PSYCHOSOCIAL CHALLENGES OF STREET CHILDREN IN LIMPOPO PROVINCE AND EFFICACY OF SOCIAL SKILLS TRAINING

by

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology

at the

North-West University (Mafikeng Campus)

in the

Department of Psychology

FACULTY OF SOCIAL SCIENCES

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March 2015

DECLARATION

I, Mokoena Patronella Maepa, declare that this thesis hereby submitted to the North-West University for the degree of Doctor of Philosophy in Psychology has not been previously submitted by me for a degree at this or any other university; that it is my own work, and that all materials contained therein have been duly acknowledged.

Signature.....

Date..20/04/2015

ACKNOWLEDGEMENTS

- To my Comforter, God Almighty. The creator and giver of life. I am nothing without You. I am thankful for Your love, mercy, and protection at all times. Let Your name be glorified.
- A special thanks to my mentor and promoter, Prof E.S. Idemudia. Your tremendous support, guidance, patience, words of wisdom and knowledge are immeasurable. Without your supervision, this project would not have been a success. You always believed in me. May the Almighty God bless you.
- To Prof. P. Serumaga-Zake, your statistical input allowed the completion of this work. I thank you very much.
- To Dr Oluyinka (a.k.a Yinka), your support and critical review of this work helped me to see light where there was darkness. God bless you.
- Dr Sam Oladipo, your input to this work is much appreciated.
- To my colleagues and friends, Nyambeni, Tesfaye, Mandu, Mantwa, just to name a few, your support and encouragement helped me to pull through.
- To my family, my grandmother, Elizabeth, you are a mother to me, my cousin-sister Patricia and her family, you have always been there for me, I thank you. My uncle Sy, you always believed in me; my aunt Mapula and her family, your continuous support goes a long way in my life. My cousin Willie, your support is much appreciated. My brothers, James and William, God is with us.
- To all my former colleagues at Limpopo Provincial Department of Health, Psychology division and Botlokwa Hospital. Thank you very much for your support.
- To my colleagues at North-West University (MC), Psychology Department, thank

you very much for your support and words of encouragement.

- To all my friends (Sma, Lindelwa, Dumisani, Nonhlanhla, Ncina, just to name a few cause you are so many). Your support at all times is much appreciated. Other special friends who helped me introspect and find the special lady hidden inside me. Your support is appreciated at all times.
- To my newly found God given sisters, Kgoacky, Modiegi, Anikie and Maureen, but not forgetting Dudu. You welcomed me into your space and showed me what sisterhood is all about. I thank you all.
- To my special mother, Modjadji Joyce Maepa, this space is not sufficient for me to express my sincere thanks to you. You left me way too soon. I wish you were here to see the success of this project. I do believe you are with me in spirit. May your soul rest in peace. I will always love you.
- To all too numerous to mention who contributed to the successful completion of this research work, I am forever grateful.
- I also thank God for my husband and children in the future. You are part of this vision of my life.
- Finally, the financial support I received from North-West University made the completion of this project possible.

DEDICATION

I dedicate this work to my wonderful, beloved and amazing mother, Modjadji Joyce Maepa. *Modjadji kgosi ya mosadi*. Your death caught me off guard, left me without a mother, a friend, my pillar of strength. You were an amazing person in my life and you taught me a lot of things and, above all, to trust in God who will always be with me. I begin to see your character in me. You have left a huge void in my life. You will always be in my heart. I wish you could live to see the end of this work. I will always miss you, till we meet again. Your daughter, Mamma.

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ABSTRACT

Aim: The aim of this study was twofold: firstly, to explore the psychosocial challenges of street children compared to non-street children, and secondly to develop intervention strategies, implement and assess the effectiveness of those intervention strategies among street children.

Method: The study followed a two in one study method to achieve its aim. This approach involved two phases, phase I entails assessment of psychosocial challenges of street children using a quantitative independent sample group design with an experimental and control group of street children (N-300) with ages ranging from 8-18 years with the mean age of 15.92 (SD= 1.89) and non-street children (N-300) with ages ranging from 8-18 years with mean age of 15.46 (SD= 1.87). Phase II entails the designing of social skills training package and exposure of street children to the training which used a pre-test and post-test experimental and control group design with (N-24) street children who were randomly assigned to the experimental and control group.

Results: Phase I study hypothesis was tested using an independent sample *t*-test. Results revealed significant statistical differences between street children and non-street children on self-esteem $t(598) = 20.03$, $p < .000$, resilience $t(598) = 9.48$, $p < .000$, coping strategies $t(598) = 11.73$, $p < .000$, history of childhood trauma $t(598) = -27.24$, $p < .000$, parental warmth $t(598) = 14.02$, $p < .000$ and parental supervision $t(598) = 20.92$, $p < .000$ and socio-economic status $t(598) = 11.64$, $p < .000$. Phase II study hypothesis was tested using analysis of covariance (Ancova). The findings indicated the efficacy of SE-RE-CO social skills training as street children who participated in the programme showed improved self-esteem, $F(1,21) = 25.16$, $p < .000$, partial $n^2 = .545$, resilience, $F(1,21) = 7.44$, $p < .079$,

partial n^2 =.262 and coping strategies F(1,21)= 33.71, p <.000, partial n^2 =.616. compared to non-street children who did not participate in the social skills training programme.

Conclusion: The study concludes that street children experience more psychosocial challenges than non-street children. SE-RE-CO social skills programme can help street children to deal with the challenges they face. It is therefore recommended that tailor made intervention programmes be designed for other vulnerable children.

CHAPTER ONE

GENERAL INTRODUCTION

1.1. BACKGROUND OF THE STUDY

The phenomenon of street children is worldwide (Connolly, 1990), and it is also a concern in the Republic of South Africa. According to UNICEF (2007), the statistics of street children globally are in millions, and in South Africa, available information indicates that there were estimates of 5,000 street children in 1987 and the number rose to 10,000 by 1995 (Fortune, 2010). The Tshwane Alliance for Street Children (2005) reported about 100, 000, and Youth Xchange (2010) reported about 250, 000 cases

The United Nations defined street children as "any boy or girl for whom the street has become his or her habitual residence and/or source of livelihood; and who is inadequately protected, supervised, or directed by responsible adults" (quoted in Lusk, 1992, p. 294). These children referred to in this case are individuals younger than 18 years of age with inadequate parental, foster, or institutional care (National Coalition for the Homeless, in Ligon, 2000). The definition of street children differs by the characteristics of these children such as their sleeping location, family ties, school attendance, leisure, survival activities, occupation on the street environment, etc. (UNICEF, 1986) leading to categorisations of these children to the time spent on the street. The categories include children of the streets or children in the streets.

Children of the streets can be explained as children who live on the streets all the time without their families. They do not engage in school going activities like other children who are not on the streets. The difference between children of the streets and children in

the streets is that children in the streets go to streets during the day engaging in income-generating activities. They still live with their families and attend school (Hutz & Koller, 1999 in Raffaelli et al., 2000). Martins as cited in Raffaelli et al. (2000) used family ties to further highlight the distinction of street children: the first group was distinguished from other groups as group of children with existing stable family ties working on the streets going home at night. The second group go back to their families' occasionally spending much time on the streets. The third and final group is comprised of those children who were completely on the streets by their own with total loss of family contact.

Reasons why children go to the streets are unique to their individual situations. The reasons may include poverty, neglect, family breakdown, death of one or both parents as a result of HIV/AIDS or diseases, verbal, physical, and sexual abuse (Gwadz, Clatts, Leonard, & Goldsamt, 2004; Hickler & Auerswald, 2009; Whitbeck, Crawford, & Hartshorn, 2012). One way of explaining the rise in the number of street children in South Africa lies in the reported cases of child adversities which play a role in why children run away from their homes and live on the streets (Idemudia, Kgokong, & Kolobe, 2013). For example, Rape Survivor Journey (2011), reported that in 2009/2010 the number of reported cases of attempted murder cases against children increased from 843 to 936 while sexual offences cases were reported to be 7, 276. In addition, reported cases of neglect and ill-treatment of children were 3, 473 nationwide and 245 in Limpopo Province alone by year 2010/2011(South African Police Services, 2011). A steady rise in the number of children in street situation in South African cities has been remarkable; a situation which if not addressed could lead to increased violence and inappropriate responses towards these children.

In addition to living on the street, street children have been reported to have many problems related to psychosocial issues such as substance use (Sharma & Joshi, 2013) and sexual and reproductive health issues including HIV/AIDS and other STDs (Kruger & Richter, 2003). This means many of these children might be experiencing a double tragedy. Not only do they have to deal with living on the street, but they also have to deal with a wide range of psychosocial sequelae that might arise as a result of lacking adult care for their health, physical growth, personality development and progress. Among some of the psychosocial challenges that street children in South Africa are grappling with are: vulnerability and resilience (Le Roux & Smith, 1998a; Malindi, 2009); family violence, parental alcoholism, abuse and poverty (Le Roux, 1996). Unfortunately, the available studies in South Africa have not taken into account other psychosocial challenges that street children are facing.

These challenges include but are not limited to low self-esteem (Whaley, 2002), poor resilience and coping strategies (Lightfoot, Stein, Tevendale, & Preston, 2011). Children who have been abused report less negative effects as a result of high self-esteem (Sachs-Ericsso et al., 2010). In order to survive the harsh living conditions on the streets, street children need to be resilient (Malindi &Theron, 2010). If these children are not resilient enough, they are likely to engage in high risk drug use, sexual behaviours and other harmful acts as a way of coping with trauma and other adversities (Towe, ulHasan, Zafar, & Sherman, 2009).

Researchers reported that childhood trauma (Gwadz et al., 2004), parenting style (Mathur et al., 2009), and socio-economic status (Chireshe, Jadezweni, Cekiso, & Maphosa, 2010) serve as contributing factors for children to run to the streets. In the current study, these

psychosocial challenges are explored and compared between street children and non-street children to understand their differences on self-esteem, resilience, coping strategies, childhood trauma, parenting styles and socio-economic status. A thorough understanding of these psychosocial challenges is of paramount importance in the development of intervention strategies.

Psychosocial challenges in this study are understood as a combination of psychological challenges (self-esteem, resilience, and coping) and social challenges (childhood trauma, parenting style and socio-economic status). Self-esteem refers to the way an individual perceives or evaluates him or herself (Kille & Wood, 2012). This evaluation can either be positive or negative and it is imperative for individuals as it determines how they handle challenging situations. For example, high self-esteem acts as a buffer when people are faced with adverse situations (Sachs-Ericsso et al., 2010) making it an important character that enables the individual to successfully manage adverse events. These childhood abuses have a negative impact on people with low self-esteem.

Inversely, emotional abuse has been found to affect self-esteem negatively (Brodski & Hutz, 2012). This indicates that children who are exposed to abuse will develop low self-esteem and as a result of this low self-esteem, they may be unable to cope appropriately with the abuse at hand and opt for the streets. Focusing on self-esteem alone in order to solve or prevent problem behaviours among street youth is not sufficient (Lightfoot et al, 2011), therefore this indicates a need to explore other factors. In this study, resilience and coping styles are explored together with self-esteem.

Resilience refers to an individual's ability to use his or her strengths to deal with adverse situations (Richardson, 2002). This resilience differentiates between people who can use their personal characteristics to cope with challenges and those who cannot. Children who are resilient are likely to cope with childhood trauma because resilience serves as a protective factor for them (Roy, Carli, & Sarchiapone, 2011). However, in other instances abuse and neglect has negative impact on children's' resilience levels (Collin-Vézina, Colema, Milne, Sell, & Daigneault, 2011). This indicates that abused children can develop poor resilience.

This then creates a need to explore other methods of handling adversities among children in diverse situations such as coping strategies. Coping strategies refers to the use of cognitive and behavioural methods applied to address a demanding stressful situation (Lazarus & Folkman, 1984). These strategies include problem/solution focused coping or emotion focused coping, maladaptive coping and adaptive coping. Street children compared to non-street children after being abused at home or due to poor socio-economic status in the home run to the streets. This signifies the use of solution focused coping rather than problem focused coping. This can be so as a result of their low levels of self-esteem and resilience.

When on the street, these children tend to still use more of solution focused coping which also include maladaptive forms of coping mechanisms such as engaging in activities that violate social norms (Miles & Okamoto, 2008) such as shoplifting, pick pocketing, handbag snatching and even sniffing glue (Ficher, Shinn, Shrout, & Tsemberis, 2008). They also engage in violent activities, increased risk taking behaviour exposing them to HIV infection (Rachlis, Wood, Zhang, Montaner, & Kerr, 2009) theft and robbery

(Aransiola & Agunbiade, 2009). However, other forms of coping methods used are not in conflict with the law and societal norms. Those activities include income-generating activities such as becoming a market porter and car washer (Aderinto, 2000).

These maladaptive coping mechanisms are mainly put in place when these children are on the streets as a result of childhood trauma experienced while at home (Mathur et al., 2009). Childhood trauma is therefore then explained from the child maltreatment term which is defined as any form of abuse that harms or has a potential to harm the child such as verbal, emotional, psychological or even sexual abuse executed usually by the parent or guardian but can still be any person (Leeb, Paulozzi, Melanson, Simon, & Arias, 2104). The abuse a child experiences has negative effects on the child's self-esteem, resilience and coping mechanisms as already mentioned above. This indicates some form of a relationship between the history of childhood trauma and self-esteem, resilience and coping styles linking it to high numbers of children on the streets.

The definition of child maltreatment above argues that children are abused at home and mainly by the primary caregiver who is usually the parent. This abuse can be explained in terms of poor parent-child relationship associated with poor parenting styles (Brodski & Hutz, 2012). Parenting styles is defined as the manner in which parents convey their feelings (verbally and non-verbally) to their children (Bornstein & Zlotnik, 2008). Good parenting style such as parental emotional support helps children develop high self-esteem and less psychological distress when faced with adverse events (Boudreault-Bouchard et al., 2013). Poor parenting styles (such as parents setting high standards for their children) put children at risk of developing low self-esteem (McClure, Tanski, Kingsbury, Gerrard, & Sargent, 2010). Furthermore, in a study conducted among

homeless children, it was found that effective parenting; parental support in particular, helps children develop adaptive coping skills to help them overcome adversity (Herbers, Cutuli, Supkoff, Narayan, & Masten, 2014).

Parenting styles can negatively be affected by factors such as poverty (Katz, Corlyon, La Placa, & Hunter, 2007) and parental illness (Razaz, Nourian, Marrie, Boyce, & Tremlett, 2014). In this study, poor parenting style is therefore linked to poor socio-economic status. This indicates that children raised in poor socio-economic situations are faced with multiple challenges like their basic needs being insufficiently met leading to limited resources to cope with adversities (Lazarus & Cohen, 1977). Socio-economic status means a person's socio-economic standing in terms of class, status and party (Weber, 1952). It includes the individual/family's ability or inability to meet basic needs such as housing, food and clothes (Conger & Eldner, 1994; Mistry, Lowe, Benner, & Chien, 2008).

1.2. STATEMENT OF THE PROBLEM

Vulnerable children, street children in particular, are constantly exposed to risk that affects their wellbeing. Street children are forced to engage in violent activities in order for them to survive the street life (Harden, 2014). Engaging in violent activities predisposes them to be imprisoned or even face other hazardous circumstances. The current state of violence and crime in South African streets is worrisome. These create a vicious cycle of challenges. The children might grow to become adults who are dependent on the system. The crimes they commit also affect society in general. Due to their low level of education, engaging in criminal activities leading to imprisonment/

custody, street children negatively affect the country's economy as they do not contribute positively in the labour market. While in custody/in prison they rely on the state for support.

They are at risk of mental health due to their excessive use of substances. They are also at risk of poor physical health as they are predisposed to illness that comes with poor hygiene and unfavourable weather conditions. They do not access health care facilities easily. They are a kind of an abandoned and forgotten population. A history of child abuse and victimisation makes children vulnerable for abuse in adulthood (Whitbeck, Hoyt, & Yoder, 1999) as such these abuses should be prevented to break the cycle.

The psychosocial challenges faced by the millions of children living on the streets remain understudied. Dryjanska (2014) stated that in the last two decades research dedicated on issues pertinent to street children has been stable with 117 publications globally. Africa has taken the lead in researching this problem. South Africa has been paying attention to issues ranging from children's rights to social security as street children in this country are perceived to be a vulnerable population (Dryjanska, 2014).

The street children phenomenon is an issue of concern among researchers (Baron 2010; Hoersting & Jenkins, 2011; Shiluvane, Khoza, Lebese, & Shiluvane, 2012; Idemudia et al., 2013). It is important to understand that street children are children in need of care (Ward & Seager, 2010) rather than to be seen as rebels. The welfare of these children should be a matter of paramount importance because various effects of abuse among children can result into health risk behaviour such as crime and other activities predisposing them to psychological distress (Beck, Palic, Andersen, & Roenholt, 2014).

In order to curb the street children phenomenon research has been conducted globally (Aptekar, 1989b; Kombarakaran, 2004; Thompson, McManas, Lantry, Windsor, & Flynn, 2006; Baron, 2010; Hoersting & Jenkins, 2011). Yet the numbers of studies reported in Africa (Ezeokana, Obi-Nwuso, & Okoye, 2014; Lalor, 1999; Lawal, 2011; Lugalla & Mbwambo, 1999) are still less compared to the numbers of children that are visible on the streets, let alone in South Africa.

A body of literature to date that deals with street children focuses on factors such as risky sexual behaviours and substance use activities (Tyler, 2008), exposure to violence and aggression the consequences of which include behavioural problems, social isolation, rejection and other related problems (Anooshian, 2005; Olley, 2006). Other researchers focused on the survival strategies of street children which at times are illegal activities such as theft/shoplifting, drug economy, panhandling or survival sex (Gwadz, et al., 2004) and car/house break-ins (Idemudia, 2007). A general understanding from these studies is that street children are perceived as problematic indicating a serious need of intervention methods for these children. Responsibilities to curb this phenomenon have been shifted between social workers, the community and police (le Roux & Smith, 1998b) and this shows that psychological intervention strategies are still to be formulated and tested.

In order to formulate meaningful programmes aimed at transforming street children into adults that can benefit society, an understanding of their dynamics is of paramount importance (Kaime-Atterhög & Ahlberg, 2008). Responding to the psychosocial needs of street children should be considered as a significant concern. Intervention studies aimed at addressing street children from a psychological perspective are few. Much research has

been conducted form social work perspective but mainly focusing on social challenges experienced by street children (Lefeh, 2008; Mthombeni, 2010) with only few studies in the psychology discipline. For example, le Roux and Smith (1998a) did a study on psychological characteristics of South African street children. In their study, the main variables studied were vulnerability and resilience. Other psychological factors such as self-esteem and coping strategies have not been explored.

In Free State Province, Malindi (2009) also conducted a study among street children where he focused on the concept of resilience. Le Roux (1996) in his study of the South African street child only focused on the characteristics of those children, namely, gender age and reason for leaving home to the streets (family violence, parental alcoholism, abuse, poverty, and personal reasons) without studying the psychological factors such as self-esteem, resilience and coping. This creates the knowledge gap in this area.

Street children phenomenon is a complex issue, therefore, no single factor can be attributed to it. The above mentioned studies have only been focusing on one or two factors associated with street children. Studies that combined psychosocial challenges in an attempt to give a clear understanding of a street child are not documented. One other study closely similar to the current study by topic and population was conducted recently in Rwanda by Kayiranga and Mukashema (2014). The study aimed at investigating the reason behind the persistent existence of street children in Rwanda. This study was qualitative in nature limiting the possible inclusion of a bigger sample group and exploration of other variables. Therefore, this present study is different from the above mentioned studies as it explores more variables combining the psychological and social challenges faced by street children. By so doing, it is understood that well informed

intervention techniques for street children, mainly in Limpopo Province, can be formulated.

Intervention studies for homeless youth have been conducted with a few that were true experiments (Alterna, Brilleslijper-Kater, & Wolf, 2010). Available data in Limpopo Province is by Shiluvane et al. (2012). They conducted a study on intervention programme to improve the quality of life of street children in Mopani district, Limpopo Province, South Africa. This is a study that is closer to the current one in an attempt to give empirical knowledge about intervention methods for this phenomenon. These authors have suggested various intervention methods such as preventing the occurrence of the phenomenon, preventing the worsening of the phenomenon and reducing or curbing further development of pathologies among street children. These suggested intervention methods are not from a psychological perspective and are not formulated specifically for the street children. Additionally, the suggested intervention methods have not been put to experiment to assess their efficacy. This further broadens the existing knowledge gap in this area, particularly in Limpopo Province and South Africa as a whole.

Thus far, in South Africa, psychosocial challenges and social skills training have not been adequately studied, not to mention combining them in one study. Therefore, the current study attempts to close the existing gap first, by exploring various psychosocial challenges faced by street children compared to non-street children serving as baseline information to guide the formulation and implementation of intervention techniques which are psychological in nature addressing self-esteem, resilience and coping skills. Lastly, the formulated intervention methods are empirically tested for their effectiveness.

1.3. AIM OF THE STUDY

The aim of this study was twofold: firstly, to explore the psychosocial challenges of street children compared to non-street children, and secondly to develop intervention strategies, implement and assess the effectiveness of those intervention strategies among street children.

1.4. OBJECTIVES OF THE STUDY

In order to achieve the above aim, this study has the following objectives:

- To compare street children and non-street children on psychosocial challenges i.e. self-esteem, resilience, coping strategies, history of childhood trauma, parenting styles and socio-economic status.
- To design and administer social skill training to street children and assess its efficacy.

1.5. SIGNIFICANCE OF THE STUDY

In South Africa, documented studies conducted among street children have utilised mainly the qualitative or triangulation research methods and do not include experiments. The available formulated intervention programmes have not been tested empirically for their effectiveness (Shiluvane, et al., 2012). To the researcher's knowledge, this is the first study in South Africa to assess the psychosocial challenges among street children, formulate social skills training and assessing the effectiveness of the programme through a quantitative experimental research method. This study has also utilised a two-in-one study approach which is a rare research approach. Therefore, this study adds to the current methodological research knowledge.

The challenges in understanding the street children phenomenon is unexplained by one single theory as there are many reasons for homelessness. This is also due to the reason that many studies in this field have focused on one or two social or psychological variables not combining the two, as such a psychosocial theoretical explanation of this phenomenon is still lacking. The study will add to the existing theories in trying to explain this phenomenon.

Most studies of street children have focused on why children leave home, but few have explored the broader psychosocial challenges that can help with a clear understanding of the street children's cases (Raleigh-DuRoff, 2004) leading to the prevention of this pandemic, a challenge to date. The study will help with the understanding of the role played by the environment (childhood trauma, parenting styles and socio-economic status) in predisposing children to run to the streets. Society in general (Henley, McAlpine, Mueller, & Vetter, 2010), parents in particular (Asgeirsdottir, Sigfusdottir, Gudjonsson, & Sigurdsson, 2011) will understand the role they play in influencing the homelessness of their children by realising how different parenting styles affect the parent-child relationships which often lead to child abuse and later different behavioural problems of children causing them to run to and remain on the streets.

From understanding the psychosocial factors associated with street children, preventative measures aimed at addressing the cause of the phenomena directly are formulated. In addition to the factors that predispose children to homelessness, exploration of children's individual characteristics such as form of self-esteem, resilience and coping styles will help provide further necessary information regarding the prevention of this phenomena.

Most available data in this area of research is from the western countries (Aptekar, 1989b; Kombarakaran, 2004; Thompson et al., 2006; Baron, 2010; Hoersting & Jenkins, 2011) leading to a knowledge gap in South Africa. The studies conducted in South Africa have not clearly highlighted tailor made intervention strategies (Malindi, 2009; Shiluvane et al., 2012). Lefeh (2008) indicated that circumstances found in street children necessitate specialised well designed programmes that will help these children to be integrated in to society. As a result, this study will help in filling the knowledge gap and broadening the understanding of street children's psychosocial challenges and the intervention thereof. South African children and parents can identify with the results and, as such, the study will help with the development of more intervention strategies that cater for the people it is aimed for to help in an attempt to curb this phenomenon of street children. Moreover, by understanding the parenting styles, relevant education will be provided to parents and the public in general and this information will also serve as a prevention strategy.

Implementation of policies governing street children in South Africa has not been effective (Lefeh, 2008). This calls for the review of existing policies and development of new policies aimed at curbing this phenomenon. As such, the current study will help inform policies related to the issues affecting children, and street children in particular, and seeing to it that they be implemented.

1.6. SCOPE OF THE STUDY

The study focused on understanding psychosocial challenges and social skills training which serve as intervention strategies for street children. Psychosocial challenges were

divided into psychological factors, which included self-esteem, resilience and coping. Social challenges included parenting styles, family functioning during childhood, socio-economic status of the family and homeless ideation. Social skills training intervention strategies included programmes mainly in the form of self-esteem building, resilience building, coping skills training and empowerment. The study was conducted in Limpopo Province.

CHAPTER TWO

THEORETICAL FRAMEWORK AND PERSPECTIVES

The current study relied on theoretical explanation for different variables and adopted the Bronfenbrenner's ecological system theory to conceptualise all variables.

2. THEORETICAL FRAMEWORK

2.1. Ecological system theory

Ecological system theory by Bronfenbrenner (1979) provided the basis for understanding the study variables and therefore guiding the implication of the intervention. This model indicates that behavioural courses and outcomes such as homelessness are products of activities that take place within defined settings and/or in response to the demands of social systems. The main aim of any intervention from the ecological perspective is to help children and adolescents to make better decisions about their activities when they find themselves in difficult settings, and eliminating or reducing situations that promote deviant behaviour (e.g. the street) with more positive settings that help promote healthy and safe behaviour (leaving the streets). This can only be achieved by a clear understanding of how the child is affected by the different systems around him or her.

This approach proposes that all important activities take place within defined, declined settings (environment where the person lives in) forming systems that are connected to one another (Bronfenbrenner, 1976; Bronfenbrenner, 1979). These activities are a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to-face setting that play various roles for the normal development of the child. The different systems interact and combine the relationship between an

individual and his/her multiple social and physical surroundings during the development period. These interactions are key to this developmental process of a child because failure for the interaction results in poor child development. Bronfenbrenner (1979) identifies the ecological systems that interact around the individual: the microsystem, the mesosystem, the exosystem, the macrosystem and the chronosystem. The current study variables overlap across these different systems in explaining psychosocial challenges of street children.

An individual's relationship in every setting is impacted by various relationships. This is because the developing person exists as a result of the linkages and processes taking place between two or more settings such as the relations between home, school, and community at large (Bronfenbrenner, 1994). In addition, Bronfenbrenner (1994) indicates that an individual has physical, social, and symbolic features that enable or disable the engagement in sustained, progressively more complex interaction with, and activity in the immediate environment.

In this study, it is the individual characteristics such as self-esteem, resilience and coping strategies that plays a role on his or her interaction with other systems. Children who have high self-esteem (Sachs-Ericsso et al., 2010), good resilience (Ungar, 2012) and appropriate coping skills (Tamminen & Holt, 2012) can interact well with other systems around them. Research indicates that when self-esteem increases, resilience also increases (Karatas & Cakar, 2011) leading to more appropriate coping skills. However, the very same system can affect the child's self-esteem, resilience and coping strategies negatively because this theory explains that individual characteristics and the environment in which the person lives change over time. For example, the risky family's

framework indicates that emotional self-regulation and tendencies for angry and hostile interpersonal styles are reinforced by the individual's family (Repetti, Taylor, & Seeman, 2002). In addition, childhood trauma has a negative impact on the child's self-esteem (Sachs-Ericsso et al., 2010).

This trauma usually takes place in the family environment leading to a child's choice of running to the street due to poor relationships in the family setting or the school setting. For example, McMorris, Tyler, Whitbeck and Hoyt (2002) designate that parental alcohol problems and sexual and physical abuse characterise the background for homelessness in children signifying poor relations at home. This then brings us to the first system, namely, the microsystem. In this study the microsystem and the mesosytem overlap in explaining parenting styles and childhood trauma among street children. The reason for the overlap is that when microsystems interact, a mesosystem is formed and encompasses the relationship between two or more settings (i.e., relationship between school and peers).

The microsystem which is closely related to the mesosytem is explained as a pattern of activities, social roles and interpersonal relations experienced by the developing person in the interaction with the immediate environment (Bronfenbrener, 1994). This is in a setting (i.e., family, school, peers) in which a person is operating. In this study, this system mainly focuses on parenting styles which influence the childhood trauma.

Parenting styles play a significant role in how parents socialise their children. This is supported by Bowlby (1969) who says, a warm, intimate and continuous relationship between the child and the mother (even other primary care givers) gives the child security and reduces anxiety and distress as the child has a secure base to explore the environment

(Bowlby, 1969; 1973). Poor relationship between the parent and the child leads to parenting styles which contribute to the parents' abuse of their children. Patterson (1992) says that the main cause of antisocial behaviour which is one of the common characteristics of street kids is influenced by environmental factors such as parents, peers, and schools as they affect the child's developmental process.

Violent homeless youth are more likely to come from families where they have experienced violence in the form of abuse (Anooshian, 2005). This declares that street children have experienced trauma in one form or the other which affects their normal development process, hence the decision to run to the streets. The normal child development process is also affected by dysfunctional family system in which the child lives (Thrane, Hoyt, Whitbeck, & Yoder, 2006). The dysfunctional family system can be as a result of many factors. For example, Katz et al. (2007) reported that poverty influences parenting styles. Poverty affects the household or the entire community which functions in the exosystem.

The exosystem comprises linkages and processes taking place between two or more settings containing the developing person. This is an environment in which the individual is not directly involved, but which impacts him/her anyway (i.e., relationship between parents, caregiver's place of employment, local media, and community agencies).

