheiro, 2006).

2.6.2 Understanding the Nature and Extent of Residential Care

From available global figures, it appears that many residential care facilities are still being built and a significant number of children continue to be placed in such care centres (Carter, 2005; Pinheiro, 2006; Save the Children; 2003; UNICEF, 2003). In Central and Eastern Europe, and the former Soviet Union countries in particular, between 1989 and 2002 it was estimated that the ratio of children entering residential care had increased by approximately 3% (Carter, 2005). England (Barter, 2003), Italy and Spain (UNICEF, 2003) were previously reported to have had an escalating number of children living in residential care. These numbers have however declined considerably over the last 20 years. High rates of child institutionalization are also

reported in industrialised countries such as Japan where children who survived the post-war era still live in large hospital-like buildings managed by unqualified and overworked staff (Goodman, 2000). Canada and Latin American countries, particularly Colombia, Brazil, Bolivia and Chile, are reported to have significant numbers of children in institutional care with Colombia accredited with the highest number (UNICEF, 2004). Bulgaria, Romania, Slovakia, Estonia, Latvia, Belarus, Russia and Ukraine have also been reported to have a profoundly increased number of infants (under the age of three) in residential care (Pinheiro, 2006). China has been found to have the lowest number of children in residential care but it is possible to find children placed in institutions for the mentally ill or disabled adults (UN, 2005).

In Africa, institutional care for orphans was limited. Yet not all children in institutional care are orphans. A larger percentage of them have contactable parents and families although poor, disadvantaged or dysfunctional (Macleod, 2001; Powell, et al., 2004; Save the Children, 2003; UNICEF, 2004). Evidence from Ethiopia, Tanzania and Uganda demonstrates this fact (Subbarao & Coury, 2004). This finding concurs with an earlier study conducted by the MGECSW, then known as the MWACW, (2002), which found that very few children on the streets had no family to go to. Many of the children could live with their families only if provided with adequate social, financial and/or medical support (Powell, et al., 2004; Save the Children, 2003; UNICEF, 2004). The accumulating impact of HIV/AIDS has generated an orphan crisis, and has deepened the social costs and long-term effects of institutional care on children's psychological and social development (UNAIDS/USAID, 2003; UNICEF, 2005).

Until recently, the only institutional care facilities that existed were established by missionaries before independence. Today, many childcare institutions are mushrooming in Africa, for example, in countries like Lebanon; Liberia, Morocco; and Zimbabwe (Ghosheh, 2001; Powell, et al., 2004; UNICEF, 2006). In Uganda, during the early years of the HIV/AIDS pandemic, many institutional care facilities were closed down by Save the Children Organization in the hope of promoting community-based care (UNICEF, 2002). A growing number of countries such as Eritrea and Ethiopia have begun to deinstitutionalize orphanages and opt for more family-like settings, for example, children's homes and children's villages (Subbarao & Coury, 2004).

Formal orphanages in these countries have been changed into community-based resource centres where day care services for foster parents and skills training programmes for adolescents are made available (UNAIDS/USAID, 2002). Family-like settings on the other hand, are becoming popular forms of residential care as they are believed to provide most of the children's basic and economic needs. However, uncertainties remain about whether children's psychological and safety needs are being adequately met (Subbarao & Coury, 2004; Save the Children, 2003).

The development of residential institutions for children gained momentum with colonialism, industrialisation and continuing urbanization (Save the Children, 2003). Although residential institutions have assumed the role of bringing up vulnerable children throughout the world, the greatest concern was the adverse effect this form of care has on children's psychosocial development. This had been well documented in western countries several decades ago and it had led to the abandonment of this form of care and the closure of orphanages in these countries (Rutter, 1982). Several international donors have even made it policy not to continue supporting the construction and maintaining costs of institutional care facilities unfortunately, at the negative end of the spectrum, institutional care in many developing countries remains a common option due to widespread public and political support for these institutions (Powell et al., 2004).

2.6.3 Why are Children Growing up Outside the Care and Protection of their Biological Home and Family Environments?

There are many reasons given for the separation of children and adolescents from their families. Global transformation has brought about changes within the family and social structures, generating living patterns and relationships different from old customary models. In times of family and socio-economic challenges, families are under increasing stress. Their inability to raise their children and the failure of social protection systems to support the affected families demanded an urgent social response (Save the Children, 2003).

Family breakdown has been reported to account for most removals and displacement of children into residential care (SOS-Kinderdorf, 2005). Family breakdowns could be internally or

externally caused or a combination of both. Internal causes may take the form of divorce, remarriage, disappearance of one or both parents, unstable family relationships, parental disability and mental illness, and parental death (Petersen & Hamburg, 1986; Pinheiro, 2006; Save the Children, 2003; Tolfree, 2003).

In Namibia, alcoholism is recognised as a wide-spread social problem, and it has been linked to violence against women and children, abuse and neglect in the home environment. Moreover, the grabbing of family inheritance is another phenomenon within the Namibian context increasing children's vulnerability. The inheritance is a result of parental death, debts that may be left behind by parents or simply the greed of relatives, consequently creating a need for disadvantaged children to be salvaged from inauspicious environments (MGEWCW, 2006).

External causes might include the proliferation of poverty, unemployment; retrenchment, and low remuneration. Most families are unable to obtain incomes proportionate to the costs of basic necessities such as food, clothing, housing, transport, and medical care (Bassuk, 1993; UNICEF, 2005). Community violence, lack of community resources and social support all threaten the family's health and existence.

In most African countries, more children still become orphans and are separated from their families as a result of causes other than AIDS. Although orphans, CHHs and HIV positive children receive much media attention, they are not the only ones affected by AIDS. A number of already vulnerable children in Sub-Saharan Africa, in addition to the above mentioned, are indirectly affected by HIV/AIDS, poverty and social instability. The social safety nets and services become besieged and are further weakened when teachers, health service providers, civil servants and other significant people fall ill or are preoccupied with their sick and dying relatives (Pinheiro, 2006; Richter & Rama, 2006). Deininger, Garcia and Subbarao (2003) add that children in households fostering orphans are adversely affected. Crisis fostering in the context of HIV/AIDS is said to exacerbate the prospects of non-orphaned children as a result of the increase in the orphan dependency ratio. Pronounced areas that appear to be under significant threat for the non-orphaned children include learning opportunities; health; family life; social protection;

economic and food security; rights to development and a sense of hope for the future (Richter & Rama, 2006).

2.6.4 Impacts of Residential Care on Child and Adolescent Development

Most institutional care facilities throughout the ages have been established with noble motives. For years, well-intentioned local and international agencies, governments, organizations and individual philanthropists believed that if children are removed from environments riddled with potential adversities which pervade their lives, they will become productive citizens (Save the Children, 2003). Besides changing adolescents' exposure to risk environments, they are provided with rules and reassuring structure, which adolescents are willing to accept, while also highlighting their independent roles. Although rules provide limits to children's behaviour and consequences for rule violation, a careful balance should be considered. Children and adolescents do less well when there are too many rules, too few, or inconsistent rules (Harvey, 2007). In spite of the enhancements in residential care facilities, subsequent evidence of the harmful effects of institutional care on the development and well-being of children has become a major concern for child welfare authorities and developmental psychologists. Awareness of the outcomes of the effects of institutional care has been reinforced for decades in many countries (UN-CRC, 1989).

2.6.4. 1 Resources: Caregiver Competencies and Financial Implications

The effects of institutional care on children can be a result of caregiver characteristics such as age, education and training programs, situational factors in the home, marital relations and circumstances beyond the home such as community and social support (emotional, physical or material support (Barrera & Ainlay, 1983; Engle & Ricciuti, 1995; Richter, 2004). Caregiver social support can indirectly increase caregiver stress and directly affect positive caregiver-child interactions. It is well-known that lack of knowledge on child development and the importance of caring relationships between caregivers and children affect how caregivers behave with

children (Benasich & Brookes-Gunn, 1996). The caregivers can inappropriately respond to the child (Reis, 1988).

A caregiver may be internally distracted by personal and external concerns that cause her stress, anxiety and/or depression (Wahler & Dumas, 1989). As a result of caregiver depression during the children's early years, there is a common consent that the child may show disturbed reaction to such behaviour (Martins & Gaffan, 2000). Effects of maternal depression on infants manifest in the form of behaviour disorders; anxiety, depression and attentional problem and these are likely to persist into childhood and early adolescence (Pettersen & Albers, 2001). Being a male child has also been evidenced to increase children's risks for psychopathology (Field, 1994; McLennan, Kotelchuck & Cho, 2001).

Residential care is extremely expensive not only in building costs but in terms of sustainability (Tolfree, 2003). Tolfree's (2003) argument is built on research findings carried out by Powell, et al. (1994; 2004) and Meintjies, et al. (2007), who after examining the operating and capitalisation of residential care facilities, revealed similar findings. The resources needed to care for a small fraction of vulnerable children at excessively high costs, could provide more effective and cost-efficient care for more children if used to support family and community-based initiatives or other forms of alternative care that adequately meet child/youth developmental needs (Powell, et al., 2004; Tolfree, 2003). The costs of care for children in residential institutions is estimated to be between 10-12 times more per capita than the cost of community-based care (Desmond, 2002). However, it is worth mentioning that subsequent experience and observations have shown that several family and community-based initiatives, unless well structured and sustained, can also prove to be unsatisfactory for the children and their caregivers (Save the Children, 2003).

Furthermore, the provision of substitute care for vulnerable children and adolescents in the form of residential care places a profound strain on social policies and practices in developing countries, frequently marked by the scarcity of financial resources and a lack of subsidised programmes for children. Additionally, existing social policies and practices are likely to be

based on outdated childcare practices and legal systems; or to be incompatible with the CRC guidelines (Pinheiro, 2006; Save the Children, 2003).

2.6.4. 2 Societal Consequences

In addition, institutional care is viewed as a profound societal threat. For instance, it may contribute to social exclusion likely to promote stigma (as expressed in the attitudes and behaviours of caregivers) and discrimination which has a powerful effect on children's self-esteem and identity. Social segregation and isolation are likely to prevent children from actively participating in purposeful activities of society during the childhood years as well as in adulthood (Save the Children, 2003). Moreover, residential placement might be perceived by children themselves as a form of rejection by the family or by society resulting in feelings of abandonment, loss of a sense of belonging, loss of self-esteem and loss of identity (Pinheiro, 2006; Tolfree, 2003). Children and young people growing up in institutions are particularly deprived of developing their own African cultural identity and are alienated from a communal upbringing.

2.6.4.3 Child Development Implications

A concern about the effects of institutional care on children was evoked as far back as the 1940s, when early research scientists such as Bowlby (1951); Provence and Lipton (1962) and Spitz (1965) conducted scientific studies on children placed in residential institutions. In the early 1970s, institutional effects on children's well-being were re-visited. To date, modern research studies conclusively show that long-term institutional care has unavoidable lifelong detrimental effects on children's physical, social, and psychological development, more so psychologically for children under the age of 5 years (Bowlby, 1951; Powell, et al., 2004; Provence & Lipton, 1962; Spitz, 1965; Tizard, Cooperman, Joseph & Tizard, 1972; Tolfree, 2003).

One theoretical perspective grounded in attachment theory states that a major cause of the detrimental effects of institutional care is the separation of children from their primary caregivers

and significant others. This affects the emotional bonding between the mother and the child and prevents a child from developing a secure emotional attachment to the mother (Hawkins-Rodgers, 2007; Johnson, 1999; Leathers, 2002; Powell, et al., 2004; Rutter, 2000). The alternative argument put forward by Casler (1961) is that the negative effects of institutional care are primarily due to a lack of cognitive stimulation. Both of these arguments have been extended by more recent research (Pinheiro, 2006; Save the Children, 2003).

Institutional care is likely to deny the youth opportunities to acquire a capacity for independent thinking and problem solving. It has the propensity to directly or indirectly foster a state of dependency and expectation resulting in what is referred to as 'Institutional Syndrome' (Johnson, 1999; Save the Children, 1995). Upon entry into institutional care, children can lose the basic skills learned prior to institutional placement, such as the ability to look after themselves and to develop caring relationships as well as a sense of identity. Childcare institutions tend to deprive children of adequate stimulation and mobility (Tolfree, 2003). Due to virtually non-existent physical therapy or developmental programmes, children are left in a state of total inactivity for months or even years. There is however a counter argument that there are very few residential care centres, which are financially and physically resourced to provide a higher standard of living. But such centres can thrive only as long as resources are available (Subbarao & Coury, 2004). Nevertheless, in some instances, children are without enough stimulation and opportunities for mobility, they experience learning difficulties, and the growth of their arms, legs and spinal cord become distorted from a lack of use. It has further been indicated that minimal contact with children outside of the institution has been indicated to lead to some children resorting to self-harm. This situation is aggravated when staff members react to such cases with physical restraints (Pinheiro, 2006).

Children's rights may be infringed upon and the resultant effects may last into adulthood. The violation of their rights could be physical or sexual and, perpetrated by the caregivers and/or by older children within the same residential environment (UN-CRC, 1989; Save the children, 2003). Studies that have systematically described and analysed the phenomenon of residential care postulate that it is extremely rare to find any residential institution for children which fully

respects their rights and which offers adequate conditions for child development (Bowlby, 1951; Tolfree, 2003).

Extensive research studies on institutional care and child development suggest that developmental delays, potential irreversible psychological damage, criminal convictions, promiscuity/prostitution, aggression, substance abuse, early/premature parenting and poor academic performance were highest among adolescents from institutional care (Hawkin-Rodgers, 2007; Pinheiro, 2006; UNICEF, 2005). Involvement in crime is more likely to be associated with the older children. Although there is no single factor to explain the development of challenging behaviour in children and adolescents, it is important to take into consideration the onset of the behaviours (Pinheiro, 2006). A study conducted in Russia among young people who leave long-term residential institutions revealed that one in three young people become homeless; one in five ends up with a criminal record; and, one in ten commits suicide (Harwin, 1996). A return to high risk environments is reported to be highly probable. There are no interventions put in place to assist with the reintegration process. Research has also shown that the emotional vulnerability of young people in institutional care makes them easy targets for child sexual trafficking (Carter, 2005).

A similar study in the US was conducted with youth in the juvenile justice system. The study reported that about 90% of young people were found to be at greater risk of early death as a result of homicide (Teplin, 2005). The possibility of many young people ending up in prisons and/or in psychiatric institutions is alarming. A set of studies by Krank, Klass, Earls and Eisenberg, (1996, p.575) established that "long-term institutional care in early childhood increases the likelihood that impoverished children will grow into psychiatrically impaired and economically unproductive adults". Often, young people lack the motivation needed to become mature self-supporting adults ready to contribute to society and to parent and nurture the next generation.

There is undeniable evidence that institutional care has negative outcomes for individual children, families and society as a whole. These negative effects can be severe in instances where

the conditions of the institution are poor (Pinheiro, 2006). The effects cannot be reduced to tolerable levels even with substantial expenditure, such as good staffing, good physical structures or an exceptional standard of education, because some issues experienced are unavoidably related to the form of care provided (Frank, et al., 1996; Pinheiro, 2006; Tolfree, 2003). It is acknowledged that it is the relationships between individuals rather than the structure that has a greater impact on children's ability to grow physically, emotionally, socially, and intellectually. The nature and magnitude of these effects however, remain unclear (Frank et al., 1996). The tables overleaf (not exhaustive) include a summation of international scientific studies on the damaging effects of residential care on children and adolescents in comparison with other forms of care. These studies used scientific sampling techniques and standardized instrumental tools. Even though there is a dearth of academic and empirical research on the issue of resilience and adolescents in institutional care in Namibia, Dawes and Donald (2000) suggest that research findings not necessarily specific to the context under study remain relevant and applicable provided there is thoughtful consideration and appropriate inference.

Table 1: Studies on Children and Adolescents in Residential/Institutional Care

Authors	Sample and Methodology	Key Findings
Altshuler & Poertner, (2002)	The sample size was made up of 63 adolescents and the study measured overall health and self-concept, emotional health and disorders, achievement of social expectations in education and employment.	* Youths living in institutional care or group homes took more risks, were not achievement orientated and were more prone to peer influence. * The absence of a helpful adult was of great concern. It is crucial to help these youth connect with an adult who can provide needed support and guidance as these youth transition into the community. * In terms of resilience, problem-solving skills and feelings of safety, youths in the study appeared to be doing well.
Berrick, Barth, Needell & Jonson-Ried (1997)	The study compared 52 613 children under six years in group homes and foster care. Group homes included child care institutions with six or more sleeping beds including residential treatment but excluding hospitalization.	* Group care for young children resulted in less stability, lowered rates of adoption, and a greater chance of remaining in group care than foster care. * Group care was found to be very costly and should only be used when there is no clear and convincing evidence that the outcomes will override those of foster care and community-based care, which might be long-term.
Colton (1992)	The study compared 12 children's homes to 12 specialised foster homes. The focus was on children 12 years old and older.	* Residential caregivers were found to make far greater use of inappropriate and ineffective techniques of control and discipline. * The children's homes were generally found to be more depersonalised than foster homes. * The findings further suggest that the relations between foster parents and foster children is characterised by greater familiarity, reciprocity and social closeness than the relations that existed between residential caregivers and the youngsters they looked after.

Authors	Sample and Methodology	Key Findings
Zoccolillo, Pickles, Quinton & Rutter (1992)	The study examined 171 people who had been in group-cottage children's homes and compared them to a group of 83 who had parents with mental health problems.	*Being reared in institutional care increased the risk of pervasive social dysfunction and conduct disorder in adult life
Triseliotis & Hill (1990)	The study looked at 124 adults reared in adoptive families, foster homes and residential care (for an average of 11 years).	*The adopted and to a somewhat lesser extent, those formerly fostered, experienced more intimate, consistent, caring, and closer attachments to their caregivers compared to those in residential settings
Hodges & Tizard (1989)	39 formerly institutionalised children (now adolescents) were studied. Each was compared to a matching comparison group.	*There was evidence that ex-institutionalised children showed more behavioural and emotional difficulties than the comparison group. *Children who had spent at least the first two years of their life in residential care were likely at age 16 years to have more social and emotional problems, and more disruptive behaviour than other children.
Quinton, Rutter & Liddle (1984)	81 adult women who had been institutionalised as children (mostly before the age of 5) were compared with 41 who had never been placed in residential care. The reasons for residential admission were their parents' inability to care for them, rather than problem behaviours. The comparison groups' parents had some form of psychiatric disorders.	*25% of institutionally-reared women developed personality disorders and showed severe parenting difficulties as adults, whereas the non-institutionalised women showed no evidence of personality disorders. *The institutionalised women were predisposed to lives of poverty more than the non-institutionally reared women.

Existing data on the impact of residential care on children, adolescents and adults, provides very little information about the influence of gender, ethnic background or individual characteristics. Potential context-based variables may also have been overlooked in existing research studies. Nonetheless, early and modern study findings drawn from evidence-based research reported that there is virtually no new or old data to contradict the above mentioned negative effects of residential care (Tolfree, 2003).

Tolfree, (2003, p.7) summed up residential institutions as follows:

Institutional care is an artificial setting which effectively detaches children not only from their own immediate and extended family and from their community of origin, but also from meaningful interaction with the community in which the institution is located. The long-term effects on children's development can be profound.

Studying the life experiences of children and adolescents in residential care is vital in understanding their positive functioning and avoiding of negative developmental outcomes. What is equally important is studying those children who seem to maintain well-being under adverse circumstances. There are numerous possible explanations as to why some children may appear to have escaped the potential detrimental effects of long-term residential care. It may be that some children reared in residential institutions have experienced relatively low levels of adverse situations or living conditions (HIV/AIDS, poverty, family disintegration, parental neglect, violence within the family; death, drug and alcohol addiction, childhood sexual, emotional and/or physical abuse, etc.) that do not result in detectable high levels of mental and psychological delays. Another possibility could be that those children have acquired protective factors that were involved in redirecting them from exhibiting negative consequences to manifesting positive outcomes.

2.7 Resilient Adolescents in Residential Care

There are inconsistent findings documented in the literature regarding resilience among adolescents in general. Some researchers have begun questioning if a state of resilience is a healthy state (Hunter, 2001; Hunter & Chandler, 1999). Haase (1997), while studying resilience in adolescents with cancer, determined that these individuals developed defensive mechanisms to deal with their cancer diagnosis. However, these defences had the potential of adversely affecting their physical health if left unchecked.

In addition to these contradictions, there is limited documentation in the literature regarding cross-sectional and longitudinal studies on resilience amongst adolescents in residential care. Available literature and research studies, though not specific to Southern African adolescents, have focused on identifying characteristics of resilient adolescents and processes that create and encourage resilience in adolescents living in residential care.

A study conducted by Losel and Bliesener (1994) in Germany described characteristics of resilient teenagers in residential homes. The authors contacted special educators and social workers working in 60 foster care centres to identify resilient teenagers. Comparisons were made of two age groups – 14 to 17 year olds, both of which had grown up under accumulated stressful life events and circumstances. The findings obtained from a sample of 66 young people showed that resilient youth were more intelligent and flexible; they had positive self-esteem, greater perceived self-efficacy and they perceived themselves as having a sense of control over their lives. They were actively involved in purposeful activities. Moreover, they tend to be more realistic about the future. Another longitudinal study examining the resilience phenomenon was conducted by Henry (1999) using a data sample of 7 teenagers in residential placement. The focus of the qualitative study was to determine processes by which maltreated children develop adaptive personalities despite aversive family experiences during childhood. The findings indicated that resilient youth had an ability not to blame themselves for their circumstances; instead they distanced themselves from situations. They had a sense of self-worth and belief in the future. A rather different approach was

taken by Ungar (2001) who looked at 43 case studies of youth with experience in child welfare (institutional placement), mental health and correctional settings. The study provided an overview of how these youth socially constructed the 'resilience concept', and how they gave meaning to their deviant behaviour, however unacceptable it may be judged to be by the caregivers and society at large. The deviant behaviors of these youth were explained as ways by which they successfully cope with the risk factors they face. The results bring to light how adolescent behaviour is part of their identity formation and empowerment over their own lives.

Complementing the above studies are three studies carried out with adults reared in foster care during childhood and adolescent years. In England, Rutter and Quinton (1984) and Rutter, Quinton and Hill (1995) carried out longitudinal studies that focused on youth in foster care in an attempt to understand the elements of continuity and discontinuity in their lives. Data was collected on the basis of interviews with both men and women who lived in institutional care. The studies highlighted specific factors that in combination helped change the course of development of these individuals in positive ways. It was found that positive experiences were associated with an individual's strong belief in his/her ability to control their life, and therefore, to plan his/her life for greater personal and professional success. In a similar retrospective study, Jackson and Martin (1998) carried out a research study in England on adults who lived in institutional care during their childhood. The study focussed on a sample of 105 adults, 38 of whom were assessed as resilient on the basis of a school achievement indicator. The study identified factors such as having a significant pro-social adult - particularly an adult who values education, having close relationships with friends who do well at school; and having an interest in various activities (hobbies). The findings further suggest that resilient adults have an internal locus of control; they are more satisfied with their lives and are in better health compared to those who appear to be non-resilient under the same conditions.

2.8 Conclusion

The existing literature review on resilience amongst adolescents in residential care revealed that this is a pertinent issue, given the vulnerability of these adolescents. This group of people are among the most vulnerable groups socially due to the scope and complexities of the life challenges they face within their ecosystemic contexts (Shaffer, 2002). For instance, they generally show evidence of psycho-social difficulties.

The literature also focused on substitute/alternative care as it can serve as a protective factor or motivator for some adolescents (Scudder et al., 2008). Yet, as it removes the child from an environment considered to constitute a threat to the individual's development and safety, multiple risks are involved. The threats are indicated as those that undermine the basic human functioning or protective systems for development. A significant risk factor, in particular, is separation from biological parents. The effects of the separation depend on the surrounding circumstances.