In this instance, a child who grows up in poverty struck family where parents are frustrated by the demands of society and poor socio-economic status. Parents do not have adequate support from their relatives and the community in helping the children but end up neglecting and abusing the children in different ways. The abused children, due to

poverty, inadequate supportive family networks and external social support and other resources, are unable to deal with the abusive home environment effectively (le Roux & Smith, 1998). These challenges have already impacted on their self-esteem, resilience and coping strategies negatively, with limited resources, the child decides to run to the streets.

Limited resources are explained from the macrosystem subsystem. The macrosystem is an overarching pattern of micro-, meso-, and exosystems characteristic of a given culture (Bronfenbrenner, 1994). That which affects society as a whole as a result of societal structures and values is called the macrosystem. The structures of the macro system include social structures, cultural groups, political organisations and religious structures. Community characteristics that the child lives in, directly or indirectly influence him or her to run to the streets. In this case, children run to the streets as a result of lack of community resources, including intervention methods to help them deal with adverse events.

According to this model, the momentum of the individual's activity can be changed in two ways, that is, by first changing the settings in which individuals engage in everyday activities and secondly changing the individual's response to influences in particular settings (Bronfenbrenner, 1979). This is particularly rewarding because of the interaction between the person and the environment. In the current study, formulated intervention strategies are focused mainly on the individual (i.e. the street child) to equip him or her manage challenges that exist in different subsystems effectively.

In summary, street children compared to non-street children have had poor interaction with the microsystem, mesosystem, exosystem, macrosystem and chronosystem. It is as a result of multiple factors in a child's life, especially the dysfunctional family (poor parenting styles, child abuse and low socio-economic status) systems leading to poorly developed personal characteristics such as self-esteem, resilience and coping styles which negatively impact on interaction with peers and society in general that make children run to the streets. Unavailability of community resources, including intervention techniques at hand makes it difficult for the children to deal effectively with adversities and as a result opt for street living. An intervention should not be limited to only providing supportive, positive settings for the individual, but it should also create linkages that both change dynamics of relationships in existing settings and create entry points in to new more positive settings. Consequently, intervention should be formulated starting from the individual, microsystem to the chronosystem (the systems the child find himself or herself in) (Bronfenbrenner, 1979). For the purpose of the current study, intervention strategies are formulated based only on the individual. However, suggestions for interventions with other systems are provided.

2.2. THEORETICAL PERSPECTIVE

Theories serve as a foundation of understanding complex spectrum. Each theory reviewed in this study provides important and appropriate information to help understand the current study variables. Theories help explain study variables in a logical and scientific manner. This section is an overview of the major theoretical perspectives regarding psychosocial factors in this study. These psychosocial factors include self-esteem, coping, resilience, parenting style, childhood trauma and socio-economic status.

2.2.1. Self-esteem Theory

Self-esteem is the desire to be worthy, to love and to belong, to be strong, secure, and be appreciated by others (Samuels, 1977). It refers most generally to an individual's overall positive evaluation of the self (Gecas, 1982; Rosernberg, Schooler, Schoenbach, & Rosernberg, 1995). It is composed of two dimensions which are dimensions of competence and worth. The competence dimension refers to the degree to which people see themselves as capable and efficacious. The worth dimension refers to the degree to which individuals feel they are persons of value. People who see themselves as competent and capable about things are likely to have high self-esteem.

Trait self-esteem reflects the person's general sense that he or she is the sort of person who is valued and accepted by other people (Leary, 1999, p 34). The sociometer theory is against the idea of linking self-esteem to social acceptance because if self-esteem is based on the approval of others it is false and unhealthy and it may lead to people acting not on their own will as they would want to protect their interpersonal relations (Leary, 1999). Global self-esteem is associated with the overall psychological well-being (Rosenberg et al., 1995).

This self-esteem acts as a form of defence mechanism when faced with adverse situations. It can be built up, be stored in a reservoir which is filled-up by successful self-verification and when the self-verification process is disrupted, it is used up. Self-esteem is considered to be highly stable although it is responsive to changes in social situations (Samuels, 1977). For example, the child seeks care and love from his/her parents and family members and approval form his/her peers that he/she associates with. If these people are not providing that love and appreciation, the child's self-esteem will be

negatively affected as this is a sign of disapproval. In case of lack of love and appreciation, as in the case with street children, negative self-perception results.

Self-esteem can be viewed as a central characteristic that plays a role in the development of an individual's identity process (Cast & Burke, 2002). When a person's identity is verified in social group interaction, the self-esteem is built up. It is a factor that protects individuals and helps them to remain engaged in the situation while they find new ways of verifying their identities. In the case of persistent failure for individuals to verify their identities, self-esteem declines much quicker, leaving the individual more vulnerable to the negative effects of lack of self-verification. This means that the higher the levels of self-verification, the more an individual's low levels of self-esteem, the more the resources needed in order to try various things that alter perceptions in such a manner that identity standards are matched (Samuel, 1977). For a child who experiences lack of love and approval, the self-esteem gets lowered and the child perceives himself or herself negatively and makes negative decisions about his/her own life.

This self-esteem is important in such a way that it ends up affecting the child's decision making. The negative decisions do vary but can include decisions such as suicidal ideation, deviant behaviours and even running away from home. This is mainly because the child sees himself/herself as a person of no worth. Self-esteem can be as seen as a buffer that is used in times of need and this indicates that the more self-esteem is in reserve, the more alternatives will be tried by the individual in times of needs.

In this case, street children compared to non-street children did not receiving adequate approval from their abusive parents and guardians to nurture their worth and as a result

their overall perception of the self was negatively affected. In times of adversities, as a result of abuse or other factors, due to lack of self-worth in the current environment, they see themselves as unworthy and running to the street comes as an alternative.

2.2.2. Resilience Theory

According to the youth resilience framework developed by Rew and Horner (2003), an individual has risk and protective factors that help him or her to deal either adequately or inadequately with internal or external stressor. For some people, the one side (either the protective or the risk side) dominates (Rutter, 1987) and those who achieve better outcomes when faced with adversities are said to be resilient (Rutter, 1993). Risk factors can be explained as internal or external hazards a child is exposed to (Jessor, 1991) and increases the child's vulnerability or susceptibility to negative developmental and health outcomes (Engle, Castle, & Menon, 1996). Protective factors in an individual are those characteristics an individual relies on and uses to overcome stressful events.

This theory suggests that individuals are able to sink into a depressive state during stress and they are also capable of bouncing back from the depressive state. In case of street children, this resilience can be in two ways. First, the child might find difficulties in coping with stressful life events at home and run to the streets. Secondly, on the streets, the resilience can be seen as a coping factor for these children as they are able to cope with the harsh life on the streets (Malindi, 2009).

In addition to bouncing back, resilience is also understood as a return to a single global equilibrium after several functional groups have provided the individual with various

sources that aid the recovery process. This indicates that resilience is built in many ways including the destruction or renewal of systems. For example, positive family factors and active engagement in social activities are important traits in helping an individual to build resilience (Jacelon, 1997). Street children lack this positive family factor as they are raised by parents or care givers who do not provide adequate warmth and support for them (Fantuzzo, Perlman & Dobbins, 2011) due to abuse (Mathur et al., 2009). As such, they are likely to lose their ability to be resilient.

The loss of resilience is usually accompanied by a change in the system simplifying crisis and the attempt to return or restore to a desirable state requires management of alternatives (Gunderson, 2000). In this case, crisis is associated with the trauma they experienced. The restoration of a desirable state can take place when there are protective processes that mediate the risks (Rutter as cited in Jindal-Snape & Miller, 2008, p. 219). Those protective processes include, lessening the impact of risk or exposure to risk, decrease the number of risk factors, increase self-esteem and self-efficacy and provide access to opportunities, increase confidence and develop necessary skills. All these are regarded as building factors for resilience and they help people recover when they are under stressful life events. In the case of street children compared to non-street children, they find themselves in an environment that has high risk factors (abuse by parents and guardians) and low protective factors (low self-esteem, poor parenting styles) hindering them to develop capacity to deal with stressors effectively.

2.2.3. Transactional model of stress and coping

The transactional model of stress and coping is a framework for evaluating the processes of coping with stressful events. Stress has been defined by Lazarus and Folkman (1984) as the relationship between the person and the situation which the person views as threatening to the well-being and taxing his/her coping mechanisms. The perception by a person who lacks resources to deal with a particular situation results in the situation becoming stressful. According to this theory, an event is not stressful in nature, however, what is stressful is the person's perception of the event as a danger to him/her that defines that event as stressful.

Lazarus and Folkman (1984), continued to define coping as defined as a constant process of varying cognitive and behavioural efforts to manage external and internal demands that are viewed as demanding or exceeding the person's resources which subsequently influence the emotional arousal (Folkman & Lazarus, 1988). Coping is not regarded as a stable thing in a person in different stressful situations; rather, it is coping strategies available at a particular point in time for that specific stressful situation. One can manage to effectively cope with a situation in the current moment but in future struggle to cope with that very situation.

There are two general forms of coping, namely emotion-focused coping and problem-focused coping (Lazarus & Folkman, 1984). In emotion-focused coping, the emphasis of coping strategies is more on changing the individual's emotional response to the stressful event while on problem-focused coping the coping strategy is emphasised in changing the problem itself by acting on the situation. The type of coping strategy used depends on the cognitive appraisal. An individual needs this dynamic and complex coping process to

challenge stressful life situation interpreted as the transactions between the person and environment. These transactions depend on the impact of the external stressor to the individual as they are mediated by the person's appraisal of the stressor, the social and cultural resources at his or her disposal (Lazarus & Cohen, 1977; Cohen, 1984).

This stress and coping framework further explains that, there is what is called appraisal which is influenced by the person factor (primary appraisal) and the situation in particular (secondary appraisal) . Person factors include a person's beliefs and commitments that can influence the appraisal process which is the process of categorising a stressor with effect to its significance for the person's well-being while the situation factor involves the aspects of the stressor itself which assess the coping mechanisms available and the effectiveness of theses mechanisms (Lazarus & Folkman, 1984).

From this clarification, stress comes as a result of the relationship between the person and the environment when the person views that a situation is demanding and his/her resources are limited to deal with the challenges that threaten his/her well-being (Lazarus & Folkman, 1984). This suggests that an event becomes stressful only when the person experiencing it feels unable to deal with it may be due to their perception of limited resources. This theory indicates that the abusive environment (secondary appraisal) children experience and their perception (primary appraisal) of the limited resources (low self-esteem and poor resilience) affect the way they cope with adverse situations.

As explained in the resilience theory above (that some people are more exposed to risks than others), in this study, street children are exposed to abuse (Gwadz et al., 2004) which threatens their well-being. This is supported by findings which indicate that

abused children suffer impaired psychological, social and physical functioning and ineffective coping strategies (Wilson, Vidal, Wilson, & Salyer, 2012). Abused children compared to non-abused children are exposed to more risk and have fewer resources to deal with it and as a result, use ineffective coping strategies including the use of substances to alleviate the trauma (Lee, Lyvers, & Edwards, 2008).

For children who run to the streets compared to those who do not run to the streets, child abuse, poor parenting styles and poor socio-economic status are viewed as stressful and their resources (low self-esteem, poor coping and poor resilience) to deal with their challenges are limited. This theory indicates that there is a need to help children on the street to develop more appropriate ways of coping with their challenges.

2.2.4. Trauma theory abbreviated

The trauma theory (Bloom, 1999) stipulates that children get traumatised when they are in a situation where their lives or those of loved ones are threatened. Truamatised children suffer from disrupted attachments. This disrupted attachment affects their development systems especially if the perpetrator is the attachment figure (Bloom, 2003). According to Bowlby (1969), attachment occurs when there is a warm, intimate and continuous relationship between the infant and the mother in whom both satisfaction and enjoyment is found. The attachment develops gradually and gives the infant security and reduces anxiety and distress. As a result of trauma, the normal attachment process is disrupted. This then creates challenges for the developing child because normal attachment is crucial to a person's healthy development (Bowlby, 1969).

Attachment theory has identified universal patterns of human need that arise when individuals are placed under stress or when they experience anxiety (Bowlby, 1973; 1980). In this instance, maltreatment may be seen as insensitive parenting where maltreated infants see their caregivers as unresponsive, unavailable and rejecting. The infants may also view themselves as unworthy and unable to elicit appropriate attention and care from the attachment figure.

A child who experiences trauma feels unworthy and his or her development is disrupted. For a child's brain to develop normally, the brain needs to be adequately stimulated though at the same time protected from potential overwhelming stress (Bloom, 2003). In case of inadequate protection, the internal protective mechanism which is natural to all human beings, the fight or flight reaction kicks in. Children who are exposed to traumatic situations, with inadequate protection, the more sensitive to trauma they become. If the child cannot get help (fight) or run away from the traumatic event (flight), there will be increased risk of physical changes. The child will try these reactions several times; failure to get adequate help, the child will develop learned helplessness and eventually give up the attempt to challenge the situation (Bloom, 1999).

Children who are exposed to risk on repeated occasions lack the required safety and protection relevant for their normal brain development. As a result, they are faced with challenges of managing their anger, aggression and impulses which lead to risky taking behaviour such as alcohol and drug abuse, engaging in violent crimes, which is a temporary coping mechanism (Bloom, 1999). Due to the amount of trauma experienced, the child's capacity to think clear is impacted, consequently poor judgments and decisions are made as a need for self-protection (Bloom, 1999).

This theory indicates that children (street children) who are exposed to risks (in the form of trauma) on repeated occasions without adequate protection from the attachment figure (parents and guardians) have abnormal child brain development which influences their judgment, decision making and problem solving skills and end up using maladaptive coping mechanisms such as drugs and substance abuse and engaging in violent risky activities including running to the streets compared to children who are not exposed to risks (non-street children).

2.2.5. Parenting style theory

Parenting has been described as the process or a state of being a parent. Parenting includes nourishing, protecting, and guiding the child through the course of the child's development. It is a continuous series of interactions between parent and a child, and these interactions change both partners in the parent-child dyad. Baumrind (1967) indicated that effective parenting consists of multiple elements that are melded together to form distinct styles. Parenting styles have the broadest influence on a child's behaviour, because they create a general environment in which particular parenting practices can either be received or rejected by the child. The primary processes through which parenting styles influence development are therefore indirect.

The key element of the parental role is to socialise the child to conform to the necessary demands of others while maintaining a sense of personal integrity. In Baumrind's (1968) conceptualization of parenting style, parents' values and the beliefs they hold about their role as parents and the nature of children help define naturally occurring patterns of affect, practices and values. One broad parenting function is control. The configuration of

practices associated with authoritative parenting reached beyond the issue of authority demands, communication style and nurturence. Baumrind (1967) found that parents who differ in the way they use authority also tend to differ along other dimensions which can include the relationship with their children.

Baumrind (1991) categorised parenting styles into authoritarian, authoritative or democratic, permissive and un-involved. Baumrind (1967) has explained them as follows: authoritative parenting, characterised by high levels of parental nurturance, involvement, sensitivity, reasoning, control, and encouragement of autonomy; authoritarian parenting, consisting of high levels of restrictive, punitive, rejecting, and power-assertive behaviours; permissive parenting, characterised by high levels of warmth and acceptance, but low levels of involvement and control; and uninvolved parenting which is characterised by low levels of warmth and control.

These parenting styles have an impact in the development of different behaviours in children. Okorodudu (2010) reported that there is a positive relationship between permissive parenting style and adolescent delinquent behaviour which is a prominent character of street children. Permissive parents do not give adequate supervision to their children and as such their children find it easy to engage in unacceptable behaviours. This can also be applicable to homelessness, i.e. children can easily run to the streets as they feel neglected and without the parent being aware of such a matter. Children are also deprived of an opportunity to learn to deal with challenges in an appropriate manner from their significant others. Hence the involvement in unacceptable behaviours which they usually observe from the environment (Bandura, 1977), and eventually run to the streets.

This is different from children who are raised in warm, caring and supportive environments by parents who utilise authoritative parent styles.

Authoritative parenting characteristics are competence-enhancing and are protective of children's later development of antisocial behaviour. On the other hand, authoritarian and permissive parenting increase the risk of the development of antisocial behaviour (Hart, O'Toole, Price-Sharps, & Shaffer, 2007; Jones, 2008). This is because positive parenting, including parental warmth and emotional sensitivity which are related to lower levels of aggression, psychological controlling and uninvolved parenting styles are effective in elevating the level of aggression in children (Kawabata, Alink, Tseng, van Ijzendoorn, & Crick, 2011) and this aggression is one of the street children's characteristics. Parental illicit drug use is significantly associated with internalizing and externalizing behaviour in children because positive and warm parenting provides a supportive context for children to thrive and acting as a buffer from negative and stressful environments (O'Campo, Caughy, & Nettles, 2010).

This theory indicates that children raised by parents who utilise authoritative parenting style which is a parenting style characterised by high levels of nurturance, involvement, and warmth are less predisposed to risk factors and are equipped with better skills and resources to use when faced with adversities. On the contrary, children raised by parents who utilise authoritarian, permissive and uninvolved parenting styles are more exposed to risk with fewer skills and resources to challenge adverse situations and have an increased risk for the development of antisocial behaviour (Hart, O'Toole, Price-Sharps, & Shaffer, 2007; Jones, 2008). This is further supported by the research which revealed that children

with a history of parental neglect are likely to experience homelessness (Fantuzzo, Perlman, & Dobbins, 2011).

In the present study, this theory designates that street children compared to non-street children have been raised by parents who utilise authoritarian, permissive and uninvolved parenting styles. These parenting styles predisposed them to high risks such as trauma (Cluver, Bowes, & Gardner, 2010; Rukmana, 2008) with few resources to cope. Non-street children compared to street children are raised by parents who utilise authoritative parenting style and are exposed to less risk and receive support and guidance to learn appropriate ways of dealing with their challenges.

2.2.6. Socio-economic understanding

Weber (1952) conceptualized inequality along three related tracks, that is, class, status and party, serving as a major basis for power and influence. In this theory class refers to economic resources, party refers to political power and, status refers to honour and prestige. Class subtype is usually seen in the labour market environments as there are different levels of skilled people (skilled, semi-skilled and unskilled). These different levels of skills differentiate people and how they are ranked in terms of power and class. This is because class starts with the relationship to means of production although including a more complex analysis of property (ownership of wealth). People belong to different class categories which hierarchically arrange them on the basis of distinctive lifestyles, consumption patterns, and modes of conduct or action giving them a particular status associated with social estimation of honour (Weber, 1924) which may or may not be linked to property and market situation. People who belong to a certain hierarchical

group are said to have a certain standard and they need to develop visible lifestyles, and therefore relate or not relate with certain pre-defined social groups. This might be education, and selection through attending the right school and university. A certain status is associated with the choice of a particular thing over the other.

The theory's assumption is that the position of individuals within the social system might be of a high or low class (Weber, 1924). The upper class is characterised by more wealth and political power, the middle class is explained as people with good education who can have their basic needs met though with no political power and the lower class which is also known as the working class is comprised of people who are employed but with no financial security as a result of their low salary paying jobs (Sutton, 2009). This class standing influences their chances of encountering stressors. For low class people, they have increased chances of experiencing stressor and due to limited resources; there are increased chances of emotional distress (Aneshensel, 1992). This assumption is also supported by Pearlin (1989) who believes that those of lower social standing are exposed to more stressful conditions when there are few resources to cope with those conditions.

People who are in a lower social standing fall within the sociological paradigm that explains that disadvantaged social groups experience stress as a result of social conditions (Aneshensel, Rutter, & Lachenbruch, 1991). This therefore indicates that street children, the disadvantaged social group, compared to non-street children are exposed to poor socio-economic status leading them to experience more stressors with fewer resources to cope and alternatively they run to the streets to beg for money or commit crime to generate some sort of income. This is in line with the general strain theory by Agnew (2001) which suggests that strains are associated with low social

control such as poverty creating pressure for the individual to engage in crime as a coping mechanism.

Street children compared to non-street children have been raised in families where their parents or guardians have not been nurturing and involved in their lives due to the parents' psychological distress associated with poor socio-economic status (Conger & Elder, 1994). This family situation, poor socio-economic status in particular, is in itself stressful to the developing child, creating threats and demands that challenge the child's survival (Wheaton, 1990) and the child runs to the streets in an attempt to cope with the situation.

2.2.7. Cognitive Behavioural Group therapy: Theoretical understanding

Durkin et al. (1971) indicate that the history of group therapy was pioneered by Joseph Hersey Pratt in 1905 who worked with tubercular patients and the main aim of the group was to help patients understand their illness and how they could contribute to their own recovery. In those days, the group members participating in the groups were between 80 and 100. Another pioneer in group therapy is Tregant Burrow who in 1920 introduced group analysis which he later called "phyloanalysis" (Durkin et al., 1971). Because his work was mainly with residential people, the tension between the doctors and patients were analysed and discussed in a group. Currently the most common pioneer of group work is Irvin Yalom who introduced the principles of group therapy. These principles are discussed latter in this section. Group therapy has become popular after World War II as a response to the shortage of personnel trained in individual therapy to assist those affected (Corey & Corey, 1987).

After this pioneering work was done, group therapy is now understood as a type of psychotherapy that involves one or more therapists working with several people at the same time (Weiner & Craighead, 2010). Positive reinforcement is emphasised in this therapeutic method. Group therapy is utilised in wide range of settings. This type of therapy is widely available at a variety of locations, including private therapeutic practices, hospitals, mental health clinics and community centres. Group therapy is sometimes used alone, but it is also commonly integrated into a comprehensive treatment plan that also includes individual therapy and medication. Group norms established early in the process of group therapy tend to persist, and encourage a complete turnover in the group population (Yalom, Houts, Newell, & Rand, 1976). It is within the group context where members have an opportunity to practise new social skills and apply new knowledge in order to deal with symptoms such as depression, sexual difficulties, anxiety and somatic disorders (Corey & Corey, 1987)

Group psychotherapy is differentiated from other groups such as group counselling, personal-growth groups, T-groups, structured groups and self-help groups. Group psychotherapy usually focuses on treating pathologies such as depression, anxiety, sexual difficulties and psychosomatic disorders whereas T-groups focus on educating through experience in which experimentation can occur, data can be analysed, new ideas are encouraged (Corey & Corey, 1987).

Normally, groups consist of a small number of members ranging from 6-12. Corey and Corey (1987) argue that fewer numbers less than 5 and more numbers over 16 should be avoided. They further indicate that the similarity of members in the group can lead to greater degree of cohesion which is one important element in a group. A balance of age

and gender should be considered when forming a group. After deciding on the group size and members, the leader further decides about the duration (usually 90 minutes to 120 minutes) and the frequency of meetings (usually once a week depending on the nature of objectives of the group) (Aveline & Dryden, 1988). The leader should introduce the purpose and objective of the group to members during the first session and also members should introduce themselves by their first names.

Burlingame, Fuhriman and Mosier (2003) found group therapy to be effective and most preferred method is the cognitive behaviour group therapy. Furthermore, Foulkes (as cited in Maglo, 2002) indicated that group therapy is effective as it allows opportunities for the individual to identify their difficulties in the presence of and through interaction with others whom they share the same challenges with as growth of awareness of their responsibilities is facilitated through feedback.

Group therapy can be formulated from various theoretical modalities such as group cognitive behavioural therapy. The current study adopts the cognitive-behavioural group therapy (CBGT) because its core principle is the cohesiveness in the group while utilising approaches that are task orientated and designed to seek the solution to the current presenting problem (White as cited in Petrocelli, 2002). Alladin (as cited in Aveline & Dryden, 1988) indicate that CBGT has four main goals. The first goal is to provide a safe social environment for participants to facilitate disclosure of problems and engaging in experimenting with different behaviour patterns. The second goal is to encourage social interaction among group members so that they may give each other feedback. Thirdly, the CBGT help participants learn methods of behavioural and cognitive change such as

problem solving skills. The last goal of CBGT is to help introduce to members methods of understanding maladaptive behavioural and cognitive patterns.

Depending on the challenges faced by group members, the therapist structures the treatment of the group according to the needs of the clients. However, many studies indicate that treatment involves cognitive, behavioural, or cognitive behavioural approach to reducing negative emotions (Jacobsen & Jim, 2008). Besides creating group cohesiveness, the aim of this study's social skills training programme which utilised principles of cognitive behaviour group therapy was also to provide street children with a safe social environment that encourages social interaction for them to learn methods of behavioural and cognitive change leading to improved self-esteem, resilience and appropriate problem solving skills. Cognitive behavioural social skills training helped adults with chronic schizophrenia to learn coping skills (Granholm et al., 2005). In addition this method was chosen as other researchers (Petrocelli, 2002) found it effective in treating many clinical symptoms including behavioural and emotional problems among children (Butler, Chapman, Forman, & Beck, 2006) in an individual or group setting (Jaycox, 2004).

2.2.7.1. Principles of group therapy

In *The Theory and Practice of Group Psychotherapy*, Yalom (1985) and Yalom and Leszcz (2005) outline the key therapeutic principles that have been derived from self-reports from individuals who have been involved in the group therapy process. The principles are as follows:

2.2.7.1.1. The instillation of hope

In psychotherapy, installation and maintenance of hope is as crucial as it has been indicated that high expectation of help before the start of therapy is correlated with positive outcomes. Group therapy serves as a source of hope for other group members when they see fellow group member's progress.

2.2.7.1.2. Universality

Being in a group of people experiencing the same things helps people see that what they are going through is universal and that they are not alone as many people enter therapy with thinking that they are unique with their own challenges. Group therapy provides the platform for them to realise that other people have the same challenges as theirs. The groups also offer mutual support and psycho-educational approach to the client's experiences.

2.2.7.1.3. Imparting information

Group members are able to help each other by sharing information. Imparting information also includes didactic instruction which entails giving formal instructions or psycho-education. This is an important part for the programme. Group members also give each other advice and this process is called direct advice.

2.2.7.1.4. Altruism

Group members are able to share their strengths and help others in the group, which can boost self-esteem and confidence. Members also learn from giving, not only from receiving. They have an opportunity to benefit from one another.

2.2.7.1.5. The corrective recapitulation of the primary family group

The therapy group is much like a family in some ways as there are authority/parental figures, peers/sibling figures, deep personal revelations, strong emotions, competition and hostility. Within the group, each member can explore how childhood experiences contributed to personality and behaviours. They can also learn to avoid behaviours that are destructive or unhelpful in their real life.

2.2.7.1.6. Development of socialization techniques

The group setting is a great place to practise new behaviours. The setting is safe and supportive, allowing group members to experiment without the fear of failure. Ground rules which encourage open feedback are very important as they help group members obtain very considerable information about maladaptive social behaviour.

2.2.7.1.7. Imitative behaviour

Individuals can model the behaviour of other members of the group or observe and imitate the behaviour of the therapist because the therapist influences the communicational patterns in their groups by modelling certain behaviours. Group members learn from observing one another when solving problems. This imitative behaviour plays an important role more especially in the early stages of the group.

2.2.7.1.8. Interpersonal learning

By interacting with other people and receiving feedback from the group and the therapist, each individual can gain a greater understanding of himself or herself. This is a developmental cycle wherein it is a process of constructing our self-regard on the basis of reflected appraisals read in the eyes of other people.

2.2.7.1.9. Group cohesiveness

Because the group is united in a common goal, members gain a sense of belonging and acceptance. Members of a more cohesive group are more likely to accept one another and this acceptance and approval are most important in the individual's developmental sequence

2.2.7.1.10. Catharsis: Sharing feelings and experiences with a group of people can help relieve pain, guilt or stress. The group offers a platform for group members to gradually explore previously avoided or unknown parts about themselves.

2.2.7.1.11. Existential factors

While working within a group it offers support and guidance. Group therapy helps members realise that they are responsible for their own lives and actions.

CHAPTER THREE

LITERATURE REVIEW

3.1. INTRODUCTION

Street children phenomenon is a phenomenon of great concern. Various researchers (Ezeokana et al., 2014; Hoersting & Jenkins, 2011; Malindi, 2009; Shiluvane et al., 2012) conducted research in this field although some gaps still exist. As indicated in the problem statement, there are few studies conducted with the variables contained in the current study. As a result, in this chapter, the literature concerning the variables involving street children including other study populations which can be linked to the current study has been reviewed including the literature on homeless and runaway youth. The review starts by looking at the reasons why children are on the streets and what challenges they face on the streets. This is done in order to highlight other issues related to street children even though they are not the focal point of the study. The main study variables for phase I of the study include self-esteem, resilience, coping strategies, childhood trauma, parenting styles, socio-economic status. The literature review for phase II highlights the training in social skills.

3.2. ISSUES ASSOCIATED WITH STREET CHILDREN

Majority of children leave home to the streets as a result of abuse at home. While on the streets they face different challenges including re-victimization by police and peers (Kudrati, Plummer, & Yousif, 2008). This was also found to be the case with adult women who were veterans. In this study, these women joined the military to run away from abuse at home or to escape homelessness after they were abused. While in the

military they were re-victimised and forced to go back to homelessness (Hamilton, Poza, & Washington, 2011). In the case of street children, such children are likely to face even worse social environments that compound the problems they have faced prior to homelessness. There are cases of street children being beaten by police, detained and sometimes sent home to their rural homes (Lugalla & Mbwambo, 1999). When they got home, they found that the initial adverse circumstances that made them run away had not changed; they then again ran back to the streets making it a vicious cycle. This indicates that the adversity they endure does not end when they leave home, but rather still continues even when they are on the streets (Miles & Okamoto, 2008).

After running away from home to the streets, life on the streets remains challenging. Challenges range from adaptation to street life, finding food and shelter. Homeless people, including street children, use vacant buildings as shelter for sleep at night (Milburn et al., 2011). If there is no shelter available, they sleep in open spaces at the parks or dangerous places such as sewage pipes and under the bridges. Regardless of these harsh conditions, the children opt to stay on the streets and learn to survive.