The literature essentially focused on the salutogenesis paradigm, emphasising on building strengths and health promotion irrespective of individuals' culture, ethnicity, gender and socio-economic situations. In this review it was found that children and adolescents living in long-term residential institutions do not all follow a path of destruction, difficulties and hopelessness. Furthermore, their future prospects are not exclusively dependent on adult caretakers. Some adolescents might be more or less-resilient depending on how existing protective factors interact to influence each other. The outcomes for different individuals vary in the face of different adversities, in a given context across time (Masten, 2001). Thus, resilience is a dynamic process and is not an 'all or none phenomenon' (Luthar, Doernberger & Zigler, 1993; Fergus & Zimmerman, 2004). There appears to be a consensus on potential risk stressors, as well as on key protective factors that facilitate resilience and well-being in the context of social constraints. These protective factors that generally foster resilience fall into three main categories: internal (individual), interpersonal (family relationships) and external factors (school, church, community, etc).

Without doubt, studying of the resilience concept is especially challenging in a world where it is impossible to remove all sources of risk that may negatively impact youth development. Sometimes stressors are so overwhelming that even resilient individuals may require assistance to enable coping. Although much has been learnt about resilience in early and recent research, studying resilience is severely challenged by the inconsistency in its definition and the implications that may be drawn from the way it is currently applied. For instance, when resilience is defined narrowly as an individual trait, the environmental context is likely to be disregarded. Furthermore, personal qualities (such as high intelligence and social competence) may be difficult to modify in terms of intervention as they have a strong biological basis. An overemphasis on individual traits can also minimise the presence of environmental and contextual risk factors over which health professionals and policy makers may have more influence.

Existing literature in comparison to the Namibian case study of residential institutions has shown that there is a dearth of study evidence in this area. The review has further shown that the extended family system, considered to be the first child care option is under extreme pressure to adequately care for OVC. Like many other developed and developing countries, the Namibian child welfare sector has regulatory frameworks for residential care. As much as the child welfare policies advocates for community-based support, a gap remains between the relevant policies and service provision.

Out of a need for places of safety, many children are being placed in registered and non-registered child care facilities. This has led to the mushrooming of childcare facilities without notification to the MGECCW. Low quality care and abuse of vulnerable children cannot be controlled. Given how complex it is to build systems that serve vulnerable children, there is generally a lack of data on; (1) the number of children living in residential care, and (2) child welfare workforce with specific skills to inform initiatives to enforce the child welfare sector. In contrast to existing literature, the Namibian welfare sector has not designed effective interventions that empower OVC to succeed despite adversity. The relevant Namibian child welfare policies do not highlight the detrimental

psychosocial effects of long-term residential care as overtly as the international policy literature.

From the reviews presented in this chapter, it is clear that extensive research has been conducted into resilience amongst the vulnerable groups. The literature is however limited, generally and in particular to Namibia in that it fails to:

- Explain the effectiveness of residential care in developing African nations.
- Specifically consider resilience amongst adolescents in residential care within the African context, taking into consideration the ethnicity, culture and socio-economic situation in some of Africa's developing countries.
- Few studies have documented the processes that contribute to resilience amongst young people in residential care.
- The current research evidence on adolescent resilience in long-term residential care is limited to cross-sectional designs
- The methodology used is based on American and European norms developed as per the social needs of their countries. There is a need for methodologies and analyses specific to the Namibian environment.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 Overview

This chapter outlines the methodology used to conduct the research. The chapter serves to summarize the research design and research methods. In order to achieve the objectives of the study, a mixed-method approach was deemed most appropriate. The qualitative (primary) approach defines the lived experiences of individuals, their distinctiveness, and structure of the phenomenon, whilst the quantitative (secondary) approach addresses the phenomenon's dimensions and frequency (Blaxter, Hughes, & Tight, 1996). A review of the sample description, pilot study and data collection measures are provided. Further, ethical considerations and the data analysis process are discussed. The chapter concludes with a discussion on reflexivity in research.

3.2 Research Design

This study was mainly descriptive and exploratory in nature. Exploratory and descriptive studies are useful, particularly when research is breaking new ground; hence, yielding new insights into a topic for research (Babbie, 1998). Seeing that this is a study of experiential lived realities of a particular collection of individuals, it employed a mixed-methods approach – one that incorporates both qualitative and quantitative methods of data enquiry. The rationale for using a mixed methodology design in this study is for complementary purposes (examining different facets of the same questions), gaining a new perspective on the issue and expansion (adding breadth and scope to the research study). The strength of the multi-methods approach is in its ability to test for differences across variables. It also allows for identification of specific factors and variables not identified in the literature (Tashakkori & Teddlie, 1998). A combination of the two approaches within a single piece of research hence enables correlation and mutual validation of the findings (Flick, 2006). Moreover, the two methods are associated with

enlarging the researcher's point of view, enriching tools and techniques of data collection and comparing results for a better analysis of integrated data.

Traditionally, an abyss has been seen to exist between qualitative and quantitative research methods, with each belonging to distinct methodological doctrines. The distinction is most commonly applied at the methodology level: the process of data collection, and the form in which the data is recorded and analyzed (Brannen, 1992). The question as to which empirical research approach to use has been debated in recent years (Blaxter, Hughes & Tight, 1996; Mouton & Marais, 1996). But beyond this old controversy, these two approaches, as detailed below, are now frequently thought of as different but complementary. Their primary purpose is to generate an understanding of the society and grasp how individuals, groups and institutions act and have an influence on each other (Neuman, 2003).

3.3 Research Approach

3.3.1 Qualitative Design

Qualitative methods have their roots in several disciplines; including anthropology, sociology, psychology, and linguistics (Forman, Creswell, Damaschroder, Kowalski & Krein, 2008). In psychology, these methods are used to investigate human behaviour, emotions and cognition (Plattner, 2001). This approach emphasises processes and meanings that are not measured in terms of quantity, amount, intensity or frequency. Rather, it portrays the socially constructed nature of reality of the area under investigation (Guba & Lincoln, 1994). Moreover, qualitative research aims to facilitate a comprehensive understanding that attempts to obtain a deeper interpretation of the phenomenon "as nearly as possible as its participants feel or live it" (Sherman & Webb, 1988 as quoted by Blaxter, Hughes, & Tight, 1996, p.61).

Qualitative research lends itself to interpretative enquiry and allows for "deep", "thick" and "rich" data to be produced, often from a variety of sources (Hewitt-Taylor, 2001, p.

39) using specific qualitative research methods such as hermeneutics, ethno-methodology and phenomenology (Mouton & Marais, 1996). Sampling in qualitative research is purposeful and is guided by theory rather than probabilistic considerations as the intention is usually to involve a “detailed encounter” with a small selection of cases (Babbie & Mouton, 2001, p.279), intensely engaging the researcher in the process before, during and after (Forman et al., 2008; Patton, 2002). Data collection and analysis in qualitative research is concurrent. Findings are generalized from one context to similar settings as those in the study. This gives meaning to the information collected and explains how and why things turned out the way they did within those settings (Struwig & Stead, 2001). Conclusions founded on empirical data are drawn inductively. The researcher establishes hypotheses and theoretical models that are based on different phenomena in reality. Most hypotheses tend to emerge as a result of qualitative investigation (Forman et al., 2008).

According to Neuman, (2003), there are five main methods to be used for qualitative research: observation, interviewing, ethnographic fieldwork; discourse analysis and textual analysis. Researchers using any of the aforementioned methods of data collection and analysis have developed several ways to link theoretical ideas to measurement procedures that will produce quantitative information about empirical reality. The quantitative paradigm is discussed next.

3.3.2 Quantitative Design

Quantitative research design relies on the positivist approach to social science, which regarded research as scientific and objective with an emphasis on observable behaviour only (LeBeau, 1996; Neuman, 2003; Shaughessny et al., 2000). Quantitative data in its basic form is usually numerical and statistical, allowing for systematic descriptions of the social phenomenon under study. Furthermore, it enables standardization of tests, questionnaires, systematic observation and objective comparisons such that the results of the analysis are not dependent on the researcher (Punch, 1998; Shaughessny et al., 2000).

Researchers using this approach give emphasis to the measuring and analysis of causal relationships between variables that reflect theoretical constructs that are connected to underlying explanations (Neuman, 2003). This research process is carried out in a sequential manner and any changes made after the data collection process has started may produce invalid findings (Forman et al., 2008). Sampling in quantitative research is representative and randomized. This ensures the generalization of results from the study sample to the population that it represents. Moreover, data analysis in quantitative research is primarily and largely deductive with a sequence of discrete steps that precede data collection. Researchers are more concerned with investigating existing theories using different methods of data enquiry (Forman et al., 2008). These theories should however, be able to be rejected and falsified (Mouton & Marais, 1996).

Some researchers are critical of the comparable abilities of the two methods as sometimes proposed by the advocates of mixed methodology. Their main critique is whether both approaches are tapping the same aspects even when they appear to examine similar issues. The very fact that qualitative research is concerned with individuals' life perspectives, process and context details, while quantitative design draws attention to causality, variables and a heavily pre-structured approach to research means that qualitative and quantitative data may not be comparable (Bryman, 1988). Findings could be highly contrasting with either method providing a more favourable portrayal of participants' experiences. In this study, both approaches - qualitative and quantitative are not only used for comparison purposes. The results of the questionnaires assisted in directing the main research method, which were qualitative in-depth interviews.

3.4 Sample

3.4.1 Site Selection

In this study, purposive sampling, an example of a non-probability sampling method, was used (De Vos, 1998; Neuman, 2000). With purposive non-probability sampling, particular settings, persons, or events are selected deliberately as they are most likely to

bring forth significant information required about the entire population. In purposive sampling, cases are selected for their relevance to the research topic, but this does not mean that the samples are not representative of the population (Babbie & Mouton, 2001; Maxwell, 1996).

The initial sampling frame consisted of 3 residential care institutions, identified to be the biggest in the country providing long-term residential care (MGECW, 2006). The centres receive funding; and provide food, and educational facilities. Although there were other centres that accommodated children, they were excluded because they provided food and accommodation on a temporary/short-term basis only. However, only one residential care centre was included in the main phase of the research. Approval to conduct research in the other two proposed sites was only granted by the Ministry of Gender Equality and Child Welfare three months after the initial research study was anticipated to have been completed.

3.4.2 Participant Selection

A total sample of 62 adolescent participants between the ages of 11-19 years (mean age = 14.45, standard deviation SD = 2.26) was purposely selected from a larger sample of 120 children and young people (aged 0-25 years). One selected male adolescent chose not to participate in the study. According to the IRP (2002) this is a good return rate as the Child Youth and Resilience Measure (CYRM) needs a minimum of 61 participants for adequate statistical power. In addition to the adolescent participants, the sample included three caregivers (see section 3.7.1.1 below for the selection criteria). The caregivers were known to have cared for these adolescents over periods of 4, 21 and 22 years respectively.

The ethnic composition of the participants comprised black, white, basters; and coloureds/mixed races. The Basters and Coloureds' racial groups are both established groups in Namibia (Malan, 1995). The identity of Basters, a term preferred and used by the people themselves, refers to an ethnic group descended from white fathers

(trekkboers) and khoikhoi mothers (Hottentots). The ancestors of this group originate from the Cape Province in South Africa. On the other hand, the Coloured group are descendants of black and white European parents. Like Bastards, Coloureds speak Afrikaans as a home language, although their accent differs considerably (Absalom, 2001). Irrespective of the participants' age, gender, ethnic/race, and socioeconomic background, the participants were comparable in terms of the common challenges they had experienced.

3.5 Measures

3.5.1 Qualitative Data Collection

Semi-structured or focused interviews were chosen as the method for *qualitative* data gathering because of the researcher's interest in the participants' experiences. Due to the sensitive nature of issues experienced by participants as well as ethical issues of privacy and protection, semi-structured interviews were decided upon rather than focus groups. Interviews are non-standardised face-to-face one-on-one purposeful conversations between the researcher and individuals. This form of data enquiry allows for greater flexibility in scope and depth than focus groups (Shaughnessy, Zechmeister & Zechmeister, 2000). Because of this flexibility, interviews can be used in a wider range of situations. Interviews are well suited for studying naturally occurring life situations. Because of their non-standardised nature, the semi-structured questions can be re-formulated/modified as new themes emerge, thus allowing the researcher control over the line of questioning so that specific topics are covered. Qualitative semi-structured interviews are the best way of getting the insider's perspective and finding out what those individuals feel and think about their worlds (Babbie, 1998). Interviews also allow for non-verbal observation.

Interviews however, also have disadvantages such as, they are time consuming, and limit the researcher to a small sample. Qualitative interviewing provides 'indirect' information filtered through the views of interviewees, some of whom are not equally articulate.

Qualitative interviews may also provide inaccurate information due to poor recall by the participants (Yin, 1994). Additionally, a researcher's presence introduces the possibility of interviewer bias. For example, the researcher may phrase the wording of a question to fit the respondent (Mouton & Marais, 1996). The latter possibility is generally considered to be an advantage in qualitative research as it enables the researcher to be flexible and adaptive.

For the present study, the interview guide questions were open-ended. Although the interviewer followed the order of the pre-set questions regardless of the interviewees' responses, respondents were allowed to navigate their own stories/experiences.

3.5.1.1 Interviewing

The interview and questionnaire guides (see Appendices A and B) used for this study were developed for the IRP, by Professor Michael Ungar (Ungar, 2006). Professor Ungar was contacted and permission was obtained to use and adapt the interview and questionnaire. To ensure consistency, the interview guide consisted of nine main questions. To each main question, probing questions were added which allowed further understanding (Darlington & Scott, 2002). The probing questions were also asked in the event that the participant did not sufficiently answer the main question.

To further give essence to the information gained from the interviewed adolescent participants, focused interviews were also conducted with the participants' caregivers. The caregivers were above 35 years and the highest grade passed ranged between grades 9-10. The caregivers undertake a three phase formal training program: the first training is a three month basic mother-training course which includes aspects of child/youth development; HIV/AIDS; child protection policy; first aid; basic counseling; house and financial management; health and nutrition; self-development; residential and organizational structure, services provided and how the caregivers can make use of such services for self-development. The second is a 2-5 years mother-training program which is a bit more intense. The third and final training phase is a 6-10 years mothers'

professional course (SOS-Kinderdorf, 2005). In addition, the caregivers attend ongoing short-term courses on child care issues offered by local institutions.

The interview guide examined four important and ecologically nested aspects of resilience, as gathered from mainly western literature (see chapter 2). The investigated aspects included: (1) individual traits; (2) interpersonal relational factors; (3) community factors; and (4) cultural factors, with special attention to the influence of culture and context on how resilience is manifested in everyday practises.

3.5.2 Quantitative Data Collection

The instrument used for data gathering was structured *questionnaires*, investigating the same variables as previously covered in the qualitative interviews. The aim is to infer a characteristic or a relationship between variables in the general population that is too large to observe (Brannen, 1992). Statistically, a quantitative method allows for the researcher to translate abstract social phenomena into measurable variables, as in this study (Babbie & Mouton, 2001). Shaughnessy, Zechmeiser & Zechmeister (2000 p. 158) noted that this technique is probably the best method in “dealing with highly personal or embarrassing topics, especially when anonymity of respondents is preserved”. Moreover, people are more likely to answer honestly as the process is not intrusive. Furthermore, when compared to other research methods, administering questionnaires is more cost effective, and covers a wider and larger sample. Structured questionnaires ensure a high response rate, accurate sampling, minimum interview bias and a high degree of personal contact. Some of the disadvantages of conducting structured questionnaires are that they usually have no platform or lack the opportunity for respondents to answer, ask, clarify or motivate questions or experiences in their own words (Shaughnessy, Zechmeiser & Zechmeister, 2000). The structured questionnaires used are clarified below.

3.5.2.1 Questionnaire One: The Child and Youth Resilience Measure (CYRM)

The Child and Youth Resilience Measure (see Appendix C) is a cross-cultural measure created by a multi-disciplinary team for the International Resilience Project (IRP) led by Prof. Michael Ungar in 2002. The CYRM aims to measure how well youth are coping with adversity within their given contexts and examines health resources/factors associated with resilience as an outcome in different contexts using the ecological model (Ungar, 2005).

This questionnaire contained three sections:

Section one

This section consisted of a range of questions designed to gather demographic information of the participants, including age; gender; ethnicity; level of education; the number of times adolescent participants had moved homes; the length of stay in the current residential care; and, whom they considered to be family (people they had lived with, for example, one or both parents, siblings, friends, foster family, etc.).

Section two

This section of the questionnaire included 28 self-report questions. Each question/item is rated on a 5-point likert scale (1=Not at all; 2=A Little; 3=Somewhat; 4=Quite a bit; 5=A Lot) to indicate how well a youth is coping with adversity. This enabled identification of patterns and healthy resources in the lives of youth that appear to successfully negotiate healthy outcomes within their own unique contexts (Ungar, 2006).

Section three

This section consisted of 10 closed-ended and 6 open-ended self-developed site-specific questions which were drawn on the basis of the findings from the qualitative interviews. Four items (2, 4, 9, and 10) were reverse-scored. Like the CYRM, the questions were designed to measure embedded factors related to positive growth and development of children/youth under adverse circumstances.

The CYRM questions have been proven to be valid but the subscales change according to the status of respondents. The measure therefore shows low comparison across groups/populations as per Van de Vijver and Leung's work (1997). Steenkamp and Baumgartner (1998) argue that observed differences among subscales/item scores reflect true differences across groups. Face validity of the CYRM has been demonstrated through the "from the ground up" process of its joint development and implementation. The different subscales (individual, relational, community and culture) all showed acceptable internal consistency reliability with Cronbach's alpha values of .84, .66, .79 and .71 respectively (Ungar et al., 2005).

3.5.2.2 Questionnaire Two: Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997)

The Strengths and Difficulties Questionnaire (Goodman, 1997) (see Appendices D and E) is a screening instrument used to detect the severity of childhood and adolescent emotional, behaviour and relationship problems. The Strengths and Difficulties Questionnaire was used as a measure of resilience by rating lower difficulty scores as representing greater resilience and higher difficulty scores as indicating less resilience. It consists of 25 statements, 10 of which are considered to be strengths and 14 of which represent difficulties and 1 neutral item. Each statement is rated on a three-point likert scale ("not true", "somewhat true", "certainly true") to indicate how far each attribute applies to the child. The 25 items in the SDQ are equally divided between five subscales, generating scores for Conduct Problems; Inattention-Hyperactivity, Emotional Problems, Peer Problems, and Pro-social Behaviour. All scales, except the Pro-social Behaviour scale are added up to give a total difficulty scores. Each of the 25 items is rated on a 3-point scale ranging from 0-2. Total problem scores are classed within normal, borderline and abnormal ranges (Goodman, 1997; Goodman, Meltzer & Bailey, 1998; Goodman, Ford, Sommons, Gatward & Meltzer, 2000).

Internal consistency for each of the five subscales has been shown to be good with a mean Cronbach's alpha of 0.73 (Goodman, 2001). The same questionnaire can be completed by either parents or teachers of 4-16 year olds or by 11-16 year olds themselves (Goodman, 1997), depending on their level of understanding and literacy (Goodman, et al. 1998). The SDQ has a track record of cross-cultural applicability with translations into over 40 languages. In addition, the SDQ has normative data from diverse countries. It includes a balanced focus on strengths as well as difficulties (Goodman, Meltzer & Bailey, 1998).

Various studies from diverse countries have yielded favourable results regarding the SDQ's construct validity, reliability and clinical usefulness. The SDQ has been shown to correlate highly with similar yet more established measures such as the Rutter Child Scales (Goodman, 1997), and the Child Behaviour Checklist (Goodman & Scott, 1999). It has been shown to have acceptable levels of test-retest reliability of 0.62, it discriminates well between children with and without psychopathology (Goodman, 2001), and it is effective in community and clinical-based samples (Goodman et al. 2000).

3.6 Procedures

3.6.1 Research Strategies

Permission to conduct the study was requested from the administrators of the residential care and the Ministry of Gender Equality and Child Welfare. Before approval was granted, the researcher was asked to make a brief presentation on the proposed research study. After approval was obtained, initial contact was then made with the research site and the purpose and methodology of the study was explained to the rest of the staff that the researcher was to be working with.

Before the data collection process began, a considerable amount of time (approximately three-four months) was spent by the researcher with the youth and the residential care

staff members, in particular, the caregivers. Due to the stressful life events experienced by the children and because of their distrustful nature (Hutson & Liddiard, 1994), the aim was to establish a relationship of trust and build rapport with the youth to help ensure a rich data collection process. This was achieved by interacting with participants on a daily basis, hence gaining their confidence. The research strategies are detailed as follows:

3.6.1.1 The First Wave of Data Collection

The researcher made appointments with individual caregivers where the purpose of the research study was explained to them again. As part of the discussion, the caregivers were also asked to provide a brief overview of their backgrounds. At the meetings, three caregivers were identified as suitable participants using the criteria identified below, and thereafter, informed written consent (see Appendix K) was obtained from the selected caregivers for their inclusion in the interviews. The signed consent forms were kept on record. This was done confidentially with each caregiver.

The interview guide examined caregivers' perspectives of aspects of young people's lives that help them cope despite the many life challenges experienced. The interviews were conducted in English. The interviews were also conducted separately and the interview format for each caregiver was kept the same. Initially, the interviews were projected to last for about 2 hours; however, some participants shared their life experiences in detail, and some were more articulate than others. Therefore, the time ranged from 1½ to almost 3 hours.

3.6.1.1.1. Inclusion Criteria for the First Wave of Data Collection

The following inclusion criteria were used to identify the interview participants: the caregiver should have worked at the residential care for a substantial amount of time and be able to provide insight and knowledge into the personalities and behaviours of the children because of the parenting, disciplining, guidance and support they provide the children with.

3.6.1.2 Second Wave of Data Collection

For the second wave of data collection, the researcher and caregivers met again to identify adolescents whom they felt would be suitable participants for the qualitative component of the study. Eight youth participants were identified for the second wave of interviews. These were the participants whom the caregivers felt appeared to be more and less resilient, and whom the caregivers felt they knew well enough to evaluate. Permission to conduct interviews was also obtained from the adolescents themselves (see Appendix J). The selected adolescents were approached by the researcher for written assent after each participant had been provided with general information about the study in age-appropriate terms. The caregivers were asked to be present as the youth gave their written informed assent to ensure that they felt supported and safe. However, none of the participants felt they needed the caregivers' presence while giving assent as the researcher had established a relationship of trust and built rapport with the adolescents. Some participants also felt they were old enough to assent without the presence of an adult.

3.6.1.2.1 Inclusion Criteria for the Second Wave of Data Collection

The eight participants identified for interviews were divided into two groups; the first set was those perceived by their caregivers as more resilient and the second set was those who appeared to be less resilient as assessed on multiple outcomes. Criteria by which resilient adolescent participants were identified for interviews included the following: the adolescent should have experienced adversity and, in spite of exposure to life stressors, they demonstrated an ability to cope and do well in life (Gunnestad, 2006; Luther, Cicchetti & Becker, 2000; Masten, Best & Garmezy, 1990; Ungar, 2005; Werner & Smith, 1982).

Criteria for identifying the second set of adolescents for interview participation were that the adolescents showed difficulties in any or all of the individual, relational, community and cultural aspects of functioning according to the caregivers. McMillan and

Schumacher (2001) stated that the selection of a limited number of interview participants allows for greater insight generated from the qualitative inquiry, which depends more on the richness of information provided and on the analytical capabilities of the researcher than on the number of participants.