In order for these children to survive, they need to learn to adjust to street life and its different conditions. In most instances, street children use deviant ways to adapt to the challenges of street life. For example, Miles and Okamoto (2008) reported that street youth violate societal norms by engaging in deviant behaviour due to the strain they find themselves in. The chances to commit crime increase as homelessness increases. Homelessness, irrespective of street homelessness or shelter homelessness is associated with non-violent crimes such as subsistence strategies. This is more among the street homeless where engagement in non-violent criminal behaviour is mainly as a result of

survival strategies (Fischer et al., 2008). This includes shoplifting, pick pocketing, handbag snatching and even sniffing glue.

Another way of surviving with street life is to be part of an existing group. There are various groups which are differentiated due to their survival methods. For example, there is a group of "Oogles". This group is described as those children on the street that have a place to stay such as a permanent home or shelter and come out to hang on the streets, rely on adult support for survival. The "Oogles" also do not maintain street rules such as not divulging what is happening on the streets to the general public. Once a child has moved from "Oogle" behaviour he/she is then called street smart. These are those street children who learn to survive on their own and stick to street rules (Bender, Thompson, McManus, Lantry, & Flynn, 2007). No adult support is needed for their survival as such, these groups become beneficial.

Due to their survival methods, street children are being treated as societal outcasts, rather than being treated as children in need of help and protection (Henley, McAlpine, Mueller, & Vetter, 2010). As a consequence, they are exposed to many challenges and find themselves in impoverished settings which expose them to things such as sexual assault, violence and illnesses making street life more and more challenging. Society ill-treats homeless youth due to their tendency of violating social norms. As a result, this violation of societal norms causes strain on them in order for them to survive (Miles & Okamoto, 2008). Street children are considered to be thieves who are prone to commit crimes and experiences of victimization (Thompson, Jun, Bender, Ferguson, & Pollio, 2010). Another interesting reality is that these street children share the streets with millions of

adults, many of whom regard them as nuisance, if not as dangerous mini-criminals and as such they are not wanted by society in general.

Society stigmatises street children and, as a result, their chances finding of legal money generating activities are lessened and they opt to engage in criminal activities which lead to their incarceration (Gwadz et al., 2004). Other activity that predisposes them to stigma is their abuse of different substances ranging from glue, cocaine, heroin, etc. (Paquette, Roy, Petit, & Boivin, 2010). This is done more by children of the street who are considerably more likely than children on the street (market children) to sniff glue, use alcohol, smoke tobacco, get arrested by police, earn money by begging and stealing, be criminally victimized, and suffer from health problems (Wittig, Wright, & Kaminsky, 1997). Owing to ill-treatment from society, street children end up forming gangs and taking part in illegal activities which may be seen as a way of maltreated youth modelling deviant role models (Akers, 1998), and due to the reward of social acceptance in peer groups (Bender, 2010). This can be seen as a survival strategy during survival of the fittest of the street life.

However, street children do not experience negative attitude from the community all the time. For instance, in Canada, homeless individuals reported high level of support from their social networks and this perceived support was associated with better physical and mental health together with reduced chances of victimization (Hwang et al., 2009). This was further supported by the findings of Bender et al. (2007) that showed that street youth rely on societal help for their survival. This social support can be in two ways, first, it can be seen to perpetuate the problem of homelessness, and second, it might be good for homeless people. When social support perpetuates homelessness, homeless

people will not want to leave the streets as they know that there are people who cater for their basic needs while on the streets and as such do not worry about finding other means of living such as shelter or reunification with a family.

Above and beyond gang formation and societal ill-treatment, there are other challenges faced by street children. Being homeless in most cases is associated with drug use, involvement in violent activities, poor health outcomes and increased risk behaviour and exposure to HIV infection (Rachlis et al., 2009). Risk behaviours may or may not have begun while at home, once homeless, such young people are more vulnerable to the typical lifestyle of street children. The stress of street life in itself exacerbates the behavioural issues of homeless youth whether or not they had these problems before homelessness and there are no gender differences with regard to engaging in deviant behaviours (Gwadz, Nish, Leonard, & Strauss, 2007).

From the above information it can be seen that there are different types of challenges experienced by children who grow up in adverse conditions and environments. The challenges vary from low self-esteem, poor scholastic performance, poor socialization and even health-risks behaviour. The health-risks behaviour that are as a result of adverse childhood experiences include smoking (Ford et al., 2011), and binge drinking (Keyes et al., 2011). These behaviours are more like learned behaviours. Bandura (1977) argued that children's behaviour is as a result of what they have learned and observed from other people around them implying that children usually display behaviour which they have seen happening.

In the case of street children who have been exposed to drug use whether directly or indirectly, they may regard drug use as a suitable way of living regardless of its consequences as it is what they have learned. For example, a study that was conducted in Brazil by de Carvalho et al. (2006) showed that 50% of the sample were children under the age of 14 who reported high proportion of exposure to high risk sexual behaviour and they were engaged in sexual activities with multiple partners and in most instances without condom use making them more vulnerable to HIV and ST infections. In the very same study, majority of participants (83%) reported alcohol use though other forms of drugs such as injectable drugs were minimal (de Carvalho et al., 2006).

Street children are exposed to various drugs. In the variety of drugs available at their disposal, Webe et al. (2010) found crystal methamphetamine as one of the substances used by street children and is initiated at much higher levels compared to other drugs. Homeless people use substances to such an extent that they develop substance use disorders. It was found that 82% of homeless women from shelters and streets have at least one type of substance use disorder (Torchalla, Strehlau, Li, & Krausz, 2011). Homeless youth are often addicted to drugs and alcohol and this usually comes as a result of identification with the homeless youth culture. Patterns of drug use among homeless youth are also associated with depressive symptoms among many psychological challenges that affect street children (Hadland et al., 2011). Some street youth use drugs as a result of provocation. Such provocation can be in the form of insults, threats, and other negative treatment which they are exposed to (Baron, 2010).

In addition, other challenges faced by street children include sexual abuse. Melander and Tyler (2010) conducted a study with homeless young adults and indicated that the history

of sexual abuse is directly linked with street sexual victimization and experiencing more types of physical abuse and neglect is positively correlated with partner violence and victimization. This partner violence also puts them at risk for HIV. This may still be applicable in the case of homeless children.

Furthermore, being on the streets predisposes the youth to hazards that can lead to premature deaths (Hickler & Auerswald, 2009). These deaths can be as a result of various causes such as pneumonia, overdose of drugs, suicides and murder or even being knocked down by cars. A study conducted among pregnant homeless women revealed that medical care is minimal even after reporting pregnancy in a health sector. This puts them at risk for miscarriages which constitute another health hazard (Hathazi, Lankenau, Sanders, & Bloom, 2009). All these challenges faced by street children are likely to affect their self-esteem, resilience and their coping strategies

3.3. SELF-ESTEEM OF STREET CHILDREN AND NON-STREET CHILDREN

Dynamics associated with street children are many. They range from personal characteristics to environmental factors (Jessor, 1987). Self-esteem is one of the personal characteristic dynamic of street children. Rosenberg (1965) defined self-esteem as a positive or negative attitude a person carries towards a particular object which is the self. Self-esteem is a desire to be worthy, to love, to be appreciated and to be loved. According to Samuels (1977), individuals have a need to increase and maintain their feelings of worth, effectiveness and self-satisfaction and are satisfied by the approval they receive from others and if they are disapproved, frustration results (Samuels, 1977).

Kille and Wood (2012) indicated that self-esteem refers to how a person evaluates themselves and their global self-worth. Self-esteem further includes things such as feeling confident, secure, competent or proud with oneself (Thomaes, Poorthuis, & Nelemans, 2011). There are mainly two categories of self-esteem, namely, low self-esteem and high self-esteem. People with high self-esteem evaluate themselves positively and have positive self-regard whereas people with low self-esteem evaluate themselves negatively and have negative self-regard. When people evaluate themselves, it is mainly on two aspects, on stable and on moment-to-moment factors. The stable factors are understood as trait self-esteem while the moment-to-moment factors are understood as state self-esteem (Kille & Wood, 2012). The trait self-esteem fluctuates from time to time though it has a stable level that it does not go beyond (Thomaes et al., 2011).

Contingent self-esteem is viewed as the extent to which self-esteem is contingent upon outcomes and achievements (Kernis, 2002). This is when people's self-esteem depends on the outcome of a particular activity or event. This self-esteem fairly remains stable for an individual across his or her own life span (Kille & Wood, 2012) though it develops during middle and late childhood (Thomaes et al., 2011).

Self-esteem is explained from two models, namely, the cognitive model and the affective model. The cognitive model focuses on those positive self-evaluations that have to do with the individual's thinking about himself or herself whereas affective models focus on positive self-evaluations that have to do with the individual's feelings (Kille & Wood, 2012). From the affective model, high global self-esteem symbolises a good enough feeling about the self and value as a person (Rosernberg, 1965). It is further regarded as an outcome of a success and having positive social relations. This is the explanation of

the role played by others in influencing a person's self-esteem. This basically means how a person thinks and feels about themselves as a result of how other people's influence affects their self-esteem. On the other hand it is believed that early childhood experiences play a huge role in the development of a person's self-esteem either low or high self-esteem (DeHart, Pelham, & Tennen, 2006).

In addition to the above statement, research has indicated that parenting and genetic influences, peer influences and competence-based influences have an impact in a person's development of high or low self-esteem (Thomaes et al., 2011). University students have indicated that acceptance involvement and psychological autonomy-granting styles contribute positively in their self-esteem (Zakeri & Karimpour, 2011). Moreover, low sense of autonomy in adolescents contributes to low self-esteem which in turn contributes to adolescents' identification with peer groups who violate social norm (Hesari & Hejazi, 2011). This basically indicates that children who come from families where parents are not encouraging them to be independent end up developing low self-esteem and, as a result, seek the company of peers who will boast their self-esteem and in most cases those peers are those children who engage in deviant behaviours. This is because self-esteem is maintained through positive self-representations (Peixoto & Almeida, 2010) which these children get from these peers instead of their parents and guardians.

Self-esteem among children does not only affect homelessness but a variety of aspects in a child's life. For example, the interaction between implicit and explicit self-esteem is associated with suicidal ideation which is seen as a way of coping among children (Creemers, Scholte, Engels, Prinstein, & Wiers, 2012). Suicidal ideation is often taken as

maladaptive way of coping which is a common factor among the population of street children. These children are those children who do not receive the necessary approval from the significant other and resorts to maladaptive coping.

Whaley (2002) found a positive association between self-esteem and homelessness. This self-esteem may reflect a person's attempt to portray himself/herself in a positive light whereas that might not be the actual case meaning that children with low self-esteem are likely to decide to become homeless. Those who were homeless but with no reports of low self-esteem are likely to report low self-esteem as a result of the treatment they receive while being homeless creating a cycle between low self-esteem and homelessness. This low self-esteem is also related to cultural homelessness (Hoersting & Jenkins, 2011).

In addition, self-esteem was found to have a relationship with loneliness and life satisfaction among adolescents (Kapikiran, 2012). When an adolescent has low self-esteem, he or she becomes lonely and unsatisfied with his or her life. This supports what was indicated by Samuels (1977) who said that self-esteem feeds on approval by other people. In the case of street children where they are ill-treated and neglected by society (Henley et al., 2010) they will not have adequate approval or relationships to boost their self-esteem and their social networks remain limited, reducing their coping resources.

The approval children need is from parents and significant others. Parents and significant others play a significant role in the development of a child's low or high self-esteem (Thomaes et al., 2011). Dentale, Vecchione, De Coro and Barbaranelli (2012) reported that dismissing/avoidant attachment increases implicit-explicit self-esteem discordance.

That is because parents who use avoidant attachment are emotionally unavailable for their children to give them nurturance and care that will help in the development of high self-esteem.

Additional to the emotional avoidant or unavailable parent, it has been reported that individuals with high self-criticism have been exposed to various types of adversities such as neglect, mother having antisocial behaviour and parental absence (Pagura, Cox, Sarren, & Enns, 2006). Children with low self-esteem see the environment as hostile and unsupportive towards them. As a result they do not bother to depend on approval by others to enhance their self-esteem and they do remain with low self-esteem. Parents are supposed to be the ones complementing their children and rewarding them to boost their self-esteem. However, as a result of poor relations, the relationship is distorted to such an extent that boosting their children's self-esteem does not happen.

The belief is that high self-esteem can protect people, especially young people, against vulnerability to a wide range of social stressors. Ni et al. (2010) found that higher levels of self-esteem could reduce the risk of mental health problems, meaning that, self-esteem can serve as a protective factor. In this case, self-esteem can serve as a protective factor for people and particularly children in general when they are in distress, street children inclusive. On the other hand, children who are living under stressful situations can have low self-esteem which can negatively affect their coping mechanisms as they are at risk due to their low self-esteem. Stein, Leslie and Nyamathi (2002) indicated that a history of childhood abuse among homeless women had an impact leading to a wide range of problems such as low self-esteem, depression and chronic homelessness. In the case of street children who run away from home due to adversities they have faced, they had

limited coping resources. The adversities can lead to internalising the views of the offenders and as such, form negative self-perceptions which affect self-esteem negatively (Ju & Lee, 2010). These studies indicate that there is a relationship between trauma and self-esteem.

High self-esteem appears to act as a protective factor or as a resource that buffers people from negative experiences and those with low-self-esteem may likely experience psychopathology as they lack this protective factor or resource (Zeigler-Hill, 2011). In this case, those children with low self-esteem are likely to be found living on the street as a symbol of a disturbance that occurred as a result of a trauma experienced. They were unable to cope with maltreatment at home and that made them to run to the streets. This is because it was highlighted that self-esteem was found to be lower in the group of homeless and runaway youth than their non-homeless counterparts (Maccio & Schuler, 2012). However, this study used a small sample size and did not include a control group, yet concluded the comparison between homeless/runaway youth and non-homeless/runaway youth. Contrary to these findings, recently, in Nigeria (Anambra State) Ezeokana et al. (2014) conducted a study among male and female street children. Their results revealed no significant statistical difference on self-esteem between street children and non-street children. The difference was also not found between street children who had contact and those who did not have contacts with their families.

Further research explored gender differences in self-esteem and social support among street children in Nigeria (Lawal, 2011). This study concluded that female street children have more low self-esteem than male street children. Another study conducted among a sample of 208 homeless youth who were interviewed in a wide range of settings

(pedestrian walkway, public parks), in New York City and Toronto found that these youth have low self-esteem as a result of the social stigma they experience (Kidd, 2007).

Furthermore, a study to examine the subjective well-being of street children in China (Cheng & Lam, 2010) was conducted among 88 male and female public street children and children from Protection and Education Center for Street Children in Shanghai (China). The study discovered that street children had low levels of self-esteem which was associated with their subjective well-being; children with low levels of self-esteem had reported poor subjective well-being. This relationship between self-esteem and other related functions was further explored in a cross-sectional study conducted among 150 homeless youth which revealed that higher levels of self-esteem are associated with low levels of psychological distress (Dang, 2014). The findings of this study indicate that self-esteem serves as a protective factor for homeless youth faced with adversities as already indicated previously.

This point was further supported by different researchers. Firstly, the study conducted by Lightfoot, Stein, Tevendale and Preston (2011) revealed that self-esteem and social support are regarded as important personal constructs for homeless youth because they serve as protective factors for these youth. Secondly, Kidd and Shahar (2008) conducted a quantitative study among 208 homeless youth who were exposed to different types of adverse situations. The findings of this study indicated that self-esteem serves as a protective factor for homeless children. Additionally, Sharma and Verma (2013) conducted a study to explore the survival of street girls. They did this by exploring a sample of 115 street girls from across four countries; India, Indonesia, Philippines and South Africa. The study results publicised that these street girls have high self-esteem.

This shows that, to some extent, homeless youth have high self-esteem. Karatas and Cakar (2011) argue that when an individual's self-esteem increases, the resilience also increases. This shows a link between self-esteem and resilience, arguing that people who have high self-esteem are also likely to be resilient and vice versa.

3.4. RESILIENCE OF STREET CHILDREN AND NON-STREET CHILDREN

The main understanding of resilience is that people have particular strengths, which are often referred to as protective factors that help them survive difficult situations they find themselves in (Richardson, 2002). Resilience can be explained as a complex set of processes that depend on the interaction of the individual and his or her environment to decide which factors, under which circumstances, are the most protective (Ungar, 2012). It is further indicated that social ecological perspective of resilience suggests that resilience is a process resulting from interactions between individuals and their environments, and depends upon individual characteristics, the social determinants of health that affect children and their families (Ungar, 2012). This indicates that it is crucial to consider that resilience should be understood as an interaction between the individual and what happens around him or her. This implies that a person's resilience can be influenced either positively or negatively by significant others in their lives and the role played by their society.

In a study conducted by Lee and Cranford (2008), the effects of parental drinking problem on children were moderated by resilience. This meant that the negative effects of parental drinking problem decreased in magnitude with resilience serving as a moderating factor because when resilience increased, drinking problem decreased,

decreasing the chances of abuse among children. This conclusion can be explained in terms of Resnick and Taliaferro's (2011) findings which suggest that individuals may promote resilience in youth by reducing exposure to risk, increasing resources and assets, and mobilising and facilitating powerful protective systems for the youth.

In the case of children, there are several factors that affect the development of resilience. Those factors are categorised in terms of internal and external factors. Internal factors include biological (health, genetic predispositions, temperament, gender) and psychological (cognitive capacity, coping ability, personal characteristics). The external factors that influence resilience among children include family environment (parents and their parenting style, siblings and grandparents) and outside family environment (peers, school teachers) (Mandleco & Peery, 2000).

A study conducted by Zakeri, Jowkar and Razmjoee (2010) revealed that acceptance-involvement parenting style has a positive relationship with resilience. Furthermore, the warmth, supporting, and child-centred parenting style are associated with the development of resilience which then serves as a protective factor when facing challenging life events. When parents are involved in rearing their children, they help these children build resilience which helps them in future when dealing with stressful life events. For example, resilience was found to moderate the relationship between childhood emotional neglect and psychiatric symptoms in adulthood (Campbell-Sills, Cohan, & Stein, 2006).

From the previous description of factors that influence resilience in children, it is regarded that the fact that some individuals have a relatively good psychological outcome

despite suffering risk experience can also be regarded as being resilient (Rutter, 2007). This includes individuals' ability to recover from adverse experiences. It is seen as an adaptive process that an individual undergoes when facing challenging situations (Wagnild & Young, 1990). This resilience may be altered by risk or protective factors the individual has in a given situation. These protective factors that can range from less exposure to risk in the person's life to availability of resources that will help the person cope. Some of these resources are within the person, his or her family and friends or community in general (Resnick & Taliaferro, 2011).

As indicated previously, there seems to be a positive relationship between self-esteem and resilience as Graham-Bermann, Guber, Howell and Girz (2009) indicated that children who are high in self-worth and social competence were found among those children with high self-esteem and were also resilient. Resilience once again like self-esteem serves as a protective factor for street children. This was supported by Roy, Carli, and Sarchiapone (2011) who indicated that resilience serves as a protective factor in alleviating childhood trauma related suicidal behaviour. The very same resilience was also found to play an important role in health related behaviour among adults (Perna et al. 2012). In addition, resilience was found to buffer or moderate the relationship between exposure to violence and Post-Traumatic Stress Disorder (PTSD) symptoms of re-experiencing among Mi`Maq youth (Zahadrick et al., 2010). This suggests that children who have been exposed to violence and have low resilience, their likelihood of developing PTSD is high and those with high resilience have less chances of developing PTSD.

Homeless children were identified as resilient by Obradović (2010). This resilience is found to be one of the factors that help homeless youth to survive harsh living conditions on the streets (Malindi & Theron, 2010). This can help explain the reason behind the increasing number of street children despite the harsh living conditions of the streets which they are faced with on daily basis. This resilience served as a protective factor because these youth's resilience was associated with lower levels of psychological distress. Wingo et al. (2010), indicated that resilience moderates depressive symptom severity in individuals exposed to childhood abuse or other trauma which is usually the case among street children. Street children's survival strategies are in different ways and some of those include drawing mercy from other people by dressing in dirty tattered clothes. This can be seen as a resilient character.

Recently, a qualitative study conducted among eleven street involved males in Chicago revealed that street males use the street bond as their resilience strengthening factor (Harden, 2014). Other researchers reported that peer mutual trust and friendships is an important means of survival for children who have left their immediate families for the streets (Kaime-Atterhög & Ahlberg, 2008). Moreover, Libório and Ungar (2010) indicated that some form of child labour such as street markets contribute to the resilience of children as those jobs come with potential outcomes and they contribute to reasons why children continue working on the streets. Other behaviour that indicates resilience among male street youth includes finding shelter on the streets, exchanging sex in a safer manner, avoiding arrest, building relationships with clients and securing untainted drugs represent competencies (Lankenau, Clatts, Welle, Goldsamt, & Gwadz, 2005).

About a decade ago Madu, Meyer and Mako (2005) conducted a study in South Africa which aimed at investigating tenacity, purpose in life and quality of interpersonal relationships among street children. In their study, tenacity was also referred to as resilience. This study used a quantitative research approach and had four groups of participants, i.e. hardcore street children, sheltered street children, part-time street children and non-street children. This study indicated that hardcore street children are more tenacious (resilient) compared to their non-street children counterparts.

Lately in South Africa, Theron and Malindi (2010), Malindi and Theron, (2010) and Malindi (2014) have been studying the resilience character of street children. They did this by employing different research techniques with different study aims. For example, a qualitative study utilising focus group interview methods aimed at exploring the socio cultural and personal roots of resilience was conducted among a sample of 20 street youth (Theron & Malindi, 2010). The results of this study revealed that socio-cultural resources and personal strengths encourage resilience in street youth. In addition Malindi and Theron (2010) conducted another study exploring the resilience of street youth. They did this by using a qualitative research method employing both individual and focus group interviews to collect data from 20 street children. Their study concluded that street youth are resilient. This conclusion was made because these street youth reported that they were able to ask for help and use shelters for their survival. They also teased one another about their circumstances, even though at times they engaged in violent activities and religiosity which is not a common thing for street children to do. Furthermore, Malindi (2014) highlighted that street children are resilient as a result of several factors, quality of parenting, social competence, having meaningful relationships and mentors and also the use of sense of humour to deal with adverse circumstances.

However, contrary to the above studies, other researchers such as Cleverley and Kidd (2011) found that rates of reported resilience were lower for youths who had been homeless for longer periods of time meaning as time goes on, they give in to the harsh street life. The longer the time spent on the streets, the lower the resilience. In addition to this finding, Perron, Cleverley and Kidd (2014) conducted a study in Ontario among a total of 47 homeless youth with ages between 15 and 21 years. This study aimed to explore the relationship between resilience, psychological distress and loneliness. Despite the fact that this study used a small sample size, the results were statistically significant and concluded that homeless youth with high levels of psychological distress have low resilience levels.

Adolescents who have been exposed to maltreatment in the form of abuse and neglect as children have been found to be resilient though their resilience decreased in young adulthood (DuMont, Widom, & Czaja, 2007). From this study, it can be perceived that street children have an element of resilience which enables them to cope with street living. However, the question can be, if they demonstrate resilience while on the streets, what made them leave home in the first place? This question is asked because it is indicated that people who are resilient tend to use their strengths to cope with stressful situations instead of giving up (Marttila, Johansson, Whitehead, & Burström, 2013). Can this mean that besides resilience among these children, other coping mechanisms need to be questioned? This now leads us to the next section where coping strategies of street children are explored.

3.5. COPING STRATEGIES OF STREET CHILDREN AND NON-STREET CHILDREN

Coping is defined as constantly changing cognitive and behavioural effort to manage specific external and internal demands that are assessed as taxing to the person's resources (Lazarus & Folkman, 1984). Coping mechanisms utilised by children vary in the manner in which they are socialised. For example, Tamminen and Holt (2012) indicated that parents and coaches play an important role to help adolescent athletes to learn about coping mechanisms. It is known of street children to engage in bullying activities. Such behaviour can be seen as the necessary coping mechanisms within a competitive subculture of street children (Cluver, Bowes, & Gardner, 2010). A study conducted by Braddy, Gorman-Smith, Henry and Tolan (2008) indicated that adolescents who use positive coping strategies also participated in activities that enhance self-esteem. As such, engaging in activities that enhance self-esteem enables the person to use positive coping mechanisms when under distress. These self-esteem enhancing activities are unavailable to street children, hence their reports of poor coping mechanisms and low self-esteem.

Individuals' behaviour in various stressful situations is affected by their coping mechanisms. Horwitz, Hill and King (2011) indicated that coping behaviours were found to be predictive of depression and suicidal ideation which are forms of poor coping strategies. A form of coping method called passive coping is significantly associated with increased risk for mental health problems (Ni et al., 2010). This can be because with passive coping, the individual is not entirely challenging the stressor, and at a certain point in time the stressor becomes unbearable. This is not an exception among the population of street children. Due to the harsh life of the streets, street children often find

themselves engaging in high risk drug use, sexual behaviours and other harmful poor coping mechanisms (Towe, ulHasan, Zafar, & Sherman, 2009).

Furthermore, it is reported that longer periods of homelessness are associated with polydrug use though the newly homeless also engaged in drug use. This conclusion was derived from a study conducted among homeless young people in Melbourne and Los Angeles (Rosenthal, Mallett, Milburn, & Rotheram-Borus, 2008). Street children use more of drugs such as tobacco, alcohol, inhalants and other illegal drugs compared to their non-street children counterparts (Njord, Merrill, Njord, Lindsay, & Pachano, 2010). Moreover, as a coping mechanism, a recent systematic review of literature indicates that homeless youth engage in different types of violent activities both as a victim and perpetrator (Heerde, Hemphil, & Scholes-Balog, 2014).

A mixed method study approach aimed at investigating street children support mechanisms that help them cope with street life was conducted in Nigeria by Aransiola and Agunbiade (2009). This study involved 500 street children with ages between 6 and 18 years. The study results revealed that street children use a variety of coping strategies such as forming street gangs, engaging in criminal activities such as theft and robbery, and smoking drugs (Indian hemp) to cope with street life. More research was conducted in Pakistan by Towe, ul Hasan, Zafar and Sherman (2009) among a sample of 565 street boys with ages ranging from 5-19. This study disclosed that street boys engage in risky behaviours such as using drugs and exchanging sex to cope with street life.

Street boys use substances for many reasons. A study conducted in Kenya among different types of street children (begging boys, market boys, plastic boys) indicated that

different types of street children use different substances mainly to cope with hunger, to reduce fear and anxiety, to deal with stress and depression and also to help release anger and frustration (Kaime-Atterhög & Ahlberg, 2008). In addition, in Sudan, street children reported that they abused glue with a desire to experience pleasure even though at times they forget about the harsh realities of their lives (Kudrati et al., 2008). For homeless girls, they have to adopt a tough culture of violence to help them deal with risky situations. This was reported by Kennedy, Agbényiga, Kasiborski and Gladden (2010) who conducted a qualitative study using semi-structured interviews with 14 adolescent homeless girls in America.

A qualitative study which used focused group interviews to collect data from 37 street boys and girls (with the ages ranging from 12 to 18 years) in five focus group discussion sessions was conducted by Sta.Maria, Martinez and Diestro (2014). This study aimed at exploring the risk and protective factors among Filipino street children in Manila. Data was collected from street children who were divided into four categories, centre-based children, family-based children, and street-based children and those children who were living on the streets with their families. The findings designated that street children were able to cope with street life as a result of help they received from strangers they meet on the streets and also by joining gangs which provided them with economic opportunities which lessened their emotional distress.

However, other studies revealed that street youth rely on their interpersonal skills for coping with the street life (Bender et al., 2007). Even though these children reported that they rely on their interpersonal skills, they also indicated an ability to interact with others who provided them with useful information and resource and also again to negotiate

street rules (Bender et al., 2007). They further indicated that a positive attitude and peer support was a way of coping with street life. Another study indicated that the youth who used productive coping and had a positive outlook towards life were also resilient (Lee, 2011).

3.6. CHILDHOOD TRAUMA OF STREET CHILDREN AND NON-STREET CHILDREN

From a developmental perspective, emotional detachment makes people vulnerable to stresses of violence and loss (Ryder, 2007). Furthermore, attachment theory regards early parent-child relationship to be crucial in the course of human development (Bowlby, 1969). Joubert, Webster and Hackett (2012) indicated that youth who are exposed to abuse and maltreatment by their caregivers as a result of poor parent-child relationship are at risk for disorganised attachment which is associated with negative psychosocial and mental health. Results from an action research study conducted in Spain revealed that family violence is a major contributing factor to children leaving home for the streets (Julien, 2008). This is supported by a study conducted in Tanzania among full time street children, part time street children and non-street children which reported that full time street children reported more history of abuse with less support from their families compared to part time street children and non-street children (McAlpine, Henley, Mueller, & Vetter, 2010).

Various types of abuse ranging from verbal, psychological, general abuse and neglect, health and physical abuse have been reported among street children (Mathur et al., 2009). The psychological and verbal abuse is experienced both within their family and while

working on the streets. Other forms of challenges experienced by street children and homeless people in general includes physical problems (Kerfoot et al., 2007); mental, social and medical problems (van Laere, de Wit, & Klazinga, 2009) and these problems were found to be present prior to and during homelessness.

Research indicates that childhood sexual abuse is associated with homelessness (Rosario, Schrimshaw, & Hunter, 2012), and symptoms of drug use disorder (Asgeirsdottir et al., 2011) whereas childhood physical abuse is associated with alcohol use disorder (Swogger, Conner, Walsh, & Maisto, 2011). It is further reported that experiencing abuse at home was found to be the main reason for children in Bangladesh to run to the streets (Conticini & Hulme, 2007). This finding is also supported by the study conducted among a sample of 40 of homeless young adults through a qualitative research method which utilised intensive interviews to collect data from participants and found that these young adults reported that history of childhood trauma was the reason for their homelessness (Tyler & Schmitz, 2013).