Both sets of participants were expected to have lived in residential care longer than six months. They should have the ability to identify, discuss and willingly share their experienced life stories as constructed within their social contexts (Kvale, 1996), and their responses to those adversities and their perception of coping despite the challenges faced. All the participants answered all the questions. The interview format for each adolescent participant was kept the same. The interviews lasted approximately 1 hour to 2½ hours each.

3.6.1.3 Third Wave of Data Collection

Data from the first and second waves were analysed to formulate self-developed site-specific quantitative questions. Following standard procedure, the site-specific questions were added onto the CYRM. The questions are based on the theoretical framework as well as on the available literature on resilience amongst adolescents in long-term residential care. The questionnaire was constructed with both closed-ended questions (which offer participants a variety of alternative responses from which to choose) and open-ended questions (which allow participants to respond in their own words to the topic under study). The qualitative outcomes served the purpose of ensuring the validity of the variables operationalised and investigated in the questionnaire. For purposes of data analysis, all youth were included in one “at-risk” grouping. The goal was to examine differences regarding aspects of resilience that were most relevant to youth within the same context but significantly exposed to adversity. The quantitative part of the study served the purpose of ensuing statistical evaluation by gathering knowledge on how critical variables of resilience are represented and distributed among the Namibian adolescent population in long-term residential care. The CYRM and SDQ (as described

above) were administered to the participants in English. The administering of questionnaires lasted approximately 15-20 minutes each.

3.6.2 Fieldwork

The in-depth interviews and questionnaires were all administered individually. Before conducting each interview and administering each questionnaire, the researcher provided each participant with a brief review of the purpose of the study. Each question was read aloud to all participants to ensure an understanding of questions before answering. This procedure enabled the researcher to check for any incomplete items or omissions.

The interview style allowed a non-directive flow of conversation. The participants introduced topics of relevance to their own experiences (Kvale, 1996) without being judged on the content of what they said. Suggestive or leading questions or remarks were avoided (Patton, 2002). The use of closed questions that inhibit interviewees from revealing their own perspective was minimised. Instead, their awareness of their circumstances, experiences, thoughts and feelings was conveyed to them as important. The researcher paid attention to any sign of discomfort or tiredness. During the times when some questions caused negative emotional responses (a situation which occurred with one adolescent and one caregiver), emotional support was offered to the participants. The interviews were resumed after the participant regained emotional stability. Instructions were in English; however, caution was taken to ensure that interviews and the administration of questionnaires were conducted in an easy to understand and culturally sensitive manner bearing in mind that English was neither the participants' nor the researcher's first language.

During the interviewing process, particularly adolescents' interviews, questions were often rearticulated and simplified according to individual's cognitive processes. The researcher tried as much as possible to follow up questions using respondents' words and phrases. Caution was taken to ensure that participants did not deviate from the main topic. No follow-up interviews were needed. All three strategies of data collection were

conducted in places convenient to research participants; in this case, the residential care. Data was collected over a period of four months between April and July 2008. All interviews were tape-recorded and transcribed verbatim, providing a complete and accurate record of the entire interview process. The tape recording process can be highly reliable as the researcher can return and transcribe the interviews as a check against straying from the substance of the data as new hypotheses are being developed (Silverman, 2000). This process allows for another researcher to analyze and re-interpret the interviews should a need arise (Kvale, 1996). However, no two researchers analyzing the same data will produce the exact same theory/results (Glaser & Strauss, 1967; Maxwell, 1992; Rennie, 1994). Consistent with this rationale is the basic epistemology of qualitative research, which assumes that there is no accurate account of reality, and each individual participant has a unique perspective that enriches understanding of the phenomenon being explored (Van Vliet, 2008). Repetitions and comments that had no relevance to the topic were not followed up on. Grammatical errors made by the participants were not corrected.

No form of incentives were provided or used to persuade participants to participate. However, the importance of their participation in the research and how the information would be used was explicitly explained to them. As a form of compensation for their time and willingness to participate in the study, each participant received small packets of assorted snacks as tokens of appreciation. Caregivers and the administrative staff were compensated with cakes and drinks for their unwavering support.

3.7 The Pilot Study

Piloting can be done either in groups (focus groups) or individually in informal interviews (Yin, 1994). The purpose of the pilot study was to examine and refine the order of questions, as well as to validate cultural and language appropriateness of the research content and format for the main phase.

Before conducting the main research, a number of pilot sessions were carried out on all measures of data collection. There were no specific requirements for the pilot study in terms of demographics or other variables, thus the pilot sample consisted of anyone in the residential care (adolescents and caregivers) who was willing and able to articulate their feelings and share their experiences thus minimizing the process of interpretation. The pilot interviews and questionnaires were carried out among two caregivers and two adolescents. The latter were matched for age with the participants in the study but did not form part of the final research sample. The data from the pilot study were not analysed nor used in the findings of the main research study. No amendments or modifications were made to the interview and questionnaire guide as each question was individually explained to the participants throughout the research process.

3.8 Data Analysis

3.8.1 Qualitative Interview Analysis

All qualitative data analysis methods involve open coding of raw data into emergent themes, codes, or patterns of development, then into categories of information generated inductively about the phenomenon being studied, and finally identifying relationships among themes in the data to form conclusions (Creswell, 2006). During this process, the researcher begins to look at what makes a certain piece of data different and/or similar to other pieces of data within a set framework.

Analysis of the data in this study was primarily based upon the procedures and techniques of a theory-led thematic content analysis that involves the creation and application of codes to data. The data can take any number of forms such as interview scripts, observations, policy documents, field notes, photographs, video footages or texts (Braun & Clarke, 2006; Hayes, 2000; Miles & Huberman, 1994).

In this situation, the data took the form of interview scripts, which the researcher read through as often as possible, with a reflective attitude to develop an overall feel of the

data. After the initial phase of data familiarization, the researcher began to note down the pre-established categories or key theoretical themes derived from the ecological model used to analyze the qualitative interviews. The researcher read through each script over and over again. She allowed the categories to emerge from the data, and grouped the data into pre-established categories (Hayes, 2000). During this process, the researcher also captured the challenges and concerns (see chapter 4 section 4.4.2) that emerged from the study's context. Each theme and sub-themes were separately and carefully re-examined for relevant material relating to that theme. The researcher looked for differences, similarities and relationships that connected the pieces of data within the context of the interviewed participants. The researcher went back to the data as this method of analysis requires moving back and forth with the data, instead of the process occurring in a linear manner. The researcher used all of the interview data relating to each theme, and each theme's final form was assembled. The themes described factors, ideas, events and experiences that the interviewed participants perceived to have been important in their positive development towards resilience. As a final step, the researcher selected the relevant illustrative data for the reporting of the themes in relation to the research question being addressed in the study (Hewitt-Taylor, 2001; Kvale, 1996; Maxwell, 1996; Neuman, 2000). Based on the identified themes, site-specific questions were formulated and added onto the CYRM in the third wave of data collection as described below.

3.8.2 Quantitative Data Analysis

All statistical analyses were conducted using Statistica (Version 8). Initial data analysis involved generating descriptive statistics, i.e. means and standard deviations and testing the distribution of variables for normality. Demographic information pertaining to the sample (age; gender; ethnicity/race; level of education; and duration of stay in the residential care; the number of times a child moved homes and the person (s) currently/previously considered as family) were analyzed. Internal consistency reliability for the CYRM was demonstrated by calculating Cronbach's alpha coefficient. A numerical co-efficient score of 0.70 or higher is usually considered to be acceptable

(Nunnally, 1978). Relationships between the dependent (from the SDQ) and independent (from the CYRM) variables were examined using Pearson's correlations coefficient and multiple regression analysis. According to Sprinthall (1990, p.196) Pearson r is used to obtain a correlation co-efficient for data that is normally distributed, as is the case in this study, and allows the researcher to express "the relationship between two qualitatively different objects in quantitative terms". The statistical significance of the results was tested by applying a probability or p-value of .05 (Field, 2005). Categories of findings from the qualitative interviews relevant to protective factors associated with resilience were compared with the results of the quantitative questionnaire to verify validity.

The research findings and conclusions are presented and discussed in chapter five.

3.9 Ethical Considerations

The research topic and methodology were reviewed and approved by the research ethics committee of the University Of Cape Town Department of Psychology. Neumann (2000, p, 91) cautions that the authority to carry out research comes with the researcher's responsibility to "protect the interests of those being studied". Hence, research principles that ensure child protection, informed consent, restoration of participants, voluntary participation and confidentiality were upheld throughout this study.

Prior to the inquiry of the topic under investigation, access to the sampled population (and the pilot study participants) was made in person. A relationship of trust and good rapport was established with the participants, to facilitate open sharing of experiences. The nature of the study was explained to both sample groups. The adolescents and caregivers were granted the right to consent, a key consideration in ethical research. The participants were free to withdraw from the research at any time without penalty. The adolescent participants' parents could not be contacted for consent purposes due to legal matters; parental permission was therefore relinquished (Stanley & Sieber, 1992). Participants were further informed that the interviews would be tape-recorded, but the tapes would be destroyed after completion of the research.

Participants were explicitly assured of their right to ask questions during the consent procedure and interview process to ensure thorough understanding of the study. Confidentiality and anonymity were guaranteed. To safeguard confidentiality, participants' identities were not linked to the data (Polit & Beck, 2004). Instead, they were identified by a number. Melton (1992) indicates that developmentally, protection of privacy is of utmost importance for adolescents as they are at the phase of developing a sense of the self. No referrals (for distressed respondents during the interview process) were made as this was not necessary.

The study posed no harm to the participants and there was no deception (distorting information in order to make participants believe what was not true) involved. The researcher's actions, conduct and competence were considered under all circumstances. For instance, the processes of data analysis and results reporting were truthfully presented and monitored through regular supervision.

3.10 Reflexivity

In all instances, the task of conducting research brings with it responsibility and accountability. One level of accountability is found in the researcher reflecting upon her personal history, education and life perspective as it relates to those of the participants being studied. Another dimension that a researcher can reflect upon is epistemology reflexivity (Fine & Weis, 1998). Epistemology according to Holland (1999) and Willig (2001) helps us to think about the implications of making assumptions about theories that drive our research and are produced as a result of our research. During the fieldwork - from the beginning to the end of the research process - it was important for me to reflect on these dimensions: my relationship with the participants; the social field (the residential care facility); the methods employed to collect data and the data itself. Highly notable and important was for me to realize how my presence as a researcher affected different research situations and the actors involved in the production of knowledge. Reflections on these dimensions enabled me to appreciate the fact that my relationship with the

participants was both “dialectic” and “didactic” (Tierney, 1996, p. 120). This means that the production of knowledge is a result of my interaction (examining and discussing issues under investigation) with the participants. The knowledge produced is embedded or nested within the participants’ history, developmental processes, and broader social relations. “When researchers listen with close attention to what respondents say, the respondents become active agents, the creators of the worlds they inhabit and the interpreters of their experiences. And as researchers become witnesses, bringing their knowledge of theory and their interpretive methods to participants’ stories, they too become active agents” (Marecek, Fine & Kidder, 2001, p. 34). Hence, who is involved in the production of knowledge is as important as its generation (Selener, 1997).

What perhaps concerned me the most about my position as a researcher was the power and hierarchical differences between myself and the participants. I was acutely aware of my social class and educational differences between us. However, commonalities such as my nationality, gender, ethnicity, and ability to communicate with the participants in English and Afrikaans enabled me to bridge the gap with my research participants. Prior to collecting data, I spent much of my time and energy with the adolescents and caregivers at the residential care with the aim of establishing relationships based on trust. As much as I felt I had limited time and opportunity to establish trusting relationships with the participants, I developed close relationships with them, which was as much a requirement of the setting as it was of my methodological techniques. It was apparent that most participants could identify with me and they felt comfortable and incredibly willing and open to share their experiences. Even though I was only able to partially access the lives of these individuals, it was important for me to use my interpersonal skills to build rapport, maintain good relations and remain faithful and open to ethical issues. Likewise, it was vital for me to remain faithful and open to my relationship with the participants; the experiences shared by them and knowledge produced through the research in the given space and time.

What was of particular interest was how some participants categorized me as more privileged (*“you are educated and studying in a foreign country. You know more than we*

do"). In the instance of the caregivers, they would often give sentiments of appreciation (*"Please talk to these children because they are not serious with their education"*). They believed that I served as a role model – somebody the children could aspire to be like. This was perhaps particularly true of those who were observing my movements and studying me as an 'outsider' (Patton, 2002), with curiosity and interest in who I am and why I was there.

Reflexivity has been critiqued with encouraging the researcher to 'self-indulge' (Seale, 1999), and this might have an impact on the data collection and analysis process. Some researchers have argued that acknowledging one's position as a researcher does not necessarily mean self-indulgence. It is about reflecting on power relations (between the researcher and the participants) and one's life perspective on experienced lived realities, and how this influences a joint construction of meaning (Kobayashi, 2003). During any field research, the researcher needs to be aware of the power relations that place her/him and the participants in different positions. Some less-contemporary authors have suggested that by understanding one's life perspective; the researcher may remove herself from the research (Hutchinson, 1988). I acknowledged that remaining 'outside my subject matter' whilst conducting the research was difficult for me. Issues that arose during the interviews and administration of questionnaires were traumatic. At the same time, it was distressing to learn how some children fail to adjust adequately as a result of negative experiences.

In spite of the emotional issues, power and hierarchical differences, I was able to maintain a relatively competent notion of objectivity and suspend my own thoughts and opinions. It was crucial for me to ascertain that the conversations were steered back to answering the research question. As an individual and a researcher, I had to accurately reflect on participants' feelings and thoughts as well as appropriately respond to their needs and concerns (Chataway, 1997). As a coping mechanism, talking to the caregivers generally, and specifically to my mother allowed me to channel and deal with my emotions throughout the study process.

The research process was undoubtedly a valuable learning experience for me. I was deeply inspired by the resilience and capacities of the adolescent participants. The warmth and hospitality shown by the caregivers and the residential care administrative staff, all exemplified the sincere generosity that people showed towards a guest.

CHAPTER FOUR: RESULTS

4.1 Overview

This chapter reports on the results from 61 adolescent participants and three caregivers. The results are elucidated in two main sections. The first section provides participants' demographic results. Thereafter, the compilation of eight interviewed participants' profiles are briefly summarized before presentation of the qualitative data (from both adolescents and caregiver participants), with an emphasis on literature-based themes found in the data. The themes indicate protective factors which differentiate adolescents who overcome adversity and those who succumb to maladaptive, less positive outcomes. The themes might be specific to the residential care in question, in Namibia, but are not limited to new findings. Data from the caregivers were also analyzed to obtain a description of the characteristics that the more-resilient adolescents use to successfully deal with daily life adversity and the role people around them play in helping them deal with those challenges. A variety of quotations are used to give prominence to the participants' voices. In the second section, descriptive statistics are presented. Subsequent sections within the chapter present relationships between key variables and between participants' scores on the CYRM and the SDQ. This classification is based on the participants' personal transactions across four aspects of their lives: individual traits, interpersonal, community and cultural factors.

4.2 Demographic Data

The first part of this chapter provides the sample characteristics of 61 adolescent participants, with an age range of 11-19 years and mean age of 14.45 years ($SD = 2.26$). The study showed a prevalence of females (63.9%) in care, whilst males represented 36.1%. Looking at the overall levels of education among the total adolescent sample, all of the adolescent participants were enrolled in schools and one adolescent was a 2nd year university student, with 86.9% attending public schools and 13.1% attending special

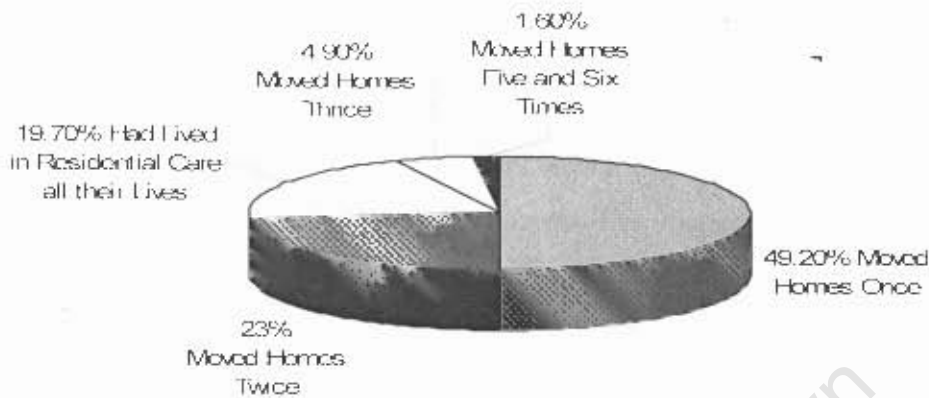
school or units for children with learning difficulties. Table 2 below shows the adolescent participants' highest level of education attained at the time of the study.

Table 2: Grade Distribution

Education	Frequency	Percentage
Secondary School Level	19	31.2
Grade 12	3	4.9
Grade 10	2	3.3
Grade 9	7	11.5
Grade 8	7	11.5
Senior Primary School Level	25	41.0
Grade 7	6	9.8
Grade 6	7	11.5
Grade 5	12	19.7
Junior Primary Level	9	14.8
Grade 4	5	8.2
Grade 3	4	6.6
Special School	8	13.1

Figure 2 below indicates how many times adolescent participants had moved residences in the last five years before residing in the current residential care. 49.2% of children had moved homes only once. The remaining participants had moved homes two to six times.

Figure 2: Homes moved in the past five years



In relation to the time spent by the adolescent participants in the residential care, the study reported a wide variation in months and years lived in the residential care. About 6% of the adolescent sample had spent between 3-6months; whilst 5% between 7-9months. The majority of the adolescent sample - 42% had lived in the residential care for periods of 6-19years; 25% had spent 4-5years; and 22% of this sample had lived in the residential institution for 2-3years.

When adolescent participants were asked whom they considered to be family, there was a wide range of responses. The majority of the participants (55.7%) considered and rated their caregivers in this residential care as being family. Biological parents were rated by 32.8% of the participants; this was followed by supportive extended family members (grandparents, aunts, and uncles) (8.2%), 3.3% of the participants rated their siblings and friends as being family.

4.3 Interviewed Participants Profile

Profile of Participant 1 (More-Resilient)

The participant is the second child of four (two sisters and an older brother). She grew up with her uncle, aunt and grandmother at a farm, while two of her siblings (except the youngest child) grew up with their biological parents. The youngest sibling has been and still lives with the grandmother, aunt and uncle. The participant met her biological parents when she was eight years old.

A year after moving into the residential care, the participant was attacked and almost raped. According to the participant, the parents (who are married) are unable to care for them because of their drinking problem. Her mother is a housewife and the father was fired from his job due to his constant drinking and absenteeism from work. As a result, they have no stable home because they cannot afford to own a house, pay mortgage or rent. The participant and her siblings' family visits (which used to be every Sunday and every school holiday) ultimately stopped. At the time of the interview, no one seemed to know the whereabouts of their parents.

As a child whilst in primary school, the participant and her siblings spent a whole year out of school. But she never gave up hope that she would go back to school and finish all her grades. She wants to study teaching after matric. She is doing very well in school and has never failed. She has a good relationship with her grandmother, aunt, and uncle. Most of her friends like talking to her about issues because she listens to them and also encourages them to work hard. She is very well mannered, extremely spiritual and has good relationships with all her teachers who the participant says encourage her and show her love. Her uncle, aunt, grandmother and parents also encourage her to study hard. She reads a lot to keep mentally healthy/strong. She has a positive outlook on life and one day she would like to help her parents stop drinking so that they can be a family again.

Profile of Participant 2 (Less-Resilient)

This participant and his sister lived in a lone-parent household before their mother passed away. They moved to another residential care facility before coming to live in the current care centre. He is the elder of the two siblings. He has a fairly good relationship with his sister. The participant's primary school years were very unstable (he started school late). He has learning difficulties and thus attends a special class. He is a very quiet boy but he does get into fights with other children who cause trouble for him and sometimes he does things he is not supposed to do. According to the participant, he lacks trust in people and therefore only has one friend at school of whom he is very fond. When he does something wrong his friend does not yell at him or ask him why he does wrong things. He is well behaved and very helpful at home but he has a pessimistic view of life. He is not doing well in school but believes that he will pass his grade. He has no relationship or contact with his father. He would like to grow up fast so that he can become a policeman.

Profile of Participant 3 (Less-Resilient)

The participant's mother passed away while giving birth to him. Two weeks after his birth, his maternal grandmother took him in but due to old-age she was unable to care for him. He has been living in residential care ever since. His parents were never married but he does have a relationship with the father and aunt whom he occasionally visits. Peer/friendship status is not a social goal for him. In fact, according to the participant, friends and religion don't play an important role in his life. He prefers to be by himself because he is easily stressed. He has scholastic problems. He is worried that he might not pass his current grade, which to him means that if he does fail he will be a nobody with no qualification. He is realistic about life's challenges, yet he sees them as unmanageable. He wants to become a tour guide.

Profile of Participant 4 (More-Resilient)

She is an orphan and has lived in residential care all her life. She has never met her parents and has no contact or relationship with any family member. Academically, she is achieving very well and has never failed a grade. According to the participant, she is only the second person from this residential care to go to university. She believes that other people have failed to make it because of negative influences from friends, teenage pregnancy, and discouragement as a result of name-calling by some caregivers. Generally, she is very cheerful, extremely confident, very outspoken and communicates well with people. She has a genuine concern for other people. She has good relationships with her caregiver (whom she refers to as mother), staff members, siblings and friends within the residential institution and teachers. She values friendship very much. At the time of the interview, she had lost a few good friends because they couldn't understand each other on certain issues. She is now careful when choosing friends. She would like to finish her studies, get a good job and live a normal and "high" life. She wants her life to be a positive influence to other children living in residential care facilities.

Profile of Participant 5 (More-Resilient)

This participant is an only child. She lived with her maternal grandmother (whom she considers to be the most important person in her life) since birth but due to old-age the grandmother was unable to care for her any longer. According to the participant, she now has a good relationship with her biological mother but she has no knowledge of who her biological father is. She does not wish to know him personally but she hopes to one day see what he looks like. She is doing exceptionally well at school (she is an A student). However, she finds life very stressful sometimes because some girls tell her about the things they do at an early age i.e. sleeping with boys, and smoking. At the time of the interview, the participant presented herself as a well mannered, intelligent, self-confident, calm and positive young lady. Sometimes when she plays games with other children, she chooses not to show much confidence because they always say to her she thinks she is high and mighty. They also tease her because of her small body. She values her friends

but she does not tell them or her caregivers her problems. Even though she often does/says the opposite of what they do and say, she knows they are good friends. Generally, the caregivers, and her teachers love her and her friends a lot. She would like to become a doctor. She would also like to own a very big house, three cars and travel around the world.

Profile of Participant 6 (Less-Resilient)

The participant is the second born of three boys; he and his younger brother stay in the same residential care. The older one currently lives with their divorced father. Before the divorce, all three boys lived with both parents, in an unstable family environment characterised by deviant behaviour such as alcoholism, neglect, and physical and verbal fights. After their parents' divorce, the two younger ones were taken to live with their maternal grandmother. Due to financial difficulties, she was unable to care for them. He has no relationship or contact with either parent but remains in contact with the grandmother. At the time of the interview, the participant experienced minor difficulties in the following areas: emotions (extremely angry), behaviour (bullying, fighting especially towards his younger brother, bedwetting during the night). His school performance is very poor. According to the caregiver, the participant is dishonest and steals almost anything. He presented himself as an aggressive boy and portrays a couldn't-care-less attitude. Furthermore, during the interview he spoke in partial sentences and failed to listen. He goes with the in-crowd of bad friends because they support him and he considers them to be friends. He is aware of his unpopularity at school and at the residential care but he seems not to mind because according to him the friends he plays soccer with like him. He has no personal goals.