The literature indicates that studies assessing trauma experienced by street children are still underway in Africa and other continents. For example, recently in Burundi, Crombach and Elbert (2014) conducted a study among 112 children. The sample comprised street children, former street children and children living with their families. The study discovered that street children and former street children reported regular exposure to violence and traumatic life events compared to children staying with their families. These abuses affect the victims for a long time. This was found among a total of 64 homeless youth (43 males and 21 females) who participated in quantitative study aimed at identifying the incidence of physical and sexual abuse (Keeshin & Campbell,

2011). This study was conducted in Salt Lake City, Utah and the study found that about 42% of the youth reported a history of physical and sexual abuse which still affected them and expressed a need to receive treatment for the trauma.

In New York City, Gwadz, Nish, Leonard and Strauss (2007) found that homeless youth and at-risk youth who were recruited from a drop-in centre to complete a structured interview have experienced trauma in one way or the other in and out of their homes. The prevalence of trauma in this population is high compared to other populations. These findings are further supported by the results of other studies. For example, a study conducted by Kennedy et al. (2010) reported that homeless adolescent mothers have experienced high levels of cumulative victimization and adversity. They reported chains of risk that accumulated over the course of their childhood and adolescence, including fundamental lack of caring and support from their families.

Other than being abused at home, research conducted in Khartoum, Sudan revealed that street children were exposed to various types of abuse ranging from physical abuse to sexual abuse while on the streets (Kudrati et al., 2008). These children abused each other in their groups or they were abused by other street children from other groups, police and adults. They reported that to prevent these abuses they had to alternate their sleeping areas even though at times it was unavoidable because they met the abuser during the day (Kudrati et al., 2008). This indicates that a cycle of abuse continues while homeless and these abuses have negative consequences for the children.

The relationship between childhood trauma and drug use has been reported by various researchers. For example, Huang et al. (2011) indicated that childhood maltreatment is

related to subsequent illicit drug use and drug-related problems in young adulthood. Homeless female sex workers are likely to be dependent on heroine (Miller et al., 2011) and the initiation into drug injection is similar for all children. Moreover, younger boys who had experienced sexual trauma are at increased risk for drug initiation (Roy, Boivin, & Leclerc, 2011) which leads to drug dependence.

Drug dependence is prevalent among people with lifetime physical or sexual abuse history (Oviedo-Joekes et al., 2011). This drug dependent behaviour is mainly witnessed among homeless people because identification with homeless culture is also associated with both alcohol and drug addiction (Thompson et al., 2010). Furthermore, criminal behaviours, methods for making money and aspects of homeless culture are associated with being drug addicted. Youth who have more substance users in their networks reported greater alcohol, cigarette, and marijuana consumption regardless of whether these network members provided tangible or emotional support (Wenzel, Tucker, Golinelli, Green Jr, & Zhou, 2010).

In addition, childhood adversities were found to increase the onset of substance dependence in male and female children (Whitesell, Beals, Mitchell, Keane, Spicer, & Turner, 2007) and this can be seen as maladaptive way children use to cope with their stressors. It is worthy to note that some children might not display a particular behaviour as a result of adversity. Some may report somatic complains. For example, Vanaelst et al. (2012) found relationship between childhood adversities and psychosomatic and emotional symptoms as a way of responding to a particular stressor.

In a South African study, it was found that the history of childhood adversity was associated with increased risk of mental disorders in an adult sample. This was regardless of a particular type of adversity though parental substance abuse showed high significance or risk for the development of any disorder (Slopen et al., 2010). This behaviour was also observed among adolescents (Cheng & Celia, 2010). This can still be applicable in the case of children more especially that are not yet developed to have necessary skills to deal with adversities, street children included.

In most cases, the abuser is the parent or the guardian and the abuse happens due to several reasons. For example, it was proven by Ju and Lee (2010) that physical abuse is common in children of parents with low socio-economic status. On the other hand, Fantuzzo, Perlman and Dobbins. (2011) reported that children with histories of neglect are likely to experience poverty. These children experience poverty and are indirectly neglected by their parents who are away from home seeking employment with reduced constant contact with their children due to the low socio-economic status they are experiencing. All these add to child adversities and as such children need to adopt various coping mechanisms. Failure to develop those adaptive coping mechanisms leads to children running to the streets.

3.7. PARENTING STYLES OF STREET AND NON-STREET CHILDREN

Parenting plays a significant role in the process of child rearing and child development. Children learn how to deal with the environment and the stressors that may be present in their lives through interaction with their parents. Parent-child relationship plays a crucial role in the child's development of normal or abnormal behaviour. This parent-child

relationship exists in the form of parenting styles. Parenting styles are in such a way that children develop a secure or insecure attachment with their parents or guardians (Bowlby, 1969).

Parenting styles are viewed as several elements that explain how parents express their attitudes towards children's responsibilities. It is how parents' feelings about their children are conveyed. It can be in the form of body language, tone of voice, emotional display and e.t.c. (Bornstein & Zlotnik, 2008). Parenting includes the ways in which parents interact with their children in order to equip them to be future members of society. It includes techniques that parents use to rear their children, be it to support, protect and manage them for their growth. The parenting practices also include how parents reward or discipline their children (Crockett & Hayes, 2011). In general, parenting practices or styles have been explained mainly by focusing on parental support that has to do with parental warmth and parental control.

Parents who utilise authoritative parenting style tend to control the child by establishing rules that the child should follow. They show parental love and care for the child utilising less harsh manners when disciplining the child. Children are given the opportunity to voice out their opinions due to the open communication between the parent and the child (Bornstein & Zlotnik, 2008). It involves high levels of responsiveness to the child's needs or demands and high levels of demandingness for a child to perform to a certain level (Crockett & Hayes, 2011). The expectations they set for their children are developmentally appropriate and they are clearly communicated to children. They are supportive towards their children and they guide them properly with love and care. The punishments for the children fit the crime they have committed. Authoritative parenting

style has been found to be a positive predictor of self-esteem (Zakeri & Karimpour, 2011).

In authoritarian parenting style, control is over emphasised on children with little democracy. Harsher punishment methods are used when children do not abide by set rules as parents are less nurturing. Children are not given the opportunity and necessary support to explore the environment and their maturation is not enhanced (Bornstein & Zlotnik, 2008). In addition to this, parents are less responsive to the child's needs though demanding that a child performs on high standards. As such they are quick to discipline their children who deviate from the set rules. These parents have poor communication with their children and it has a potential of negatively affecting the parent-child relationship (Crockett & Hayes, 2011). Children from this type of parents receive poor support.

Parents who utilise permissive parenting style exercise low control over their children allowing them some freedom in various aspects of life. However, they are so nurturing to the children. These parents do not actively discipline their children as there are no set of rules given to the children (Bornstein & Zlotnik, 2008). These parents are highly involved in the life of the child though with less demands on the child to perform at a particular level. They provide more love and emotional support to their children though specific rules are not clearly set. They communicate well with their children though allowing them some freedom in their behaviour as they use little or no punishment (Crockett & Hayes, 2011).

The indifferent parenting style is a parenting style characterised by lack of commitment in the child's life by parents. They are much uninvolved and spend less time with the child. Implementation of parental rules and control over the children is not a priority as they are focused more on their own lives (Bornstein & Zlotnik, 2008). These are the type of parents who are really not involved in any way in their child's life. It might be with regard to the provision of love and support or even disciplining the child. Children are left to do as they want (Crockett & Hayes, 2011). They are basically not involved in any way of the child's life.

Parents who are not involved in their children's lives are not supportive to their children. This is supported by the study conducted in Nigeria among a sample of 200 non institutionalised street children which revealed that single parenthood which involves inadequate care and support for the children is associated with lack of attachment between the child and parents and also with the development of aggressive behaviour (Olaleye & Oladeji, 2010). To further confirm the significance of the parent-child relationship, recently in Nigeria, Ekpiken-Ekanem, Ayuk and Adadu (2014) conducted a study among street children using multiple data collection methods to collect data from 2916 male and female street children. The results of their study showed parent-child relationship which is characterised by parenting styles and type of home (divorced parents) contributes to children running to the streets.

Parenting styles that include harsh methods also contribute to children running away from home. For example, in a data obtained from the police in Balochistan, Pakistan by Achakzai (2011) about the causes of children running away, it was found that parents who are strict towards their children and who do not supervise their children

appropriately though giving continuous punishment have contributed to their children running away from home. Harsh punishment methods by parents who also do not appropriately supervise their children and single parenting are characteristic of dysfunctional families. According to Sarnon, Alavi, Hoesni, Mohamad and Nen (2013) prolonged dysfunctional family background (divorce and conflicts) and authoritarian parenting style (parents focusing on disciplining them instead of giving love and attention) contribute to children running away from home. This conclusion was drawn after conducting a qualitative study in Malaysia utilising face to face interview to collect data among 53 children aged between 7-12 years who run away from home. Furthermore a sample of 15 youth in Singapore indicated that they ran away from home as a result of dysfunctional family backgrounds (single parenting) and conflicts and disagreements with parents associated with discipline (Khong, 2009).

More than a decade ago in Cameroon, Matchinda (1999) indicated that authoritarian parenting style was found to be associated with children running away from home. In addition to this, Fantuzzo et al. (2011) reported that children with a history of parental neglect are likely to experience homelessness. It can also be found that due to this parental neglect which is related to parental control, the parents of these children are not even aware of their children missing to the streets. A group of 159 incarcerated adolescent males reported that they ran away from home as a result of lack of affection and control from their parents due to the poor attachment they had with their parents (McGarvey et al., 2010).

Parenting styles result in parents abusing their children in one way or the other. Many children are living on the streets as a result of abuse at home, involvement in criminal

activities, or of rejection by families (Cluver et al., 2010; Rukmana, 2008). This indicates that parenting styles are in such a way that children receive inadequate support from their parents. This symbolises poor attachment with the caregiver which leads to child experiencing verbal and psychological abuse within the family (Mathur et al., 2009). When children run away from home to the streets, while on the streets their fear of returning home is mainly due to fear of abuse and if they return, they indeed experience the abuse (Ju & Lee, 2010).

When on the streets they engage in deviant behaviours. Delinquency is one of the characteristics of street children. Some scholars (Trinker, Cohn, Rebellon, & Gundy, 2011) indicated that authoritative parenting is negatively associated with delinquency while authoritarian parenting is positively associated with delinquency. This highlights that children's delinquent behaviour is as a result of the relationship they have with their parents. This was supported by a study conducted by Schroeder, Higgins and Mowen (2012) who reported that adolescents who had a low stable attachment with their parents were more likely to have highest offending tendencies. However, on the other hand O'Campo, Caughy and Nettles (2010) indicated that parenting does not play a role in children's behavioural problems which can include delinquency and even running away from home.

Positive parenting in childhood as a factor of good parenting has been found to be associated with positive psychological adjustment in late adolescence while parental psychopathology is associated with less effective parenting and poor psychological adjustment in late adolescence (McKinney & Milone, 2012). This further supports the notion that indeed parenting plays a vital role in child development meaning that poor

parenting negatively affects the development of a child in many spheres. In addition, research shows that children with secure attachment as a results of parenting styles utilised by their parents tend to report less worry and anxiety than children with ambivalent or avoidant attachment (Brown & Whiteside, 2008).

Parent-child relationship also depends on the parents functioning. Research has indicated that stressed parents have a tendency of using harsh punitive methods on their children and these harsh methods go to the extent of negatively affecting the children's academic performance (Rogers, Wiener, Marton, & Tannock, 2009). With poor academic performance and challenges with school teachers, these children become hopeless for their future and run to the streets (Achakzai, 2011).

Other studies indicated that parent anxiety symptom as one of parental characteristics appears to ease the degree of the relationship between parent and child externalising symptoms as it is possible that these parent anxiety symptoms increase parental conscientiousness and concern (Burstein, Ginsburg & Tein, 2010). This indicates that parent-child relationship can be formed under non-stressful or even stressful circumstances.

In other studies, paternal psychological control played a role in adolescent's difficulties with emotional regulation (McEwen & Flouri, 2009). This in turn affects their way of coping. Insecure attachment and poor parenting skills play a significant role for the child's development of psychopathology after an exposure to something traumatic (De Young, Kenardy & Cobham, 2011). It can be argued that children who report psychopathology and have been exposed to trauma, had poor relations with their parents

due to poor parenting styles. This can also be applicable to the street children's population. Adolescents conduct problems and internalising behaviour is associated with their parent's degrading behaviour (Caples & Barrera, 2006). In the case of street children, they were degraded by their parents due to poor parenting styles and poor attachment. Gwadz, Clatts, Leonard and Goldsamt (2004) indicated that fearful attachment may have a negative impact on an individual's resilience due to the negative perception of self and others.

Dubowitz et al. (2011) and Bornstein and Zlotnik (2008) reported that child maltreatment is prevalent in low-income families. This low socio-economic status can be seen as a stressful situation for the family and can negatively affect parenting styles in such households such that there is not enough leisure or secure attachment building activities being engaged in by such families. Parents get frustrated about the situation and abuse their children. In some instances such parents are not even aware of the maltreatment of their children. This explains the relationship between homelessness and poor socio-economic status.

3.8. SOCIO ECONOMIC STATUS OF STREET CHILDREN AND NON-STREET CHILDREN

Socio-economic status can be regarded as one factor that affects homelessness. Housing insecurity and social exclusion as characteristics of poor socio-economic status are the major reasons for homelessness (Paraschiv, 2012). In addition to housing insecurity is housing instability which also increases homelessness (Aubry, Klodawsky, & Coulombe, 2012). When there is no fixed place for one to sleep due to the poor socio-economic

status one is facing, the street becomes an alternative solution. Due to lack of adequate finances to secure a house, either by buying or renting, people end up homeless. This challenge affects both the young and adult homeless population. When parents cannot afford to secure a house, children are the ones who severely suffer the consequences and as a result end up homeless on the streets.

In Iran, a systemic literature review of previous studies among street children indicated a relationship between poverty and becoming a street kid (Vameghi, Sajjadi, Rafiey, & Rashidian, 2010). This indicates that children growing in poverty stricken families are at risk of running to the streets. Moreover, another study conducted among a sample of 160 street children of Ludhiana city with ages between 9-12 years revealed that majority of children living on the streets are there as a result of poor socio-economic status in their house where their parents were unable to provide for them due to unemployment or low paying jobs such as labourer or street vendor (Sharmila & Kaur, 2014). A recent qualitative study conducted among street children and former street children currently based in a centre revealed that poverty, lack of food and other social challenges may influence the persistence of street children phenomenon (Kayiranga & Mukashema, 2014).

Further research by Riley, Weiser, Sorensen, Dilworth, Cohen and Neilands (2007) indicated that lower income as a factor of poor socio-economic status is the strongest predictor of homelessness among men. This can also be applicable to the whole family as it has already being discussed previously that inability to secure a house increases the chance of people opting for the streets. This has also been indicated by UNICEF (2006) when they reported that for children, living and working on the streets, their common

feature is that they usually come from low income families. These children end up living on the streets when they had actually gone to the streets to find work (Plummer, Kudrati, & Yousif, 2007).

In Nigeria it was found that most boys ran to the streets due to economic hardship at home (Aransiola & Akinyemi, 2010). This was further reported in a research conducted in South Korea by Hong, Lee, Park and Faller (2011) which indicted that more maltreated children come from families of parents with low socio-economic status than families of parents with high socio-economic status and as a result they run to the streets. The poor socio-economic status can lead to poor parenting styles due to parental distress. Low financial income affects parenting style which in turn has an impact on the infant mother attachment relationship (Bakermans-Kranenburg, van Ijzendoorn, & Kroonenberg, 2004) leading to parents abusing their children.

Children growing up in poverty stricken families have many challenges. Poverty plays a huge role in the development of children, starting from nutrition to other developmental areas such as emotional development. Poor development also includes cognitive functioning (Wong & Edwards, 2012) which plays a significant role in problem solving skills. When poverty negatively affects the development of children, it also affects their response or reaction to distress leading them vulnerable to risky behaviours (Jones, Eidelman, & Yudron, 2011). This could be in response to the poor development as a result of lack of or inadequate nutrition that is important for developing children. This poor nutrition could be linked to a relationship that was found by Beydoun and Wang (2008) who indicated that there is a positive relationship between the consumption of fruits and vegetables with socio-economic status.

In addition, another study conducted among AIDS orphans in South Africa revealed that poverty which was characterised by food insecurities in addition to stigma increases the chances of mental health problems (Cluver & Orkin, 2009). This shows the significant role played by poverty in the well-being of children. It could be argued that it is because for one to function in a highest level cognitively, emotionally and socially, basic needs such as food should have been met. In this case, these children cannot think of other possible alternatives to their challenges as they are focused on having their basic needs met and as a result they see street living as an alternative to their situation for having their needs met (Maslow as cited in Meyer, Moore, & Viljoen, 2002).

A study conducted among university students indicated that depressive symptoms were more prevalent among students from low income family background (Steptoe, Tsuda, Tanaka, & Wardle, 2007). Furthermore, financial hardships predict mental disorder onset at every stage of the life-course of individuals including children. A disadvantaged position in childhood predicts disorder persistence and severity as there will be poor or lack of access to resources resulting from poor socio-economic status (McLaughlin et al., 2011). This lack of resources to cope with hardships increases the chances of engaging in illegal activities as it is indicated that poor people are more likely to be less satisfied in their various areas of life and they have poor coping mechanisms because of the unavailability of resources (Lever, Piñol, & Uralde, 2005).

Children from a high socio-economic status families reported increased physical activity and high self-esteem as they had access to various sporting codes that might come with a fee (Veselska, Geckova, Reijneveld, & van Dijk, 2011). During participation in those sporting codes they learned more adaptive ways of coping with challenges and in turn

their self-esteem was also enhanced. This happened because of the positive relationship between socio-economic status and self-esteem has (Zhang & Postiglione, 2001).

Socio-economic standing affects behaviour adjustment during childhood and adolescence and continues in adulthood and it has an effect in adult psychosocial functioning. This suggests that if children do not develop adequate coping skills that will aid them deal with their predisposed poor socio-economic standing, the challenge is likely to continue in their adult lives. Other researchers argue that being born in an economically disadvantaged family background increases the likelihood of accumulating risks associated with that disadvantage (Schoon, Sacker, & Bartley, 2003). A child born in a poor socio-economic background has more chances to engage in risk behaviour associated with his/her poor socio-economic status, e.g. shoplifting, pick pocketing etc. than the one with a high socio-economic background. However, Sutherland (2012) indicated that socio-economic status does not play a role in the initiation of risky behaviour such as smoking and alcohol consumption among young people but rather single parent family has been found to be the contributing factor. This is so because when a family has one parent, parental supervision gets minimal.

In some instances it has been found that the symptoms of delinquency are worsened by poverty-related stress which is more harmful in children and adolescents than adults (Nikulina, Widom, & Czaja, 2011). Children are also more likely to be arrested for their delinquency resulting from poverty just as poverty-related stress also exacerbates internalizing symptoms such as anxiety and depression (Santiago, Wadsworth & Stump, 2011). Exposure to poverty over a long time also increases the development of behavioural problems and negative health outcomes (Najman et al., 2010) and a variety

of health-threatening processes (Raphael, 2011). It is argued that poverty makes people become and remain homeless creating a vicious cycle which seems difficult to break (Moxley, Washington, & McElhaney, 2012).

3.9. EFFICACY OF PSYCHOSOCIAL INTERVENTION STRATEGIES FOR STREET CHILDREN

High rates of childhood adversity such as physical and sexual abuse were reported among homeless youth (Mathur et al., 2009). These youth also indicated that their childhood abuse was still affecting them and as such needed help (Keeshin & Campbell, 2011). All these point to the fact that homeless children need various forms of intervention such as drop-in-centres, community outreach services and more for them to survive. The organisations that provide these services also need funding either from government or non-governmental organisations for them to function effectively (Esparza, 2009) making this a challenge as there are often inadequate funds for intervention programmes. According to Howell (2011) children who witness intimate partner violence experience adversities and therefore, need intervention programmes which aim at minimising their problems and promoting resilience as well as catering for their coping strategies.

The findings from a study conducted by Kudrati et al. (2008) in the Sudan indicated that it might be more effective to develop humane, long-term, large-scale programmes to re-integrate children in their original families or communities. Ideally, this would involve first building trust and rapport with these children through street work and encouraging them to leave the streets voluntarily. A similar study conducted in the United Kingdom also indicated that many homeless drug users had the motivation and skills to participate

in peer programme training of, "Take Home Naloxone", but their fears related to involuntary homicide needed to be addressed first (Wright, Oldham, Francis, & Jones, 2006), indicating a need for a good rapport. A good rapport between the intervener and street children can help these children to cooperate in any intervention programme.

A good rapport can only be established when the intervener clearly understands the children's needs. This is because understanding street children from their perspective is an important consideration in any intervention programme (Kaime-Atterhög & Ahlberg, 2008). Practitioners teaching children and adolescence coping mechanisms should take into consideration the type of stressors they encounters, whether controllable or uncontrollable, in order to formulate appropriate intervention strategies. For example, coping with uncontrollable stressors may require youth to develop active coping strategies (Clarke, 2006).

In South Africa, Le Roux (1996) reported that street children need to be identified and counselled in order to help them cope effectively especially those that are new to the streets as they may not yet have set in the negative aspects of the streets. In this regard, community integration that includes psychological, physical, social domains and independence/self-actualisation among adults with psychiatric disabilities and history of homelessness has been suggested (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007). Moreover, Miles and Okamoto (2008) have recommended that homeless and runaway youth can be helped in translating their deviant behaviours into prosocial outlets through community based social skills training. The most important thing to consider when intervening is reducing vulnerability to homelessness and helping people to leave and stay out of homelessness (Moxley, Washington, & McElhaney, 2012). When these

interventions are formulated it is important to consider several factors affecting the street children in order for the intervention to be effective (Werb et al., 2010).

It is important to consider which areas need to be addressed instead of generalising the intervention for all children. For example, in South Africa, an intervention programme aimed at promoting resilience in young children through the strengthening of mother and child relationship was found to be effective (Visser et al., 2013). In this case, resilience was not directly built, rather the focus was on strengthening mother-child relationship which should in-turn have positive influence on these children's resilience

There are various intervention programmes formulated for different people that have yielded promising results. For example, research indicates that children who have behavioural problems and are receiving treatment perceive themselves as having an average self-concept and are considered to be optimistic (Rodriguez & Eden, 2008). In other studies, homeless people who are struggling with homelessness and had participated in a work-skills training programme showed improvements in work and related life skills. These work and related life skills were associated with improvement in self-concept. The work skill programme showed a positive impact on skills development and employment to those who were unemployed (Nelson, Gray, Maurice, & Shaffer, 2012).

Experimental intervention studies have also been proven to be effective. For example, a recent experimental study was conducted with 30 children with ages between 7 to 11 years. They were equally and randomly assigned to experimental and control groups where they participated in an Art therapy intervention programme for 10 weeks. The

programme was from a cognitive behaviour therapy approach and used narrative therapy techniques. The results of pre- and post- intervention indicated that children who participated in the intervention showed more improved self-esteem than those children who did not participate in the intervention programme (alavinezhad, Mousavi, & Sohrabi, 2014). Another experimental study aimed at improving self-esteem was conducted among 24 children who were assigned to an experimental group and control group conducted by Karacan and Güneri (2010). The children who participated in the 8 week self-esteem bibliocounselling programme showed improved self-esteem when the pre- and post-test scores were analysed.

In Tanzania, a study was conducted among street children, former street children who were in rehabilitation and school going street children aimed at assessing the difference in life priorities as per living arrangement (Nalkur, 2009). The results of this study revealed that former street children were similar to school going children with life priorities. These results indicate that the rehabilitation programme that former street children engaged in was effective. Additionally, an intervention that included cognitive behavioural components to help homeless youth with challenges such as drug abuse yielded better results compared to other intervention methods such as peer-based intervention, vocational skills or brief motivational intervention (Altena, Brilleslijper-Kater, & Wolf, 2010).

Other researchers have formulated various intervention strategies given particular population under their study. For example, Stahler et al. (2005) formulated a Briges programme aimed at helping homeless youth abstain from cocaine use. Those who

participated in the programme reported 100% abstinence at follow-up. This indicates that when intervention programsme are tailor made, they are effective.

Grocott and Hunter (2009) conducted a study with youth to participate in a 10-day development voyage programme and the results indicated that the programme helped increase the youth's self-esteem which in turn decreased their vulnerability to homelessness. Further research shows that group social cognitive training with adolescence facilitates improvements in self-esteem and cognition (Barrett, Webster, & Wallis, 1999). These studies show that there are different methods which can be used to help build self-esteem among children and adolescents.

Wing, Wrenn, Pelletier, Gutman, Bradley and Ressler (2010), found that resilience could present a potential focus for treatments and intervention in individuals exposed to childhood abuse or other traumas. Similarly, self-esteem and resilience can be increased in group counselling through the use of Rational Emotive Behaviour Therapy and art therapy (Roghanchi, Mohamad, Mey, Momeni, & Golmohamadian, 2013). This conclusion was made after a pre- and post-experimental study with the experimental and a control group was conducted among 24 Iranian students. Participants in the experimental group were exposed to treatment for ten sessions in ten weeks while participants in the control group were not exposed to any sort of treatment. Other researchers conducted empirical studies where direct individual resilience intervention programme was the focus of attention. For example, Cheng et al. (2012) conducted a study among 77 people to help strengthen their resilience. Participants in this study attended individual intervention programme which included resilience assessment, strengthening and maintaining group approach and resource and referral link for 2-3

weeks. The results indicated that individual resilience intervention helped in improving people's resilience.

Recently in Nigeria, Olowokere and Okanlawon (2014) conducted a quasi-experimental (pre-test-post-test non-equivalent group design) study to evaluate the impact of psychosocial intervention on vulnerable children's' resilience. This study was conducted among a total of 109 (50-experimental and 59 control group) vulnerable children. Even though this was a pilot study, the results revealed that children who participated in the resilience building session showed improved resilience when tested again in the post intervention assessment. This increase in resilience also showed significant increase in high self-esteem among the intervention (experimental) group.

Among children who have a diagnosis of diabetes mellitus, coping skills training have been found to be effective (Grey & Berry, 2004). These children attended a coping skill training which aimed at increasing their sense of competence and mastery in 2 to 3 groups with the facilitator and engaged in activities such as role playing and giving each other feedback. They attended the training for 3 to 5 weeks for a period of one to half hour per session. Another coping skills training was conducted by Jafari, Eskandari, Sohrabi, Delavar and Heshmati (2010). This was a semi-experimental study focusing on coping skills training in reducing relapse among people with substance dependency. This study was conducted among 27 participants of whom 13 were in the experimental group and 14 were in the control group. The experimental group was exposed to 12 sessions of coping skills training. The study revealed significant results between the two groups on coping skills which helped enhance resilience.

Other intervention methods were found to improve problem solving skills. Hemphill and Littlefield (2001) developed an intervention programme called "Exploring Together" which focused on anger management, problem solving and social skills training for children with behavioural problems. In this treatment programme, sessions were conducted in groups of 8-10 participants for the duration of one and half hour during a period equivalent to the school term. Their study revealed that those children who participated in the programme showed reduced behavioural problems and increased social skills at home.

From the above literature, it is clear that street children need various forms of intervention strategies that cater for their needs. Campbell-Sills, Cohan and Stein (2006) reported that resilience moderated the relationship between the history of childhood trauma and psychiatric symptoms. Research also shows that people who use adaptive coping strategies have high self-esteem (Doron, Thomas-Olliver, Vachon, & Fortes-Bourbousson, 2013). In addition, task-orientated coping is related to resilience. As such there is a need for street children to receive self-esteem building and resilience building activities and also coping skills training.

3.10. SUMMARY OF LITERATURE AND IDENTIFIED GAPS

The literature on street children uses various terms to refer to these children. For example, some studies use samples of street children (which included children of the street and children in the street), runaway children, homeless children, and street-involved youth, without really clear distinctions. Generally, the studies reviewed indicate that street children are children in need of help. Their reasons for taking to the streets

vary and so are their challenges indicating an urgent need of intervention. The literature comparing self-esteem, resilience, coping, childhood trauma, parenting styles and socio-economic status between street children and non-street children is very scarce. Resilience is explored together with coping and often explained as a group process. Childhood and socio-economic status are explained as push factors for children running to the streets with little information about parenting styles.

Most research focused on one or two variables such as resilience or coping strategies of these children. About two decades ago, South African research focused mainly on pathways to homelessness in which it was indicated that poverty and abuse make children to run to the streets and only recently have resilience and coping strategies come to be explored though at a slow pace.

The literature to date indicates that there are more boys than girls on the street. Furthermore, street children have been viewed as problematic children, yet research shows that this is a vulnerable population at risk of development of psychopathology (Malindi, 2014). These children live in groups in most major towns. They rely on nearby drop in centers and shelters for help in times of serious need. They are usually school drop outs who engage in money earning activities such as car wash, car park instructor. They use the money they earn to buy food, alcohol and cigarettes.

The available data of South African street children is scarce given the number of children found on the streets. Although research has been done in the past, this phenomenon did not receive much attention like other phenomena such as rape against women, orphanhood and HIV/AIDS. Most studies conducted in South Africa are outdated, with a

few recent studies conducted though in the same area of focus (such as reasons for homelessness) and in few geographical regions in the country. It is like this was a forgotten population in South Africa.

Just like in South Africa, most global research to date has focused on reasons why children run to the streets (homelessness) and challenges faced by these children while on the streets, and only suggesting interventions strategies. There are few studies conducted in this area that consist of both the experimental and control group, meaning comparing street children to those children in the normal population. Many South African studies are qualitative in nature using small sample sizes without control groups. Clear intervention studies for this population are very scarce. Intervention studies that have been tested with an experiment for their efficacy are rare, let alone studies that involve a two in one study approach.

3.11. HYPOTHESES

- Street children will report low self-esteem, poor resilience, poor coping strategies, and high history of childhood trauma, poor parenting styles, and low socio-economic status as compared to non-street children.
- Street children who have been exposed to the social skill training will report improved self-esteem, resilience and coping skills than those street children who have not been exposed to training.

3.12. OPERATIONAL DEFINITIONS OF TERMS

Psychosocial: The American Heritage Dictionary of the English Language (2009) defines it as an aspect of psychological and social behaviour. In this study it means the score of psychological and social variables (self-esteem, resilience, coping, parenting styles, childhood trauma and socio-economic status). These variables were measured by instruments explained in the methodology section.

Street children: In this study street refer to boys and girls under eighteen years of age who are found on the streets unaccompanied by adults and they either work or live on the streets. This term of street children will be used interchangeably with homeless children in this study.

Self-esteem: This refers to the scores on the Rosenberg's self-esteem scale. High scores on the scale indicate high self-esteem while low scores indicate low self-esteem.

Resilience: Resilience refers to scores on Conner-Davidson's resilience scale. On this scale high score indicates high resilience and low scores indicate low resilience.

Coping: In this study coping refers to scores obtained from Caver's brief coping scale. Higher scores on this scale indicate adaptive coping styles while low scores indicate maladaptive coping styles.

Childhood trauma: This refers to scores on Sanders and Becker-Lausen's child abuse and trauma scale. This scale is divided into negative home environment/neglect subscale sexual abuse subscale, punishment subscale and general abuse subscale. High scores on

this scale indicate high history of childhood trauma while low scores indicate low history of childhood trauma.

Parenting styles: It refers to scores on Steinberg, Lamborn, Darling, Mounts and Dornbusch's parenting style index. This scale has two subscales, parental warmth and parental supervision. High scores on parental warmth subscale indicate adequate parental warmth while low scores indicate poor parental warmth. High scores on parental supervision subscale indicate good parental supervision while low scores indicate poor parental supervision.

Socioeconomic status: This refers to scores on Barbarin and Khomo's household economic and social status index. The scale has two main indicators which are material resources and social capital. High scores on this index indicate high socio-economic status while low scores indicate low socio-economic status.

Social skills training (intervention strategies): This refers to a planned social skills training conducted by a therapist on an interpersonal interaction with street children aimed at empowering them to deal with their adversities.

CHAPTER FOUR

RESEARCH METHOD

The study followed a two-in-one study approach in order to achieve its aim. This approach involved two phases, phase I entails assessment of psychosocial challenges of street children and phase II entails the designing of social skills training package and exposure of the street children to the package. The results of phase I informed the formulation of the self-esteem-resilience-coping (SE-RE-CO) social skills training programme. The two phases are reported on below.

4.1. STUDY ONE

4.1.1. Research design

The study adopted an independent sample group design. This type of design involves two or more separate groups or participants taking part in the experiment only once. The advantage of using this type of design is that more participants are used for the study to increase the external validity of the study (Cribbie, Arpin-Cribbie, & Gruman, 2010). The other advantage of using this design is that there is no problem with order effects. This design was adopted in this study because the study comprised two groups, i.e group of street children (experimental group) and non-street children (control groups) who were compared on the self-esteem, resilience, coping strategies, childhood trauma, parenting styles and socio-economic status.

4.1.2. Setting of the study

This study was conducted in Limpopo Province of South Africa. The province is situated in the northern part of South Africa and shares its boarders with Botswana, Zimbabwe and Mozambique. The province is occupied by diverse ethnic groups that include Pedi, Venda, Tsonga, Ndebele, Afrikaner and English. It is divided in to five districts, namely: Vhembe, Mopani, Capricorn, Sekhukhune and Waterberg. Its population is estimated at about 5 518 000, which is 10.4% of South Africa's population (Statistics South Africa, 2013). It has about 74,4% of poverty rate in South Africa (Statistics South Africa, 2014). The major occupations are farming and mining. The data for this study was collected from four towns (Polokwane, Messina, Thohoyandou, and Tzaneen) in Limpopo Province.

4.1.3. Participants

A total of six hundred (N = 600) participants participated in the study. They comprised street children, three hundred (n = 300) and non-street children, three hundred (n= 300). Among the three hundred street children, 42% were males and 58% were females. The age of participants ranged from 8-18 years with the mean age of 15.92 (SD= 1.89). Majority of the street children were from South Africa (62%), followed by those from Zimbabwe (36.3%), and Mozambique (.7%). Many of these children (20.7%) came to the streets at the age of fifteen and have been on the streets for a period of about 2 years (30.7%). They reported not having one or both parents (67.7%) as both parents (37.3%) have died.

Among the non-street children, 56.7 % were females and 43.3% were males with the age ranging from 8-18 with mean 15.46 (SD=1.87) were interviewed. All participants in this group were in school and staying in their homes. In this group, all children (100%) were South Africans and majority of them (76.7%) reported having both parents.

Table 1. Sample characteristics

Demographic variables	No of respondents	
	Street children (N= 300)	**Non-street children (N=300)**
Sex		
Male	174 (58%)	130 (43.3%)
Female	126 (42%)	170 (56.7%)
Age	15.92 (SD= 1.89)	15.46 (SD= 1.87)
	Range= 8-18 years	Range= 8-18 years
Level of education		
No answer	1 (.3%)	
No formal education	1 (.3%)	
Some primary education	107 (35.7%)	2 (.7%)
Primary education completed	80 (26.7%)	31 (10.3%)
Some high school	109 (36.3%)	267 (89.0%)
High school completed	2 (.3%)	
Nationality		
South African	188 (62.7%)	300 (100%)
Zimbabwean	110 (36.7%)	
Mozambequean	2 (.7%)	
Have parents		
No both parents	203 (67.7%)	70 (23.3%)
Have both parents	97 (32.3%)	230 (76.6%)
Reason for no parents		
No answer	91 (30.3%)	232 (77.3%)
One parent died	93 (31.0%)	47 (15.7%)
Both parents died	112 (37.3%)	5 (1.7%)
Does not know one parent	4 (1.3%)	16 (5.3%)

4.1.4. Sampling method

A purposive sampling technique was adopted to select the street children. This sampling method was chosen due to the nature of participants under study. In this type of sampling method the researcher knows the characteristics of participants under study (Maree, 2007). Participants were approached by the researcher in their groups in four towns (Polokwane, Messina, Thohoyandou, and Tzaneen) in Limpopo Province. Selection of these towns as data collection site was based on the availability and visibility of numbers of street children. Participants were recruited from street junctions next to traffic lights and car parking spaces where they are often seen mostly begging for money and food. Other participants were recruited from municipality leisure parks while others were found at abandoned and vandalised buildings. Street children who were found to be under the influence of substances (mostly sniffed glue) during data collection were excluded from participating.

Non-street children were sampled using simple random probability sample from a population of 674 learners from the local secondary school and after-care centre that serves to assist children with homework and care for the children until their parents come to collect them after work. The reason for using non-street children was to serve as a control group in order to compare their scores on self-esteem, resilience, coping, childhood trauma, parenting styles and socio-economic status with those of street children. This will assist in formulating the intervention programme for street children.

4.1.5. Instruments

A questionnaire that consisted of measures of psychological variables (self-esteem, resilience, and coping) and social variables (parenting styles, history of childhood trauma and family socio-economic status) was used to collect data for the study.

Section A- demographic variables, Section B- self-esteem scale, Section C- coping scale, Section D- resilience scale, Section E- childhood trauma scale, Section F- parenting style index and Section G- household socio-economic status index. The descriptions of the measures follow below:

4.1.5.1. Rosernberg Self-esteem Scale

Rosenberg Self-Esteem (RSES) scale is a 10-item scale that measures global self-worth by measuring both positive and negative feelings about a person. All items are answered on a four point likert scale format ranging from 0 = strongly agree to 3= strongly disagree. Five of the items (2, 5, 6, 8 and 9) are reverse scored before the overall score is achieved. This is a frequently used scale designed to assess self-esteem in adolescents (Rosenberg, 1965). The scale scores range from 0-30 with 0 being the lowest and 30 being the highest. In this study, a score of 14 and below after a cut-off point of 15 in the overall total score of 30 suggests low self-esteem. Higher scores (15 and above) on the scale suggest high-self-esteem. Reliability of this scale for black South Africans has been found to range between .78 and .92 (Westaway &Wolmarans, 1992). In this study the Cronbach's alpha of this intrument was .67.

4.1.5.2. Connor–Davidson Resilience Scale (CD-RISC; Connor and Davidson 2003)

The CD-RISC is a self-report scale consisting of 25-items and measures the ability to cope with stress and adversity. Each item is rated on five point frequency response ranging from 0 ("not true at all") to 4 ("true nearly all the time"). The total range score is between 0 and100. In this study higher scores are scores of 51 and above and such scores indicate greater resilience. For this rating to be achieved, they are based on how the participant has felt in the past month. Alpha reliability observed was 0.89 in the study conducted by Singh and Yu (2010). The reliability of this instrument in a South African population was found to be at 0.93 (Jørgensen & Seedat 2008). In this study the Cronbach's alpha was .86 indicating that the instrument was reliable.

4.1.5.3. Brief COPE

Brief COPE (Carver, 1997) consists of 28 items to assess 14 coping strategies. The items are scored on a 4-point likert-scale with responses ranging from 0 (I have not been doing this at all) to 3 (I have been doing this a lot). According to Carver (1997), there is no specific way of scoring this scale to come up with "emotion focused", "problem focused" or "overall" coping index. In addition, there are no instructions to score the scale to come up with either "adaptive" or "maladaptive" coping style. In this study, items which indicated a maladaptive coping were reverse scored and a total overall single score was obtained. The total score for items is 84 with scores from 43 and above indicating appropriate coping styles. Two studies in South Africa (Mostert & Joubert, 2005; Pienaar & Rothmann, 2003) reported reliability indices ranging between 0.83 and 0.92. The instrument was found reliable with a Cronbach's alpha of .67

4.1.5.4. Child abuse and trauma scale

History of childhood trauma was measured using the child abuse and trauma scale (CAT). This is a scale developed by Sanders and Becker-Lausen (1995). The scale contains three distinct factors reflecting negative home environment/neglect (14 items), sexual abuse (6 items), punishment (6 items) and general abuse (16 items) in childhood and adolescence. This is a 38 item scale with responses ranging from 0= never, 1= rarely, 2= sometimes, 3= very often and 4= always. The total score on this scale is 152 and a higher score (77 and above) on this instrument indicates a high history of child abuse. Sanders and Backer-Lausen (1995) reported a Cronbach's alpha of .89. This instrument also demonstrated to be reliable in this current study with a Cronbach's alpha of .93.

4.1.5.5. Parenting style index

Parenting style index by Steinberg, Lamborn, Darling, Mounts and Dornbusch (1994) is a self-report 18-item Likert-type scale with 4 additional questions and is used to measure the parenting style. The scale has two dimensions of parenting which are "acceptances or warmth" and "control or supervision". The first 18 items (my parents) alternate between the involvement and psychological autonomy-granting scales. All of the psychological autonomy items are reverse scored, with the exception of item 12. The last 8 items (my free time) compose the strictness/supervision scale. The response style of the first 18 items ranges from 0 (which means strongly disagree) to 3 (which means strongly agree). Responses for parental supervision questions ranged from 1-6 and 1-3 for their different questions. The scale was used by Denbi (2007) among the South African population and the reliability coefficients obtained for the scales were 0.81 and 0.77. The instrument demonstrated to be reliable in this study with Cronbach's Alpha of .72 for parental warmth and .62 for parental supervision.

4.1.5.6. Household Economic and Social Status Index

Household Economic and Social Status Index (HESSI) (Barbarin & Khomo, 1997) is a self-report instrument that combines multiple indicators of the material resources (e.g. food, housing, durable consumer goods, utility expenses, and assets) and social capital (e.g. occupation, education, and marital status) available to South African households. This scale was used by Barbarin and Richter (2001; 1999) in their different studies among the South African population to assess the socio-economic status. In this study questions such as parents' level of education, their occupation, type of house, etc. are asked.

Various researchers have included these factors in their measurement of social economic-status. Some included factors such as age (Sutherland, 2012) household income (Sutherland, 2012; Zhang & Postiglione, 2001; Birkeland, Melkevik, Holsen, & Wold, 2012), family structure and size (Sutherland, 2012; Cerin & Leslie, 2008), education attainment (Cerin & Leslie, 2008; Birkeland, Melkevik, Holsen & Wold, 2012; Sutherland, 2012; Veselska, Geckova, Reijneveld, & van Dijk, 2011; Zhang & Postiglione, 2001;) and employment status (Cerin & Leslie, 2008).

4.1.6. Procedure

The street children were personally approached by the researcher on the street of towns where they were seen begging for money or food. The researcher first established rapport with the participants and left without administering the questionnaires. This happened on two occasions until the third time when participants were willing to participate in the study. After establishing rapport, the researcher explained the purpose of the study and

identified willing participants who were ready to participate. The researcher helped the participants in completing the questionnaire one at a time. Ethical considerations were explained. Participants signed consent forms, their names were not written on the questionnaires and participants were also informed that participation was voluntarily and they could withdraw at any time should they felt uncomfortable in continuing with the study. Questionnaires were administered under the trees, from taxi parks and shopping mall pavements where street children were accessible.

Data from the non-street children sample were collected from one after care-centre and one local high school which were approached by the researcher. Participants were assisted by the researcher to fill in the questionnaire one at a time. At the school, the researcher had randomly selected a number of classes in which learners could participate in the study. Learners were given instruction on how to complete the questionnaire. Questionnaires were completed in the presence of the researcher so that if leaners had questions, the researcher was available to clarify those questions.

4.1.7. Ethical considerations

The study was approved on different levels at North-West University and Limpopo Provincial Department of Education. Department of Psychology, Higher Degrees Committee and Ethics Committee at North-West University had given the initial approval after the proposal had been presented at these sections (NWU- 00117-10-A3-Mafikeng Health). The Limpopo Provincial Department of Education also approved that data could be collected from the Ramathope Senior Secondary School (see Appendix F). The Principal of the said school after consultation with the parents has gave permission

that the data collection in school could precede. Participants were informed about the nature and purpose of the study. They signed assent forms before participating in the study. They were also informed that their participation was voluntary and they could withdraw their participation at any time.

4.1.8. Data analysis

Data was analysed using the Statistical Package for Social Sciences (SPSS- version 20). Data in this phase one of the study was analysed using independent sample *t*-test. Independent sample *t*-test allows the testing of the difference between the two subcategories in a categorical value (Bridge & Sawilowsky, 1999). In this study, the difference between street children and non-street children was assessed in terms of self-esteem, resilience, coping, childhood trauma, parenting styles and socio-economic status and tested using independent sample *t*-test.

From the results of phase I of the study, it was found that street children differ from non-street children on self-esteem, resilience, coping strategies, history of childhood trauma, parenting styles and socio-economic status. The results of phase I informed the development of the intervention programme for phase II.

It was deemed necessary to formulate a social skills intervention programme to help the street children. The intervention programme was mainly formulated to help street children with the intrinsic factors (self-esteem, resilience and coping strategies) that will help them deal with adverse challenges. This was so because other challenges they

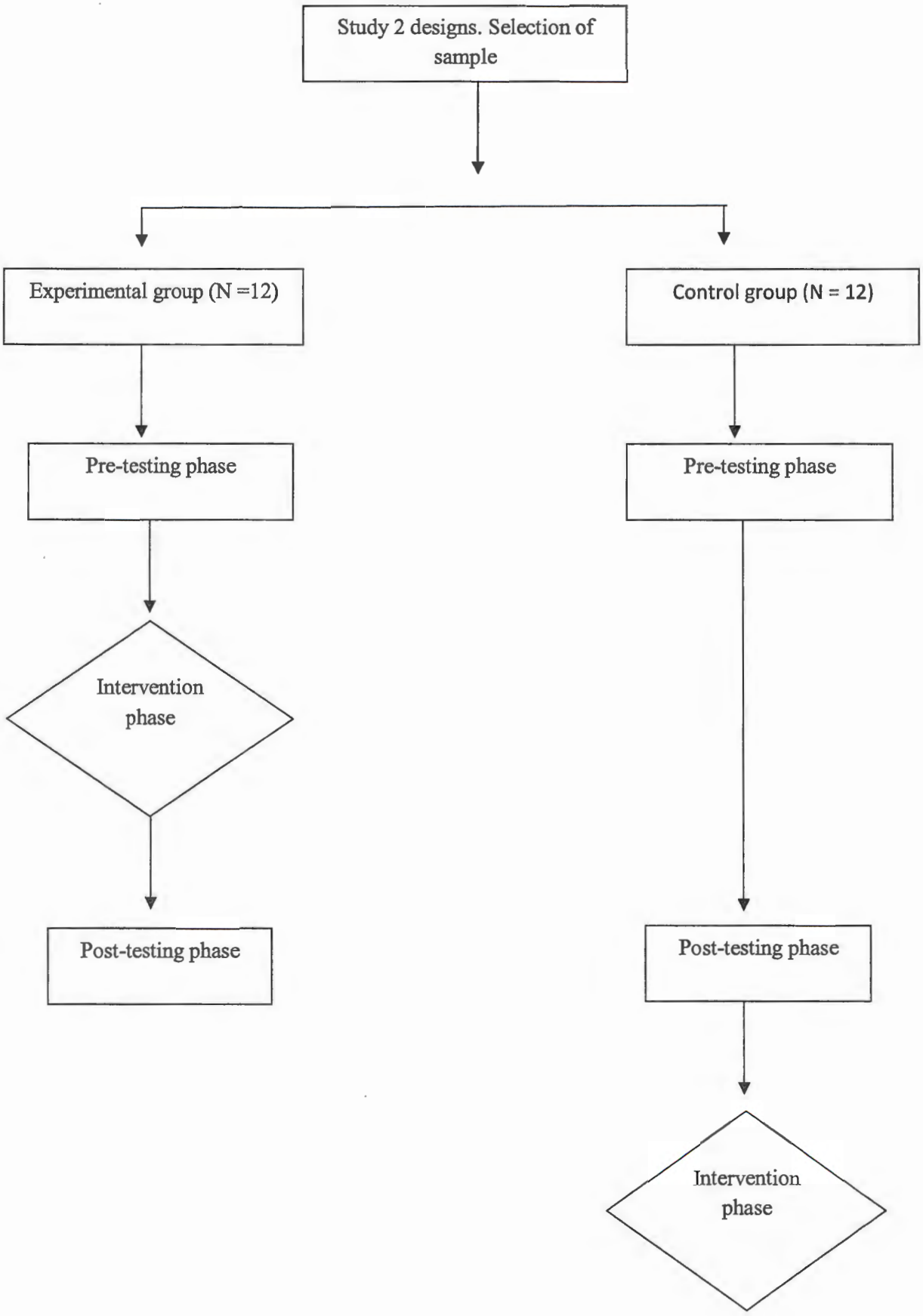
reported (history of childhood trauma, poor parenting styles and poor socio-economic status) are extrinsic factors that they do not have control over.

4.2. STUDY TWO

4.2.1. Research design

This phase of the study adopted pre-test-post-test design. In this design conditions were the same for both the experimental group and the control group except that the experimental group was exposed to treatment whereas the control group was not (Dimitrov & Rumrill, 2003). In this study, both the experimental and the control groups were made up of street children with one group (experimental group) exposed to the social skills training and the other group (control group) not exposed to the training in order to assess the efficacy of the training on self-esteem building, resilience building and coping skills training. As such street children who participated in Phase I were the same participants in this Phase II of the study. The SE-RE-CO social skills training programme (self-esteem building, resilience building and coping skills training) serves as an independent variable whereas self-esteem, resilience and coping strategies instrument scores serve as dependent variables in the study.

Figure 1. Design for Phase II study



4.2.2. Setting of the study

The study was conducted in Polokwane, the capital city of Limpopo Province. Polokwane is situated at the centre of the province with a diverse culture of Pedi, Venda, Tsonga, Ndebele, English and Afrikaans with a total population of 628, 999 people (Statistics South Africa, 2011). This city is developing on various fields such as agriculture, mining and tourism. It is surrounded by suburbs, townships and villages. It is situated along the N1 road that connects South Africa to the rest of Africa. This city houses many people who have come in search for employment and other opportunities to help improve their lives.

Upon interaction with the participants in phase I study, it was realised that sometimes the participants went to a shelter that caters for children with different sorts of challenges to beg for food. Some of the participants were former residents of this particular shelter. As a result, it was requested that the shelter be used to house the intervention sessions. One room was made available for the intervention session. Participants who participated in the phase I study were asked to visit the shelter on days scheduled for sessions.

4.2.3. Participants

A total of 24 street children participated in this intervention phase of the study. They were selected because they participated in the first phase of the study and were also willing to continue with phase two study. The age of participants ranged from 14 to 17 years with mean age of 15.65. Males and females were equally distributed in both the experimental and control group.

4.2.4. Sampling method

Twenty four children were purposively selected to participate in this study. After the participants were selected, twelve street children were randomly assigned for the experimental group and another twelve street children were randomly assigned to the control group. Age and gender were considered and were matched for the two groups, i.e. at least participants' age should range the same between the experimental and control group and also equal gender representation.

4.2.5. Instruments

4.2.4.1. *Rosernberg self-esteem scale*

The Rosernberg self-esteem scale which was used in phase one of the study was also used in this phase to assess participants' self-esteem before and after the intervention process. This instrument was discussed in detail together with its psychometric properties in the phase one study.

4.2.5.2. *Connor–Davidson Resilience Scale*

The CD-RISC scale used in the phase one study was also used to assess resilience of participants before and after the intervention process. This instrument was discussed in detail together with its psychometric properties in the phase one study.

4.2.5.3. *Brief COPE*

The Brief COPE scale used in the phase one study was also used in this phase to assess participants' coping strategies before and after the intervention process. This instrument was discussed in detail together with its psychometric properties in the phase one study.

4.2.5.4. SE-RE-CO social skills training programme

The SE-RE-CO social skills training programme (see guidelines in Appendix A) was formulated by the researcher to help in building self-esteem, resilience and teaching coping skills for street children. The programme was formulated from a psychological perspective guided by the cognitive model for low-self-esteem (Fennell, 2006), The *Reach Out*! Youth Participation Model for building resilience proposed by Roth and Brooks-Gunn (as cited in Oliver, Collin, Burns, & Nicholas, 2006) and coping skills training which is derived from social learning theory (Monti & Rohsenow, 1999). It has a set of questions that participants answer, for example, "what is self-esteem?" It also consists of the opportunity for participants to perform role play tasks in the presence of the therapist and also homework that participants complete on their own and bring for discussion in the follow-up session. This training programme was validated by three registered psychologists who answered the questions of this programme and agreed that the programme could assist in building self-esteem, resilience and teaching coping skills (See Appendix A).

4.2.6. Procedure

4.2.6.1. Assessment

All assessments were conducted at pre-test and at three months post-test. Other experimental intervention studies among homeless sample use three, six or twelve month's interval to do post intervention assessment of the treatment (Carmona, Slesnick, Guo, & Letcher, 2014). Furthermore, a systemic review of intervention studies conducted among homeless youth indicated that follow up to assess the effectiveness of programmes was done one month or three months after the intervention (Altena et al., 2010).

Assessments were done at shelter that houses homeless children. The choice of this shelter was as a result of its convenience as it provided a hall for the group sessions. A well-established rapport was an important factor in this phase. Participants were informed of the purpose of the study and that their participation was voluntary. Those who showed interest in participating were assured of confidentiality.

After participants agreed to continue with the study, both groups were pre-tested on self-esteem, resilience and coping strategies. Participants in this phase are no longer assessed on childhood trauma, parenting style and socio economic status as this is not the focus of this phase of the study. This is because the study is only aimed at assessing those variables that are intrinsic to the participants. These are self-esteem, resilience and coping. Self-esteem, resilience and coping are included in the intervention because it is believed that these are factors that an individual child can learn and improve upon. Unlike childhood trauma, parenting style and socio-economic status that an individual child cannot change and do not have control over. The ecological systems theory which

served as a framework for this study indicates that intervention should be formulated starting from the individual, microsystem to the chronosystem (Bronfenbrenner, 1994). In this case individual characters are the target for the intervention. A study among homeless youth has advised that homeless youth should be helped with self-esteem as it serves as a protective factor for them when faced with adverse situations (Kidd & Shahar, 2008).

After the pre-testing, the participants in the experimental group were exposed to social skills training aimed at self-esteem building, resilience building and coping skills training. Participants in the control group were not involved in the social skills training until after the post-testing phase. They were then exposed to the social skills training after the experiment as this is an ethical requirement. The techniques and principles of group intervention were adhered to in this process.

4.2.6.2. Experimental conditions

Two separate groups, experimental (street children attending social skills training) and control group (street-children not in the social skills training group) were formed between April and October 2012. Each group met once a week for three months. Each session lasted for a period between 60 to 90 minutes. A total of 18 sessions were conducted. Sessions were conducted on weekends by the researcher who is a qualified therapist with four years of clinical practice.

Experimental group: street children in this group were introduced to the SE-RE-CO social skills training. The social skills training emphasised self-esteem building,

resilience building, coping skills training and empowerment of street children. Each topic was discussed one at a time.

Control group: street children in this group completed the questionnaire at- pre and post-assessment periods but received no social skills training until after the experiment was concluded.

4.2.6.3. Group process

The social skills training group process was guided by Yalom's (1985) group psychotherapy principles. The focus of the group was on what is happening in participants' lives, their emotions and their perception of their own situation. The principles include instillation of hope, universality, imparting information, altruism, and corrective recapitulation of the primary family group, development of socialization techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors.

The training started with rapport building session. Rapport building which is characterised by a warm empathetic relationship between the therapist and the client is an important process in any therapeutic process (Rogers as cited in Corey, 2009). Group rules were established. These were the rules that all participants agreed to. A plan to deal with group members who violated group rules was also discussed and agreed upon by participants. Some of the group rules included showing respect for one another, adhering to time for group sessions, not laughing at each other's responses and more. One of the major punishment measures for those violating group rules was that a participant who

violated group rules would stand on one leg with both hands raised for a period of about ten minutes. The researcher had informed the participants of the general purpose of the group. Participants were provided with new books for them to document information being discussed. A variety of structured exercises were held. Information on self-esteem was provided. During this process, a leaflet prepared by the researcher was used to facilitate the session. Information on the leaflet covered topics such as definition of self-esteem, signs of high self-esteem, signs of low self-esteem, what contributes to a person's self-esteem, advantages of having high self-esteem and ways to build one's self-esteem.

SE-RE-CO social skills training programme discussed below was formulated in an attempt to empower participants, to build their self-esteem and resilience as well as training them on coping skills. Topics discussed were generated by the therapist. The format of the session followed the same pattern on different topics being presented. Each and every week the group leader met with participants for about 60-90 minutes. Each session began with ice breaking activities. The topics discussed were generally introduced briefly in the previous session. The therapist presented the content for the particular day and group member's participated in role plays for each and every different character being discussed. They did that taking turns with other group members observing them. To encourage active participation, the therapist asked questions during the discussions of each and every sub topic.

Participants were allowed to explain the topic discussed in their own understanding. Active participation was encouraged throughout all sessions. Exercises also included role playing aimed at giving each participant an opportunity to demonstrate their understanding of the topic being discussed. Participants were encouraged to practise what

they had been role playing on even after the sessions. Towards the end of the session, a summary and reflection of the session was done before participants were given homework. The same procedure was followed during the session on resilience building, coping skills training and empowerment sessions. The difference is that, each topic had each information schedule that was discussed with participants.

Self-esteem building: This session followed the cognitive model for enhancing self-esteem (Fennell, 2006), participants were exposed to self-esteem building training. The cognitive model of low self-esteem indicates that as a result of early life experiences that threaten the person's sense of worth, people form negative conclusions about themselves. Participants were trained on how early life experiences can affect their perception of their current life situations and their reaction thereof can affect how they feel about themselves. Early life adversities such as abuse and neglect, the belief one holds about him or herself such as I am not worthy, critical incidents with potential difficulties, the use of maladaptive behaviour which can lead to the confirmation of own belief and criticism and to low levels of self-esteem. Self-esteem is about self-perception and self-evaluation is influenced by the world around the individual. In this session, an atmosphere that helped participants to pass positive comments and remarks about each other was encouraged.

After this explanation was made, a few examples were discussed so as to enable participants to understand how one's self esteem can be lowered or boosted. Participants were able to make their own example in their own words. For example: Participant B said *"Sometimes is not stress but how other people talk about this person can affect their self-esteem. Also when people tease you can end up having low self-esteem. Bullying also*

affect self-esteem because you are threatened and cannot defend yourself." (Also see Appendix B, page 2).

Vague responses from participants were clarified with them and appropriate term or meaning was highlighted by the group leader each time. Participants also indicated which signs could indicate that a person had high self-esteem or low self-esteem. To ensure that this was well understood, some of them volunteered to role play the character of a person with low self-esteem and the one with high self-esteem. After this role play session, they were taught factors that could help boost a person's self-esteem. For example, they were asked to list the positives about themselves on questions such as "what do I like about who I am? What are some of my achievements? By so doing, it was hoped that the child could realise that there were things that she/he was capable of doing and the unique characters that made him or her different form other children and as a result learn to evaluate oneself positively. In addition to this Curie and Arons (2013) mentioned that taking care of the self, doing good things for others, giving oneself rewards could help boost self-esteem. These are part of the information discussed with participants and in this session participants were able to learn from each other in a non-threatening non-intimidating manner. After the session, homework which focused on how to improve and maintain self-esteem was given.