Profile of Participant 7 (More-Resilient)

This participant is the third of seven children. She is doing extremely well at school and is well mannered, but had unstable primary schooling. Her parents are divorced. Both are in other relationships. The mother remarried and she lives with four of the participant's

siblings. The participant and two of her older sisters stay in the same residential care. Before coming to live in the current home, they lived in an after care centre. The participant does not know where her mother and the rest of her sisters are. They have no relationship with either biological parent and they do not get along with each other. According to the participant, she doesn't really want to live in the residential care nor does she like her school sometimes. She believes that a lot of the children don't like her. She does value her friends a lot. At the time of the interview, the participant occasionally consulted with a psychologist. She appears to be a self-confident young lady. However, she does not easily warm up to people. She would like to become a soccer player or a model or both if that is possible.

Profile of Participant 8 (Less-Resilient)

This participant has a twin brother and both have lived in the same residential care since they were a few weeks old. Before coming to live in their current home, they lived with their mother who was unable to care for them. As a result they were constantly in and out of hospital. They exhibit symptoms of sleep disturbances. Both have no relationship or contact with either biological parent. According to the participant, he is happy with his friends especially his twin brother whom he considers to be much stronger than him. Scholastically, he is not performing well but he likes his school and some of his teachers because they don't call him names or say bad things to him. Unlike his twin brother, the participant is developmentally challenged - he is very slow in everything he does. He has a low self-value. One day he would like to become a soccer player.

4.4 Qualitative Data Analyses

This was the main phase of the qualitative study and therefore the focus of the investigation. The purpose was to show that resilient adolescents who overcome adversity have certain characteristics that work as a counterbalance. According to Luthar, Cicchetti & Becker (2000) and Rutter (2000), such characteristics do not only help children withstand adversity but enable them to cope in different ways. Furthermore, they develop

age-appropriately, turning biographical disruptions into positive development. These characteristics, influenced by various factors (such as culture; self-appraisal of the adversity; and feedback from the environment) are dynamic and connecting in different ways for different children across time.

4.4.1 Characteristics of the More- and the Less-Resilient Adolescents

While children may be, in general, adaptable and resilient, some do emerge from childhood with negative attributes. Presented below are several key themes and participants' responses quoted throughout the discussion to illustrate these themes. Each section begins with information from the more-resilient participants, thereafter followed by data captured from the less-resilient participants. Quotations are referenced by a number in brackets. This number refers to a particular participant's response (i.e. (1) referring to participant number 1 and so forth).

4.4.1.1 Intrapersonal Traits

Problem-Solving Skills

All four of the more-resilient participants disclosed a range of problem-solving skills which caregivers noted to vary from youth to youth. Participant 4 spoke about her limited abilities to problem-solve, but she also demonstrated a determination to find solutions when she admitted: *"I don't always know the answers to every problem. Sometimes things happen for a reason and if I can try resolving a problem it is good for me but if I cannot resolve a problem I just go and sit in my room and think about it, because I do not like being a loser. Where I can help I will help resolve things"*. Akin to participant 4, participant 5 narrated her limited abilities to problem-solve but later acknowledged her reliance on significant others to help her solve problems: *"at my age I don't think I am able to solve all problems. My grandmother helps me a lot"*. Participant 7 shared similar feelings about her problem-solving abilities: *"I try to understand the difficulties I face and other people face. I like keeping things to myself and not talk to anyone because children like making fun of me. Sometimes I talk to one good friend of mine at school."*

There is also a person that I tell about the things happening to me. Her name is Ms Y, the psychologist. Other times I just pray. Sometimes even the children that say bad things to me sometimes come to me for help and I just help them. I don't like being angry all the time". She described her growing assertiveness in terms of fighting against the attempted put-downs of other people. For example, when other children make insulting remarks about her or her parents: *"...sometimes I also say bad things back to them. Sometimes I just sing while they say bad things to me".*

According to Harvey (2007), children who know how to be assertive are least likely to be victims of others. The latter statement was supported by caregiver 3 who indicated that the youth who grow up well despite adversities tend to see themselves as survivors and not victims because *"...they don't give up"*.

Unlike the more-resilient participants, three of the less-resilient participants reported their inability to come up with solutions to problems, which the caregivers reported is a general problem in the home. The participants further mentioned that their problem-solving skills are worse than other adolescents. Participant 2 recounted: *"I struggle to solve problems. I am only a boy. Maybe one day when I grow up a little"*. When the participant finds himself facing difficulties: *"I don't talk to anybody. I just keep quiet"*. Their powerlessness to solve problems was also evident in the way they dealt with problems. Participant 8 referring to his sleeping problems demonstrated a sense of self-awareness when he said: *"I am not good at school. At home my mother tells me that I always do something before I sleep. This is one problem I cannot solve. Things happen and nothing I can do about it"*. Participant 3 described his ability to problem-solve as *"a little bit better than others"*. He believes that he is able to help with certain problems but *"he's not fully qualified to solve problems"*. The caregivers recognized the disempowering space these participants occupy due to over-dependence on others to solve problems for them: *"a few are averagely good at problem solving. Most are struggling. It's like they are failing to think. They rely too much on others to solve things for them"* (caregiver 3).

The following coping strategies were used individually by the more-resilient participants: thinking through and not acting impulsively; seeking help and taking action; prayer and belief in God, belief in oneself; being hopeful and positive: *"...even when things are not going well"* (1). The less-resilient participants (2 and 8) employed two main coping strategies – praying, and occasionally talking to their caregivers. Participant 3 said: *"I try to stay positive and not focus on the negative but it's hard because bad things are all over the place. Not often I speak to someone I trust"*. Participant 6's coping strategy of *"I get angry and fight"* was rather aggressive. What was clear throughout the interview was that the participants seemed to be aware of life's challenges. However, they expressed limited control over challenges.

Positive Self-Concept

A positive self-concept includes positive thinking, encouraging others to try and do their best, and being determined to succeed against all odds. Additionally, a sense of power and control, purpose, worth and self-efficacy is reflected (Harvey, 2007). An ability to assist others is also associated with good health (caregiver 2). The more-resilient participants in this study demonstrated a positive self-concept when they admitted that they hold themselves in high esteem. According to caregiver 2: *"...they value themselves and see themselves as important person"*. The participants reported that they are happy with who they are. For example: *"People ask me why I am in here then God places a thought in my head that I am a good person. I believe in myself and I believe I'm a good person and people ask me that because they don't understand"* (1). Participant 1 further demonstrated her sense of control when she said: *"I think I have a sense of self-control but God is in control of my whole life. Just because I am in control of my life does not mean I can do what my friends are doing like drinking and smoking"*. These participants demonstrated an ability to reflect on their sense of control, self-confidence and positively appraise themselves through the following illustrations (4): *"I believe in myself. I don't really show people about my self-confidence. I don't even show people that I am angry or unhappy. I think my self-confidence shows already when I help organize events, MC at certain events"*. In relation to their self-confidence, participant 5 explained: *"I don't*

really show much confidence because then some people will say that you think you are all high and mighty”.

The participants demonstrated a balance between independence and dependence as remarked below: *“I don’t like relying on people. What the village gives me I appreciate and I try stretching it out. I don’t like depending on people. I don’t like asking here and there. Even when I don’t have cab money like this other day I walked from the university to here (residential care)”* (4). The same thoughts echoed in participant 5 who narrated an extract from her story: *“I am half dependent and half independent. Like if I want to buy something I have to wait for someone to give me money, buy me clothes, food, a car to take me to school. Or if I am not feeling well or something happened to me, I depend on my friends to help and support me because like I said before I don’t want to be a lonely person. Sometimes I also do things without having to wait for someone to tell me. Like I do my school work, clean the house, wash dishes and many other things”.*

Throughout their narratives, the more-resilient participants demonstrated awareness of others’ opinions but also demonstrated self-awareness, in that they were able to acknowledge and articulate their difficulties as well as reflect on their positive aspects. For example: *“I think I am very clever. I work very hard especially in my school work. I want to become a doctor. I think I am going to be successful when I grow up”* (5). Their self-awareness was also evident in the ability they showed to learn, achieve more in school and work towards successful future careers. They perceive success as achievable even for young people like themselves living in residential care: *“I feel very happy for people who achieve success because I know God will give us a chance to be a success”* (1).

Even in the midst of challenges, their self-efficacy was measured and enhanced by a sense of responsibility for their actions and for the well-being of others. Participant 1 found herself taking on an autonomous role of caring for her parents: *“The other day my mother and father came here drunk. It was in February about 10 in the morning on Saturday. They came to visit us. When I saw them at the here (residential care) I asked them nicely to come with me so I can take them home”* (when they still had a home). The

latter comments serve as an illustration of empathy, pro-social behaviour and a sense of duty on the participant and those around her.

The self-concept reflects how individuals define themselves and who they perceive themselves to be. However, when the self-concept has been attacked by negative experiences for example self-blame from others or from oneself it can be negatively affected. The belief is that the event happened or is happening because of me. Moreover, an attack on the self-concept may lead to perceived failure to live up to formerly held moral and religious principles as well as ideals for oneself (Van Vliet, 2008). Participant 1 explained: *"I think my parents drink a lot because I am in here. I told them that drinking won't solve the problem because if they keep drinking too much, I'll never leave this place and they'll lose us forever"*. Another great concern was the negative remarks from other children: *"when my parents drink a lot I am embarrassed and angry with them. I know other children will say bad things to me when they see them drunk and I know I have to help them but I don't know what to do for them"*.

All the less-resilient participants 2, 3, 6 and 8 reported that they are self-confident but according to participant 8 *"it depends on situations"*. Yet, participants 6 and 8 displayed a low self-worth resulting from the experienced disapproval of other children: *"they say that I am not clever in school and that I will fail school"* (8). The less-resilient participants appeared to lack assertiveness and self-efficacy as reported by participant 3: *"I wait for someone to tell me what to do. Otherwise I don't do anything"*. According to the caregivers, *"some of them know what they are supposed to do but they wait for me to tell them or they do something when they see someone doing it"*. From their narrated extracts, even with (participants' 2 and 3) sense of self-confidence, they appear to have an inability to accept, deal and cope with what they perceive to be bad things. Participant 2 for example said: *"It bothers me a lot that I am not able to control the way things happen, especially the bad things"*. They felt that they cannot control what happens to them or their families, evidence of an external locus of control.

An observation was made by caregiver 3, who reported that participants 2 and 3's self-confidence was evident within a group setting rather than individually. When asked by the researcher if they are dependent or independent, participant 3 reported that he is: *"...50% dependent and 50% independent. I rely on other people for help"*. The other less-resilient participants 2, 6 and 8 indicated that they are entirely dependent on their caregivers and others for everything. In response to these feelings, reassurance, validation, praise and encouragement were deemed by the caregivers to be self-concept boosters. *"When a child is not confident, that is when you come in to help him and to praise him into bringing their confidence back"*.

Social Competence

Social competence can foster positive interactions, positive life choices and this, in turn, can increase resilience (Harvey, 2007). Deficits in skill competence can limit adolescents' abilities to meet social expectations, an issue well documented in international literature (Luthar & Zigler, 1991).

When interviewed adolescents were asked about their ability to act and use age-appropriate social behaviours, they all reported on the consistent structure and clear behavioural expectations provided for by their caregivers and teachers at school. They know what is expected of them, what behaviours are acceptable and unacceptable. *"My tannie here...and when we go on holiday, my aunt, uncle and grandmother tell us that we shouldn't have bad behaviour towards our teachers, our house mother. We should respect them"* (1). The participants also mentioned how they are taught not to fight and to address people properly and to be considerate of others, to help when asked or simply offer to help: *"my mom here is a very strict person. When greeting people she hates it when you only say hello, you have to address everyone by name"* (4). Three of the more-resilient participants (1, 5 & 7) also shared their thoughts on how nervous they become when they are around people they have recently met.

Throughout their narratives, the more-resilient participants demonstrated an ability to initiate and maintain social interactions with their friends and teachers, as well as to show

respect for adults and their friends. Participant 1, for example, initiated social interactions with her siblings and other younger children in the home by teaching them about God, playing and taking care of them. Participant 5 displayed her social skills when interacting with children at the school kiosk where she helps out during school breaks. The social skills for resilient participant 4 were demonstrated while interacting with adults and disabled children by helping them with activities such as dressing up, serving food and performing first aid when necessary.

The social skills reflected upon in this study by the more-resilient participants included respect towards self, other people (children and adults alike), personal property, shared space and other people's belongings. Additionally, it included peace-building skills (such as assertiveness without being aggressive when managing conflict) and helping others. It also included feelings of being popular. None of the less-resilient participants thought of themselves as popular. They did however believe that: *"here and there are people who like them"* (3).

The less-resilient participants, particularly participant 3, indicated that his social behaviour, whether acceptable or unacceptable is self-learnt and shaped by *"...looking at the outside appearance of other people"*. Therefore his social behaviour has nothing to do with what the caregivers or family members teach, require or expect from him. As reported by the caregivers, less-resilient participants (2, 6 and 8) also demonstrated an inability to listen effectively, and this impacted negatively on their social interactions. *"She (the caregiver) makes us do right things but we don't listen all the time"* (6). Another remarked: *"my mother here teach me but when I go talk to other people, I forget the things she tell me"* (8). The less-resilient participants further demonstrated an awareness of lack of social skills, which made it difficult for them to receive the necessary support to help them rise above their social circumstances and improve their social connections.

Ability to Live with Uncertainty

Both groups of participants (the more and less-resilient) expressed feelings of uncertainty over situations and their future. Of particular concern was how their future will turn out. This was reiterated by the caregivers when they remarked: *“they (the participants) become uncertain about the life that waits them outside these walls”* (caregiver 3). The more-resilient participants, for instance, remarked: *I don’t always know what’s going to happen and I don’t know everything or understand all things but its okay because as I grow I will learn and understand better”* (5). Participant 1 reported on how uncertain she sometimes felt about her life: *“I am not sure about going to school anymore because my parents are drinking. When we are writing the exam, I think about what they doing. Maybe they are fighting again and they are drinking...I just want to leave school. But then God tells me don’t leave school...don’t let your parents drinking affect your life because it’s not your fault that they are drinking”*. Despite their uncertainties, the more-resilient participants remained positive and indicated a willingness to learn from their mistakes, circumstances and opportunities, and know more within their contexts.

The less-resilient participants said: *“Most things I cannot change. I can’t bring my mother back”*. Participant 6 said: *“I don’t know what’s going to happen to me and my brother”* (2). Participant 8 said the following about his way of living: *“I am so used to things not working out all the time so I can live with so much. I don’t want it like that but its life”*. The researcher asked how this affects his life and the participant said: *“ag...I can’t complain. I don’t want to complain because things never okay. So I just live my life”*. These participants appeared to have accepted unfavourable situations as “matter of fact”.

Sense of Humour

Humour is another building block of resilience. It helps young people distance themselves from using negative responses such as alcohol or drug use as stress releasers, and it also helps them achieve cognitive mastery of stressful experiences (SIRCC, 2003). Caregiver 1 reported that humour acted as a buffer for some of the participants: *“humour is very important because it makes anyone happy and it makes children think that life is*

not always about problems, problems, problems and being negative". Humour can reduce emotional pain (Harvey, 2007). The more-resilient participants, for instance, participant 4, used humour as a way of releasing stress, anger and taking life less seriously: *"I think it's important to make jokes. It's very important. Like in our youth house, I like Gwaraing people (way of making jokes/fun of people). There's this one girl here she doesn't like it when I make jokes, she totally hates it. She gets so angry and I always tell her she should laugh she shouldn't always be angry. I tell her you shouldn't always take things serious in life. You should also sometimes laugh about it"*. Participants 1 and 5 narrated similar stories: *"It's very important because we can't always be sad, and we should not always think about our problems, we should also think about the damage we are doing to ourselves when each and every minute we are just thinking about our problems for example, what am I going to do tomorrow...I am writing a test and I didn't study"*. In a slightly different vein, participant 7 believed that *"a sense of humour is needed but it depends on the type of jokes one makes. Some jokes can bring out trouble"*.

Three of the less-resilient participants (2, 3, and 6) found this building block of resilience irrelevant, as they felt that humour does not play a role in their lives. They did not show or appreciate a sense of humour. It appeared as though they had masked their pain by not responding to humour. Participant 6, for instance, explained: *"It's not important to me. Sometimes people make jokes about serious things. Its only when me and my friends play soccer then we make jokes about each other"*. Participant 8 admitted that a sense of humour plays a role in his life.

Although a sense of humour is a valuable tool that enables children to cope well with anger and other daily challenges, a balance between humour and reality was also encouraged by the caregivers: *"there has to be a balance, because the adult must tell the youth that life is not everyday a joke"* (caregiver 2). Humour is usually associated with popular people (SIRCC, 2003).

Future Aspirations

The need to set personal goals is established in the literature and is found to guide adolescents' actions, subsequently influencing their development. How adolescents translate these goals in such a way as to ensure a good future depends on their individual interests and discernment of workable options. Moreover, being future oriented gives a sense of hope and internal locus of control where individuals feel a sense of control and power over their environments (Krovetz, 1999).

All the more-resilient participants indicated that they are future oriented which included taking education seriously, studying further and eventually, having successful careers which they believed are possible through hard work, commitment and perseverance. Participant 4 narrated her goals and aspirations: *"I want to finish my studies. Not that I want to live rich but I just want to live a normal and high life as I'm living here in the village. Not only that I want to show people that I did it, it should also be a positive thing to me but should also be a positive thing to others. Like the children living here should be able to say...okay I also want to do like what Y did (referring to herself). Like for example my aunt last year at my matric farewell she surprised me by bringing scooter bikes escorting me to the farewell party. And you know...the children say I also want to go to grade 12. I want my matric farewell to be better than Y (hers). I felt so good; it's like an encouragement for them also. One day when I achieve my goals it will be for the orphans to know that they can also make it. I have big goals. Sometimes I also talk to them. Like yesterday I was speaking to some of the boys because they know I was very naughty when I was young, one of them told me we also want to experience what you experienced we also want to know what's wrong and what's right. I tell them that it's not necessary for you to experience it for you to know its wrong or right".* In retrospect, none of the more-resilient participants were pessimistic about the future. In fact, when asked what they thought of their lives, they reported that they desired to experience the love of their biological parents just like other children. Some of them reported that they wish their parents would stop drinking too much.

Participant 4 further responded: *"When you grow up as an orphan you do not always appreciate the things around you, you always have the problem that you do not belong here. You also need to have your own parents' love and so on and when that kind of thing is missing then a lot of things are missing. I have a lot of dreams and I hope that when I achieve all my dreams it will be an encouragement for the rest of the orphans. I do not only dream for myself but I also do it for the other orphans, because they are also going through what I went through. I dream of becoming and achieving big things in life"*. Participant 7 responded: *"I want to live with my biological parents like other children outside. I don't really want to be here"*. Participant 5 said: *"I think I am going to be successful when I grow up"*. Participant 1 said the following about her life: *"Maybe its better that I am in here because maybe I could be in danger outside while they (her parents) are drinking"*. They are hopeful and positive about the future. Participant 1 was able to foster this sense of hope when she said: *"...each and every human being has to have hope"*. The caregivers in the current study also found these youth to be optimistic about the future. Their hopeful thoughts and wishes for the future were linked to interests in pursuing helping professions which may be used to validate the experiences they had endured.

The less-resilient participants (2, 6, and 8) indicated that they are future oriented, whilst participant 3 reported to be content with living for the present. Although participants 3, 6, and 8 could talk about their future goals, they lacked the perseverance to see through their personal tasks and goals. They further indicated that they rather follow the in-crowd as remarked by participant 2: *"I do things my friends do or don't do but things I know I'm not supposed to be doing"*. The participants however refused to talk about what those things are. The caregivers acknowledged that these youth among many others seemed to have given up on future dreams, for instance, further studies and as anticipated, ultimately having a good life. They lacked flexibility and adaptability, and a belief that their efforts towards excellence can make a difference, hence, it is likely that they will not aim further than the present.

Abstinence from Substances like Alcohol and Drugs

The overriding theme was that all eight participants reported that they had never used alcohol or drugs but they know and are aware of children within the residential institution who do use such substances. Participant 1, for example, explained: *“What the children do is that they put socks together and pour some kind of spirit on the socks then rub the socks together and they sniff. They start acting all funny; some start fighting with the other children and do crazy things. Sometimes I pretend to act like them so that they don’t get angry with me and so that they think I am feeling like they are feeling”*.

Less-resilient participant 3 also reported: *“I don’t use drugs or alcohol but I know of some youth that I live with that use dagga*. Whilst the less-resilient participant 2 tried smoking cigarettes, he actually never took up the bad habit. *“...I have tried smoking cigarettes and I stopped”*. The caregivers recognized that substance use (not particularly referring to this sample group) may be linked to the physical violence experienced in the centre - ranging from kicks to punches and other forms of aggressive behaviour. The violence tends to be particularly directed towards the younger children (Pinheiro, 2006).

4.4.1.2 Relationship Factors

Quality of Caregiving

A caring, supportive and stable family has been found to be a consistent key protective factor in the lives of children (Luthar & Zigler, 1991; Masten, Best & Garnezy, 1990). The participants assessed their physical environment and quality of caregiving as good. In this study, the physical/material conditions refer to food (eating regularly), clothing and hygiene, the experience of affection and care, opportunities offered to attend school and focus on schoolwork. Children were provided with a sense of security (discussed further on in the chapter) after removal from an environment of potential harm.

All the eight interviewed participants described how the caregivers provided them with support and consistent guidance. The following were cited in illustration to some of these issues: *“She teaches us the right things from wrong. She tells us not to get into trouble.*

When we get into trouble she is always there helping us. Even when we do something wrong in the house, she always helps us. She buys food for us with the money she gets to look after us. She makes sure we eat breakfast, lunch and dinner everyday” (7). Participant 5 explained that her caregiver makes sure they are properly dressed in the mornings and she keeps track of their school performance: *“She reminds us when it's study time or time to do our homeworks”*. Participant 1 illustrated how the caregivers also teach them to be self-reliant: *“she tells us that we need to learn to do things by ourselves right now so that we can be prepared for the life outside”*. According to these participants, they listen to what their caregivers communicate to them. The caregivers also stressed that love is essential for the children: *“they need to feel the attention, the love and that there is someone to care, someone they can depend on throughout their whole life”* (caregiver 1).

The less-resilient participants further reported on how well they are looked after by their caregivers: *“they ensure that everyday you have a blanket over you. Like now its winter they ensure that you have a blanket. They make sure there's food, electricity and a roof over your head”* (3). The participants explained that the caregivers expect them to study hard and to do very well at school. In support of the caregivers' caregiving skills, participant 8 said: *“my caregiver sometimes checks my homeworks to see how I did do”*. Participant 6 made a comparison of his past and present life: *“when I was staying with my parents, they didn't care if we were in the house or not or if we have eaten or not. When we went to live with my grandmother she gave us food when she gets. Here in the... (Name of residential care), my tannie looks after us. She gives food everyday and wash our clothes”*. She also *“tells me to go to school, play and wash myself”* (2).

The caregivers spoke at length about striving hard to give the youth the finest care-giving experience by being empathetic and guiding them in the best way possible: *“I do not treat them as if they are not mine. I love them. I support them. Sometimes they complain also but I talk to them and tell them we are different people here in the houses, different mothers and different ways of disciplining so what's important is to learn to accept and appreciate each other differences”* (caregiver 3). Yet, the caregivers reported

experiencing challenges of working with young people. *"Its not an easy job, especially with teenagers who always think they have grown up and want to do what they want to do...some ask a lot of questions about themselves, their families and sometimes you can see the worry in their eyes about their lives"* (1). Moreover, the caregivers are of the opinion that most of the children perceived the residential care as a permanent placement rather than an intermediary place of living: *"most do have a belief that the residential home will be forever theirs. Some of them think that the things provided for them in here will stay forever and that they do not need to go out of here"* (caregiver 2). Some of them even resent or reject efforts to return back home. *"They don't even want to stay with their biological families, even the ones that are working, they are still staying here. When they are on leave, they are coming here. Some of them when they come back from the holidays, they tell you I am not going back there again and we cannot also force them"* (caregiver 3).