Resilience building: The *Reach Out*! Youth Participation Model proposed by Roth and Brooks-Gunn (as cited in Oliver, Collin, Burns, & Nicholas, 2006) directs that young people need to be involved in making of decisions that affect them. For them to be able to participate in the decision making process they need to be able to voice out their opinions. This model suggests that building resilience among young people include

developing interpersonal and communication skills, increasing their confidence, self-esteem and self-efficacy and encouraging them to have relationships with adults in their communities. In addition to resilience building, discussions and exercises, this model was found relevant as other sessions included self-esteem building. Furthermore, a good interpersonal relationship was encouraged among the participants and the group leader and this increased communication of participants' thoughts.

The session started with a recap of what happened in the previous session. In this session, active participation was also re-emphasised. The therapist presented the topic for the day and from there asked the group their own understanding of the concept resilience. Initially, participants were reluctant to utter responses until the concept was clarified in simpler terms. Mowbray (2011) argues that in the process of resilience building, participants need to understand what is resilience, why is resilience important and etcetera. Hence in this session these points were highlighted.

Mowbray (2011) further states that a person's attitude, experience, skills and relationships are important in helping build resilience. After a passive participation by group members, the therapist asked for one volunteer whom together they could role play a conversation between a person with a negative attitude towards life and the other one trying to show her other options. This activity made participants to relax as they saw the therapist role playing. They were now able to respond to questions posed to them. For example, it was asked, what are the signs of a resilient person? *Participant F responded by saying "this people also go to church. They make friends at school and church." Participant C's response was "they listen to the advice of other people. When elders guide them they also show respect. They play well with other children."* Role plays

seemed to be important in each and every session. Positive verbal feedback was also constantly given to sustain the participation level.

Coping skills training: This is a form of social skills training derived from social learning theory (Monti & Rohsenow, 1999). The principle of social learning theory is that behaviour is learned. When a person can practise and rehearse a new behaviour such as learning to cope in a challenging situation, that in itself can influence the person in many ways and help improve coping skills (Bandura as cited in Grey & Berry, 2004). The aim of coping skills training is to increase competences and mastery by retraining inappropriate or constructive (maladaptive) coping styles and patterns of behaviour into more constructive (adaptive) behaviours (Grey & Berry, 2004). It was hoped that the very same aim would be achieved in this current cognitive behavioural social skills training programme. It was hoped that this aim would be achieved by teaching group members adaptive ways of dealing with challenging situations in their lives.

The teaching process started when the therapist introduced the topic for the session. From the introduction of the topic, group members were asked to share their own understanding between adaptive coping patterns and maladaptive coping patterns. Differences between adaptive coping patterns and maladaptive coping patterns were clarified with practical daily examples. For example Participant C indicated that *"when elders give advice or reprimanding, some children run away from home. Also their friends influence them and they start to drink alcohol"*. Participant F said *"These people like to fight. If you happen to do something to them by mistake, they will not even ask what is wrong. They just start to fight. They are always fighting."* Furthermore, the

advantages of adaptive coping skills and disadvantages of maladaptive coping skills were discussed.

Termination

Before the sessions were terminated, a review of the previous sessions and homework that were given was done. Questions regarding the overall sessions were asked and clarified. Several role plays on different topics discussed earlier were also done. A general discussion of the group process was also done. Verbal feedback was given to the participants and the therapist.

5.2.7. Data analysis

Data collected at this phase of the study was analysed using the SPSS version 22. Even though other experimental studies (Olowekere & Okanlawon, 2014; Wilson, Vidal, Wilson, & Salyer, 2012) have used either independent or paired t-test statistical method of data analysis to test the effectiveness of the intervention programmes, the current study utilised analysis of covariance (ANCOVA). The advantage of ANCOVA method is that it has greater experimental control by controlling the known extraneous variables. In addition, the main purpose of ANCOVA in randomized control-group pre-test post-test experimental design is to reduce error variance because the random assignment of subjects to groups guards against systematic errors (Dimitrov & Rumrill, 2003).

CHAPTER FIVE

RESEARCH RESULTS

This chapter presents the results of hypotheses tested. The results are divided into two sections, results for psychosocial challenges among street children compared to non-street children and results for social skills training programme. The phase one of the study utilised independent sample *t*-test data analysis method to test the hypothesis while phase two utilised analysis of covariance (ANCOVA). The results are presented in tables and graphical representation.

5.1. RESULTS OF THE STUDY

5.1.1. Psychosocial challenges of street children compared to non-street children

Phase I study hypothesis stated that street children will report low self-esteem, poor resilience, poor coping strategies, and high history of childhood trauma, poor parenting styles, and low socio-economic status as compared to non-street children. This hypothesis was tested using an independent sample *t*-test statistical data analysis method. Results are presented in Table 2 below.

Table 2: Results of independent sample *t*-test analysis comparing street children and non-street children on self-esteem, resilience, coping strategy, history of childhood trauma, parenting styles and socio-economic status.

	Street children		Control group			
Variable	Mean	SD	Mean	SD	T	*P*
SE	13.44	4.058	19.77	3.667	20.036	.000***
R	56.03	15.542	67.50	14.075	9.480	.000***
C	41.64	6.760	50.32	10.940	11.736	.000***
PW	23.84	5.969	31.23	7.132	14.023	.001**
PS	2.38	2.077	8.01	4.171	20.927	.001**
CAT	86.01	19.196	42.72	19.719	-27.242	.001**
GA	10.97	3.008	8.216	3.549	-10.249	.001**
PN	45.77	10. 506	18.286	11.198	-31.003	.001**
Pun	15.21	4.046	9.678	4.802	-15.218	.001**
SA	8.823	6.651	3.836	4.308	-10.898	.001**
HESSI	28.91	6.510	36.174	8.580	11.646	.000**

NOTES: SE= Self-esteem; R= Resilience; C= Coping; CAT= Child abuse and trauma; PW= Parental warmth; PS= Parental supervision;. GA= General abuse; PN= Parental neglect; Pun= Parental punishment; SA= Sexual abuse

: * = p< 0.01; ** = p< .05; *** = p< .000

The study indicated that street children reported low self-esteem $t(598) = 20.03$, p< .000, poor resilience $t(598) = 9.48$, p< .000, and poor coping strategies $t(598) = 11.73$, p< .000 compared to non-street children.

The different mean scores indicated that street children scored lower on self-esteem ($\overline{X}$ =13.44, SD=4.06), resilience ($\overline{X}$ = 56.03, SD=15.54) and coping ($\overline{X}$ = 41.61, SD =

6.76) compared to non-street children self-esteem ($\overline{X}$ = 19.77, SD = 3.67), resilience ($\overline{X}$ = 67.50, SD = 14.06), and coping ($\overline{X}$ = 50.32, SD = 10.94).

The study also revealed significant statistical difference on childhood trauma $t(598) = -27.24$, $p<.000$. The type of trauma was characterised by general abuse $t(598) = -10.24$, $p< .000$, parental neglect $t(598) = -31.00$, $p< .000$, parental punishment $t(598) = -15.21$, $p< .000$, and sexual abuse $t(598) = -10.89$, $p< .000$ (see Table 2 above).

The study indicated that street children scored high on history of childhood trauma ($\overline{X}$ = 86.01, SD=19.19) as compared to non-street children ($\overline{X}$ = 42.72, SD = 19.72). Among the categories of abuse reported, street children scored high on general abuse ($\overline{X}$ = 10.97, SD = 3.01), neglect ($\overline{X}$ = 45.77, SD = 10.51), parental punishment ($\overline{X}$ = 15.21, SD = 4.10) and sexual abuse ($\overline{X}$ = 8.82, SD = 6.20) than non-street children's general abuse ($\overline{X}$ = 8.21, SD3.55), neglect ($\overline{X}$ = 18.28, SD = 11.20), parental punishment (= 9.70, SD = 4.80) and sexual abuse($\overline{X}$ = 3.83, SD = 4.31).

Furthermore, significant statistical differences were found on parental warmth $t(598) = 14.02$, $p< .000$ and parental supervision $t(598) = 20.92$, $p< .000$. Street children scored low on parental warmth ($\overline{X}$ = 23.84, SD = 5.70), parental supervision ($\overline{X}$ = 2.38, SD = 2.10) than non-street children's parental warmth ($\overline{X}$ = 31.23, SD = 7.13) and parental supervision ($\overline{X}$ = 8.01, SD = 4.17).

In addition to this, it was indicated that street children will report significant low scores on socio-economic status compared to non-street children. The study results revealed that more street children come from low socio-economic backgrounds as compared to non-street children $t(598) = 11.64$, $p < .000$. This was further indicated by different means scores between the two groups where street children reported lower socio-economic status ($\overline{X} = 28.91$, SD = 6.51) than non-street children ($\overline{X} = 36.175$, SD = 8.60). This means that phase one hypothesis was accepted.

5.1.2. SE-RE-CO Social skills training for street children

Phase II study hypothesis stated that street children who have been exposed to the social skill training will report more improved self-esteem, resilience and coping skills than street children who have not been exposed to training. The hypothesis was tested using analysis of covariance (ANCOVA). The results are presented in table 3 to 12. The results revealed that after significant adjustment by the covariate self-esteem, SE-RE-CO social skill training which focused on self-esteem building varied significantly with post-intervention self-esteem score, $F(1,21) = 25.16$, $p < .000$, partial $n^2 = .545$ (See Table 3 below). Comparisons of adjusted group means as displayed in Table 4, reveals that the experimental group reported significantly improved self-esteem compared to the control group.

Table 3. Ancova Table for self-esteem

Source	SS	Df	MS	F	P	N^2_p
Corrected model	3.561	2	1.780	15.595	.000	.598
Pre-test SE	.186	1	.186	1.63	.216	.072
Intervention	2.872	1	2.872	25.16	.000	.545
Error	2.387	21	.114			
Total	63.000	24				

R Squared = .598 (Adjusted R Squared = .559)

Table 4. Table of means for self-esteem

Groups	Unadjusted mean	Adjusted mean
Experimental group	1.92	1.897
Control group	1.17	1.187

Figure 2. Self-esteem post-test between experimental and control group among street children

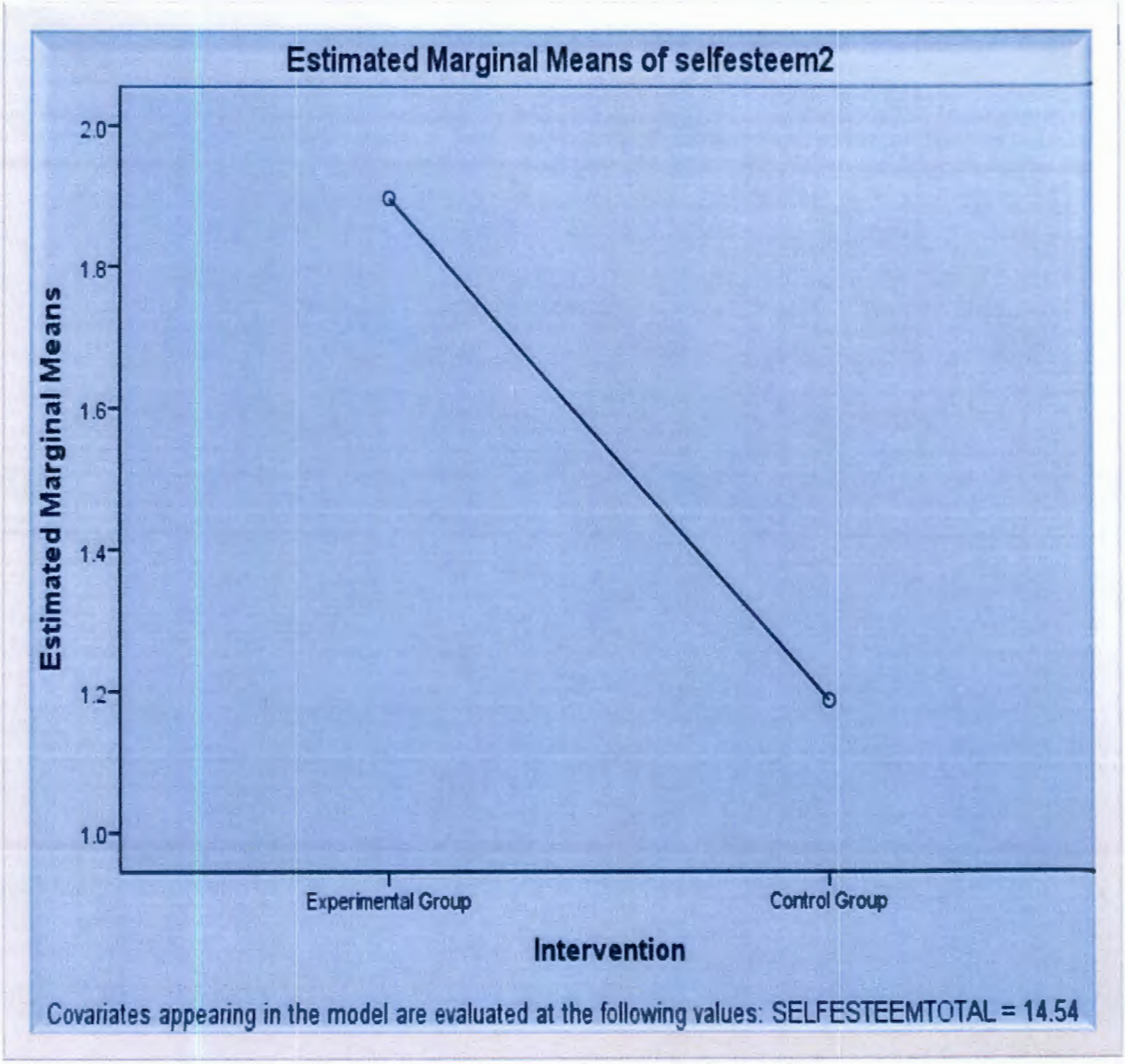


Figure 2 shows that there is a difference in self-esteem level between the experimental and control group after the self-esteem building sessions.

Table 5. Ancova Table for resilience

Source	SS	Df	MS	F	P	N^2_p
Corrected model	2.590	2	1.295	8.072	.003	.435
Pre-test Resilience	.548	1	.548	3.418	.10	.140
Intervention	1.194	1	1.194	7.443	.079	.262
Error	3.368	21	.160			
Total	63.000	24				

R Squared = .435 (Adjusted R Squared = .381)

The results indicated that after significant adjustment by the covariate resilience, SE-RE-CO social skills training which aimed at resilience building varied with post-intervention resilience score, $F(1,21)= 7.44)$, $p <.079$, partial $n^2 =.262$. See Table 5 above. Comparisons of adjusted group means as displayed in Table 6, reveal that the experimental group reported more improved resilience compared to the control group.

Table 6. Table of means for resilience

Groups	Unadjusted mean	Adjusted mean
Experimental group	1.83	1.779
Control group	1.25	1.305

Figure 3. Resilience post-test between experimental and control group among street children

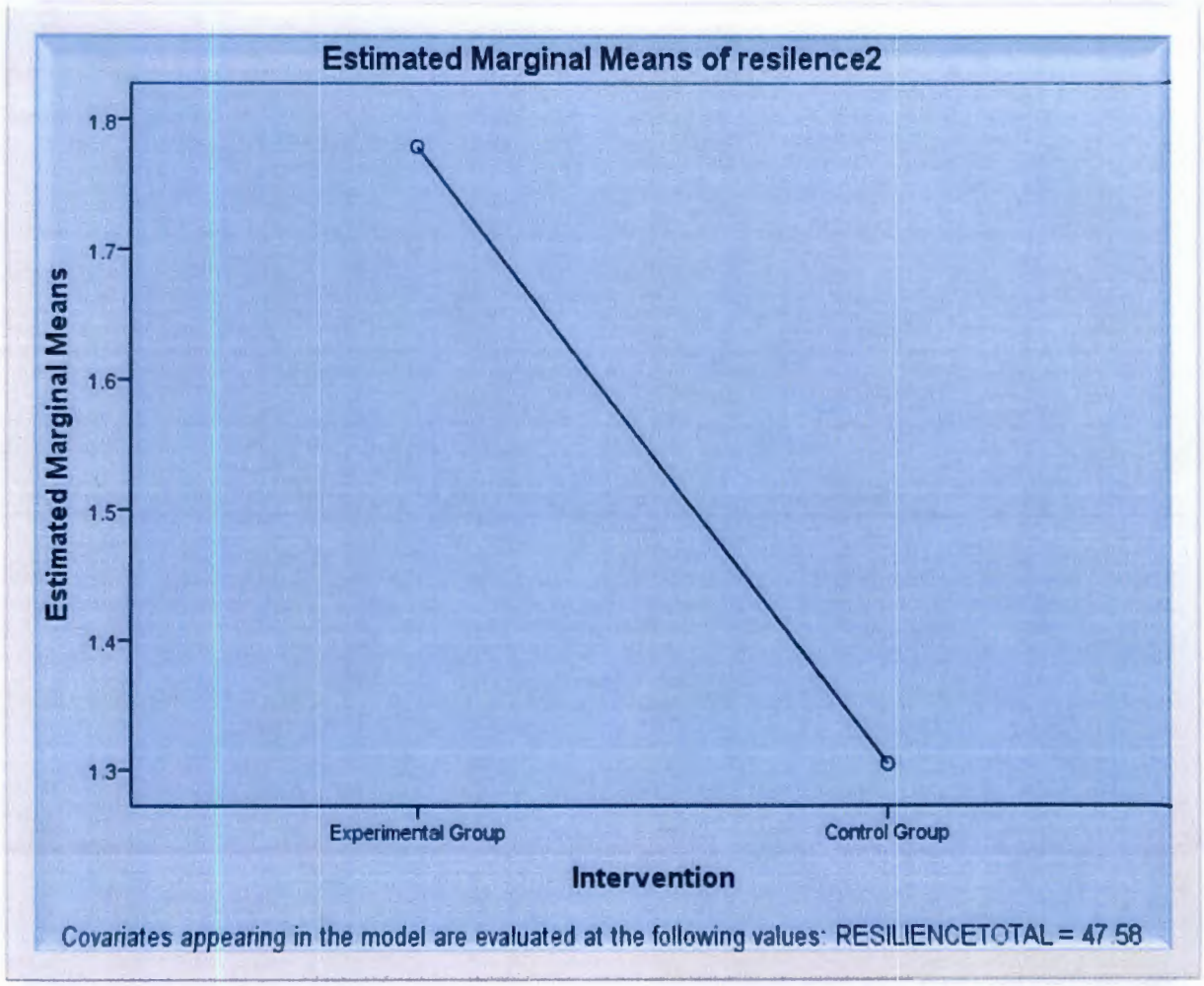


Figure 3 above shows that there is a difference in resilience level between the experimental and control group after the resilience building sessions.

Table 7. Ancova Table for coping strategy

Source	SS	Df	MS	F	P	N^2_p
Corrected model	3.880	2	1.940	19.608	.000	.651
Pre-test Coping	.505	1	.505	5.107	.035	.196
Intervention	3.336	1	3.336	33.71	.000	.616
Error	2.078	21	.099			
Total	57.000	24				

R Squared = .651 (Adjusted R Squared = .618)

Table 7 above indicates that after significant adjustment by the covariate coping, social skills training which aimed at coping skills training varied significantly with post-intervention coping score, $F(1,21)= 33.71$, $p <.000$, partial $n^2 =.616$. Comparisons of adjusted group means as displayed in Table 8, reveal that the experimental group reported significantly improved coping skills compared to the control group.

Table 8. Table of means for coping strategy

Groups	Unadjusted mean	Adjusted mean
Experimental group	1.83	1.831
Control group	1.08	1.085

Figure 4. Coping post-test between experimental and control group among street children

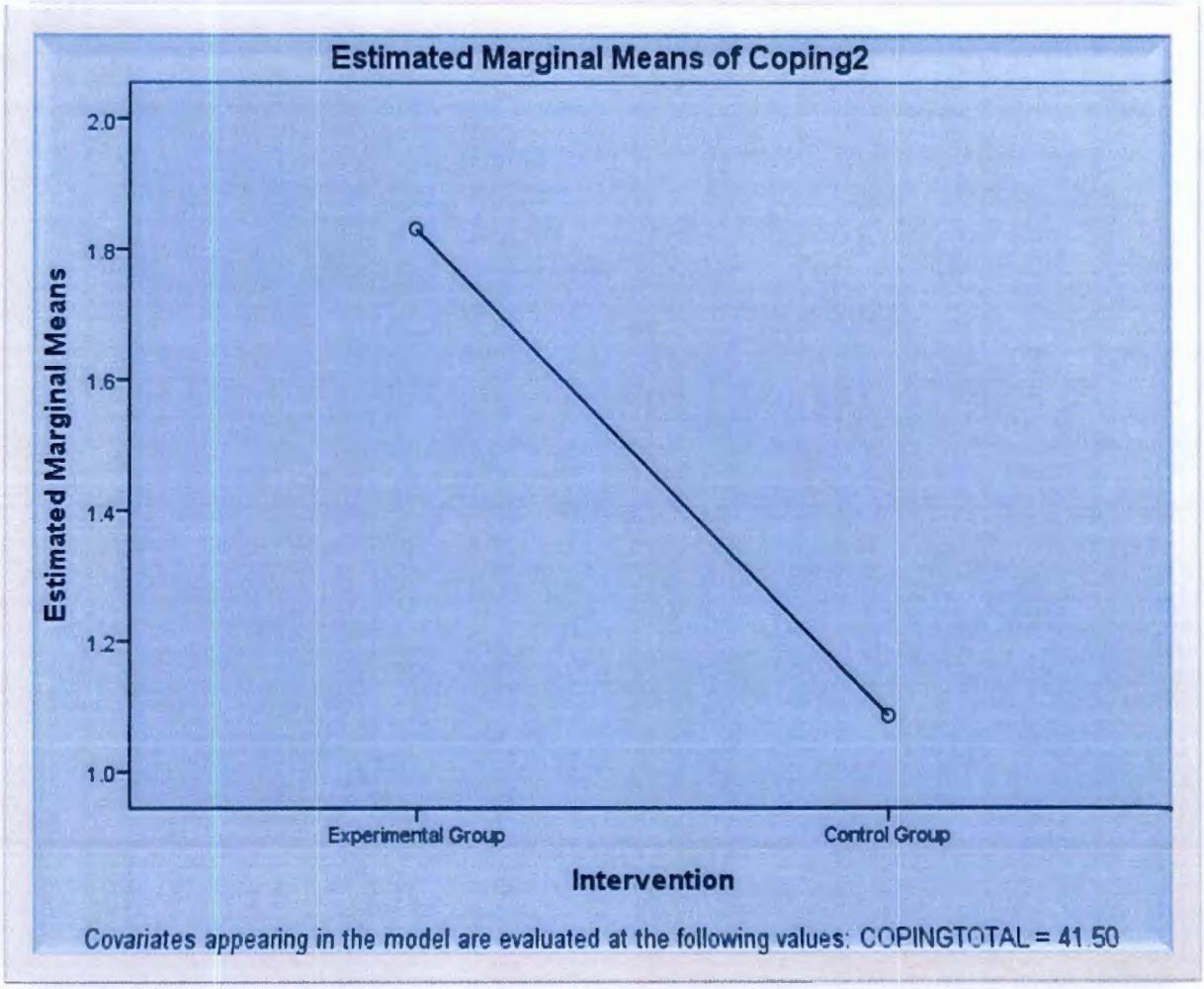


Figure 4 above shows that there is a difference in coping strategies level between the experimental and control group after the coping skills training sessions.

Table 9. Ancova Table for adaptive coping strategy

Source	SS	Df	MS	F	P	N^2_p
Corrected model	1311.019	2	655.509	48.674	.000	.823
Pre-test Adaptive coping	973.51	1	973.51	72.28	.000	.775
Intervention	338.62	1	338.62	28.85	.000	.579
Error	282.81	21	13.46			
Total	14942.00	24				

R Squared = .823 (Adjusted R Squared = .806)

Table 9 above indicates that there is no statistical significance difference between the control group and the experimental group with regard to coping skills training with focus on adaptive coping skills. However, Table 10 bellow indicates that a comparison of adjusted group means reveals that the experimental group reported significant improved adaptive coping compared to the control group.

Table 10. Table of means for adaptive coping strategy

Groups	Unadjusted mean	Adjusted mean
Experimental group	27.33	27.61
Control group	19.833	19.57

Figure 5. Adaptive coping post-test between experimental and control group among street children

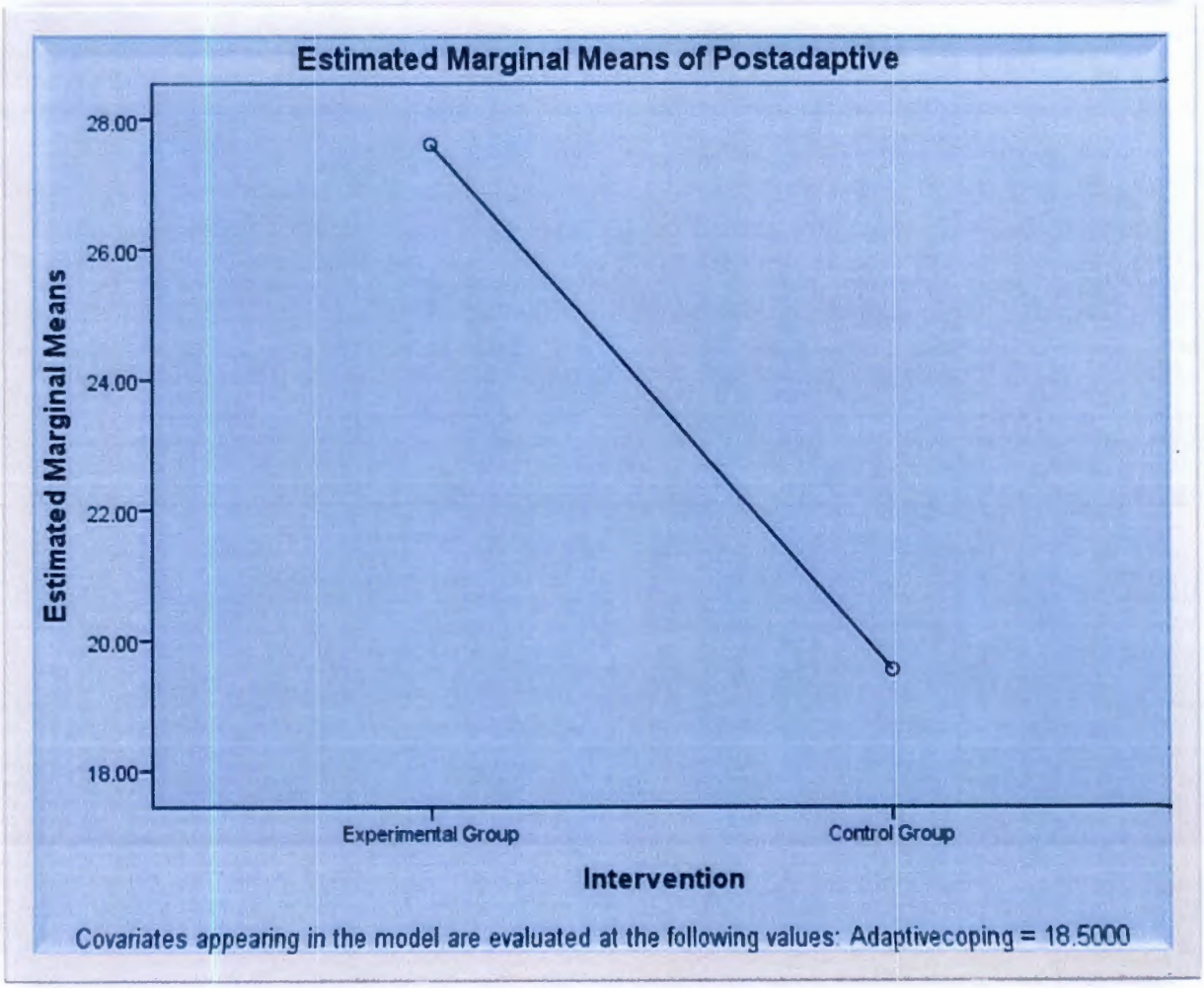


Figure 5 above shows that there is a difference in adaptive coping strategies level between the experimental and control group after the coping skills training sessions.

Table 11. Ancova Table for maladaptive coping strategy

Source	SS	Df	MS	F	P	N^2_p
Corrected model	1014.446	2	507.223	25.656	.000	.710
Pre-test maldaptive coping	555.07	1	555.07	28.076	.000	.572
Intervention	404.954	1	404.954	20.48	.000	.494
Error	415.179	21	19.77			
Total	8675.000	24				

R Squared = .710 (Adjusted R Squared = .682)

Table 11 above indicates that there is no statistical significance difference the intervention has made between the control group and the experimental group with regard to coping skills training with focus on maladaptive coping skills. However, Table 12 bellow indicates that comparisons of adjusted group means reveal that the experimental group reported significantly decreased maladaptive coping skills compared to the control group.

Table 12. Table of means for maladaptive coping strategy

Groups	Unadjusted mean	Adjusted mean
Experimental group	13.00	13.26
Control group	21.75	21.49

Figure 6. Maladaptive coping post-test between experimental and control group among street children

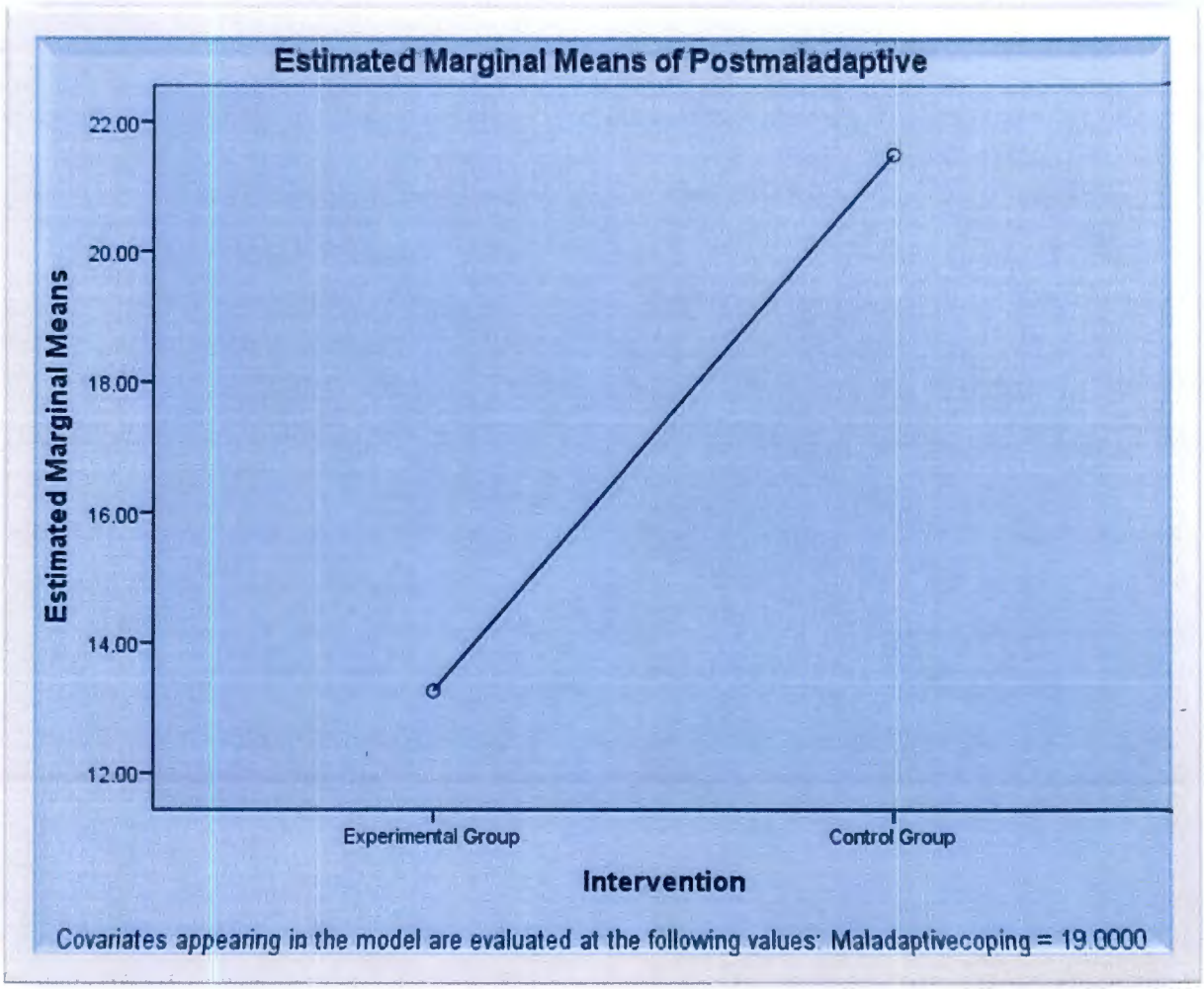


Figure 6 above shows that there is a difference in maladaptive coping strategies level between the experimental and control group after the coping skills training sessions.

- Looking at the results above, it is concluded that the hypothesis that stated that street children who have been exposed to the social skill training will report more improved

self-esteem, resilience and coping skills than street children who have not been exposed to training is accepted.

CHAPTER SIX

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

6.1. DISCUSSION

The aim of this study was twofold: firstly, to explore the psychosocial challenges of street children compared to non-street children, and secondly, to develop intervention strategies and assess the effectiveness of the intervention strategies among street children. The psychosocial challenges explored in phase I study were self-esteem, resilience, coping, parenting styles, history of childhood trauma and socio-economic status. The intervention developed and assessed in phase II study was SE-RE-CO social skills training.

6.2. PSYCHOSOCIAL CHALLENGES OF STREET CHILDREN COMPARED TO NON-STREET CHILDREN

Hypothesis one: Street children will report low self-esteem, poor resilience, poor coping strategies, high history of childhood trauma, poor parenting styles, and low socio-economic status compared to non-street children.

Self-esteem as one of the psychosocial challenges faced by street children can be influenced and controlled by many factors, one of them being the environment a child grows in. The results of this study indicated that street children have low self-esteem compared to non-street children. This study results are in line with the results of the study conducted by Maccio and Schuler (2012) who reported that self-esteem was found to be lower in the group of homeless and runaway youth than their non-homeless and runaway

counterparts. Further research that supports these findings was that of the study conducted in China which revealed that street children have low levels of self-esteem (Cheng & Lam, 2010). Furthermore, Hoersting and Jenkins (2011) reported that low self-esteem is also related to cultural homelessness whereas on the other hand belonging and commitment to any cross-cultural identity is related to lower levels of self-esteem taking a two dimensional approach. Contrary to the current study findings, in Nigeria (Anambra State) a study conducted by Ezeokana et al. (2014) revealed no significant statistical difference in self-esteem between street children and non-street children.

These reports of lower levels of self-esteem among street children are in line with the Self-esteem theory which specifies that, for children to have high self-esteem, they need approval from significant people in their lives mainly parents and guardians. In this case, due to poor parent-child relationship that exists between street children and their parents/guardians and the trauma they experienced, they lack approval and hence their report of low self-esteem (Samuels, 1977).

The current study results further indicated that street children reported poor resilience than their non-street children counterparts. These results are supported by the findings of Cleverley and Kidd (2010) who indicated that the rates of reported resilience were lower for youths who had been homeless for longer periods of time meaning that as time goes on they give in to the harsh realities of street life. Contrary to the study findings, Obradović (2010), Malindi and Theron (2010), and Malindi (2014) reported a different view by indicating that street children are resilient. Interesting enough is that regardless of the low scores on resilience among the street children in this study, majority of them have been on the streets for as long as two years. This raises a significant question

"What could be the reason why these children are still on the streets?" To answer this question, it might be because of the available support these children provide each other and other support received from people who give them money and food (Bender et al., 2007; Harden, 2014).

The results of this study also revealed that street children use more of maladaptive coping strategies compared to non-street children. They have been engaging in drugs to cope with their challenges. These results are consistent with the findings of Towe et al. (2009) and Webe et al. (2010) who indicated that street children use drugs and alcohol to cope with their challenges (de Carvalho et al., 2006).

Their use of maladaptive coping strategies is also associated with engagement in non-violent but criminal behaviour (Fischer et al., 2008) such as formation of gangs (Aransiola & Agunbiade, 2009) and much more other deviant behaviour. This can be as the result of the harsh life on the streets where street children often find themselves engaging in high risk drug use, sexual behaviours and other harmful coping mechanisms (Towe et al., 2009). This is because longer periods of homelessness are associated with polydrug use (Rosenthal et al., 2008). Consistent with the current study findings, Njord et al. (2010) reported that street children use drugs such as tobacco, alcohol, inhalants and other illegal drugs more compared to their non-street children counterparts. On a different note, some of the street children try to reach out by asking help from other people. This is supported by Sta.Maria et al. (2014) who indicated that street children cope with street living as a result of help they get from strangers on the streets.

Another form of maladaptive coping utilised by street children include illicit drug use which is associated with the history of childhood physical abuse (Huang et al., 2011). This is in line with stress and coping theory of Lazarus and Folkman (1984) which postulates that stress comes as a result of the relationship between the person (in this case the street child) and the environment when the person views that the situation is demanding but his/her resources are limited in dealing with the challenges. It is difficult for street children to have more appropriate resources to cope with their challenges as most of the time they are viewed as outcasts (Henley et al., 2010) although they are in need of help as a result of the abuse.

Their uses of maladaptive coping strategies can be associated with many factors. For example, from the theoretical explanation of Samuels (1977) it is indicated that children are frustrated when they are disapproved by others and this negatively affects their self-esteem. This lack of approval creates a barrier between the person who seeks help and the one to draw help from, limiting coping resources. The other factor that might negatively affect street children's coping styles is the history of the abuse they encountered. These children have been abused by their parents with poor socio-economic status which resulted in lack of training in adaptive coping skills. This is consistent with the previous work of Asgeirsdottir et al. (2011) who found that family conflict/violence exacerbates externalising problems among males, while sexual abuse exacerbates internalising problems among females. This internalising and externalising behaviour can signify maladaptive coping strategy.

The results further showed that history childhood trauma is more prevalent among street children compared to their non-street children counterparts. Cluver et al. (2010) believe

that parents and guardians abuse their children. This was not exceptional in the current study as children reported that they were abused either by the parent or the guardian. Children experience verbal and psychological abuse both within the family and when working on the streets (Mathur et al., 2009). Furthermore, Lugalla and Mbwambo (1999) discovered that police officers also abuse street children. These abusers are the significant people in society who could be thought to be the protectors of these children. Due to this verbal and psychological abuse, children run away from home to the streets. Their fear of returning home is mainly due to fear of abuse and if they return, they indeed experience more abuse (Ju & Lee, 2010). This makes homelessness a vicious cycle and intervention strategies are needed for the cycle to be broken.

The types of abuse reported by street children in this study ranged from general abuse, sexual abuse, parental punishment and parental neglect. This is consistent with previous research that indicated that many children are living on the streets as a result of abuse at home, involvement in criminality, or of rejection by families (Cluver et al., 2010). Rukmana (2008) also agrees that homelessness is associated with the history of domestic violence. Street children reported more history of childhood sexual abuse than the non-street children. The findings are consistent with the work of Rosario et al. (2012) who agreed that childhood sexual abuse was found to be associated with homelessness among the homeless youth more than their non-homeless counterparts.

Street children in this study also reported high history of physical abuse than their non-street children counterparts. These findings were supported by Keeshin and Campbell (2011) who indicated that there is high history of physical assault among street children. These street children reported that they were abused by adults who were either a parent

or guardian. Other street children in other studies reported that they were abused by their fellow street children (Kudrati et al., 2008). In addition to the sexual and physical abuse reported, the study findings further indicate that street children in this study compared to non-street children had been neglected by their parents and guardians. This was reported in other studies which indicated that street children had experienced neglect as one form of abuse (Mathur et al., 2009).

The current study findings further indicated that street children reported poor parenting styles as their background compared to non-street children. These findings are consistent with the work of Olaleye and Oladeji (2010) who indicted that among street children, single parenthood which involves inadequate care and support for the children is associated with lack of attachment between the child and parents. This poor parent-child relationship as a characteristic of parenting style has an influence on children's run away behaviour (Ekpiken-Ekanem et al., 2014). Further studies that are in line with the current study findings indicate that children are on the streets as a result of inappropriate punishment methods utilised by parents who do not give adequate supervision to their children (Achakzai, 2011). In addition, Sarnon et al. (2013) found that authoritarian parenting style contributes to children running away from home.

Poor parenting styles reported by street children in this study was categorised into parental warmth and parental control or supervision. These results are consistent with previous research. For example, Fantuzzo et al. (2011) reported that children with a history of parental neglect are likely to experience homelessness. Furthermore, adolescent males reported that they ran away from home as a result of lack of affection

and control from their parents due to the poor attachment they had with their parents (McGarvey et al., 2010).

Street children compared to non-street children reported lack of adequate parental warmth and parental control or supervision as characteristics of poor styles. There are various factors that can contribute to this lack of adequate parental warmth and supervision (Crossley & Buckner, 2012). The issue of parental neglect in this study can also be attributed to high rates of HIV/AIDS in South Africa. Statistics South Africa (2011) have reported that the number of people living with HIV in South Africa increased from an estimated 4,21 million in 2001 to 5,38 million by 2011 with an estimation of 10,6% of the population being HIV positive in 2011. In addition to this, World Health Organization (2011) reported that in sub-Saharan Africa, 1 in 20 adults are living with HIV accounting for 69% of people living with HIV/AIDS worldwide. HIV/AIDS has a potential of resulting in serious dysfunctional family system due to parents or care givers' ill-health. Due to this, children are forced to care for themselves and ill parent or caregiver at a young age when they are still developing. This results in lack of adequate parent-child attachment and parental supervision.

The explanation of this report in the current study is that parents utilising authoritative parenting style abuse their children by neglecting their needs and as a way of coping, these children run away from home. It can also be found that due to this parental neglect, the parents of these children are not even aware of the missing child and necessary protective measures such as reporting the missing children to the police are not followed. Children also view their environment as hostile and want to protect themselves. In this case the only way of protecting themselves from their abusive parents or care giver is by

running away from home. However, other researchers found a different view from this finding. In their study, O'Campo et al. (2010) reported that parenting did not play a role in children's behavioural problems which can include running away from home.

The study results further indicated that street children come from families with poor socio-economic backgrounds more than their non-street children counterparts. This poor socio-economic status is understood as one of the reasons why children leave their homes for the streets. Findings similar to these were reported by Aransioola and Akinyemi (2010) who discovered that in Nigeria, most boys run to the streets due to economic hardship at home. Children run away from poverty at home to seek jobs on the streets. Majority of them are found doing casual jobs such as car washing, pushing grocery trolleys and etc. The findings were further supported by Riley et al. (2007) who reported that lower income is the strongest predictor of homelessness. This is because socio-economic theory indicated that people with lower social standing (in this case is poor socio-economic status) are exposed to more stressful conditions when there are few resources to cope with those conditions (Pearlin, 1989).

Consistent with the current study results, Dubowitz et al. (2011) reported that child maltreatment was prevalent in low-income families. There are different types of abuse by parents that can be attributed to socio-economic status. For instance, parental neglect could be as a result of poor socio-economic status wherein parents are forced to spend most of the time away from home searching for jobs. In most cases, due to lack of or inadequate skills for formal employment or illiteracy, street children's parents end up working as labourers for longer hours leading to insufficient supervision of their children

(Sharmila & Kaur, 2014). When these parents do not find jobs, the children themselves try to find jobs on the streets and end up living there (Plummer et al., 2007).

For these children who come from low socio-economic backgrounds, the socio-economic situation (extrinsic factor) at home serves as a predisposing factor where as their temperament (intrinsic factors) which includes low self-esteem and poor resilience serves as precipitating factors. These children find themselves in distressing poverty stricken families which affects their response to that particular stress leaving them vulnerable to risky behaviours including homelessness (Jones et al., 2011).

The findings are consistent with the work of Kort-Butler (2010) who found that low self-esteem was more among adolescence that experienced and witnessed victimisation leading to later delinquency than those with high self-esteem. This delinquency can be viewed as maladaptive coping skills utilised by street children who were abused. For example, Thompson et al. (2010) has indicated that alcohol and drug addiction is associated with homeless culture identification which forms part of coping mechanisms.

Street children have reported low self-esteem which could have been negatively influenced by their socialisation which never allowed them to believe in themselves. This is mainly due to the trauma they experienced as reported by scholars such as Rosario et al. (2012); Asgeirsdottir et al. (2011); and Swogger et al. (2011). This trauma negatively affected the parent child attachment, which according to Bowlby (1969; 1973), provides a secure base from which the child can explore the environment and in a way boost self-esteem. As these children view themselves as unworthy and unable to achieve compared to their peers, they also view themselves as inadequate of coping with the stressful life

events they find themselves in. They also find themselves under pressure for belonging to a certain group regardless of whether they acknowledge the principles of that particular group or not in many cases those principles include engagement in deviant behaviour and this pressure of belonging leads them into participation in deviant behaviour. However, some children have reported that regardless of deviant behaviour learnt through the pressure of belonging, these social networks they belong to provide them with emotional support (Wenzel et al., 2010).

Graham-Bermann et al. (2009) indicated that high self-worth and social competence were found in children who are resilient. This is in line with the current study as it was found that non-street children who were found to be resilient also reported high self-esteem compared to the street children who reported poor resilience and low self-esteem. This indicates that as children are resilient; their self-esteem is enhanced, leading to more adaptive coping mechanisms.

Even thou street children in this study reported low resilience; it does not mean that they totally lack resilience. Their resilience scores were lower compared to those of non-street children. This is more in line with what was reported by Ungar (2012) who indicated that social ecological perspective of resilience suggests that resilience is a process resulting from interactions between individuals and their environments. In this case, the resilience of street children could be boosted by the relations they have with one another.

The study findings are also in line with the youth resilience framework (Rew & Horner, 2003) which highlighted that there are risk factors and protective resources present throughout an individual's life. In this instance, low self-esteem and poor resilience serve

as a risk factor while on the other hand gang formation on the street serves as protective factor for these street children. This can suggest that in one way or the other, the support these children provide to each helps them adjust to street living hence prolonged periods of homelessness.

Street children in this study reported high history of childhood trauma which could be attributed to poor parenting styles. Parenting is a role that includes caring for children, protecting them, teaching them and guiding them in life lessons. Such activities are possible when there is a positive parent-child relationship which plays a significant role in stressful events and helps in reducing child abuse (O'Campo et al., 2010). The positive relationship can be symbolised by the type of communication style parents use with their children. This parental communication was found to be the factor of parent-child relationship associated with child sexual abuse and also playing a significant role against this type of abuse (Ramírez, Pinzón-Rondón, & Botero, 2011). Good parental communication can also help parents to teach children appropriate ways of coping with stress. But if parents themselves lack insight and parental communication is poor, child abuse will still continue.

In this study street children reported low self-esteem and also poor attachment to their parents as they reported poor parental warmth and parental supervision. This is not a new thing as Dentale et al. (2012) think that avoidant attachment increases implicit-explicit self-esteem discordance. Mother's childhood sexual abuse was associated with using punitive discipline (Kim, Tricket, & Putnam, 2010). The mother might not have properly and adequately dealt with her own trauma which tends to affect her parenting style. This can be a cycle of abuse going on in the family which requires more insight and external

intervention from various stakeholders to break it. In this study, street children reported low self-esteem with poor relationship with their parents and non-street children reported high self-esteem with good relationship with their parents. This has been found in earlier work of Huis in 't Veld, Vingerhoets and Denollet (2011) who indicated that higher levels of self-esteem are associated with secure attachment styles provided by parents who use appropriate parenting styles.

Parents' own stressors play a role in the maltreatment of children (Farkas & Valdés, 2010). The stressors vary and can range from anything from substance abuse to poor socio-economic status. Due to poor socio-economic status, parents are forced to leave children alone without adequate parental supervision to look for employment (Slack et al., 2011). When parents leave children alone, that in itself is neglect. The assumption that could be made about high parental neglect could be that this is the type of child abuse that is often unrecognised by either the parent or the child. However, when investigated, it is realised. Children become vulnerable to any form of stressor and abuse as a result of inadequate parental supervision and care. The results of this study show that street children compared to non-street children have low self-esteem, poor resilience and utilise poor coping strategies which are associated with their history of childhood trauma, poor parenting styles and poor socio-economic status.

6.3. SE-RE-CO Social skills training for street children

Hypothesis two: Street children who have been exposed to social skills training will report improved self-esteem, resilience and coping skills more than street children who have not been exposed to training.

The study has revealed significant statistical differences on pre- and post- test scores on self-esteem and coping strategies but not on resilience between street children who have been exposed to social skills training and those street children who have not been exposed to training. This was evaluated through the formulation of an intervention programme called SE-RE-CO social skills training programme. This programme includes self-esteem building, resilience building and coping skills training activities. The results of this study are consistent with the work of Grocott and Hunter (2009) who reported that the youth who participated in a 10-day development voyage programme showed increased self-esteem. Other researchers have formulated various programmes which were experimentally tested to assess their effectiveness with a given phenomenon. For example, Sobhi-Gharamaleki and Rajabi (2010) reported that life skills instructions were effective in increasing the self-esteem of students who were suspected of mental disorder. Contrary to the findings of this study, Babakhani (2011) did not find social skills training to effectively improve self-esteem.

Further intervention experimental studies have been found to be effective in improving self-esteem. For example, an Art therapy intervention programme (alavinezhad et al., 2014) and bibliocounselling (Karacan & Güneri, 2010) showed improved self-esteem among children who participated in these programmes more than those children who did not participate in the programmes when the pre- and post-test scores were analysed. Other studies supporting the current findings indicate that self-esteem and resilience can be increased in group counselling through the use of Rational Emotive Behaviour Therapy and art therapy (Roghanchi et al., 2013).

Even though resilience has improved more among street children who have been exposed to SE-RE-CO social skills training compared to those street children who were not exposed to training, the results did not reach an acceptable statistically significant level. This can be can be no surprise as other researchers such as Obradović (2010) earlier reported that homeless children were identified as resilient and as such there were no significant statistical differences on pre-test and post-test scores. Street children are regarded as resilient as they continue living life under harsh living conditions on the street, hence the intervention showed no significant differences. In addition, the social ecological theory of resilience suggests that resilience is a process resulting from interactions between individuals and their environment (Ungar, 2012) and is performed over time (Van Breda, 2013) and as such the effectiveness of the intervention can only be determined after a long period of time.

Contrary to the findings of this study which revealed no significant statistical difference on resilience when pre- and post-intervention scores are analysed, a study conducted by Olowokere and Okanlawon (2014) indicated that children who participated in the psychosocial resilience building session showed improved resilience when tested again post intervention compared to those children who did not participate in the intervention. Other studies also indicated that resilience can be increased through group counselling (Roghanchi et al., 2013) or individual interventions (Cheng, 2012). As the youth resilience framework (Rew & Horner, 2003) indicated, there are risk factors and protective factors that affect a person's resilience, in this study the SE-RE-CO social skills training could serve as a protective factor for the street children over time.

Lazarus and Folkman's (1984) stress and coping theory showed that both the person and the environment play a significant role in how the person copes with stressors. In this study, street children who were involved in SE-RE-CO social skills training reported improved coping skills compared to non-street children who were not involved in the training when their pre- and post-test scores on coping were analysed. The results of the study are supported by other studies that proved that coping skills training are effective. For example, Grey and Berry (2004) believe that children who attended a coping skills training which aimed to increase their sense of competence and mastery showed improved coping skills after the programme. Jafari et al. (2010) also reported that among a group of people with substance dependency, those who attended coping skills training showed improved coping skills after the intervention compared to those who did not attend the intervention. This improved coping skills also helped in enhancing resilience among the participants.

The results of this study designate that SE-RE-CO social skills training programme has shown significant improvement of street children's coping skills. Children were taught the use of more adaptive coping strategies over the maladaptive coping strategies to deal with their stressors. This is in line with Clarke's (2006) work which indicated that for children to be able to deal with stressors, they need to develop active coping strategies. Learning adaptive ways over the maladaptive ones include translating deviant behaviours into prosocial outlets (Miles & Okamoto, 2008). This SE-RE-CO social skills training is supported by the social ecological theory the main aim of which is to help children and adolescents to make better decisions about their activities when finding themselves in difficult settings, and eliminating or reducing situations that promote deviant behaviour (e.g. the street) with more positive settings that help promote healthy and safe behaviour

(leaving the streets) (Bronfenbrenner, 1976; Bronfenbrenner, 1979). According to this theory, an individual exists within a nested system and can be helped to deal with challenges imposed on him/her by other systems around him. In this study, it is the individual characteristics such as self-esteem, resilience and coping strategies that play a role in his or her interaction with other systems. Children who have high self-esteem (Sachs-Ericsso et al., 2010), good resilience (Ungar, 2012) and appropriate coping skills (Tamminen & Holt, 2012) can interact well with other systems around them. As such the SE-RE-CO social skills training programme aimed to achieve this in order to help street children deal with their challenges in a more appropriate manner.

6.4. CONLUSION

Despite the limitations observed in this study, in light of the findings, a number of conclusions are drawn. The results showed that street children differ with non-street children on psychosocial challenges. Street children reported low self-esteem, poor resilience and coping strategies compared to non-street children. In addition, street children reported high history of childhood trauma, poor parenting styles utilised by the parents and poor socio-economic status compared to non-street children. This study shows that street children are faced with many challenges. As such they need specific intervention programmes to help them while on the street and subsequently helping them off the streets.

The study also showed that SE-RE-CO social skills training programme is effective in improving self-esteem, building resilience and teaching appropriate coping skills among street children. The psychological treatment utilising SE-RE-CO social skills training

helped street children in the treatment group to attain better social skills compared to the street children in the non-treatment group.

This two in one study among street children brings to light the psychosocial challenges faced by street children. It also provides other perspectives of understanding family dynamics of where these children were raised. When planning for intervention with homeless and runaway youth, rapport, confidentiality and unconditional positive regard for them is of paramount importance (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009). This will help to change the apparently unchangeable lives of street children and a possible friendly atmosphere that encourages dialogue with them in order to understand their dynamics is needed.

This study brings about the need to seriously advocate for the needs of street children through different channels including involvement of non-governmental organisations, primary health care workers, social workers, school teachers, and the police in order to draw effective policies that can help govern this vulnerable population. In the long run, these children need to be reintegrated in to society and this will need step-by-step gradual tailor made programmes.

In the current study, the psychosocial challenges faced by street children in Limpopo Province of South Africa are not different from the challenges faced by street children globally although these challenges are not the same compared to those faced by non-street children. This study helps to fill in the existing knowledge gaps in terms of psychosocial challenges faced by street children and the intervention thereof. These findings lay a foundation for future studies in this area.

6.5. RECOMMENDATIONS

The current intervention programmes about working with street children and other vulnerable children neglect psychological counselling as an important factor of empowering the children. In order to provide an effective intervention programme for these children, the psychosocial component needs to be taken into consideration. On the basis of this study, it is therefore recommended that the relevant stakeholders working with children on various levels should not take for granted issues affecting children. Children's needs should be adequately addressed by relevant stakeholders who have a thorough understanding of the effects of the adversities on these children. In addition children should be empowered with interpersonal skills which will allow them cope with life adversities.

Support should not only be given to the street children but to their families that can be traced. This can lead to a broader understanding of the reasons for homelessness. Attention should be focused on the whole general environment of the child, i.e. from home, school and the community as a whole. Great efforts including those of prevention must be exerted on the parents and communities to understand the long term effects of the phenomenon of street children. Intervention supported by relevant officials aimed at educating the community about the issues of street children can serve as a prevention method. Buckner (2008) indicates that the next generation of studies on homeless children needs to have clear implications for policy and intervention programme designs. Available prevention programmes for the phenomenon of child abuse in South Africa should be monitored, evaluated and strengthened. Identification of the loop holes in the current prevention methods is necessary in order to enable the formation of new methods.

Policies and acts governing children should also be monitored and strengthened so as to help reduce child adversity and homelessness among children.

It is also recommended that shelters housing and providing services for all sorts of vulnerable children, street children included, should start equipping them with social skills training in order to help prevent them from running away to the streets so that when those children are re-integrated with their families they are able to adjust and cope well.

In trying to deal with homelessness among children, awareness about children's psychosocial needs, and the protection of and response to these needs should be raised bearing in mind that when there is an intimate and warm parent-child relationship, human care becomes easy (Hundeide & Armstrong, 2011). There has been an indication that awareness campaigns about issues related to child abuse are needed. This indicates that more services catering for the biopsychosocial needs of these children are urgently needed.

The findings of this study suggest that street children are vulnerable and abused children who have been exposed to adversities on different occasions. When children are less exposed to abuse and other adverse situations, they will be less likely to run to the streets engaging in maladaptive coping mechanisms. Psychologists and other practitioners working with vulnerable children should be able to empirically assess challenges faced by these children in order to plan for proper intervention and prevention methods. By assessing vulnerable children at risk of running to the streets and providing them with appropriate intervention and support systems, the number of street children visible on the streets could be reduced.

Psychoeducational programmes should be rendered to parents and children in terms of awareness about the effects of abuse on children. Centres accommodating street children and other vulnerable children should be child friendly and offering an opportunity for these children to learn some skills so that they will not run away as they will be realising that they have a potential to learn and do something different about their lives.

6.6. IMPLICATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

The study has indicated that street children differ from non-street children in the general population on psychosocial challenges experienced. This study has shown that poor parenting styles have a potential of making parents abuse their children and as such children run to the streets. The findings support the previous work which indicates that child adversity is a contributory factor to homelessness among children. Furthermore, this study provides insight into personal characteristics of street children which also play a significant role in homelessness.

This study has provided a basis for future research in exploring psychosocial challenges of street children and how they serve as a basis for intervention formulation. Implications for future research indicate that children should be understood as people who exist within an ecological system. Future research should include factors such as child functioning in a school, home and community setting.

Understanding the predictors of child neglect and child abuse in general is of critical importance to the development of child maltreatment prevention strategies. A clearer understanding of the risk and protective factors associated with child abuse would enable

more effectively targeted and tailored interventions.

Although poor parenting styles, childhood trauma and poor socio-economic status can lead to homelessness, individual characters such as self-esteem, resilience and coping skills can also lead to homelessness. This shows that among children found on the streets, others chose to be on the street as they could not manage to deal with adversities at home and there might be other children who are currently at home enduring abuse but do not run to the streets as they have the capabilities to cope. Future studies should explore the reason why other children who are abused at home do not run to the streets.

An investigation in order to establish a different role played by parenting styles as characterised by parental warmth and parental supervision regarding issues of child adversities is needed. More research can focus on other mediating factors or causal factors related to this phenomenon.

This study has demonstrated that psychological treatment (SE-RE-CO social skills training) can be the appropriate alternative method in dealing with the street children phenomenon. This is because after intervention was introduced, there was a significant difference between the experimental group (those exposed to treatment) and the control group (those not exposed to treatment). The present study provides new insight into the phenomenon of street children in Limpopo and South Africa as a whole. This lays the foundation for future studies on intervention strategies which can be applied in different populations of street children and other vulnerable children.