Caregivers' Involvement in Children's Activities

Equally important to the participants is the caregivers' interest and involvement in constructive activities. Weisner and Gallimore (1977, p.176) stated that "sharing tasks helps families cope with change and crisis". Participation in school or leisure-related activities has been identified as sources that provide physical and emotional outlets for children. It enables them to channel their energies appropriately and can increase self-esteem and confidence (UNICEF, 2002). Furthermore, when caregivers partake in children's activities, children learn from an early age tasks, values, and norms that help them adapt to their environment. Ultimately, they grow up into well-adjusted adults, integrating life changes that structure their communities (Weisner, 1982).

Three of the more-resilient participants felt that the caregivers are not very involved in their school-related activities. The participants felt that a lack of education might be restricting caregivers' involvement and participation in their school work and other activities that were of importance to them. Participant 4 explained: *"In any orphanage home they should not have people that are not qualified, because at our village none of our mothers are qualified and we cannot look up to them and say we want to become like*

one of them when we grow up. Maybe people with qualifications like social workers are an encouragement, because they have studied and some people study and some it is from the heart that they do the job". Participant 1 however felt very positive towards her caregiver's involvement when she said: *"...she helps us with homeworks when we have difficult sums"*.

All the eight participants indicated that they were expected to perform home-related activities or routine tasks which included cooking; washing dishes; making up their beds and cleaning their bedrooms, the yards (particularly the boys); as well as grocery shopping by the older children. In addition, the more-resilient participants' range of leisure-related activities (purely for the sake of enjoyment) varied from cooking, to playing in the park, church activities, going for walks, sometimes to look for plants and planting pots, attending parties, group recreational activities such as camping, and extra-curricular activities as and when organized by their different schools.

The more-resilient participants further indicated that they do not share activities with their caregivers and the activities are not assigned according to children's age as reported by caregiver 1. Instead *"they all take turns in doing the routine tasks so that they can learn and develop their competencies"* (caregiver 3). This finding is contrary to that reported by the less-resilient participants, who indicated that they are expected to perform age-appropriate activities.

Whilst the less-resilient participants 2 and 3 reported that they do not partake in leisure-related activities together with their caregivers, participants 6 and 8 commented on caregivers' involvement in helping them with homework, reading and interpreting biblical scriptures. Participant 8, for instance said: *"we pray together. Sometimes we play soccer and netball together"*. The contradiction in findings is reported by the caregivers to be a result of their differences in parenting styles.

Communication

All the eight participants positively reflected on their communication with the caregivers. They highlighted that they were encouraged to openly and freely express their points of view; and to discuss and share personal issues. The participants also felt that the caregivers emphasized educational achievements and had high expectations about their school performance. In three cases of the more-resilient participants (1, 5 and 7), communication between them and the caregivers appeared to be natural. *"When we have a problem we go to her because she tells us that we can always talk to her about anything. When she has a problem she sometimes comes to us especially me to see if we can help her. When we do something wrong she speaks to us, she tells each one of us in the house and corrects us so that we don't do it again"* (1). Participants 5 and 7 further reported that even though their caregivers tell them to freely and openly speak about anything especially when they are not happy with something or someone, their main sources of strength, support, advice, encouragement and affection were her psychologist (5) and grandmother (7). *"My grandmother...she's very open. My tannie does tell us to talk to her about anything. She teaches us things, she tells us not to fight but I still prefer to talk to my grandmother"*. Participant 4 reported a lack of communication between her and the caregiver. She felt that they cannot freely speak to her about things because she does not care about them: *"we do not have much communication with our youth leader except when we need something or when we have a problem or when she calls us to send us. That is the only time we communicate"*. The researcher asked about how this makes her feel and she reported that: *"sometimes we are okay with it but often we are not, because we feel she does not care about us. At other times we accept it and she is white and we also feel it is because we are black that she does not want to communicate with us. In the beginning we care a lot but now we are used to it"*.

The less-resilient participants further expressed a heightened sense of satisfaction with caregiver communication through the following extracts: *"she talks to me very good. She likes discipline, like the teachers at school"* (8). *"She discipline me and she also encourage me to work hard and have a good future"* (3). Another commented: *"at my parents house they shout and beat each other all the time. Here in the village my tannie*

shouts sometimes when she's angry with me but she's nice. My grandmother also talks to us good" (6).

However, communication between the less-resilient participants and caregivers did not appear to be spontaneous. These participants did not really share or discuss their personal and challenging experiences with their caregivers. The caregivers attributed the lack of caregiver-participant communication to ineffective listening and to participants' inability to accurately express their feelings and needs: *"The youth don't usually talk about the things bothering them. This tends to affect the problem-solving process"* (caregiver 3). The caregivers described attempts to decrease the lack of caregiver-participant communication: *"if something is wrong, I talk about it and I show them I don't like what you did and I explain to them what is right in that thing he did and what's wrong in that thing he did"* (caregiver 1).

Monitoring/Supervision

The sustainability of residential care centres depends to a large extent on the monitoring and supervision of children. Consistent monitoring and supervision deters inappropriate behaviour such as anti-social and delinquent behaviour (Subbarao & Coury, 2004). In this study, the caregivers reported monitoring to be a big role that they play in the youth's lives. All of the eight participants reported that their caregivers always know where they are because they are expected to inform them of their whereabouts. Other expectations included: completing house chores; respecting residential care personnel (including caregivers) and peers; not leaving the residential home without adult permission; and ensuring that weekends and holiday visitations are arranged prior to the date. Participants are expected to be in the village everyday before sunset, except if they are attending a school function whereby they are picked up.

In the absence of any caregiver (particularly during their off-days), there are assistant mothers who take over the running of the house, but the routine tasks are kept as predictable and as stable as possible. For violation of rules, for example fighting, there is no mandatory form of punishment enforced upon the younger children. This however

does not apply to the older adolescents who reported that: *"If you do not come back that night they will punish you, because you did not tell someone or if you do not complete your house chores. They deduct money from our allowances"* (4). Or *"If you always come late in the house then she takes you to the office to report you"* (7).

One less-resilient participant further reported that another way caregivers and sometimes external family members keep track of their whereabouts is through cell phone-use (for those who have): *"my family from outside communicate with me through the network of cell phone. We communicate by sending cell phone messages. Sometimes they come here to find out how I am doing. The people here, I usually tell them where I am going and if it's late and I am not yet back they come look for me where I said I will be"*. One participant indicated that often he forgets to tell his caregiver where he is going because he: *"likes to play"* (6).

All the three caregivers reported that in their efforts to monitor or supervise young people, enforcing rules and monitoring behaviour is an extremely challenging process. Some youth become defiant and reject the rules: *"it is challenging working with young people. Some do as they are told and some do as they want, some do as they used to before coming here. When they reach the age of 15/16years they think I am old now and I will do as I want and that's when you see things come out"* (caregiver 1).

Positive Mentors and Role Models

Caregivers and other people who act as mentors or role models can provide models of and reinforcement for problem-solving, motivation and other skills (McCallin & Fozzard, 1991; Punamaki, 1987; Richman & Bowen, 1997). In this study, both sample groups (the adolescents and the caregivers) stressed the importance of having mature, responsible and affirmative role models, who have the capacity to influence the youth positively. *"Youth must have a role model, a strong role model...it will help him think positive about his growing up"* (caregiver 2).

The adolescents, for instance, the more-resilient participant 4 admired her mentor, who despite hardship and life's challenges managed to make a success of her life: *"my social worker is a very nice person. She always told me to let my negative things that is happening to me in my life to let it encourage me and it was what encouraged her in her life. When we were together she always told me let your education be your first thing in your life and study hard"*. From participants 1 and 5's descriptions, their role models believe in God; they strive for self-improvement; they are independent, very loving and caring individuals who are always willing to help others. Participant 7's role model is one who has mastered a skill well— Jennifer Lopez, whom she admires for her singing talents. Two of the less-resilient participants (3 and 6) also indicated that having a role model is important. Participant 3, for instance, admired his role model's (residential care brother) ability to remain positive and make a success of his life. Participant 6's role model is a Namibian artist, whom he admires for his musical talent. The less-resilient participants 2 and 8 indicated that they have no role models.

Supportive Family Relationships

Much of the literature on supportive relationships presumes that families and non-parental adults can help protect children from the negative effects of stressful situations. Early bonding between mother and infant and the quality of interaction has long been emphasized as absolutely fundamental to promoting resilience (Mann, 2001). Children in residential care, in particular, need to be provided with a support system that consists of a variety of adults to whom they can turn, instead of being dependent on one support system. For instance, for children lacking close contact with biological family members, the concept of family can be broadened and extended to people outside of the biological family (Sinclair & Gibbs, 1998).

Seven of the interviewed adolescents had at least one adult who was supportive, nurturing and available to them. These people were a caregiver (for the more-resilient participant 4 and three less-resilient participants), a grandmother, biological mother, uncle and aunt, and friends. The caregivers also acknowledged the importance of being supportive and of providing a safe haven where children can come and share their worries and concerns.

However, as much as they wanted to have open relationships, the participants did not feel the same way.

Participants were asked about the quality of their relationships with the caregivers and the more-resilient participants (4, 5 and 7) indicated that their relationships are characterised by a lack of trust. Participant 7, for example, remarked: *"sometimes there is no relationship between me and her (caregiver). I don't share everything with her like she wants me too. I feel she doesn't understand. Often she will just go and tell other mothers what I told her. That's what they always do. It's a good relationship we have but just not all the time"*. She also appeared unhappy with her siblings' relationships and she saw the relationship as emotionally unsupportive as it is based on jealousy and rivalry between the three sisters. At the time of the interview, she said that she is making an effort to maintain positive ties with her three sisters.

Lack of trust is a common occurrence reported by the caregivers in this study. Caregiver 1, for example, explained: *"they do not have trust in the adults. They prefer to talk to people of their own age. Most times they talk to their peers, maybe also because some are a little bit scared of adults...considering their family backgrounds. From the workshops we attend, they say if a child stays 6/8 years in a bad environment, it takes so many years to bring him/her out sometimes"*. Another said: *"It's not easy to build the trust"* (caregiver 2).

Participants believed that their caregivers are not always tolerant of their behaviours: *"sometimes when you say things they say you are disrespecting but sometimes I do that although they say I am disrespecting. Because I am young I say it then come back and say that I am sorry although I know they were the wrong ones"* (4). But despite this, it was very clear that the caregivers were the people who took care of them. Participant 4 added: *"it's like they have forgotten about the bad things I did in the past. They are now more encouraging, they help me a lot"*. Participant 1 stated: *"they are very happy with the way I am living my life including my teacher. Today (on her birthday) she told me what a nice person I am. She always says good things to me. My whole class came and*

gave me hugs and told me that they love me". In contrast, participant 5 was clear that she is not bothered by what her caregivers or family think of the way she lives her life: *"I only care of the opinions that my grandmother gives"*.

Three of the less-participants (1, 6 and 8) felt that they could turn to their caregivers for support. Participant 8, for example, who had no knowledge of his biological family, related the following: *"I like my mother (referring to caregiver). Sy is n' bietjie streng maar sy is goed met ons (she is a bit strict but she's good with us). She is the only mother I know"* (8). Participant 3 indicated that although he has adults in his life he can turn to, he has no close-knit relationships with any of them. With regard to what their caregivers or members of their families think about the way they live their lives, participant 3 further remarked: *"I think people think our lives are different just because we live in here. I tell them it's a normal life. We are surrounded by other children who are not from our biological parents but we take each other as brothers and sisters. It's just a normal life"*.

Peer and/or Friendship Support

Apart from supportive relationships with family and non-parental adults, social support from peers has been evidenced to boost children's resilience. Peers have a strong influence on the development of any child. Positive peer relationships as described in previous studies provide an arena of support outside of the family. Research has also documented that feeling supported, guided and reassured, not only protects children against harm but also promotes self-esteem and helps children build a sense of hope and purpose (Luthar, 2000).

In this study, the peer support system was based on friendship. The more-resilient participants reported that they received and gave social, emotional and academic support to the few close friends they have at school and university. They also indicated that they don't think that they are popular but they know that a few of their friends and especially their teachers like them. Furthermore, participants felt unconditionally accepted by their friends, and they felt they could turn to them for support, encouragement, and comfort. They would, for instance, encourage others: *"to stay away from sleeping with boys. If you*

fall pregnant you'll be chased away from this place. So don't do those things even when they say you should try it (5). Although friendships are highly valued, participant 4 reported that she had recently lost all her close friends: *"At the moment I have a lot of problems with friends. I lost all my friends, because I do not talk to three good friends. We are not having a big problem but we have not resolved it, because we are all too proud"*. Although her friendship support was low at the time of the interview, her caregiver (whom she referred to as mother) and non-parental support system compensated for the lack of support.

Friendship, school and residential care life seemed to be crucial factors affecting participants' sense of belonging. All four of the more-resilient participants felt a sense of belonging at school, which they reported was created through sharing similar goals and the same social network, culture, and language. *"Me and my friends like the same things and all our teachers like us. Even though I don't always do what they do or say I think they are good friends. Whenever I am with them I don't feel lonely"* (5). Caregiver 1 also reported that *"most of them have friends at school"*. Another caregiver remarked: *"having friends makes them (youth) feel less lonely, because that way they have someone to share and do things with"* (3). Participant 5 deeply expressed her love for school: *"oh, I love school. I love it so much. I don't like being absent. I feel I belong at school but not at the village. Sometimes I don't want to live here anymore"*. Similarly, participant 5's experience was echoed by participant 7 through the following remarks: *"I like my school but sometimes I wish I just go to another school"*. The latter statements serve as a result of the participants having experienced negative comments from children both at school and within the residential care: *"the children here treat me bad. They say mean things to me. They call me all sorts of bad names like I have big knees, I am thin and..."*. For participant 1, it was evident that she could rely a great deal not only on friends but on other people as well to make her feel at home: *"I really feel that I belong at my school because everyone they love me, they care for me. When some older children at school or other schools want to fight me, all the children come and they say to them you cannot beat her up...she's not of your age"*.

Three of the less-resilient participants also cited friendship as a positive aspect in their lives, but none of them had an extensive circle of friends. Whilst admitting to having and confiding in their school friends, they also reported that they did not have caring teachers; neither did they experience a sense of belonging at school. They further indicated that their friends were also academically challenged, hence they were not academically encouraging, yet they offered them non-judgemental support and unconditional acceptance. *"My friends are like brothers. We don't do well at school but we talk about anything"* (6). Similarly, participant 2 said: *"my friends are important to me because I can talk to them about anything. One good friend at school that I tell my things". "When I do something wrong they don't yell at me and ask me why I did those things"*. Participant 3 indicated that friendship is not important to him. *"I am most of the times by myself. I like it that way because I get stressed very easily"*. This may be an added stressor for him in the context of poor support structures. All four of the less-resilient participants admitted to not having caring teachers and they also indicated that they did not feel a sense of belonging at their different schools. An interesting finding which emerged from the data was that the more-resilient and three less-resilient participants have identified friends at school (as opposed to friends within the residential care) as support structures outside the home. Caregiver 1 however cautioned that: *"friends are important in the lives of these children but they don't always choose the right friends"*.

Community and Neighbourhood Support

When participants were asked about the community's positive social influence in their lives, both sample groups reported that they experienced the community as unsupportive. The participants also reported that there was no encouragement from the caregivers to maintain contacts with the community. One of the more-resilient participants, for example, remarked: *"the community thinks that this place is meant for orphans but it's not true. It's just for children whose parents can't look after them"* (5). An interesting finding was that the participants believed that the community's lack of support and interaction could be a result of the children's problematic behaviours: *"...the children of this village especially the bigger ones they go to the shops and they steal a lot. Then people call the police. The children here always deny and they shift the blame on*

someone else. That's why the community thinks children here are mad and don't know how to behave" (1). Participants strongly felt that it would make a huge difference if the community would view them as individuals, rather than one of the youth in residential care: "...they constantly discriminate against us. Example one boy did something bad at spar (the supermarket) now they do not want to take any youth from our village to do holiday jobs. They say we are not scared, because you will also do what that boy did. They like confusing us with other people although each one of us has our own bad sides but they see us as the same. They do not see us as individuals but they see us as the village youth" (4). In addition, she indicated that even though they do not maintain contact with their community or neighbours, she is determined to make use of every opportunity to engage in community development programmes and assist other children who are less fortunate than herself: "At the moment I am involved at the Special Olympics working as volunteer helping children that are physically disable. I assist with the training, dishing out the food, assisting them to dress up, and first aid when necessary. I also help at Philippi Trust Namibia (a local counselling training centre) and volunteer as a leader of the youth clubs".

The less-resilient participants further illustrated how the community and the caregivers demonstrate a lack of commitment to residential care activities: "The community don't understand why children are living here. Their minds are not focused on us and they don't understand the purpose of things that are being done here. They are not even involved in the things we do. Whenever the staff here try to do something to involve them, even the caregivers here they have a negative attitude towards it and say things like...ag, its nonsense" (3). In a similar vein, participant 2 said: "Sometimes when something bad happens, the mothers here and other people do not want to help us. They say that children living here are not okay in their heads". "They look at us like we are not normal" (6). "They say we are problem children" (8).

The youth's sentiments were echoed by caregiver 3 when she said: "the community does not understand. I remember one incident some people went on air to complain. I think people are insecure. People really don't know, they don't care or they are not sure why

these children are here. If communities can be informed, that way they will have a better understanding of what is really going on here". She encouragingly noted that: *"Sometimes they (the youth) do have good ideas; they don't get really the support they need. If from our side we really assist the youth, I think they might just be ok".*

4.4.1.3 Community Factors

Avoidance of Violence

The participants were asked if they are exposed to violence and three of the more-resilient participants said that they are exposed, although indirectly (1, 4 and 5). The violence could be prevalent in both victims experiencing and witnessing acts such as individual or gang fights, domestic violence, or drug busts, within the residential care, in their parental/family homes, at school, in the community or neighbourhoods. *"I think I am indirectly exposed to violence. The children here use something that makes them act differently. I don't know if you'd call it drugs or something. When I was also staying with my parents, the children whose parents were living next to my mother and my father their parents always drinking and the father was using drugs. When he comes home, he starts hitting the children and their mother. Sometimes I think I am protected to be here (1)".* In a slightly different vein, participant 7 reported: *"before I came to live here I use to fight a lot because children made me angry with things they say to me. I am not very strong but I just use to fight a lot. But all that has changed especially when I started seeing the psychologist".* She attributes her change in behaviour to the direct response to intervention, for instance, to seeing a psychologist. Similarly, when asked about how they avoid violence they said: *"you can't avoid violence because it's everywhere" (1).* Participant 7 spoke about how one of her older sisters always advises her to avoid fighting even when other children say nasty things to her. The caregivers also reported that they teach the youth alternatives to violence and violent behavior.

Two of the less-resilient participants indicated that even though the caregivers teach them to avoid violence, they still engage in it. Participant 2, for example, rationalized his violent acts as follows: *"because other children in the residential care make me very*

angry, especially when they swear at me". They indicated that they resort to violent acts as a way of protecting themselves from others who might want to hurt them. They used anger and aggression as strategies for dealing with violent acts/threats. Participant 6, in particular, demonstrated anger management problems. *"I don't avoid violence all the time. If someone wants to fight me I fight them back. I also hit my younger brother a lot because he makes me angry"*. Participant 8 on the other hand said: *"I don't fight because my brother (his twin brother) protects me"*. Participant 3 reported a concern regarding his inability to easily be overwhelmed by the stresses of life; hence, he has difficulty maintaining his composure. *"I am a very stressful person"*. *"The thing that helps me stay calm is sweets. So I eat sweets"*. Children and young people's exposure to unstable, interpersonal violent backgrounds within parental or external home environments was seen by the caregivers as a perpetuating factor. *"Some of them their background plays a role in what they are doing now...you will see because their characters show"* (caregiver 3). As an intervention strategy, the caregivers encouraged the children to use the 'flight' and 'no fight' approach.

Meaningful Activities

A growing body of literature has shown that participation in useful tasks, activities and even hobbies can promote resilience (Boyden & Mann, 2000; Mahoney, 2000). When the activities (including income-generating activities) are not dead end jobs, performed for long hours in stressful surroundings, young people do not only generate an income but they also build self-efficacy and confidence. Furthermore, constructive activities create and enhance feelings of competence and skill mastery (UNICEF, 2002).

In this study, three of the more-resilient participants (1, 4 and 5) indicated involvement in meaningful activities and events. These ranged from visiting her grandmother, working at the school kiosk (5); to weekly afternoon kids and youth club, church activities (1 and 4); counseling training, going camping (4 and 5) and working as a martial arts guide for a motor racing company (4). While working as a martial arts guide, participant 4 has demonstrated an increased self-confidence and belief in her abilities. Working at the school kiosk has increased participant 5's numeracy skills, it has taught her the value of

money and it also enabled her to interact with her peers. Participant 5's visits to her grandmother enabled her to talk and discuss issues of a personal nature that she prefers not to share with the caregivers. Participants 1 and 4 reported that participating in church activities has helped them stay connected to the higher power (God).

When asked whether the different activities they are exposed to present them with any risks, they answered: *"they don't present any risks but if they did I'll try to handle it"* (5). Participant 4 said: *"yes some do present big risks but we have to be alert"* (referring to the Martial Arts). Participant 7 (who sometimes plays soccer with the boys) did not disclose what meaningful activities or events she would like to be involved in. It was clear that participant 7 had to deal with the possibilities of being ridiculed in a male dominated sport activity as evidenced by her statement: *"...children like making fun of me"*.

All four of the less-resilient participants admitted to being provided with opportunities to experience meaningful activities. This sentiment was also reiterated by the caregivers. The activities included praying (and going for confirmation classes), attending church, braaing, going to the beach during some holidays, watching movies, participating in sport activities (such as soccer, and netball) and involvement in a youth drug prevention group called TADA, particularly for participant 3. They also indicated that not all activities present them with risks, but some do, for instance: *"sometimes when someone kicks you by mistake or you bump into each other while running"* (6). Counteracting the above statement, the caregivers noted that: *"if there are risks then we talk to them and come up with suggestions of doing it differently which the adolescents do not always agree with"* (caregiver 2). Moreover, the caregivers reported that the less-resilient participants lack perseverance and commitment to pursue their respective activities and organised programs. They appear to give up easily, hence, causing them to drop out of some of the programs. Often they would say: *"I'm sick and tired of those programmes"* (caregiver 3). In addition to showing no interest in the children's activities that might be meaningful to them, caregiver 3 also felt that there is not much support in the sense that there is a lack

of encouragement: *"if you don't even motivate the children and encourage them to take part, they are not going to learn anything"*.

Access to Resources

All the eight interviewed participants indicated that they are provided with opportunities to access resources such as attending school and receiving an education. Seven of the interviewed adolescents and caregivers noted the government's statutory role and financial contribution in making basic resources available and accessible to support social development of OVC: *"when it comes to financial matters, the government does contribute to providing the physical needs of the children"* (caregiver 2). The participants further stated: *"the government is helping us a lot right now"* (5). *"...the government also asks us to behave so that we don't get chased out of this place because there are many children in the street who have no where else to go"* (7). Yet, adolescents felt a lot still needs to be done in creating appropriate programmes to better their livelihoods, particularly when they are older. Participant 4 remarked on the following issues: *"the government should do things for people who do not have education or cannot go to school for some reasons. They should give them courses where they need not to pay so that all people can become educated and provide more jobs. Not necessarily free hospitalisation but they should decrease stuff. With inflation and everything on the increase they should provide free and cheaper things for us like free services"*.

The situation concerning health development was encouraging. Adolescents in agreement with the caregivers reported that they are able to draw on a variety of sources that provide relevant and reliable information on social and health issues affecting vulnerable young people. Participant 5 explained: *"Sometimes we also receive people from outside who come in here to talk to us about life...mm that we should take care of ourselves so that we can be better people when we grow up and finish our university. We shouldn't be like children who fall pregnant and leave school before they finish"*. Participant 7 related: *"We also invite people from the hospital to come and talk to us what life is about and sometimes they do it themselves"*.

The less-resilient participants also reported having access to school and education. *"The government's role is just to see that we finish our education here and become successful persons. For our needs they make sure that we have everyday food and clothes to wear"* (3). However, they reported that they did not receive additional information to help them grow up well and develop into responsible, productive and healthy citizens. In contrast to the more-resilient participants, participant 8 reported on the government's unavailability in his life. *"I don't know what the government does. I hear about the government but I don't know what they are doing"*. When asked if they receive additional information required for survival, they reported that they did not. It appears as though they fail to use their personal resources to access and benefit from available resources. Alternatively, these adolescents' inability to access resources might be influenced by what they perceive to be a need at that time.

Apart from attending school, and receiving talks within the residential care, two major concerns were reported by both the adolescent participants and the caregivers. Children were confined to the residential home and had limited experience with the outside world. This can hinder the socialization and developmental processes, and also create high anxiety and excitement each time they leave for a visit or are to be visited. In the adolescent participants' qualitative responses, they further reported concerns about the future for when they leave out-of-home care and return to their families, communities and the outside world in general. Caregiver 3, explained: *"the children here don't go outside this yard. Our children don't leave this place, the people come here...children rarely mingle with others...they just stay in here. That's why they cannot wait if they know that some people are coming to see or talk to them, they don't even sleep"*.

The caregivers have thus suggested that transitional programmes be instituted for the re-integration process. They also explained that they try to encourage, reassure and comfort the children but: *"the challenging thing is that some of them their parents are not visiting them and one day they go out and the youngsters are not coping with their biological parents because they do not know them, they are not growing up with them and they did*

not make times during the time the child was here to make contact with the child" (caregiver 2).

Safety and Security Needs

The qualitative accounts of seven of the interviewed participants showed that they felt a sense of safety and security, which was related to the physical and material conditions of the centre. *"Here there are securities. They also brought dogs here in the evenings to run around to catch people that might try to come in here and harm us. They removed the dogs, there are only securities"* (5). The more-resilient participant 1 on the other hand, referring to her attempted rape incident told the researcher that: *"before the incident happened when the man broke through into our house, I was feeling safe but after the man broke into the house and the incident happened we are very scared now"*. Less-resilient participant 6 explained: *"when we sleep at night, my tannie (caregiver) locks the house. Outside, there is a security guard and there are also dogs that come in to check if there is something wrong. Another less-resilient participant said: I'm in the youth house we don't have a security guard but we feel safe because we have neighbours...other houses surrounding us"* (3).

4.4.1.4 Cultural Factors

Cultural Identification

Culture consists of norms and values that drive people's thinking and behaviour. These values are often in the form of religious or cultural beliefs that can contribute to resilience or increase vulnerability (Gunnestad, 2006). In this study, the adolescents and their caregivers also reported a lack of cultural identification, lack of sense of belonging and a poor self-esteem. These include all aspects of ethnic, family, school or community identification that are distinct from global culture. The more-resilient participant 1, for example, indicated that she identified with her culture when she affirmed tribal affiliation and national identity. She further reported that her cultural identification has caused her to experience a sense of shame: *"when I see people around me sometimes I feel ashamed that I am a... (her ethnic group). My parents are drinking so much and just look at the*

other children they live with their parents and I am sitting here and my parents are far away". She felt that her cultural or tribal affiliation is identified through the destructive behaviours of other people belonging to the same tribe. Participants 5 and 7 commented that even though they are culturally grounded and are aware of the cultural programs at school, and/or church, they do not express it daily: *"I know my culture but I do not practice it daily"* (4).

The less-resilient participants' adherence to culture was also more a result of school-based than family or community based activities as explained by participant 8: *"at school they sometimes ask us to dress in our traditional clothes, bring traditional foods but me I don't. I don't know my biological parents. I know little about my culture. I don't even know how to speak my mother tongue"*. Participant 3 said: *"I am a mixed race but I don't identify with both. I am not a cultural person. I am just as I am sitting here"*. Another participant explained that: *"there is nothing and no one that makes me proud of being the person I am. I want nothing to do with any culture"*.

Looking at the participants' responses, data suggests that adherence or opposition to local culture varied accordingly. Both the adolescent participants and the caregivers agreed that having to identify with one culture in the home is problematic, especially when there are more than four different cultural identities and expressions represented. The caregivers' inability to model cultural behaviour, can contribute to youth's inability to identify with their own cultures. One way of addressing this problem is to rebuild a process centred on cultural identification involving family affirmation during visitations and local community interactions. Moreover, the rebuilding process should involve acknowledging the experiences of stigma and misunderstandings of the children's behaviour associated with certain cultural behaviours.

Divine Intervention

When participants' experience of spirituality/religion was explored, all four more-resilient participants reported that a higher power or God had intervened in their lives in varied but significant ways. The caregivers also agreed that spiritual experiences had

given these children an optimistic view and conviction that life has meaning. Participant 4, raised in a Christian environment, explained: *"spirituality plays a big role in my life because without God, you can't really depend on anything except God. I also grew up in an environment where my mom involves God in everything"*. In a similar vein, participant 1 seemed to have a rather pragmatic relationship with God that manifested itself in her turning to God through prayer. She believed that God intervenes directly in her life whenever she has a problem: *"Spirituality plays a big role because when I have a problem I just turn to God in prayer and I ask him what should I do to solve the problem and He gives me the answer"*. She also believed that prayer was her vehicle for direct communication with God. Through her connection with God, she began to see the role she could play in contributing to the well-being of others. She said: *"I go to my bedroom to pray for every child in the house and for God to relieve us from all the tenseness so that we get up safely every morning"*.

It is interesting to note that the participants not only believed in a God that loves and accepts unconditionally, nurtures, comforts, protects, and heals but they also reported belief in a God that is moralistic – moralistic referring to a set of principles that assist the individual to distinguish right from wrong (Shaffer, 2002, p.511). Participant 7, for instance, described God as an external entity who teaches her moral values. *"Believing in God is important because Jesus teaches me right from wrong and as long as I make the right choices I'll be okay"*. Participant 5 expressed her firm belief that it is not necessary for her to go to church to have a relationship with God.

Whilst the less-resilient participants 2 and 8 reported that they also believed in a higher power whom they referred to as God, participants 3 and 6 spoke about spirituality/religion with disbelief: *"I am not a spiritual person and religion to me does not play a role in my life"* (3). Similarly, participant 6 said: *"I am not much into church and praying"*.

Again, these participants seemed to have an awareness of a divine power, but they showed no reliance on religion/spirituality to help them cope in strenuous situations. This

was despite much encouragement from the caregivers who believed that spiritual development can assist the youth in understanding and accepting their unfavourable conditions and also helps them to formulate future plans and goals. It appears as though spiritual experiences have not created, for the less-resilient participants, a context of expectations that adversity can be mastered.

4.4.2 Challenges and Concerns Emerging from the Interviews

The following issues although not entirely related to the ecological framework used, were concerns emerging within the study context.

About 50% of the adolescent participants expressed a strong desire to re-establish or maintain family attachments. However, they reported that their families seldom visit them, thus, contact with family members was infrequent. Caregiver 1 remarked: *"their parents are not visiting them and maybe one day they go out and then the youngsters are not coping with their biological parents. They do not know them; they are not growing up with them; they did not make time during the years the child was here to make contact with the child"*. An overwhelming number of the adolescent participants (53%) expressed a desire to visit and be visited by their families. These visits can be used to prepare both the child and the family members for reintegration into society, and to identify potential barriers to the reintegration process. Moreover, the visitations can help the child to have a good knowledge and understanding of their family's circumstances.

It is interesting to note that although a few of the adolescent participants (16%) felt that their families were supportive of them, almost the total sample (57%) acknowledged an unwillingness to share their experiences, their challenges and their hopes, with their families and non-parental adults (including caregivers). These participants indicated that the caregivers and the families simply do not comprehend their concerns. Another important point reported by the participants was that the caregivers disclose the shared aspects of the children's lives amongst themselves.

More than half of the adolescent sample (about 46%) indicated that they felt a sense of belonging in the residential care and were satisfied with the caregivers' parenting skills. The majority (56%) however also felt a deep need to live with their biological parents, an ongoing challenge they had to deal with everyday. Some of the participants have described being away from their biological families as the worst experience. In their response to questions about the best thing that ever happened to them, one participant who has lived in residential care all her life stated the following: *"I don't know whether I should say staying in the village is the best thing because I sometimes wonder what life could have been like having biological parents/family"*. This acute awareness of a void in their lives was also apparent when they exemplified a wish for a happy loving family: *"I will not abandon my children like my parents did but give them a better tomorrow"*.

The older adolescents reported peer pressure to be another everyday challenge. Furthermore, the participants indicated that they have to deal with everyday verbal abuse, which was evident through repeated taunting and humiliation. Participant 4 narrated her story: *"When you living at the village people like telling you about your past, saying you do not know your mother and so on. They like reminding you about your past and that is a challenge for me, because now I know it is not only that they are discouraging in a way for me they may think that it is affecting me but I take it as an encouragement. People here like calling us names (loser, thief, drug dealer) and then the youth stop going to school, because they feel why they must go when no one believes in them. Sometimes these things really hurt. Some youth also don't make it mostly because of teenage pregnancy and bad influences from friends"*.

Instead of facilitating healthy development, such negativity, for instance verbal and emotional abuse through repeated taunting remarks and humiliation sometimes from caregivers and other people within the community can hamper children's success. It hinders the provision of support and nurturance of attachment to a caring adult. For them to manage effectively, good coping skills are essential (Joseph, 1994).

In addition to the above-mentioned challenges, the less-resilient participants experienced educational and learning difficulties, and bullying. Participant 8 narrated the following extract: *“Some older guys beat me. Sometimes ask me to do bad things to other children. If I refuse they beat me. It’s fun to do what your friends are doing but not always. I feel sad sometimes because I don’t know my parents. One day when I leave this place I worry where to go with my brother. If my mother here in the village one day dies, don’t know who will be family”*. Another participant explained: *“my education is most challenging for me. Sometimes I doubt if I am going to make grade 10”* (3).

The older adolescent participants expressed feelings of shame with regard to living in the residential care. The caregivers reported that often, participants would lie about their abode: *“You can even see at school, they don’t want to be associated with this place. Sometimes you will hear them telling the other person...I am staying where and where. They make up these imaginary things...they feel ashamed, they feel they cannot match up to the others”* (caregiver 1). Another caregiver remarked: *“It’s very rare that they bring their friends here to visit. Even to be seen in the residential care school bus. Some of them walk back from school; they don’t want to be collected back”* (caregiver 3). One participant, for example, illustrated: *“I know that change is good but not all the time. Like when I came to live here I don’t tell people where I stay. When the children ask if I stay here I say no. I always tell them I stay nearby”*.

The following remarks were also cited to further indicate their sense of shame about their families: *“Some of them when they come back from the holidays, they tell you I am not going back there again and we cannot also force them”*. *“Even the ones that are working, they are still staying here. When they are on leave, they are coming here”* (caregiver 3). She exemplified a youth who refuses to introduce her mother to the caregivers and would not want to be seen with her either, because of her mother’s alcoholism. In addition, the caregivers observed that confidence in the less-resilient participants emerged within a group setting as opposed to being individual-based. Another interesting finding was observed by the caregivers: *“you see the struggles and temptations these youth go through but they try to cope”* (Caregiver 2).

Most of the participants (55%) indicated that they worry about the challenges that their families were facing (such as financial difficulties and other issues not disclosed to the interviewer) and that these challenges affected them in several ways. One participant, for instance, reported that she constantly battled with the thought of whether or not to drop out of school and leave the residential care, with a hope that her parents would stop drinking. The most serious and distressing issue that faced participants was their unpredictable future. Many of them were worried about what would become of them once they are released from the residential care. Their caregivers expressed a need for the children to be prepared for an independent existence outside of the residential care.

There was also a concern regarding engagement in risky behaviour which has caused a number of children to be expelled from the residential care. Such behaviour included sexual involvement, consequently leading to unplanned pregnancies, and behavioural difficulties, often deemed to be out of control even after several intervention measures are employed. One participant narrated: *"at our village, when a girl falls pregnant they chase her out, no matter where you go you just have to go, because it is a children's village and not a mother's village"*.

Some of the participants (about 39%) felt abandoned and rejected by their families, especially those who have been placed in residential care at a very early age. The following remark illustrated these issues: *"I want nothing to do with my family...they left me"*.

When participants were asked what changes they would bring to the residential care if given an opportunity, all the participants raised issues of concern. One participant, for instance, said: *"I will make a soup kitchen for the children because they always go to other people's houses and steal food"*. Some of them expressed a desire to participate in leisure activities outside the residential care and to interact more with the community. Some of them recognised the need for the residential care to employ more professionally trained childcare workers, who genuinely care about children: *"the positive change would be that people who are psychologically educated, to work with us here in the village"*.

The older children who are able to maintain jobs and exercise personal independence and responsibility expressed a need to engage in constructive income-generating activities. They reported that: *“the current allowance provided to us does not meet all the basic needs”*.

4.5 Quantitative Data Analyses

This section concentrated on the results pertaining to the measures completed by the participants. The measures include the Child Youth Resilience Measure (CYRM), and the Strengths and Difficulties Questionnaire (SDQ) (see chapter three for details). The scores obtained on the SDQ five clinical subscales are used to predict how likely a young person is to have emotional, behavioural or concentration problems severe enough to warrant a diagnosis according to the DSM-IV classifications (Goodman, 1997). Although SDQ scores can be used as continuous variables, each of the four subscales' total difficulty scores with the exception of the pro-social behaviour subscale has three possible predictions: normal, borderline and abnormal ranges. A high pro-social behaviour score determines a better outlook for intervention, even when a child is assessed to have high difficulty scores. A low pro-social score indicate a need for intervention.

4.5.1 Descriptive Statistics

Tables 3 and 4 below represent the adolescent participants' descriptive statistics for the mean, minimum and maximum scores, and standard deviation obtained on the CYRM and SDQ subscales.

Table 3: Descriptive Statistics for the CYRM: Adolescent Participants' Scores

Variables	Mean	SD	Min.	Max.	Cronbach Alpha
Individual	45.08	6.22	29	55	.57
Relational	41.11	6.57	26	53	.59
Community	28.72	4.96	18	38	.47
Culture	20.18	3.33	11	25	.57

Internal consistency for the CYRM subscales is also presented in Table 3 above. These data suggest that all subscales have low levels of internal consistency as determined by Cronbach's alpha coefficient.

Table 4: Descriptive Statistics for the SDQ: Adolescent Participants' Scores

Variables	Mean	SD	Min.	Max.
Pro-social Behaviour	7.03	1.97	3	10
Hyperactivity	5.85	1.90	2	11
Emotional Symptoms	5.56	2.19	0	10
Conduct Problems	4.62	1.92	1	10
Peer Problems	5.67	1.67	2	9
Total Difficulty Scores	21.7	4.63	10	31

Note: Normal probability plots of the variables showed no indication of a departure from normality.

The highest mean scores were obtained for pro-social behaviour, followed by hyperactivity and peer problems, and emotional symptoms. The lowest mean scores were obtained for conduct problems. The internal consistency of the SDQ subscales was not calculated in this study because the reliability of this measure has already been well-established with similar populations (Goodman, 1997).

When looking at the overall SDQ standardised scores for the total sample of 61 adolescent participants, 70.5% of the participants' scores indicate a diagnosable psychological problem, which signifies a normal prediction range. Scores indicating abnormal ranges were obtained for peer problems (52.5%), conduct problems (49.2%), hyperactivity problems (34.4%), and emotional symptoms (31.1%), indicating a need for further psychological diagnosis. About 21.3% of the participants, including the eight interviewed participants, had high pro-social behaviour scores, and an overwhelming 78.7% had low pro-social behaviour scores. The high pro-social score indicates the likeliness for a psychological difficulty; however, a better intervention outlook is predicted. The low pro-social score indicates maladjustment, hence, requiring intervention.

The total difficulty scores of the participants who took part in the qualitative interviews, and who had been identified by their caregivers as either more-or less-resilient were classified within the normal, borderline or abnormal range. Three of the more-resilient participants scored within the normal range on each of the peer, behaviour and emotional problem subscales. The fourth participant's scores fell within the borderline range on two of the above-mentioned subscales. While two of the less-resilient participants' overall difficulty scores were assessed to have fallen into the abnormal range, the remaining two less-resilient participants scored within the borderline range.

The overall caregiver scores (on the eight interviewed participants) indicated that seven of the participants experienced minor problems in the following psycho-social areas of functioning (areas that may warrant a clinical diagnosis): getting along with other children (friendship), behaviour and emotional problems. More serious problems of hyperactivity and concentration were reported in one of the more-resilient participants. The duration of their problems were found to vary for each adolescent (between 5-12 months to over a year). For some adolescents, the impact and level of distress, particularly, in the less-resilient participants was reported to interfere "quite a lot" with their home/family life, classroom learning/school performance and relationships with friends (Goodman, 1997) (see tables 5 and 6 below

Table 5: The Caregiver Informant Version

Participants	Overall Psycho-social Functioning	Period Difficulties were Present	Level of Distress on Child
1	Minor Difficulties	1-5 Months	Only a Little
2	Minor Difficulties	Less than a Month	Not at All
3	Minor Difficulties	5-12 Months	Not at All
4	Minor Difficulties	Over a Year	Quite a Lot
5	Minor Difficulties	1-5 Months	Only a Little
6	Minor Difficulties	Over a Year	Quite a Lot
7	Minor Difficulties	Over a Year	Quite a Lot
8	Minor Difficulties	5-12 Months	Only a Little

Table 6: Difficulties Impact Scores on Child's Everyday Functioning: Caregiver Responses

Participants	Home Life	Friendships	Learning	Leisure	Are Difficulties Burdensome on Overall Family Functioning
1	Quite a Lot	Quite a Lot	Not at All	Not at All	Quite a Lot
2	Only a Little	Not at All	Only a Little	Not at All	Not at All
3	Only a Little	Not at All	Only a Little	Not at All	Not at All
4	Quite a Lot	A Great Deal	Only a Little	Only a Little	Quite a Lot
5	Quite a Lot	Quite a Lot	Not at All	Not at All	Quite a Lot
6	Quite a Lot	Not at All	Only a Little	Quite a Lot	Quite a Lot
7	Quite a Lot	Only a Little	Not at All	Only a Little	Quite a Lot
8	Only a Little	Only a Little	Quite a Lot	Only a Little	Only a Little

4.5.2 Bivariate Analyses

Table 7: Correlations between the Independent (CYRM) and Dependent (SDQ) Variables: Adolescent Participants' Scores

Variables	SDQ Pro-social Behaviour	SDQ Hyperactivity	SDQ Emotional Problems	SDQ Conduct Problems	SDQ Peer Problems	Total Difficulty Scores
CYRM total Individual	-.11	-.10	-.15	-.24	-.12	-.25
CYRM total Relational	.24	.07	.09	-.04	.12	.10
CYRM total Community	.14	-.02	.02	-.07	.17	.03
CYRM total Culture	-.03	-.23	-.00	-.30*	-.05	-.24

Note: * Marked correlation is significant at the $p < .05$ level

As can be seen from the results presented in Table 7 above, only one significant negative correlation was found. More cultural factors related to resilience were associated with significantly fewer conduct problems.

Table 8: Correlations between the Independent (CYRM), Dependent (SDQ) and Potential Confounding Variables: Adolescent Participants' Scores

Variables	CYRM Individual	CYRM Relational	CYRM Community	CYRM Culture	SDQ Prosocial Behaviour	SDQ Hyperactivity	SDQ Conduct Problems	SDQ Emotional Problems	SDQ Peer Problems	Total Difficulty Scores
Age	0.25	-0.16	-0.60	-0.19	-0.05	0.19	0.15	-0.22	-0.38*	-0.08
Gender	0.05	0.14	-0.05	-0.01	0.02	0.13	-0.13	0.10	-0.04	0.02
Educational Level	0.14	-0.25	-0.03	-0.10	-0.11	0.06	0.02	-0.35*	-0.30*	-0.22
Special School or Not	-0.10	0.00	-0.10	-0.11	0.29*	0.16	0.01	0.23	0.16	0.23
Duration of Stay	-0.08	-0.10	-0.22	-0.14	0.15	0.07	-0.19	-0.04	-0.00	-0.08
Homes Moved	-0.19	0.25	0.13	0.04	0.10	-0.11	-0.00	0.03	0.06	-0.01
Person Considered Family	-0.21	0.12	0.26*	0.01	0.09	0.02	0.15	-0.13	-0.11	-0.01

Note: *Marked correlations are significant at the $p < .05$ level

While a few significant correlations were found from the adolescent participants' scores, in general, the relationships between the potential confounding factors and the CYRM and SDQ subscales were weak and inconsistent. As a result, these variables were not included in the subsequent analyses.

4.5.3 Multivariate Analyses between the CYRM and SDQ Variables

Regression analyses between the independent and dependent variables are presented in tables 9-14.

Table 9: Emotional Problems Regressed against CYRM subscales

Variables	Beta	Std.Err. of Beta	B	Std.Err. of B	T(56)	p-level
CYRM Individual	-0.21	0.14	-0.07	0.05	-1.44	0.16
CYRM Relational	0.12	0.14	0.04	0.05	0.88	0.38
CYRM Community	0.07	0.16	0.03	0.07	0.44	0.66
CYRM Culture	-0.02	0.15	-0.01	0.10	-0.13	0.89

Table 10: Conduct Problems Regressed against CYRM subscales

Variables	Beta	Std.Err. of Beta	B	Std.Err. of B	T(56)	p-level
CYRM Individual	-0.22	0.14	-0.07	0.04	-1.64	0.11
CYRM Relational	0.05	0.13	0.02	0.04	0.40	0.69
CYRM Community	0.14	0.15	0.05	0.06	0.93	0.36
CYRM Culture	-0.33	0.14	-0.19	0.08	-2.31	0.02*

Note: * Marked correlation is significant at the $p < .05$ level

Table 11: Hyperactivity Regressed against CYRM subscales

Variables	Beta	Std.Err. of Beta	B	Std.Err. of B	T(56)	p-level
CYRM Individual	-0.10	0.14	-0.02	0.04	-0.72	0.48
CYRM Relational	0.15	0.14	0.04	0.04	1.06	0.48
CYRM Community	0.10	0.15	0.03	0.06	0.65	0.52
CYRM Culture	-0.29	0.14	-0.17	0.08	-2.03	0.04*

Note: * Marked correlation is significant at the $p < .05$ level

Table 12: Peer Problems Regressed against CYRM subscales

Variables	Beta	Std.Err. of Beta	B	Std.Err. of B	T(56)	p-level
CYRM Individual	-0.22	0.14	-0.06	0.04	-1.57	0.12
CYRM Relational	0.12	0.14	0.03	0.04	0.84	0.41
CYRM Community	0.28	0.15	0.10	0.05	1.85	0.07
CYRM Culture	-0.15	0.14	-0.08	0.07	-1.05	0.30

Table 13: Pro-Social Behaviour Regressed against CYRM subscales

Variables	Beta	Std.Err. of Beta	B	Std.Err. of B	T(56)	p-level
CYRM Individual	-0.21	0.14	-0.07	0.04	-1.54	0.13
CYRM Relational	0.26	0.14	0.08	0.04	1.93	0.06
CYRM Community	0.19	0.15	0.08	0.06	1.28	0.21
CYRM Culture	-0.14	0.14	-0.08	0.08	-2.00	0.32

Table 14: Total Difficulty Scores Regressed against CYRM subscales

Variables	Beta	Std.Err. of Beta	B	Std.Err. of B	T(56)	p-level
CYRM Individual	-0.31	0.13	-0.23	0.10	-2.34	0.02*
CYRM Relational	0.18	0.13	0.13	0.09	1.40	0.17
CYRM Community	0.23	0.15	0.22	0.14	1.60	0.12
CYRM Culture	-0.32	0.14	-0.44	0.19	-2.32	0.02*

Note: *Marked correlations are significant ($p < .05$).