More experimental intervention studies to be conducted in various regions of Limpopo Province and South Africa as a whole to further ascertain the efficacy of the social skills training programme among street children. Future studies should formulate social skills training programmes for other vulnerable children such as HIV/AIDS orphans and children dealing with traumatic events such as sexual abuse. Those programmes should be assessed for their efficacy in these populations.

Further studies that clearly distinguish between the sample (children of the streets and children in the streets) can allow generalisability of the findings. Future studies should also try to explore the differences in age and gender among this population which can have a great impact on intervention techniques.

More research on intervention should be conducted over a long period so that other factors such as work skills programmes can be included in the intervention programmes. The participants' response to the intervention can also be tested after a long period. Future studies that assess the efficacy of social skills training programmes should include follow-up studies that explore whether participants have maintained their learned skills. The focus on a comprehensive prevention of this phenomenon by including parents at risk of abusing their children, children at risk of running to the streets is also needed. The of use qualitative methods to explore the efficacy of training programmes is also encouraged.

6.7. LIMITATIONS AND STRENGTHS OF THE STUDY

This present study has a number of limitations. Due to the independent sample design

which was more cross-sectional in nature, data could not be collected over a long period of time and causalities cannot be established. The data was of self-report in nature and data from parents or guardians is not available. There might have been poor recall of childhood memories. There is also insufficient related literature which compares street children to non-street children.

Using both children of the streets and children on the streets as participants for the study could have affected the results. Children on the streets could still have contact with their families which may serve as a protective factor for the challenges they encounter on the streets.

In phase II, some of the experimental group participants did not attend all sessions. The intervention was for a brief period and the post-test assessment was done three months after the intervention was completed, and no follow up was made after the post-test assessment to re-assess the participants' functioning.

The study offers several strengths. Data was collected from those children who are on the streets surviving on their own unlike from those children who are in care centres. Their survival or coping strategies are not influenced by the help they receive in care centres. The sample size of the study is big enough to generalise the findings for the Limpopo Province. The use of control groups in all phases of the study highlights what has been hypothesised.

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APPENDIX A

TRAINING TEMPLATE

Psychosocial skills training

Variables targeted based on the base line results included self-esteem, resilience and coping skills.

For self-esteem, participants were trained in self-esteem building.

For resilience, participants trained in resilience building

For coping skills, participants were trained in coping skills.

There was also a session based on general empowerment.

Session breakdown

Rapport Building

- Establish rapport
- Clarify questions
- Information giving
- Formation of group rules

Rapport was established. Group members received books to take notes or write anything important during the group therapy. Active participation was encouraged. Group rules were established. Measures of discipline of not adhering to group rules were also set. Group members agreed that members who do not adhere to group rules will have to stand on one foot for the whole duration of the group session. Attendance register was also marked.

Self-esteem building

- Review of group rules and the purpose of group therapy
- Introduction on self-esteem
- **Self-esteem building activities**
- ***Some questions included the following:***
- What is self-esteem?
- High and low self-esteem
- What are signs of high self-esteem?
- What are signs of low self-esteem?
- What are the advantages for high self-esteem?
- How can one improve his or her self-esteem?
- Questions and clarifications
- Role plays and lessons learned
- Homework (focused on how to improve and maintain self-esteem) and introduction for the next session

Resilience building

- Review of previous session and homework
- **Resilience building activities**
- Introduction on resilience
- What is resilience
- high and low resilience
- What are the signs of high resilience in a person?
- What are the signs of low resilience in a person?

- How does high resilience help a person
- How can one improve their resilience?
- Questions and clarifications
- Role plays and lessons learned
- Homework and introduction for the next session

Coping skills training

- Review of previous session and homework
- **Coping skills training activities**
- What is coping skill?
- Good and poor coping skills
- Signs of good coping skills
- Signs of poor coping skills
- Advantages of good coping skills
- Disadvantages of poor coping skills
- Questions and clarifications
- Role plays and lessons learned
- Homework and introduction for the next session

Empowerment session-

- Review of previous session and homework
- Introduction on self-empowerment

- Self-empowerment sessions activities
- Questions and clarifications
- Role plays and lessons learned
- Review and preparation for termination

Termination

- Review of previous sessions and homework
- Questions and clarifications
- Role plays and lessons learned
- Assessment of the group and the therapist

SE-RE-CO SOCIAL SKILLS TRAINING TEMPLATE: POSSIBLE RESPONSES

Rapport Building

A good therapeutic relationship is of paramount importance in achieving the therapeutic goals. In this case, a good therapeutic relationship needs to be established first to gain entry to the children in order to achieve the group aim. This therapeutic relationship is understood as rapport.

After establishing rapport with participants, they need to be given an opportunity to ask question and the facilitator respond to those questions. Participants need to be given all necessary details of the training. This is done in order to enhance their participation during the group process. It is also important to set rules before the group session can begin. This is done to maintain order in the group intervention. In addition, group members need books to write so that they can keep information learnt for later use and also to track their progress. An attendance register is also important in order to track attendance by group members.

- Establish rapport
- Clarify questions
- Information giving
- Formation of group rules

Self-esteem building

- Before beginning with the activities of the day, it is important to review group rules and the purpose of group therapy
- Introduction the topic of the day (self-esteem)
- **Self-esteem building activities**

- ***Some questions included the following:***

- **What is self-esteem?**

  Self-esteem refers to a positive view of oneself. It is an individual's overall positive evaluation of the selves. It's a measure of how you see yourself and how you feel about your life and your achievements

- **High and low self-esteem**

  High self-esteem means you hold yourself in high regard including positive self-perception, whereas low self-esteem means you do not have a good opinion about yourself and you perceive yourself negatively.

- **What are signs of high self-esteem?**

  People with high self-esteem have high self-confidence, they believe in themselves, they think that they are worthy; they are not shy to express themselves. They do not need constant approval from other people. They are able to manage challenging situations in their lives and are not afraid to be a centre of attention.

- **What are signs of low self-esteem?**

  People with low self-esteem have poor self-confidence, always want to be approved by other people, they are shy and nervous. They struggle to cope when they are regarded as a centre of attention.

- **What are the advantages for high self-esteem?**

  Self-esteem helps a person to feel good about them. They are able to enjoy life because they are able to solve the challenges they have appropriately in an acceptable manner. People with high self-esteem are able to have friends as such, they increases their chances of social support.

- **How can one improve his or her self-esteem?**

  For a person to improve self-esteem they should first start to acknowledge their feelings lack of worth and stop perceiving them negatively. He or she should stop criticising themselves. They need to engage in positive thinking. They need to focus

on what they want to do to help achieve their goals. They can draw support from friends who care about them who have high self-esteem.

Resilience building

- **What is resilience?**

Resilience means a person's ability to bounce back when faced with adversities. It is the ability to cope when faced with hardships or difficult living conditions.

- **High and low resilience**

High resilience means the high level of tolerance that helps the person to bounce back to normal functioning after facing adverse events. Low resilience mean low levels of tolerance and the inability to bounce back to normal functioning when faced with adversities.

- **What are the signs of high resilience in a person?**

Resilient people are aware of their own emotions and they acknowledge that life is full of challenges and have a strong courage to face their challenges.

- **What are the signs of low resilience in a person?**

People with low resilience are not aware of their emotions. They do not acknowledge that life is full of challenges and have negative attitude towards stress. They are unable to cope with stress as such tend be anxious and depressed and resort to abusing substances or even thinking of killing themselves.

- **How does high resilience help a person?**

Resilience help a person to deal with challenges he or she face in life in an effective appropriate manner. It helps them survive difficult situations.

- How can one improve their resilience?

Taking care of oneself helps in improving resilience. This including eating healthy and exercising. A person can be with friends and family to help them cope with challenges. Effective problem solving skills and a positive towards life is also important.

Coping skills training

- **What is coping skills?**

Coping skills means tools an individual uses to solve problems they encounter. It can either be by seeking help from other people or solving the problem in person.

- **Good and poor coping skills**

Good coping skills include the appropriate tools a person use to solve the problem. These tools include asking help from other people or using individual resources to challenge the problem at hand. Poor coping skills mean using inappropriate tools to solve the challenge such as being in denial or blaming other people for the challenge.

What are the Signs of good coping skills?

- They are able to tackle life challenges.
- They are able to plan for their future
- They can set goals and achieve them
- They participate in various activities
- They are able to maintain their mental and physical health
- They are able to balance their life (i.e. leisure and work)
- They have purpose in life

What are the Signs of poor coping strategies?

- Poor concentration which affects one's social and occupational functioning
- Confusion
- Decreased self esteem
- Thoughts of harm to self and others
- Anxiety
- Irritability
- Impatience
- Negative coping such as abusing substances

Advantages of good coping skills

- Ability to push through, cope and successfully tackle challenges
- Ability to achieve goals

Disadvantages of poor coping skills

- Increase stress response
- Poor physical health

APPENDIX B

EXAMPLE OF PARTICIPANT'S RESPONSES

As indicated above, this was a group therapy intervention where participants were trained on social skills. The topics of training were highlighted above. And some of the participants' experiences were as follows:

Rapport and group rules

Topic: Group rules

Theme: Respect

Participant A: People should respect each other when talking

Participant B: When a person wants to talk they should raise their hands up to be given a chance to talk.

Participant C: No laughing at each other when giving responses

Theme: Order

Participant B: A person who wants to talk should raise their hand and other members should keep quiet.

Participant D: No cell phones and music

Participant E: No coming late to group sessions

Theme: Punishment of violating group rules

Participant E: When someone plays with their phone will take it away from them

Participant F: A person who does not abide by group rules should sit on the floor

Participant C: A person who does not abide by group rules should stand on one foot when tired sit on the floor

SELF-ESTEEM SESSION

Facilitator: What is self-esteem?

Participant G: Self-esteem means having self-confidence. When you believe in yourself

Participant H: Self-esteem means feeling important about you as a person.

Facilitator: What causes a person to have low self-esteem?

Participant C: Stress

Participant B: Sometimes is not stress but how other people talk about this person can affect their self-esteem. Also when people tease you can end up having low self-esteem. Bullying also affects self-esteem because you are threatened and cannot defend yourself

Participant E: Peer pressure

Participant B: When a child is bullied at school they worry about their safety and at the end develop low self-esteem especially when they do not have friends. Even at home they can still be bullied by other children

Participant C: Too many problems at home. For example when an uncle abuses a child and tells the child not to tell anyone. The child will no longer want to play with other children and they will be sad. Participant B adds by saying "the person will also be upsent minded and will not talk with other people". Participant C then continues by saying "always being afraid and thinking that you are in trouble. When they call your name you get frightened".

Facilitator: How can we help someone with low self-esteem to improve it?

Participant G: When you are threatened by other people about your own safety at school. You do not have someone to help you then you are always afraid.

Participant H: Not knowing oneself properly. You end up do things as dictated by your friends. When your friends do not support you, you feel small and not good about yourself.

Participants C: Help the person to think positive about the things in his or her life.

RESILIENCE SESSION

Facilitator: What are the signs of a resilient person?

Participant K: You will see the person by praying. They believe that God is going to help them with their problems.

Participant F: These people also go to church. They make friends at school and church.

Participant C: They listen to the advice of other people. When elders guide them they also show respect. They play well with other children

Participant L: They ask for help form teachers at school. Sometimes they ask to wash teachers' cars so that they can give them money.

Participant F: Resilient people are able to accept their problems and try to think of a way to deal with them.

COPING SKILLS SESSION

Facilitator: What are the signs of poor coping skills?

Participant B: Smoking and drinking not well for children

Participant C: When elders giving advice or reprimanding, some children run away from home. Also their friends influence them and they start to drink alcohol.

Participant L: They steel money from parents. These are children who do not want to be guided

Participant F: This people like to fight. If you happen to do something to them by mistake, they will not even ask what is wrong they start by fighting. They are always fighting at school even at home.

APPENDIX C: QUESTIONNAIRE

DEPARTMENT OF PSYCHOLOGY

UNIVERSITY OF NORTH WEST

MAFIKENG CAMPUS

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This is a research survey and this questionnaire is designed to measure the psychosocial challenges of street children in Limpopo Province and efficacy for social skills training. There are many differences of opinion in relation to this subject. We would like to know what you think and how you feel. There is no right or wrong answers. We are only interested in your opinion as it relates to your feelings. It is important you answer every item. Please do not sign your name and respond as honestly as possible.

Date: September 2010

RESEARCH TITLE: PSYCHOSOCIAL CHALLENGES OF STREET CHILDREN IN LIMPOPO PROVINCE AND EFFICACY FOR SOCIAL SKILLS TRAINING

Biographic information

Age ..... Date of birth.....

Gender ..... Nationality .....

Level of education..... Age when first came to street .....

When did you come to the streets? .....

How long have you been to the streets? .....

Do you have both parents (1) Yes (2) No

If no specify.....

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

1. On the whole, I am satisfied with myself.	SA	A	D	SD
2. At times, I think I am no good at all.	SA	A	D	SD
3. I feel that I have a number of good qualities.	SA	A	D	SD
4. I am able to do things as well as most other people.	SA	A	D	SD
5. I feel I do not have much to be proud of.	SA	A	D	SD
6. I certainly feel useless at times.	SA	A	D	SD
7. I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8. I wish I could have more respect for myself.	SA	A	D	SD
9. All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10. I take a positive attitude toward myself.	SA	A	D	SD

Responses range from 0 ("not true at all") to 4 ("true nearly all the time").

0= not true at all, 1= Some what not true, 2= Neutral, 3= Somewhat true, 4= True nearly all the time.

1 Able to adapt to change	0	1	2	3	4
2 Close and secure relationships	0	1	2	3	4
3 Sometimes fate and God can help	0	1	2	3	4
4 Can deal with whatever comes	0	1	2	3	4
5 Past success gives confidence for new challenge	0	1	2	3	4
6 See the humorous side of things	0	1	2	3	4
7 Coping with stress make stronger	0	1	2	3	4
8 Tend to bounce back after illness, injury or hardship	0	1	2	3	4
9 Things happen for a reason	0	1	2	3	4
10 Best efforts no matter what	0	1	2	3	4
11 One can achieve one's goals	0	1	2	3	4
12 When things look hopeless, I don't give up	0	1	2	3	4
13 Know where to get help	0	1	2	3	4
14 Under pressure, focus and think clearly	0	1	2	3	4
15 Prefer to take the lead in problem solving	0	1	2	3	4
16 Not easily discouraged by failure	0	1	2	3	4
17 Think of self as strong person	0	1	2	3	4
18 Make unpopular or difficult decisions	0	1	2	3	4
19 Can handle unpleasant feelings	0	1	2	3	4
20 Have to act on a hunch, without knowing why	0	1	2	3	4
21 Strong sense of purpose in life	0	1	2	3	4
22 In control of my life	0	1	2	3	4
23 I like challenge	0	1	2	3	4
24 One works to attain one's goals	0	1	2	3	4
25 Pride in my achievements	0	1	2	3	4

1 = I haven't been doing this at all **2 = I've been doing this a little bit**

3 = I've been doing this a medium amount **4 = I've been doing this a lot**

1. I've been turning to work or other activities to take my mind off things.	1	2	3	4
2. I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
3. I've been saying to myself "this isn't real.".	1	2	3	4
4. I've been using alcohol or other drugs to make myself feel better.	1	2	3	4
5. I've been getting emotional support from others.	1	2	3	4
6. I've been giving up trying to deal with it.	1	2	3	4
7. I've been taking action to try to make the situation better.	1	2	3	4
8. I've been refusing to believe that it has happened.	1	2	3	4
9. I've been saying things to let my unpleasant feelings escape.	1	2	3	4
10. I've been getting help and advice from other people.	1	2	3	4
11. I've been using alcohol or other drugs to help me get through it.	1	2	3	4
12. I've been trying to see it in a different light, to make it seem more positive.	1	2	3	4
13. I've been criticizing myself.	1	2	3	4
14. I've been trying to come up with a strategy about what to do.	1	2	3	4
15. I've been getting comfort and understanding from someone.	1	2	3	4
16. I've been giving up the attempt to cope.	1	2	3	4
17. I've been looking for something good in what is happening.	1	2	3	4
18. I've been making jokes about it.	1	2	3	4
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
20. I've been accepting the reality of the fact that it has happened.	1	2	3	4
21. I've been expressing my negative feelings.	1	2	3	4
22. I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
23. I've been trying to get advice or help from other people about what to	1	2	3	4

do.				
24. I've been learning to live with it.	**1**	**2**	**3**	**4**
25. I've been thinking hard about what steps to take.	**1**	**2**	**3**	**4**
26. I've been blaming myself for things that happened.	**1**	**2**	**3**	**4**
27. I've been praying or meditating.	**1**	**2**	**3**	**4**
28. I've been making fun of the situation.	**1**	**2**	**3**	**4**

0= never 1= rarely 2= sometimes 3= very often 4= always

To illustrate, here is a hypothetical question:

Did your parents criticize you when you were young?

If you were rarely criticized, you should circle number 1.

Please answer all the questions.

I. 1.Did your parents ridicule you?	0	1	2	3	4
NEG 2. Did you ever seek outside help or guidance because of problems in your home?	0	1	2	3	4
NEG 3. Did your parents verbally abuse each other?	0	1	2	3	4
PUN 4. Were you expected to follow a strict code of behaviour in your home?	0	1	2	3	4
R-PUN 5. When you were punished as a child or teenager, did you understand the reason you were punished?	0	1	2	3	4
PUN 6. When you didn't follow the rules of the house, how often were you severely punished?	0	1	2	3	4
NEG 7. As a child did you feel unwanted or emotionally neglected?	0	1	2	3	4
NEG 8. Did your parents insult you or call you names?	0	1	2	3	4
SA 9. Before you were 14, did you engage in any sexual activity with an adult?	0	1	2	3	4
NEG 10. Were your parents unhappy with each other?	0	1	2	3	4

NEG 11. Were your parents unwilling to attend any of your school-related activities?	0	1	2	3	4
NEG 12. As a child were you punished in unusual ways (e.g., being locked in a closet for a long time or being tied up)?	0	1	2	3	4
SA 13. Were there traumatic or upsetting sexual experiences when you were a child or teenager that you couldn't speak to adults about?	0	1	2	3	4
NEG 14. Did you ever think you wanted to leave your family and live with another family?	0	1	2	3	4
SA 15. Did you ever witness the sexual mistreatment of another family member?	0	1	2	3	4
NEG 16. Did you ever think seriously about running away from home?	0	1	2	3	4
NEG 17. Did you witness the physical mistreatment of another family member?	0	1	2	3	4
R-PUN 18. When you were punished as a child or teenager, did you feel the punishment was deserved?	0	1	2	3	4
NEG 19. As a child or teenager, did you feel disliked by either of your parents?	0	1	2	3	4
20. How often did your parents get really angry with you?	0	1	2	3	4
21. As a child did you feel that your home was charged with the possibility of unpredictable physical violence?	0	1	2	3	4
R 22. Did you feel comfortable bringing friends home to visit?	0	1	2	3	4
R 23. Did you feel safe living at home?	0	1	2	3	4
R-PUN 24. When you were punished as a child or teenager, did you feel "the punishment fit the crime" ?	0	1	2	3	4
R-PUN 25. Did your parents ever verbally lash out at you when you did not expect it?	0	1	2	3	4
SA 26. Did you have traumatic sexual experiences as a child or teenager?	0	1	2	3	4
NEG 27. Were you lonely as a child?	0	1	2	3	4
NEG 28. Did your parents yell at you?	0	1	2	3	4

SA 29. When either of your parents was intoxicated, were you ever afraid of being sexually mistreated?	0	1	2	3	4
NEG 30. Did you ever wish for a friend to share your life?	0	1	2	3	4
NEG 31. How often were you left at home alone as a child?	0	1	2	3	4
32. Did your parents blame you for things you didn't do?	0	1	2	3	4
NEG 33. To what extent did either of your parents drink heavily or abuse drugs?	0	1	2	3	4
PUN 34. Did your parents ever hit or beat you when you did not expect it?	0	1	2	3	4
SA 35. Did your relationship with your parents ever involve a sexual experience?	0	1	2	3	4
NEG 36. As a child, did you have to take care of yourself before you were old enough?	0	1	2	3	4
37. Were you physically mistreated as a child or teenager?	0	1	2	3	4
NEG 38. Was your childhood stressful?	0	1	2	3	4

If you STRONGLY AGREE with the statement, put an X on 4.

If you AGREE SOMEWHAT with the statement, put an X on 3.

If you DISAGREE SOMEWHAT with the statement, put an X on 2.

If you STRONGLY DISAGREE with the statement, put an X on 1.

1. I can count on my parents to help me out, if I have some kind of problem.	**1**	**2**	**3**	**4**
2. My parents say that you shouldn't argue with adults.	**1**	**2**	**3**	**4**
3. My parents keep pushing me to do my best in whatever I do.	**1**	**2**	**3**	**4**
4. My parents say that you should give in on arguments rather than make people angry.	**1**	**2**	**3**	**4**
5. My parents keep pushing me to think independently.	**1**	**2**	**3**	**4**
6. When I get a poor grade in school, my parents make my life miserable.	**1**	**2**	**3**	**4**
7. My parents help me with my schoolwork if there is something I don't understand.	**1**	**2**	**3**	**4**
8. My parents tell me that their ideas are correct and that I should not question them.	**1**	**2**	**3**	**4**
9. When my parents want me to do something, they explain	**1**	**2**	**3**	**4**

why.				
10. Whenever I argue with my parents, they say things like, "You'll know better when you grow up."	1	2	3	4
11. When I get a poor grade in school, my parents encourage me to try harder.	1	2	3	4
12. My parents let me make my own plans for things I want to do.	1	2	3	4
13. My parents know who my friends are.	1	2	3	4
14. My parents act cold and unfriendly if I do something they don't like.	1	2	3	4
15. My parents spend time just talking with me.	1	2	3	4
16. When I get a poor grade in school, my parents make me feel guilty.	1	2	3	4
17. My family does things for fun together.	1	2	3	4
18. My parents won't let me do things with them when I do something they don't like.	1	2	3	4

MY FREE TIME

1. In a typical week, what is the latest you can stay out on SCHOOL NIGHTS (Monday-Thursday)?

I am not allowed out

(a) before 8:00 (b)8:00 to 8:59 (c)9:00 to 9:59

(d) 10:00 to 10:59 (e)11:00 or later (f) as late as I want

2. In a typical week, what is the latest you can stay out on FRIDAY OR SATURDAY NIGHT?

I am not allowed out ___

(a) before 8:00 (b)8:00 to 8:59 (c)9:00 to 9:59

(d) 10:00 to 10:59 (e)11:00 or later (f) as late as I want

3. How much do your parents TRY to know…..

Where you go at night?	Don't try	Try a little	Try a lot
What you do with your free time?	Don't try	Try a little	Try a lot

Where you are most afternoons after school?	Don't try	Try a little	Try a lot

4. How much do your parents REALLY know...

Where you go at night?	Don't know	Know a little	Know a lot
What you do with your free time?	Don't know	Know a little	Know a lot
Where you are most afternoons after school?	Don't know	Know a little	Know a lot

Directions: I am going to start off by asking you question about your family.

1. Gender: (1) male (2) female

2. How old are you.....

a. Early adolescence .....

b. Middle adolescence.....

c. Late adolescence.....

3. How many people currently live in the house/home?.....

a. Number 18 years and older.....

b. Number 1-17 years old.....

c. Number 5 years old and under.....

Household Economic and Social Status Index (HESSI) Part II

Directions: I am going to be asking you questions about you and your education, living, and health.

4. Which ethnic group do you best identify with?

a. Zulu b. Xhosa c. Sotho d. Tswana e. Pedi f. Ndebele

g. Swati h. Tsonga i. Venda j. Other (Specify) .....

5. How far did you go in school?

a. Less than grade 5 or standard 3 b. Grades 5-7 or standard 3-5.

c. Grades 8-11 or standard 6-9 or N-1 d. Matric or N-3

e. Post matric or N-5/6 f. Tertiary education or Technikon or University

6. Who in the family earns money and what is their job? Check all that apply

In relation to	Job Description
.....Mother	.....
.....Partner	.....
.....Other parent /father	.....
..... Parent pension	.....
..... Child support grant	.....
..... Sibling/aunt/uncle	.....
..... Government grant	.....
..... Other(s)	.....

7. In what type of house/home do you live?

a. None, homeless b. Shack c. Hostel d. Room, garage

e. Flat, cottage f. Home shared with other families' g. Home that is not shared with other families

8. Does your home have?

a. A separate kitchen? (1) No (2) Yes

b. A separate bathroom? (1) No (2) Yes

9. In your home how many separate rooms are there just for sleeping?

0 1 2 3 4 or more

10. What type of toilet facility does your home have?

a. None b. Pit or bucket c. Outside flush toilet d. Inside flush toilet

11. Do you own or rent a home?

A Neither b. Rent c. Purchasing on bond d. Own

12. Does the place you live in have a:

a. Fridge.....(1) No (2) Yes

b. Television..... (1) No (2) Yes

c. Telephone or Cell phone..... (1) No (2) Yes

d. Car..... (1) No (2) Yes

e. Video Recorder..... (1) No (2) Yes

f. Washing machine..... (1) No (2) Yes

g. Microwave oven..... (1) No (2) Yes

h. Oven or stove ..... (1) No (2) Yes

13. How often have you children gone hungry because you did not have food?

(1) Never (2) Sometimes (3) Often (4) All the time

14. Do you have savings or participate in savings plan? (1) No (2) Yes

15. Do you have a life insurance and/or a funeral policy (1) No (2) Yes

16. What major health problems do you have, e.g. cancer, asthma, diabetes, HIV, Hypertension, TB, etc?

17. Of those adults 18 years and older living with you, what major health problems do they have?

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Ethics Committee
Tel +27 18 299 4850
Fax +27 18 293 5329
Email Ethics@nwu.ac.za

2010-11-29

ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title : Street children in Limpopo Province: Psychosocial profiling and intervention

Project leader: Prof ES Idemudia

Ethics number: **NWU-00117-10-A3 Mafikeng Health**

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Expiry date: 2015/11/24

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal Ethics approval certificate will be sent to you as soon as possible.

Yours sincerely

Me.Marietjie Halgryn
NWU Ethics Secretariate

P.O. BOX 1433
GA-MOTHIBA
0727
19 October 2011

Enq: Maepa M.P
078 523 4047

Limpopo Provincial Department of Education
The Head of Department
Research Unit
Polokwane
0700

RE: REQUEST OF PERMISION TO CONDUCT RESEARCH

Sir/Madam

I hereby request for permission to conduct research in Limpopo schools. The title of the study is "Street children in South Africa: Psychosocial profiling and intervention". The school learners will serve as control participants in the study.

The above mentioned study was approved by the North-West University. Kindly find the attached approval letter from the university.

Hoping for a positive response.

Regards,

.....
Mokoena Maepa

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF EDUCATION

Enquires: Dr Makola CM Telephone: 015 290 9448 Fax: 015 2970 134

PO BOX 1433
Ga-Mothiba
0726

Attention: Maepa M.P

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN SCHOOLS

1. The above bears reference.
2. The Department wishes to inform you that your request to conduct a research has been approved- **Title: STREET CHILDREN IN SOUTH AFRICA: PSYCHOLOGICAL PROFILING AND INTERVENTION** i.e.Ga-Mothiba Area: Ramathope S School and Mamahlo Primary School.

3. The following conditions should be considered:

   3.1 The research should not have any financial implications for Limpopo Department of Education.

   3.2 Arrangements should be made with both the Circuit Offices and the schools concerned.

   3.3 The conduct of research should not anyhow disrupt the academic programs at the schools.

   3.4 The research should not be conducted during the time of Examinations especially the forth term.

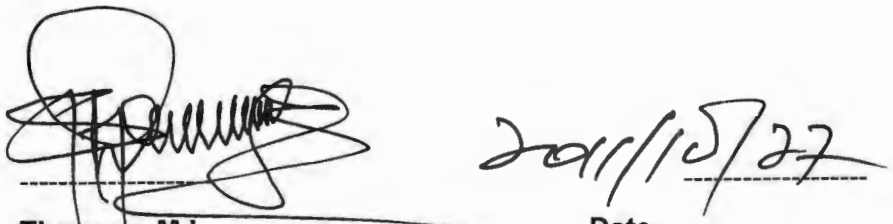
   3.5 During the study, the research ethics should be practiced, in particular the principle of voluntary participation (the people involved should be respected).

   3.6 Upon completion of research study, the researcher shall share the final product of the research with the Department.

Cnr. 113 Biccard & 24 Excelsior Street, POLOKWANE, 0700, Private Bag X9489, POLOKWANE, 0700
Tel: (015) 290 7600. Fax: (015) 297 6920/4220/4494

4. Furthermore, you are expected to produce this letter at Schools/ Offices where you intend conducting your research as an evidence that you are permitted to conduct the research.
5. The department appreciates the contribution that you wish to make and wishes you success in your investigation.

Best wishes.



Thamaga MJ **Date**

Head of Department

6632 Sethemi Street
Unit 14
MMABATHO
2735

10th November2014

CERTIFICATE OF LANGUAGE EDITING

TITLE OF THESIS

Psychological challenges of street children in Limpopo Province and efficacy for social skills training.

SUBMITTED BY

Maepa Mokoena Patronella

FOR THE DEGREE OF

Doctor of Philosophy

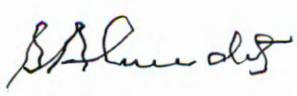
(Psychology)

IN THE

Department of Psychology
Faculty of Human and Social Sciences
North - West University
Mafikeng Campus

Has been edited for language by:

Prof. S.A. Awudetsey



Prof. S.A. Awudetsey
0722371390