There were no significant relationships between any of the CYRM subscales and emotional problems, peer problems, or pro-social behaviour. However, the CYRM culture subscale was significantly associated with lower conduct problems, hyperactivity and total difficulty scores. The CYRM individual subscale was also significantly associated with lower total difficulty scores. The association between the CYRM relational subscale and pro-social behaviour fell just short of statistical significance at the .05 level (i.e. $p = .06$).

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Overview

This chapter presents a detailed summary and discussion of the results and their possible ramifications. The themes which emerged from the data are related to existing theoretical frameworks. Moreover, the chapter draws attention to similarities and differences between the study's results and previous research. The findings are also linked to the research question and objectives. The chapter further examines and explains (1) the study's limitations, and (2) recommendations for continued training, fieldwork and practice.

5.2 Discussion of Findings

Thus far, the findings addressed the four objectives of the study. Firstly, the study primarily aimed to gain a deeper understanding of the resilience phenomenon, generally and within a residential institution in the Namibian context. Secondly, to identify protective factors - qualities that are influential in shaping adaptive passageways for young people, subsequently contributing to resilience. The main findings included individual, relational and environmental protective factors that help to facilitate resilience for adolescents: *problem-solving skills; assertiveness, positive self-concept, responsibility towards self and others, acknowledging independency and dependence on other people, seeking help, social competency skills; ability to acknowledge a lack of control over situations, having a sense of humour, belief in divine intervention or God, future-oriented; positive/supportive relationships in key settings such as maintaining and remaining connected to people in their families; developing relationships based on trust (having someone to talk to about personal and challenging issues); and being provided with opportunities for leisure and income-generating activities; adults' involvement in activities meaningful to the adolescents; consistent monitoring and supervision, having*

mentors and role models; feeling safe and secure; as well as access to resources/information.

Factors rendering children and youth vulnerable to experiencing problems in the residential care were also noted: *feelings of shame as a result of living in a residential care; experiences of humiliation and taunting remarks; worry about the future; engagement in risky behaviours; feelings of abandonment and rejection, experiences of stigma and discrimination; lack of community interaction; lack of or no consultation with regard to what the children need.*

The chapter further reports on the study's main quantitative findings. Overall, the adolescent participants showed high levels of psychological problems and low levels of pro-social behaviour, with over 70% obtaining scores indicating a diagnosable psychological problem. Minor difficulties were common even in those adolescents identified by their caregivers as resilient. No significant associations were found between the CYRM subscales and emotional problems, peer problems and pro-social behaviour. However, multiple regression analyses indicated that the CYRM culture subscale was significantly associated with lower conduct problems, hyperactivity and total difficulty scores. Moreover, the CYRM individual subscale was significantly associated with lower total difficulty scores.

Thirdly, the study demonstrated that some children who live under conditions of poverty or hardship have the capacity to develop healthy coping strategies, supportive networks and competencies. As observed in other studies, resilient adolescents see themselves as active agents of their lives through the choices and actions they make according to environmental opportunities as well as limitations. High-risk resilient adolescents were found to have a more positive self-concept, and greater self-efficacy when compared to the less-resilient group. They perceived themselves as being less helpless and were more achievement oriented. They were more oriented towards self-independence and were less characterized by conflict. They were somewhat more flexible, and had a realistic and

optimistic view of the future despite hardship. They demonstrated assertiveness and confidence in their problem-solving skills.

It is interesting to note that with the less-resilient participants, self-confidence was merely observed within group settings as opposed to being an individual trait. This might be attributed to a sense of power and control participants felt amidst the negative remarks from others. The more-resilient participants manifested a higher level of perceived control over their lives. They were reported to create, appreciate and respond to humour in contrast to the less-resilient participants.

With regard to health issues, all the eight interviewed participants reported that they had never used substances like alcohol and/or drugs. The findings suggest that they might have been well informed of the dangers inherent in the use of such substances. The caregivers' sufficient monitoring and supervision of participants' behaviour might be an additional explanation. It is also worth noting that the low substance use reported amongst adolescent participants in this study may be related to a lack of money and the fear of being caught. However, one can't rule out the possibility that some participants in this study may in fact use alcohol and/or drugs, but lied about it as they might be afraid of getting into trouble, subsequently leading to being removed from the residential home.

On the interpersonal front, all the interviewed adolescents in the study, apart from resilient participant 1, felt that the caregivers were not very involved in their everyday activities, particularly, their school-related tasks. One possible explanation limiting some of the caregivers' participation in children's school-related activities was their inability to understand the children's homework.

Furthermore, resilient adolescents had the ability to recognize the social networks (friends, school teachers, psychologists, social workers) available to them and were more satisfied with the social support they received. Often, they were more willing to take on social tasks than their less-resilient peers with equal levels of opportunities. A striking finding which emerged from the data was that seven of the interviewed participants, with the exception of one less-resilient participant (who did not believe in friendship),

identified friends at school (as opposed to friends within the residential care) as structures of support and resilience. It was also clear in the data that many children reported experiences of taunting remarks from other children within the residential care. It can thus be assumed that some of their friends outside the residential care had no knowledge of why they were placed in care; hence, they appeared to offer non-judgemental support. The study also found that the more-resilient participants had positive mentors/role models that they knew radiated a helping and caring spirit, nurturance, and unconditional acceptance, as well as someone who has succeeded and mastered a skill well despite the odds. These results show that the individual and his/her environment are mutually interacting systems that adapt to any changes they each undergo (Bronfenbrenner, 1979).

Findings of this study also indicated that the more-resilient participants tend to adopt active survival strategies such as positive thinking, belief in oneself; belief in prayer and in God; as well as critical thinking. Effective coping abilities by the more-resilient participants are a finding that is broadly consistent with the existing literature (Boyden & Mann, 2000; Garnezy, 1987; Walsh, 2003; Werner & Smith, 1992). Garbarino, Kostelny and Dubrow (1991) point out that the capacity to engage in critical and lateral thinking can help safeguard children from face-value and self-defeating interpretations.

Overall, the more-resilient participants' (1, 4 and 7) involvement in programmes that develop leadership, team building, peer mentoring and problem-solving skills reinforced individual attributes that contribute to self-esteem, self-efficacy and coping. Although participants' feelings towards the community differed, the less-resilient participants showed no particular interest in maintaining contact with the community.

The situation concerning communication was comforting. All but one of the interviewed adolescents positively reflected on communication between themselves and their caregivers. The communication process appeared to be natural, reflecting the concepts of open emotional expression and affective responsiveness (Walsh, 2003). Yet, all the participants reported that they exercised privacy regarding whom they preferred to share concerns with, about themselves, their school, parents/family, friends and other pertinent

issues. A pressing need reported by one adolescent was a desire for an open caregiver-adolescent relationship. She remarked: *"We would really like her to change or even find someone that encourages us to do well and it would be good"*. A lack of trust among children and young people from unstable family homes has been well documented in the literature (Sinclair & Gibbs, 1998).

In general, residential caregiving has the potential to provide children with growth-enhancing experiences that they would not otherwise have in a dysfunctional biological family. It can be a protective place for children in need of care and protection. *"In here they feel safe and secure...when some of them go home for holiday, when they come back, how bad they look and they tell you I am better off here than outside"* (caregiver 1). Moreover, it is a place where young people and children are helped to regain control over their lives. It is a place where they can work towards achieving success and establishing mature and long-term supportive relationships.

Lastly, the study aimed to ascertain what challenges children in residential care face, which have the potential to inhibit their ability to adapt well in the face of life stressors. An issue of concern indicated in this study and commonly described in international literature is children's adjustment to residential care. Often children might have experienced multiple failed placements or they may not have been prepared in advance for their new living circumstances (Farmer, Wagner, Burns & Richard, 2003; Smith, Stromshak, Chamberlain & Whaley, 2001). This is evident from the number of times that the participants had moved residences in the past 5 years.

Moreover, enforcing rules and structure has been reported by the caregivers as challenging and difficult. Some children become accustomed to their own way of getting through the day without curfew, rules, or restrictions, particularly those from chaotic and/or disorganised families (Slesnick, 1966).

Another concern was the confinement of children to the residential care; limiting local community integration and support, as well as exposure to the outside world. This

situation might impede their social competency/skills as mentioned in the literature review (Harvey, 2007). This finding is contrary to Ungar et al.'s (2007) cross-cultural study which revealed that children whose living arrangements comprised of biological parents, family members, guardians and residential homes, relied on resources in the communities to navigate their way to health despite adversity. The study further emphasises that unsupportive communities may have contributed significantly to the participants' lack of interest in participatory community programmes. Moreover, because societies are living in homes and environments that are broken and strained by poverty, violence, HIV/AIDS, and lack of resources, they may be less willing to provide care and protection to vulnerable children in their midst. Poor community and neighbourhood support structures have been described in previous studies (Garmezy, 1993; Hayes & Kerman, 2001). This challenge seems to significantly increase children's vulnerability.

An issue that may be more specific to this sample is that the caregivers are of the opinion that most of the children perceived the residential care as a permanent placement rather than an intermediary place of living. The following caregiver's remark illustrates this issue: *"most do have a belief that the residential home will be forever theirs. Some of them think that the things provided for them in here will stay forever and that they do not need to go out of here"*. While the reasons for this are not entirely clear, it is possible that this result can be attributed to the experienced harsh realities the participants had faced and their families might still be facing.

The participants might be trapped at a stage where they have become unwilling to improve relationships with their families. The alienation of the child from their biological or extended family has been reported in literature to occur when a child is provided for with a standard of material well-being higher than that which he/she experienced in his original family or surrounding community (Subbarao & Coury, 2004; Tolfree, 2003). This has been found to be the case in this study. Therefore, as children quickly adapt to improved living conditions, they are likely to look down on their families and communities as second-rate. In the long-term, this can cause significant difficulties with social reintegration. Failure to prepare children for the re-integration process is well

established as a common occurrence in the literature (Powell, et al, 2004; Subbarao & Coury, 2004). This was despite the fact that many of them have been identified to have contactable relatives; therefore, having the potential for family reintegration. These findings are similar to those consistently found across previous studies in this area (Powell, et al., 2004; Quinton, 1996). A central theme which runs through a significant majority of the adolescent participants' narratives is worry about their future.

As demonstrated by other research (Powell, et al., 2004), some of the adolescents in this study have expressed feelings of discontent, shame, humiliation, rejection, fear and disillusionment whilst living in the residential home. Taunting and shameful remarks may significantly increase children and young people's vulnerability. Feelings of rejection and abandonment are known common contributors to a lack of self-esteem and lack of identity in children and later in adulthood (Harvey, 2007). Furthermore, almost all the participants in this study indicated a lack of consultation on day to day issues affecting them. Child welfare bureaucracy also has the possibility to overshadow the interests of the children; hence, their needs are often ignored.

Another child protection concern that emerged in this study and that can increase the participants' vulnerability and maladaptation is bullying as experienced by one of the less-resilient participants within the residential care. The bullies have been described to be other older children. This is a risk factor for all age groups. Although the residential care was identified by one participant as a place where she no longer felt safe and secure, it remained a safe place for others, especially when their homes are vulnerable. It is a place where these young people are provided for with basic needs – food, clothing, shelter, education and health, a place where they had been given hope for education, and where caregivers (whom some refer to as mothers) care for them. Provision for basic needs has been reported by all adolescents to be important and a mechanism that can increase resilience as they do not have to worry about food and not going to school like some of them did while they lived with biological parents/family members. This had made some of them feel equal to other children living outside residential institutions.

The children and adolescents in this residential care have been placed here for the purposes of safety, following physical, sexual and/or emotional abuse, neglect, abandonment, poverty (parental unemployment), etc. Data from this study reiterates that such stressful multi-problem milieus in vulnerable children and adolescents can increase the children's chances of developing externalizing problems (such as conduct problems and hyperactivity-inattention) and internalizing difficulties (such as emotional and peer problems). In this study, the effects of individual risk exposure to adverse conditions seem to apply more to peer and conduct problems and less to emotional difficulties. These findings are contrary to those found by Quinton (1996) who indicated that children in care tend to display increased levels of difficulty on negative outcomes such as emotional distress. The total problem scores for the study's adolescent sample are reported to be within the abnormal and borderline range. Even those who were identified as more-resilient by their caregivers showed borderline levels of functioning according to the SDQ.

This study also highlighted dominant psychosocial factors which included discrepancies in educational performance, learning and attention; as well as social influences, such as family functioning, making and maintaining of peer relationships. These were identified to be particularly problematic among the less-resilient adolescents. Another apparent discrepancy was that in the interviews, participants reported in detail about not being associated with their culture. Whilst in the quantitative analyses, cultural factors were found to be protective against conduct and hyperactivity-inattention problems. However, this discrepancy can be explained by the fact that spiritual beliefs and religious activities were included in the CYRM culture subscale. Spirituality came across as an important protective factor for the more-resilient participants in the interviews, which might explain why higher scores on the cultural factors subscale were associated with fewer problems.

The study's results further indicated that almost eighty percent of the adolescent participants showed low pro-social scores. Findings based on the adolescents' data support the literature in suggesting that there is a significant need for support services to address the emotional concerns, as well as the challenging behaviours of children and

adolescents. Evidence in support of the emotional symptoms and challenging behaviours of children and adolescents was provided for by a degree of correspondence between the SDQ child self-report and the caregivers' version. Combining the data from both sources is useful in detecting and assessing strengths and difficulties of individual adolescents. Although the above-mentioned psychological problems may manifest in various ways, the risk for continuity of these problems could not be reported or predicted in this study. Hence, the scores should be interpreted with caution.

Furthermore, in the absence of a longitudinal study, it is not possible to say whether this situation is unique to Namibian adolescents in residential care or equally applicable to those living in biological homes and those without parental control. It is also not known whether what is considered "normal" or "abnormal" in Namibian norms for adolescents is the same as what is considered "normal" or "abnormal" in the USA or the UK. Findings from this study should however provide a foundation for future research and development in this field of study.

When considering the general results relating to psychological health and wellbeing, this study did not report on individuals' level of psychological functioning prior to residential care placement. It is therefore not known if problem behaviours and emotional problems were present prior to the individuals' entering the residential care, or developed while in the residential care. The existing psychological problems also suggest that there may be important confounds between the reasons for residential care placement; frequent residential movements, changes in living conditions and the proximity of the person who might have inflicted pain or disillusionment on the child. In addition, the outcomes for children are affected not just by protective factors but also by the total number and type of risk factors to which they have been exposed (Luthar & Zigler, 1991), and the level of experienced stressors. Examining and linking specific risk factors to their outcomes was beyond the scope of this study.

As identified in international cross-sectional studies, potential protective factors help to facilitate resilience even when psychological symptoms are assessed independently from

the resilience variables. However, it remains unclear how far the protective factors actually have a long-term protective effect or whether they are only correlating symptoms or consequences of adaptation versus psychological disorders (Losel & Bliesener, 1994).

Studies on resilience-promoting factors are informative for health practitioners, both in general and in relation to child welfare in particular. However, such studies do not provide answers for all children experiencing increased levels of difficulty or negative outcomes, nor do they provide a 'magic potion' that will always affect everyone in the same way (Werner, 2005). While it is important not to abandon existing knowledge, the answer does not exclusively lie in the development and establishment of intervention or support programs. An environment that promotes healthy development and is attentive to the needs of children and young people should be created. In light of the results of this study, it is necessary that certain elements that can enhance resilience are in place in the adolescents' lives, for example, a meaningful relationship with an adult or consistent people in the children's lives. Equally important is that attitude change occurs in the adult caregivers/family members and health practitioners who are in frequent contact with these young people and their contexts. Even with such an approach, there is no guarantee for positive adjustment, but it does increase the likelihood of a desired transformation.

5.3 Limitations

The present study had several limitations that require caution in the interpretation of findings.

5.3.1 Sample

Several issues specific to the sample are noteworthy. First, the study's results may not be generalisable to children and young people living in other residential care institutions in Namibia, whether in temporary or long-term care. Secondly, the study relied upon cases of individuals' life experiences and their subjective perception within one childcare

centre. For the above-mentioned reasons, great caution should be taken in the interpretation of these results and they should not be seen as conclusive.

Thirdly, the study was based on a view of the resilience concept and the presence of personal and social competencies as judged by caregivers and assessed using established questionnaires. This technique does not reflect the subjective nature of resilience as constructed by adolescents themselves. As noted by Ungar (2001), some young people may recognize their resilience and ability to triumph over adverse conditions without being perceived as resilient by the caregivers or adults. Presumably, the reverse might also be true. However, it was not the objective of the present study to holistically focus on the above mentioned factors. It is likewise worth mentioning that the generalization of results to all youth in residential care in Namibia could be explored in further research.

5.3.2 Language Barrier

The interviews and questionnaires were in English, a recognized official language in Namibia. For participants in this study for whom English was a second language, proficiency of some respondents was better than others. Some of them may not have been able to accurately express their thoughts and experiences. However, this limitation was catered for by the participants' ability and freedom to express themselves in English and Afrikaans without an interpreter. The questionnaires were not translated into and administered in the participants' home languages because more than two languages were represented in the sample group.

5.3.3 The Interviews

The limitation in this method of data collection lies in the disruptions caused during the flow of the interview process as the interviews were held after school in the living rooms of the selected houses within the residential care centre.

In terms of analyzing qualitative data, theory-led content analysis does not allow the researcher to identify new or unexpected bits of information, unless they relate directly to one of the pre-established themes (Braun & Clarke, 2006).

5.3.4 Questionnaires

Another limitation is a high dependence on self-report measures and participant recall. The results are thus susceptible to possible bias, especially in the direction of social desirability effects or under-reporting of problems (Mouton, 2001). There is however no evidence that this occurred in the present study. Bailey (1994) ascertained that to a certain extent, this can be minimized by establishing good rapport, and a relationship of trust, between the researcher and the participants.

In relation to the Cronbach's alpha coefficients, low scores were obtained. The alpha coefficients are also lower than those obtained by Ungar et al., (2005) (see p. 65). One possible reason for the low coefficients is that the measure may not be robust enough in such a complex research field or the CYRM measure may cover multi-dimensional data. This implies that the instrument may cover quite diverse attributes of resilience. This is in keeping with what Kline (1999) says should be expected for this kind of social science data.

Although the Strengths and Difficulties Questionnaire has been translated into over 40 languages and has normative data from diverse countries, it is worth repeating that the SDQ validity with a Namibian sample is unknown. The results should therefore be interpreted with caution and should not be seen as conclusive.

Based on these findings, it is of course imperative to examine and understand the same issues in the presence of a matched control group at all levels (local and regional - urban and rural) in order to have a holistic perception of the topic under investigation.

Despite these limitations, this research study provides a wealth and depth of information on resilience-promoting factors in high-risk adolescents living in residential care. It also acknowledges the impact of residential care on children's psychological well-being. Hence, the preliminary results of this study provide insights into these issues and contribute towards its understanding.

5.4 Conclusion

In light of the study's objectives, resilience in this study was defined as a process of, an outcome of, or an individual's ability to successfully adapt or bounce back despite challenging or threatening circumstances (at home, school or within the community). This dynamic process incorporated the interaction of internal and external competent functioning. Moreover, resilience was assessed on multiple domains as opposed to a single outcome. Studying resilience across domains is more appropriate when the risks and problems/challenges experienced by the young people are not specific and vary in nature, as was the case in the current study.

It is evident from the interviewed participants' narratives that adolescents studied in this research are growing up at a time of significant family, cultural and economic change and much has been speculated about the effects of this change on children's lives. Some features of change are assumed to endanger children, while some may even be beneficial. Regardless of the change, these young people confront myriad stress factors that are part of life, no matter their age, gender, ethnicity, or economic status in society.

This study has demonstrated that in order for these vulnerable adolescents to continue pursuing their journey of a healthy development, at the same time, acknowledging their difficult circumstances, there is a need to foster and support potential key protective factors that contribute towards resilience. In addition to a child's individual abilities, specific events such as developing a meaningful relationship with a significant adult who is competent, reliable, responsible and responsive can diminish children's personal weaknesses, and can develop, and support their strengths. External factors

(neighbourhoods, church, community, schools) also need to support positive efforts made by the child to enable them to function within acceptable bounds on measures of behavioural, social, and cognitive competence. However, if any one of the supportive relationships collapses or something happens to one of the significant persons, the developmental trajectory may change to a path of risk or resilience. This is in line with Masten (2000, p.5) who noted: *“the best documented asset of resilient children is a strong bond to a competent and caring adult; however, this adult need not be a parent. For children who do not have such an adult involved in their lives, this is the first order of business”*.

This study's data reports that provision of substitute parenting might be a great benefit for some children and young people, particularly, those from disorganized homes. However, assumptions should not be made about the type of relationships adolescents have with their caregivers. As we have seen in the data, the caregivers and the community added stress to the adolescents lives as a result of humiliation and repeated taunting remarks, discrimination and stigma experiences. Also important, is the consensus that appeared to be present between the caregivers and adolescents' responses regarding lack of caregiver support towards the adolescents, lack of community interaction, and lack of trust between caregiver-adolescent relationships. The adolescents also identified a need to grow up with biological parents. Their greatest concern was their future after life in a residential institution. These challenges have the potential to hinder resilience.

Resilience is not a fixed trait, but rather a dynamic process that can develop over time. This means that showing evidence of resilience at one phase or across domains does not mean the resilient individual possesses extraordinary power in a traumatic/distressing situation nor does it mean they are unaffected by negative circumstances (Luthar, 1991; Masten, 1992). Although many of the children in this study benefitted from residential care in terms of food, clothing, shelter and education, psycho-social difficulties were common. The study's quantitative findings indicated high scores on the peer and conduct-related subscales of the SDQ, which could be of possible concern in this sample. Higher scores on the CYRM culture and individual subscales were associated with fewer total

difficulties on the SDQ. Although caution should be used in inferring causal relationships on the basis of correlational research, the results suggest that increasing adolescents' individual and cultural resources (including spirituality) might help to facilitate greater resilience.

Given that a substantial number of adolescents in this study reported a lack of consultation with regard to their needs, it is imperative that their needs are identified and addressed along with those of children and young people living with biological parents/families.

Indeed, the Namibian Child Welfare Sector provides clear regulatory framework for residential care as one of a set of care options for children without parental care. This is primarily detailed in the Children's Act 33 of 1960, Child Status Act of 2006, and the National Policy on OVC as well as the Minimum Standards for Residential Child Care Facilities. The evidence from the study suggests that residential care provision for OVC continues to meet most of these children's basic needs. However, the current systems, procedures and approaches to social welfare provision for children are inadequate. The MGECSW personnel have been so focused on ensuring that social grant applications for registered child care facilities are processed that provision of social services has lagged behind. For instance, the residential care in the study had no provision of a social worker, a key role player in the psychosocial development of children. As with caregivers, residential institutions find it difficult to retain social workers largely because of low wages.

Under the current child welfare policies and legislation, there is no provision made for therapeutic interventions that effectively address children's social skills, as well as techniques designed to manage and redirect aggressive behaviour. As the study revealed, many children are prone to psychological and developmental needs. Although the child welfare sector emphasise family and community embeddedness, this is one of the criticisms of residential care as it isolates children from meaningful family and

community interactions, hence, hampering the preparation process for children to adjust outside the residential care.

The relevant policies articulate residential care as a 'last resort'. However, the policies do not highlight the pitfalls for long-term residential care, whilst, the approaches advocated by international consensus are reflected in all the existing child welfare policies. In Namibia, significant steps must be taken to bridge the gap between child welfare policies and service provision. Intervention strategies should be youth centered. 'One size fits all' responses should be avoided. Often, children's descriptions of their own experiences are different to those of people involved in their care. It is therefore of utmost importance that social workers and other childcare workers believe in the potential of these young people, and support their creativity/ideas while respecting their individual differences. Caution should however be taken against interventions that may foster dependency.

5.5 Recommendations

Therefore, based on the conclusions mentioned above, the researcher makes the following recommendations and notes potential implications.

Qualitative and quantitative research would need to be conducted on a wider population group of adolescents in residential care facilities in order to systematically and culturally/contextually:

- establish whether different types of adversities have differential outcomes;
- establish causal relationships between investigated variables;
- establish mediating and moderating processes that generate, encourage and strengthen resilience in young people living in childcare facilities; and
- develop an objective instrument to measure resilience in the Namibian context.

Because risk factors and the needs of children vary greatly throughout their developmental stages, longitudinal studies would need to be conducted. The utility of

such studies would lie in that they would provide information on the continuity and discontinuity, similarities and differences of risk and resilience-promoting factors in vulnerable adolescents over time and across cultures. Furthermore, the utility of such studies would allow for content-context interpretation and intervention strategies that are unique to a particular childcare centre and that meet the learning needs of adolescents. The aim would be to promote adolescent health during life transitions and periods of adversity.

Mandatory transitional programmes should be developed to enable young people to either reintegrate well into their biological families or to return to their communities, especially if a build up of over-age children in residential institutions is to be averted.

Vocational training programmes should be developed. At present, the Namibian child welfare department offers this service to children and adults/parents who are on the street. This could be integrated into other child and adolescent interventions. Young people need to be well equipped as they set off for independent living and employment. Ongoing support should be maintained, particularly after the youth are released from care. Equally important, intervention relevance and effectiveness needs to be monitored and evaluated periodically in order to keep abreast with new developments and ideas that meet children's present and future needs, expectations and challenges.

Existing OVC policies, procedures and regulations should be periodically assessed; gaps identified and attended to as children's needs' arise. All the key role players must thus be fully informed of such policies and consequences thereof.

Community-focused campaigns should also be developed and promoted in efforts to reduce stigma and social exclusion of vulnerable children, and increase awareness, understanding and acceptance of children in residential care in order to facilitate the process of adolescent resilience.

While adolescents' vulnerability and resilience play major roles in their success, it is crucial for the caregivers to be provided with psychosocial education as identified by the adolescent participants in this study, to effectively address the needs of vulnerable children. Psychosocial support is critical for survival as it facilitates coping and resilience. It promotes learning, development of life skills and enables children to participate fully and have faith in the future (Maynard, 1999; Snider, 2005).

The decision on whether or not to disclose sensitive information of children in residential care should be looked into to help minimise verbal and emotional abuse by caregivers.

The misconception held by the adolescent participants, that the residential care is permanently theirs, should be clarified. Children should be made aware of the institutionalization and reintegration processes from the beginning.

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APPENDICES

Appendix A: Interview Schedule for Caregivers

Interview One: The Caregiver Interview Guide Questions (with probing Questions)

1. What do you think one needs to grow up well as a youth?

- What role does religious organizations/spirituality play in the lives of youth?
- What do you and other members of your community think about the way youth live their lives, their beliefs such as gender roles, etc.
- How do youth handle change as individuals and at a community level? How do they contribute to the community?
- What is your definition of success?
- How do you feel when others around you experience success?
- What do you think about the lives of these children?
- Do you think the youth identify in any way with their different cultures? Can you describe to me or show me their day to day activities that are part of their culture and the way things are done by people around your community?

2. How do you describe people who grow up well despite the many problems they face? What word (s) do you use?

3. What does it mean to these children, their family, and community, when bad things happen?

- Can you tell me what some of these bad things are?
- What do people do to cope?
- What do they say about these things when they happen?
- Who talks about them most, least? And who is most likely to come up with solutions to problems when they occur?
- What do other people think of these solutions?
- Can you give me examples?

4. What kinds of things are most challenging for these children while growing up?

- Are there opportunities for these youth to do age-appropriate work?
- Are these children exposed to violence? How do you and these children avoid violence in their family, friends and their community?

- How does the government play a role in providing for safety, recreational needs, housing, and jobs now and in the future?
- Do these children have opportunities to experience things that are meaningful to them? What are these things? Do they present you with an amount of risk that you feel they can handle?
- How understanding is your community of problem behaviours among people of this age group? What are some of these behaviours?
- Do these children feel safe and secure here? How do other people ensure their safety and protection?
- Do these children feel equal to others? Are there others you think do not feel equal? How do these other people make them feel? What do you do as a caregiver to ensure that children don't feel unequal?
- What are these children's feelings towards the shelter and their school? Do you feel that they have a sense of belonging?
- Do they have access to school and education and any other information they need to grow up well? How do they get this access? Who provides it?

5. What do these children do when they face difficulties in life?

6. What does being healthy mean to you and others in your family and community?

- Could you describe the way you look after these children?
- How do you express yourselves/communicate to the youth and what they think of it?
- How do you monitor where they are, keep track of what they are doing?
- Are these children taught how to act socially? How well do they do it? Are some of these youth thought of well by others, popular, liked?
- Do these children have mentors or role model that they look up? Can you describe them?
- Can you describe the nature of your relationship with these children?
- Do you and these children participate in leisure activities together? Can you tell me more about this?
- Do these youth have other meaningful relationships with people at school, home or in your community that you know off?

7. What do these youth do, to be mentally, physically, emotionally, and spiritually healthy/strong? What do you as caregivers do to help them grow mentally, physically, emotionally and spiritually?

- Are they self-confident/assertive? How do they show this?
- Can you describe their ability to problem-solve? Are some better or worse than others? How do you know this?
- Do these youth have a sense of control over their world? If not, how does this affect their life?
- How much uncertainty are they able to live with?
- Do they value themselves? How does this affect their life and what they do today?
- Would you describe these youth as optimistic or pessimistic about life?
- Do they have personal goals and aspirations? What are these if you are aware of them?
- How much are they independent and how much do they rely on others for survival?
- Do they use substances like alcohol or drugs? If they do, how much do use? What do you and others think about this?
- What role does humour play in children's lives?

8. Can you share with me a story about a young person you know who grew up well in this community despite facing many challenges?

9. How has that youth managed to overcome challenges faced personally, in their families, or outside their home in the community?

- What would you say were the personal characteristics that helped to overcome difficult challenges in this young person's life?
- Who believed and supported the youth during this time?
- If one of these youth were to die today, how would you as a parent/caregiver describe them at their funeral? How would they like to be described?

Appendix B: Interview Schedule for Adolescents

Interview Two: The Youth Interview Guide Questions (with probing Questions)

1. What do you think a person needs to grow up well?

- What role does religious organizations/spirituality play in your life?
- What do other members of your family think about the way you live your life, your beliefs etc.
- How do you handle change as an individual and the changes taking place for other people in your community?
- How do you contribute to your community?
- What is your definition of success?
- How do you feel when others around you experience success?
- What do you think about your life and if you feel comfortable sharing this, can you tell me?
- Do you identify in any way with your culture? Can you describe your culture? Can you describe to me or show me your day to day activities that are part of your culture and the way things are done by people around you?

2. How do you describe people who grow up well despite the many problems they face? What word (s) do you use?

3. What does it mean to you, to your family, and to your community, when bad things happen?

- Can you tell me what some of these bad things are?
- What do people do to cope?
- What do they say about these things when they happen?
- Who talks about them most, least? And who is most likely to come up with solutions to problems when they occur?
- What do other people think of these solutions?
- Can you give me examples?

4. What kinds of things are most challenging for you growing up?

- Are there work opportunities for someone your age to do here?
- Are you or people you know exposed to violence? How do you avoid violence in your family, community and when you are with your peers?

- How does the government play a role in providing for your safety, recreational needs, housing, and jobs now and when you get older?
- Do you have opportunities to experience things that are meaningful to you? What are these things? Do they present you with an amount of risk that you feel you can handle?
- How understanding is your community of problem behaviours among people your age? What are some of these behaviours?
- Do you feel safe and secure here? How do other people protect you?
- Do you feel equal to others? Are there others you do not feel equal to? How do these other people make you feel? What do they do that makes you feel this way?
- What are your feelings towards your school? Do you feel that you belong?
- Do you have access to school and education and any other information you need to grow up well? How do you get this access? Who provides it to you?

5. What do you do when you face difficulties in your life?

6. What does being healthy mean to you and others in your family and community?

- Could you describe the way your parents or caregivers look after you?
- How does your family express themselves/communicate to you and what they think of you?
- How does your family monitor you in order to know where you are, keep track of what you are doing?
- How do you know how to act with other people? How well do you do socially? Are you thought of well by others, popular, liked?
- Do you have someone you consider a mentor or role model? Can you describe them?
- Can you describe the nature of the relationship that you have with your parents/caregivers?
- Do you and your parent/caregivers participate in leisure activities together?
- Do you have other meaningful relationships with people at school, home or in your community?

7. What do you, your family and people in your community do, to be mentally, physically, emotionally, and spiritually healthy/strong?

- Are you self-confident? How do you show this?
- Can you describe your ability to problem-solve? Are you better or worse than others? How do you know this?
- Do you think you have a sense of control over your world? How does this affect your life?

- How much uncertainty are you able to live with?
- Do you value yourself? How does this affect your life and what you do today?
- Would you describe yourself as optimistic or pessimistic about life?
- Do you have personal goals and aspirations? What are these?
- How much are you independent and how much do you have to rely on others in your life for your survival?
- Do you use substances like alcohol or drugs? If you do, how much do you use these? What do others around you think about this?
- What role does humour play in your life?

8. Can you share with me a story about another young person you know who grew up well in this community despite facing many challenges?

9. Can you share how you have managed to overcome challenges you faced personally, in your family, or outside your home in your community?

- What would you say were the personal characteristics that helped you to overcome difficult challenges in your life?
- Who believed and supported you most during this time?
- If you were to die today, how would people describe you at your funeral? How would you like them to describe you?

Appendix C: Child and Youth Resilience Measure (CYRM)

INSTRUCTIONS: Listed below are a number of questions about you, your family, your community, and your relationships with people. These questions are designed to better understand how you cope with daily life and what role the people around you play in how you deal with daily challenges.

Please complete all questions in Sections One, Two and Three.

There are no right or wrong answers. I am interested in your honest responses and reactions. Each item will be read aloud to you.

Section One: Demographic Data

What is your date of birth? -----

What is your sex? -----

People are often described as belonging to a particular racial group. To which of the following groups do you belong? (Mark or check the one that best describe (s) you)

- ☐ Aboriginal or Native
- ☐ South Asian
- ☐ South East Asian
- ☐ West Asian to Middle Eastern
- ☐ Asian
- ☐ Black
- ☐ White or European
- ☐ Filipino
- ☐ Latin American
- ☐ Other (please specify)
- ☐ Mixed Race (please list all groups that apply)

To which ethnic or cultural group (s) do you see yourself belonging? Please list as many groups as you want -----

What is the highest level of education you have completed? -----

Who do you live with? -----

How long have you lived with these people? -----

How many times have you moved homes in the past five years? -----

Please describe who you consider to be your family (for example, 1 or 2 biological parents, siblings, friends on the street, a foster family, an adopted family, etc.) -----

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Section Two: For each question in Sections Two and Three, please tick the appropriate block on your right that best describes you.

	To what extent	Not at all	A little	Some-what	Quite a bit	A lot
1	Do you have people you look up to?					
2	Do you cooperate with people around you?					
3	Is getting an education important to you?					
4	Do you know how to behave in different social settings?					
5	Do you feel that your caregivers watch you closely?					
6	Do you feel that your caregivers know a lot about you?					
7	Do you eat enough most days?					
8	Do you strive to finish what you start?					
9	Are spiritual beliefs a source of strength for you?					
10	Are you proud of your ethnic background?					
11	Do people think you are fun to be with?					
12	Do you talk to your family about how you feel?					
13	Are you able to solve problems without using illegal drugs and/or alcohol?					
14	Do you feel supported by friends?					
15	Do you know where to go in your community to get help?					
16	Do you feel you belong at your school?					
17	Do you think your family will always stand by you during difficult times?					
18	Do you think your friends will always stand by you during difficult times?					

Section Two (continues)

	To what extent	Not at all	A little	Some-what	Quite a bit	A lot
19	Are you treated fairly in your community?					
21	Are you aware of your own strengths?					
22	Do you participate in organised religious activities?					
23	Do you think it is important to serve your community?					
24	Do you feel safe when you are with your family?					
25	Do you have opportunities to develop job skills that will be useful later in life?					
26	Do you enjoy your family's traditions?					
27	Do you enjoy your community's traditions?					
28	Are you proud to be (Nationality) -----?					

Section Three: Site Specific Questions

	To what extent	Not at all	A little	Some-what	Quite a bit	A lot
1	Do adults talk to you about what you need or want?					
2	Do you wish you lived with your biological parents?					
3	Do you like living in the village?					
4	Do you feel ashamed living in the village?					
5	Do you feel the community understands why you live in the village?					
6	Do you have family members that visit you?					
7	Do you have family members that you visit?					
8	Do you feel you are being prepared for life outside the village?					
9	Do you blame yourself for the bad things that happen to you, your family, friends and/or the community?					
10	Do you worry about the future?					

Section Three (continues)

Please write your answers to each question in the space provided.

11. What do you worry about the most?

.....

.....

12. What do you wish for the most?

.....

.....

13. What is the best thing that ever happened to you?

.....

.....

14. What is the worst thing that ever happened to you?

.....

.....

15. What changes would you make in your village if you were given a chance?

.....

.....

16. What do you plan to do when you one day leave the village?

.....

.....

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Appendix D: Strengths and Difficulties Questionnaire (SDQ): Self-Evaluation Questionnaire for Adolescents

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help me if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your name

Male/Female

Date of Birth

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches or sickness			
I usually share with others (food, games, pens, etc.			
I get very angry and often lose my temper			
I am usually on my own. I generally play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other people or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the work I am doing. My attention is good			

Your signature

Today's Date

**Appendix E: Strengths and Difficulties Questionnaire (SDQ):
Evaluation Questionnaire by Caregivers for Adolescents**

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help me if you answered all items as best you can even if you are not absolutely certain or the items seem daft! Please give your answers on the basis of the child’s behaviour over the last six months.

Child’s Name ----- Male/Female Date of Birth -----

	Not True	Somewhat True	Certainly True
Considerate of other people’s feelings			
Restless, overactive, cannot sit still for long			
Often complains of headaches, stomach-aches or sickness			
Shares readily with other children (treats, toys, pencils, etc)			
Often has temper tantrums or hot tempers			
Rather solitary, tends to play alone			
Generally obedient, usually does what adults request			
Many worries, often seems worried			
Helpful if someone is hurt, upset or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, downhearted or tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Kind to younger children			
Often lies or cheats			
Picked on or bullied by other children			
Often volunteers to help others (parents, teachers, other children)			
Thinks things through before acting			
Steals from home, school or elsewhere			
Gets on better with adults than with other children			
Many fears, easily scared			
Sees tasks through to the end, good attention span			

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

- No difficulties
- Yes-minor difficulties
- Yes-more serious difficulties
- Yes- several difficulties

If you have answered yes, please answer the following questions about these difficulties:

- How long have these difficulties been present?
 - Less than a month
 - 1-5 Months
 - 5-12 Months
 - Over a year
- Do the difficulties upset or distress your child?
 - Not at all
 - Only a little
 - Quite a lot
 - A great deal
- Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life				
friendships				
Classroom learning				
Leisure activities				

- Do the activities put a burden on you or the family as a whole?
 - Not at all
 - Only a little
 - Quite a lot
 - A great deal

Signature

Date

Mother/Father/Other (please specify)

Appendix F: Information Sheet for Data Collection Authorization

Dear Sir,

Re: Permission for Authorization to Carry out a Research Study

I, Sigrid Shaanika (student number shnsig002) hereby request permission to conduct a research study on adolescents living in residential care, who are between the ages of 11-19 years. The study is in fulfilment of the **Master of Psychology at the University of Cape Town**. The main aim of the research study is to explore why some youths exposed to multiple risk factors appear to cope well despite severe adversity. The results of this study can help me understand the youth's experiences and make recommendations to policy makers, child/youth service providers and others in the helping professions on how to intervene appropriately to enhance well-being and positive outcomes to as wide a population of at-risk young people as possible.

Attached please find a copy of my proposed research study.
I have taken into consideration the ethical issues pertaining to the use of minors in this research study both as outlined by the University of Cape Town as well as by the Health Professions Council of Namibia. Please do not hesitate to contact me on these number: **+27 768347818** or email address: **siggy.shanny@gmail.com**, should there be any queries.

Yours Sincerely,

.....

Sigrid Shaanika

Date.....

.....

Supervisor: Dr. Lauren Wild

Appendix G: Information Sheet for Data Collection Site

Data Collection Site Consent Form

I,hereby request the consent of the residential care manager, to collect data on the subject under study, **“Resilience amongst adolescents living in residential care: an exploratory study of why some youths appear to cope better despite severe adversity”**. The data collection process will make use of interviews and questionnaire methods. Interviews will be audio-recorded.

- I have taken into consideration the ethical issues pertaining to the use of minors in this research study both as outlined by the University of Cape Town, the Professional Health Board of Namibia as well as by the Namibian constitution on children’s rights.
- All information collected will be kept confidential. The information which is gathered might be used, without identifying you (unless you agree), the residential care, or any other person in publications and presentations in my own country and/or others.
- I understand that participants may withdraw from the research study at any point.

.....

Sigrid Shaanika

.....

Residential Care Manager

Appendix H: Quantitative Research Consent Form for Adolescents

Youth Resilience Informed Consent Form

Before you sign this form, the researcher will read out each question aloud. You can ask questions about anything you might not understand.

- I understand that I am being asked to participate voluntarily in this research study. I am required to answer all items as honestly as I can.
- I will be asked to complete two questionnaires; (1) **The Strengths and Difficulties Questionnaire**, I will be asked about my emotional functioning, behaviour and relationships (2) **The Child and Youth Resilience Measure**. I will be asked about personal characteristics, my family, and my relationships with other people, my culture and my community that are important to me. This will take approximately 30 minutes to an hour.
- All information that is collected from me will be kept confidential, meaning that no one except the person responsible for giving me these questionnaires will know who I am. My name will not be used and the information collected from me will be combined with that from all other participants so that no one will know how I answered the questions. The information I will provide may help people, and organizations involved with youth to develop and evaluate programs that will effectively foster the well-being of these adolescents.
- I understand that I may stop participating at any point I choose.
- I have the right to ask any questions about anything I do not understand.
- If I have any concerns or questions about the study or my participation, I am free to contact the researcher.
- The information that is gathered may be used, without identifying me, in publications and presentations in my own country and/or others.
- I understand the nature of the research outlined above and agree to participate.

Signature of Participant: **Date:**

Signature of Researcher: **Date:**

Appendix I: Quantitative Research Consent Form for Caregivers

Caregiver Informed Consent: The Strengths and Difficulties Questionnaire.

Before you sign this form, please take time to read it or have it explained to you, and ask questions about anything you might not understand.

- I understand that I am being asked to participate voluntarily in this research study. I will be asked to give information on the strengths and difficulties of the adolescent's emotional functioning, behaviour and relationships; the level of distress the adolescent's problems cause and the impact of the adolescent's problems on different aspects of his/her life (at home, at school, with friends and leisure activities). I am required to answer all items as honestly as I can.
- All information that is collected from me will be kept confidential, meaning that no one except the person responsible for giving me these questionnaires will know how I answered the questions. The information I will provide may be helpful to people and organizations involved with the youth to develop and evaluate programs that will effectively foster the well-being of these adolescents.
- I understand that the interview will be tape recorded
- I may stop participating at any point I choose.
- I have the right to ask questions about anything I do not understand.
- If I have any concerns or questions about the study or my participation, I am free to contact the researcher.
- The information which is gathered might be used, without identifying me (unless I agree), the shelter, or any other person in publications and presentations in my own country and/or others.
- I understand the nature of the research outlined above and agree to participate.

Signature of Caregiver: **Date:**

Signature of Researcher: **Date:**

Research Study Request

Would you like to receive a copy of the complete research study? Yes No

Appendix J: Qualitative Research Consent Form for Adolescents

Qualitative Data Collection Youth Consent Form

A small number of adolescents are needed to take part in the research study for in-depth interviews. This will take approximately 1-2 hours of your time and will be scheduled in a place and a time convenient for you. It may be necessary for us to meet again should the time allocated run out. The aim of this research method is to obtain your life experiences and learn about how you cope with the challenges you face growing up.

- All information that is collected from you will be kept confidential, meaning that no one except the person responsible for conducting the interview will know your identity as a participant and how you answered the questions. The information you will provide may be helpful to people and organizations involved with youth at-risk in developing and evaluating programs that will effectively foster the well-being of these adolescents. Since the interview is likely to deal with events that have happened in your life, it could be emotionally draining. I would like for you to also talk about those emotional challenges that may arise.
- The information will be collected through audiotape recording to maintain your original story as much as possible.
- You may stop participating in the interview at any point you choose.
- You have the right to ask any questions about the study that you do not understand.
- The information which is gathered might be used, without identifying you (unless you agree), the organization, residential care, or any other person in publications and presentations in my own country and/or others.
- You understand the nature of the research outlined above and agree to participate and for your interview to be tape recorded.

Signature of Participant:

Date:

Signature of Researcher:

Date:

Appendix K: Qualitative Research Consent Form for Caregivers

Qualitative Data Collection Caregivers Consent Form

A small number of caregivers are needed to take part in the research study for in-depth interviews. This will take approximately 1-2 hours of your time and will be scheduled in a place and a time convenient for you. It may be necessary for us to meet again should the time allocated run out. The aim of this research method is to share your perceptions of how the adolescent exposed to severe adversity cope with adversity in different ways.

- All information that is collected from you will be kept confidential, meaning that no one except the person responsible for conducting the interview will know your identity as a participant and how you answered the questions. The information you will provide may be helpful to people and organizations involved with youth at-risk in developing and evaluating programs that will effectively foster the well-being of homeless adolescents. Since the interview is likely to deal with stressful life events that have happened in some participants lives, it could be emotionally draining. I would like for you to also talk about how some of the youth participants deal with their emotional challenges.
- The information will be collected through audiotape recording to maintain your original story as much as possible.
- You may stop participating in the interview at any point you choose.
- You have the right to ask any questions about the study that you do not understand.
- The information which is gathered might be used, without identifying you (unless you agree), the organization, residential care, or any other person in publications and presentations in my own country and/or others.
- You understand the nature of the research outlined above and agree to participate and for your interview to be tape recorded.

Signature of Participant:

Date:

Signature of Researcher:

Date: