UNIVERSITY OF GHANA

DEPARTMENT OF PSYCHOLOGY

CHILD NEGLECT AND PSYCHOLOGICAL WELLBEING IN ADOLESCENTS: AN EXPLORATORY STUDY IN THE TEMA METROPOLITAN ASSEMBLY IN GHANA

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Child Neglect and Psychological Wellbeing

DECLARATION

I, Anna Gyaban-Mensah do hereby declare that this thesis is the result of research undertaken by me towards the award of Master of Philosophy Degree in Clinical Psychology.

Except for the references of the work of other people which have been duly acknowledged, this work has never been submitted in whole or in part for any degree.

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ABSTRACT

The study explored child neglect and its impact on the psychological wellbeing of adolescents in the Tema Metropolitan Assembly of the Greater Accra Region in Ghana. The study was done in two parts using the exploratory sequential mixed method design (study 1-qualitative study and study 2-quantitative study). In study 1, 16 purposively and conveniently sampled participants made up of 5 DOVVSU officials (key informants), 5 parents and 6 adolescents were interviewed to obtain their knowledge and views on child neglect in a Ghanaian setting. Findings from the interviews indicated that the understanding of child neglect among the studied sample were similar to other documented studies. Overall, they viewed child neglect as a function of parental omissions in the care of their children. However, one striking concept that stood out was that fathers or men were identified as the most perpetuators of child neglect. Participants’ responses on the physical presentation of child neglect were further categorised and used in the development of a 29 item culture specific child neglect scale named the Child Neglect Questionnaire (CNQ). In study two, 172 conveniently sampled adolescents completed a survey questionnaire assessing the impact of child neglect on their psychological wellbeing. Five main hypotheses were tested. A significant relationship was found between scores on the child neglect questionnaire and scores on depression, self-esteem and quality of life. Results on effects of child neglect showed that adolescents who experienced child neglect reported poor psychological health (high depression and low self-esteem) and poor quality of life compared to adolescents who do not experience child neglect. Three extra hypotheses were developed and tested using the Person’s Moment Product Correlation to help validate the CNQ. Results supported the psychometric properties of the newly developed scale. Finally, a Principal Component Analysis was carried out to determine the various key factors that made up the CNQ. The PCA outcome indicated two main components (ie. Negligence and Care). Implications of findings are discussed in the study.
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DEDICATION

This work is dedicated to the Almighty God who has been faithful at all times and to my dear parents Rev. and Mrs. Gyaban-Mensah who have supported me this far, as well as Aaron and Gudrun my siblings, who have been a great encouragement.
ACKNOWLEDGEMENTS

Glory and thanks to the Almighty God for His gift of life, for His sustenance and for seeing me to a perfect end.

This work would not have been completed without the help and support of various people. I will like to thank and appreciate my thesis supervisors; Dr Margaret Amankwah-Poku and Dr. Paul Narh Doku for their hard work, unending support and encouragement from the commencement of this thesis document to the end. I want to say that you have been a great help and may God richly bless you. I also want to thank my Head of Department and Clinical supervisor, Prof C.C. Mate-Kole for his support and guidance during the writing of my thesis and my internship at the Korle Bu Teaching Hospital Psychiatric Department. I want to say God richly bless you and replenish you. I also want to acknowledge the valuable contributions of senior members and staff of the Department of Psychology for their selfless service and dedication to duty, as a result of which I have gained so much knowledge and love for this discipline.

Furthermore, I will like to thank my parents who selflessly worked to see me through an additional two years of graduate education. To you I say “May God grant you life so you can reap from the seed you have sown through me”. I appreciate all my friends (Edwin, Winifred, Christiana, Prince etc) who stood by me and encouraged me to press on towards the goal even when I felt weak and faint.

Last but not the least, I will like to thank all the individuals who selflessly participated in the study. I say thank you, I appreciate you all and God bless you.
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<tr>
<td>NCCAN</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>DOVVSU</td>
<td>Domestic Violence and Victim Support Unit</td>
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<td>ACNQ</td>
<td>Adapted Child Neglect Questionnaire</td>
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<td>NS</td>
<td>Neglect Scale</td>
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<td>MASC</td>
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<td>Child Depression Inventory</td>
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CHAPTER ONE

Introduction

The present study seeks to explore the understanding of child neglect in the Ghanaian context and to identify the effects of child neglect on the general psychological health and quality of life of adolescents between the ages of 12 to 17 years. This chapter provides a general overview of child neglect, its effects and causes. It reviews briefly, studies conducted to date and examines the state of child neglect in Ghana. In addition it addresses the statement of the problem, aims and objectives, and the relevance of the study.

Background of Study

Child neglect is considered an important component of child maltreatment, however, it has received little attention in literature and has been identified as the most frequently occurring form of maltreatment (Erickson & Egeland, 2002; Hornor, 2014; McSherry, 2007; Mennen, Kim, Sang & Trickett, 2010; Nyarko, Ammissah, Addai & Dedzo, 2014; Slack et al., 2011). Various efforts have been made by researchers to explore child neglect into detail (e.g., Boyce & Maholmes, 2013; McSherry, 2007). However, most of the studies have examined it together with other child maltreatment issues, mostly child abuse (eg. Brown, Cohen, Johnson & Smailes, 1999; Nyarko et al., 2014; Spinhoven et al., 2010). Child neglect as a concept has attracted conflicting opinions among various researchers (Dubowitz, 2007; McSherry, 2007). Different views have been proposed on what child neglect should constitute and these views are largely based on the location of the studies. These views have resulted in various definitions of neglect based on different orientations such as legal, medical, psychological, social services or lay perspective (Erickson & Egeland, 2011; Mennen et al., 2010).
Child Neglect and Psychological Wellbeing

Child neglect has been defined by the National Clearinghouse on Child Abuse and Neglect (NCCAN; 2004b) as “a failure to provide for a child’s basic needs in one of the following areas; physical, medical, educational and emotional” (pg.1). This definition limits the concept of child neglect to the failure in providing for the physical, medical, educational and emotional needs of children. Dilillo, Perry and Fortier (2006) defined child neglect as “a reflection of a caregiver’s act of omission or deficiencies in providing for the child in a manner that promotes healthy growth and development” (pg.368). Unlike the NCCAN definition, Dilillo et al. (2006) did not restrict the act of neglect to any specific need of children. Rather, they specified the importance of the provision of these needs promoting healthy growth and development in children. Thus, when parent’s provision for their children hinders children’s healthy growth and development, a situation of child neglect can be perceived.

Thomas (2013) identified neglect as a “complex phenomenon” that is difficult to define due to the pluralistic notions of what adequate care constitutes. The pluralistic notions of the constituents of adequate child care according to Thomas, has led to the problems involved in the definition of children’s needs and in the determinant of what actually constitutes neglect. Consequently, Thomas (2013) defined neglect as “the persistent failure on the part of caregivers to meet a child’s basic physical and psychological needs, likely to result in the serious impairment of the child’s health or development” (Thomas, 2013, pg.1). This suggests that child neglect occurs whenever parents or caregivers of children do not adequately provide their basic needs of food, clothing, shelter; health care needs; educational needs; emotional attachments and care among others. This leads to actual or possible harm to the child’s health and development. It can be implied that neglect is characterized by acts of omissions or failure to act on the part of parents or caregivers, in addition to the failure to
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provide or meet a child’s basic needs as identified from the above definitions. Based on these definitions and orientations various forms of neglect have been identified.

According to Doak (2007), neglect can occur in three forms; physical, emotional and educational. Physical neglect is characterized by the failure to provide basic needs such as food, clothing, and shelter; medical neglect such as refusal of or delay in seeking health care; abandonment; inadequate or lack of supervision and desertion among others (Doak, 2007; Dubowitz, Pitts & Black, 2004; McGuigan & Pratt, 2001; Straus, Kinard & Williams, 1997). Emotional neglect refers to ignoring the child’s emotional needs by being inattentive to the child’s need for affection, failing to provide the child’s needed psychological care and making the child witness various forms of spousal and domestic abuse (Doak, 2007; Straus et al., 1997). Educational neglect is characterized by the failure to enrol a child of mandatory school going age in school, permitting chronic truancy and failure to take care of a child’s special educational needs (Doak, 2007).

Other categorizations of neglect include mental health neglect; characterized by the inadequate support of children’s emotional and social development, unaddressed antisocial behaviours such as chronic delinquency and inadequate psychological care in the presence of mental health problems (Slack, Holl, Altenbernd, McDaniel & Stevens, 2003). Cognitive neglect is characterized by inadequate support of a child’s cognitive development and inadequate monitoring and engagement in the child’s academic progress (Straus et al., 1997; Slack et al., 2003). Other studies identified medical neglect to include the refusal of or delay in seeking health care for a child when sick, failure to adhere to medical instructions concerning a child after medical advice has been sought and failing to administer medications to a child as prescribed by a physician (Erickson & Erickson, 2002; Jenny, 2007; LaMance, 2012).
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Further categorizations include supervisory neglect such as allowing or encouraging a child to engage in harmful activities and leaving a child with inadequate substitute child care. For example, leaving a child alone without any substitute caregiver, permanently refusing to take care of a child and leaving a child with someone too young to care for him or her. Other aspects of this form of neglect include failing to protect a child from a third party (e.g. an abuser or persons who engage in child labour or illegal activities) (Coohey, 2003; Ruiz-Casares, Trocme & Fallon, 2012; Straus et al., 1997). Psychological neglect includes the refusal to provide a child’s needed age appropriate psychological care and the refusal or failure to respond to a child’s need for stimulation, encouragements, nurturance and protection (Coohey, 2003; Ruiz-Casares, Trocme & Fallon, 2012; Straus et al., 1997).

Environmental neglect is characterized by the failure of caregivers to ensure that a child’s environment is safe and provide the child with opportunities and resources to develop (Dubowitz et al., 2004). As defined and explained by Dilillo et al. (2006) and Thomas (2013), child neglect no matter the form in which it is presented leads to negative consequences both physical and psychological.

Effects of Child Neglect

Child neglect as established above affects children negatively both in the short term and long term with lasting effects throughout a person’s life (Nyarko et al., 2014; Sesar, Simic & Barisic, 2010).

Neglect affects children adversely in terms of their physical (e.g. injuries, death), psychological (e.g. low self esteem and worth, depression), cognitive (e.g. poor academic achievement, less creativity), social (e.g. social withdrawal, aggression) and mental health (e.g. chronic depression, psychotic manifestations) development (Dilillo et al., 2006; Dubowitz, 2009; Nyarko et al., 2014; Sesar et al., 2010, Thomas, 2013). For example, the
neglect of a child could cause malnourishment, sickness, low self-esteem, academic challenges and aggressiveness in the neglected child. Severe neglect of children could expose children to stressors that could cause the manifestation of underlying psychological and mental conditions and even lead to death. Studies have shown that child neglect is linked to low self-esteem, behavioural problems, higher depression and anxiety levels (Hartley, 2002; Holts, Buckley & Whelan, 2008; Street & Arias, 2001). It is also linked to emotional problems, social withdrawal and passivity, aggression, cognitive and academic deficits, risky behaviours and slower developmental milestones achievements due to inadequate opportunities and stimulation (Dubowitz, 2009; Hildvard & Wolfe, 2002; Hornor, 2014). Children who are neglected develop less creativity, poor impulse control and stronger feelings of frustration and aggression (Friedman, 2010). It is clear that child neglect affects children’s psychological health and quality of life.

Psychological health can be described as a state or feelings of positive mood, positive emotional ties, emotional satisfaction and feelings of calm and peace. It can be described as the opposite of psychological distress which involves higher levels of anxiety, depressed moods and feelings of loss of control (Mattiuzzi, 2008). At birth, children develop initial relationships with their immediate caregiver. This relationship provides a key experience that connects the child’s personal and social worlds. Adverse relationships usually upset the child’s ability to develop adequate and sound social and emotional understanding (Bellis et al., 2014; Howe, Brandon, Hinings & Schofield 1999). Thus, children raised in unfavourable environments may find interpersonal life stressful and frustrating, a situation that may lead to various psychological health problems such as higher levels of depression, anxiety, stress and low self-esteem or self-worth (Dubowitz, 2009; Horner, 2014; Howe et al., 1999; Street & Arias, 2001).
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Spinhoven et al. (2010) investigated the relationship between specific negative childhood experiences and depression and anxiety in later life. They reported that depression was primarily linked to childhood emotional neglect (e.g., lack of support, attention and empathy from caregivers). Emotional neglect on the whole was identified as being characteristic of people with anxiety, depression and/or dysthymia later in life. Further, the results showed that individuals who presented with more than one psychiatric disorder frequently reported of a history of emotional neglect and sexual abuse. Other studies have confirmed a strong relationship between adverse stressful life events and the onset of major depression in adolescents (Duggal et al., 2000; Lewinsohn, Joiner & Rohde, 2001). This implies that when individuals go through stressful life events as children or adolescents they are more likely to develop major depressive disorder. These adverse childhood events affect individuals by making them vulnerable to stress such that the least stressor is enough to trigger bouts of depression and anxiety (Hammen, Henry & Daley, 2000; Kendler, Kuhn & Prescott, 2004).

The existence of neglectful conditions during childhood and adolescence is therefore able to create the vulnerability to depression, anxiety and other psychological problems leading to poorer psychological health among children and adolescents. With the existence of poor psychological health and a rejecting environment characteristic of neglect, one’s quality of life is most likely to be negatively affected.

World Health Organization (1997) defined quality of life as an “individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (pg1). One’s quality of life is usually affected by physical health, psychological state, level of independence, social relationships, personal beliefs and relationships to various important aspects of the environment (WHO, 1997). Quality of life, just as psychological health, is enhanced by positive parent-child relationships which are the most critical determinants of children’s
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devolution and adjustments (Orbuch, Parry, Chesler, Fritz & Repetto, 2005). Thus, when
children are neglected they tend to develop poor physical health, poor psychological states
and poor social relationships among others which impact negatively on their quality of life. It
is therefore, necessary to assess and evaluate the quality of life of neglected children, an area
that only few studies have been done (Leeb, Lewis & Zolotor, 2011).

Risk Factors for Child Neglect

According to Goldman, Salus, Wolcott and Kennedy (2003), child neglect as well as all other
forms of child maltreatments has been identified as not having any single known cause. This
is due to the fact that it occurs across various religious, socioeconomic, ethnic and cultural
backgrounds. Instead, various risk factors that transcends across various social milieus have
been identified as being associated with all forms of child maltreatments (Goldman et al.,
2003). Four main domains of risk factors identified are parental or caregiver’s factors, which
include factors such as personality characteristics and psychological well-being (low self-
esteeleve levels, external locus of control, depression and anxiety), parental history and cycle of
abuse and neglect. To add, substance abuse (research has shown that all types of child
maltreatments especially neglect is more likely to occur in alcohol abusing families), negative
attitudes and inaccurate knowledge about child development and age of parent (Goldman et
al., 2003).

The second domain identified by Goldman et al. (2003) includes family factors such as
family structure, presence of marital conflicts and domestic violence, stress and negative
parent-child interactions. The third domain includes child factors such as age of child,
presence of disabilities in the child and other child characteristics (e.g. infants born with low
birth rate, aggressive behaviours, difficult temperaments etc). The fourth domain includes
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environmental factors such as poverty and unemployment, increased social isolation and decreased social support and living in violent communities (Goldman et al., 2003).

Socioeconomic status of parents/guardians has been identified as a major risk factor for various forms of child maltreatments with child neglect not being an exception. Studies have reported that poverty and unemployment have a strong association with child maltreatment, specifically child neglect (Goldman et al., 2003; Stith, Lui, Davies, et al., 2009).

Plotnik (2000) supported previous studies on the relationship between poverty and child maltreatment (child abuse and child neglect) with descriptions of various theories on the association between poverty and child maltreatment. The first theory explains that lower income within the family creates greater family stress which leads to the chances of maltreatment occurring in the home (Plotnik, 2000). The second theory explains that despite good intentions, parents with low incomes may not be able to provide adequate care for their children while raising them in high-risk communities (Plotnik, 2000). The third theory explains that some parents are more likely to be poor and abusive due to the existence of some other characteristics explained by Goldman et al. (2003). It can therefore be identified that socioeconomic status of a family may directly or indirectly influences the existence of child neglect.

Child Neglect in Ghana

Child neglect, as much as it occurs in other places also occurs in Ghana. Judging from the cultural differences and diversities that exist between different countries, it is necessary to look at child neglect as it occurs and present in Ghana.

Ghana’s Constitution makes provision for children in its chapter on Fundamental Human Rights and Freedoms. It spells out various rights and freedoms that children are entitled to.
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“Every child has the right to receive all measures of special care, assistance and maintenance necessary for their development.

Every child is entitled to reasonable provision from their parent’s estate.

Parents must undertake their natural rights and obligation of care, maintenance and upbringing of their children.

Children and young people must receive special protection against exposure to physical and moral hazards.

Every child has the right to be protected from engaging in work that constitutes a threat to his or her health, education or development.

A child shall not be subjected to torture or other cruel, inhuman or degrading treatment or punishment and no child shall be deprived of medical treatment, education or any other social or economic benefits by reason of religious or other beliefs by any other person (Constitution of the Republic of Ghana, 1992)”.

By this provision, the constitution entreats all parents and guardians to provide adequate care for children (a child in the context referring to any persons below the age of 18 years) under their care and supervision. The Children’s Act was also enacted by parliament in 1998 to further consolidate and to reform the law relating to the care and protection of children in the country (Children’s Act 1998, 1999).

Despite these provisions, reports from the Domestic Violence and Victims Support Unit of the Ghana Police Service (DOVVSU) and the Social Welfare Departments over the years reveal that statistics on child neglect also termed as child non-maintenance is on the rise in Ghana (Human Rights Advocacy Centre, 2008). Over the past three to four years, media
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reports on child maltreatment issues have shown that child neglect cases have risen above various child physical abuse and child sexual abuse cases in various regions of the country. For example, reports from the Ghana News Agency, (2014) show that child neglect cases reported in the Ashanti region had increased. Within the first nine months of the year 2014, 714 cases of child neglect had been reported to DOVVSU. This was statistically higher than all other reported cases including assault, defilement, threats of death, causing harm, sodomy and forcing people into early marriages among others in the region.

Reports from Tema in the Greater Accra Region also revealed that during the first quarter of the year 2014, of the 330 criminal cases reported to the DOVVSU office, 237 were child neglect (child non-maintenance) cases (Ghana News Agency, 2014). Other reports from the Eastern Region also showed that out of a total of 1,929 cases reported to DOVVSU in the year 2013, 744 cases were of child neglect. Child neglect cases in the region therefore constituted 38.6% of the total cases reported and were identified as the highest of all other cases (Ghana News Agency, 2014).

Statistics for the entire nation shows an upwards movement of the number of child neglect cases occurring in the country over the years. This is evident in the table below showing the statistics from 1999 to 2008 (Badoe, 2015; Owusu, 2013).

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In the year 2014, DOVVSU reported a total of 17,655 cases for the entire nation and of these figures, 6,158 were child neglect/child non-maintenance cases, representing about 35% of the total cases recorded. These statistics suggest that child neglect may be a persistent issue in Ghana and a problem worth investigating. Badoe (2015) further stated that the overall statistic for the year 2014 was significant and admonished the Ghanaian society to recognize child neglect as a form of abuse.

The present study will therefore focus on how child neglect is understood or conceptualized by Ghanaians and how it presents in our Ghanaian communities. The study will further explore how child neglect affects the Ghanaian adolescent’s psychological health and quality of life.

**Problem Statement**

Child neglect as stated earlier has been identified by Child Protective Services and researchers as being the highest occurring form of child maltreatment (Hornor, 2014; Mennen et al., 2010; Slack et al., 2011). In Ghana, current statistical reports from DOVVSU show that child neglect is constantly increasing in the country. This increase highlights the negative impact of neglect on the younger generation and the subsequent future generation of the country. With decreased attachments and attention resulting from neglect, some children are prone to various psychological health problems and poorer quality of life which can affect
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them as adults. Increasing rates of divorce coupled with current economic hardships could be the best link to the increasing rates of child neglect in the country (Akuamoah, 2013; Ghana Statistical Service, 2008).

Bloom (2000) argued that in areas where both parents often work longer hours, their children may be affected by parents becoming less psychologically available and providing them with inadequate supervision. In light of this argument it can be understood that parents seeking to achieve higher educational and occupational statuses tend to neglect certain aspects of care towards their children. This is attributed to parents leaving children on their own or with house helps for longer periods. This could lead to a reduction in the strength of parent-child relationship that is needed to develop and to adjust to the environment.

This situation coupled with the increased statistics from the Domestic Violence and Victim Support Unit (DOVVSU) on child neglect gives the indication that issues of child neglect in Ghana needs to be explored. The exploration of child neglect in the country will help create awareness of both adverse and subtle neglect and its impact on the Ghanaian adolescent. Also, child neglect as defined in other western countries is influenced by their cultural practices of child upbringing (Elliott & Urquiza, 2006; Shonkoff, 2003).

The present study seeks to identify if definitions and subtypes of neglect developed in these countries will apply to our Ghanaian setting. Furthermore, measures of child neglect have been developed in the West. To date, and to our knowledge, no measure of child neglect that is culture specific to the Ghanaian context has been developed. Owing to this, items on the child neglect measures are not relevant to our setting due to the collective nature of our culture. It is therefore necessary that a culture specific child neglect scale be developed for the Ghanaian society.
Aims and Objectives

The main aim of the study is to explore child neglect from the Ghanaian perspective and to assess the effects of neglect on the Ghanaian adolescent using a mixed method research design.

The first part of the study will therefore conduct interviews to explore

1. The understanding of child neglect in the Ghanaian context.
2. The perceptions Ghanaians have about child neglect.

The second part of the study will use questionnaires to explore how child neglect affects Ghanaian adolescents by assessing specifically,

1. The extent to which child neglect affects the psychological health of adolescents.
2. The extent to which child neglect affects the quality of life of adolescents.

Various measures of child neglect have been predominantly developed in the West and there is currently no measure of neglect specific to the African, specifically the Ghanaian context. The current study will therefore try to develop a culture specific child neglect scale from the understanding obtained from interviews conducted in the first part of the study. It will then validate the new scale by assessing

1. The internal consistency of the scale (i.e. whether the various items on the scale relates with each other).
2. The construct validity of the scale (i.e. whether the scale as one instrument really measures child neglect).
3. Whether the scale can identify what percentage of a given population experiences child neglect.
4. Factor structure of the scale.

Relevance of study

Exploring the Ghanaian’s concept of child neglect will provide insight into how neglect occurs specifically in the Ghanaian community and culture and its impact on adolescents. Findings will equip social workers and other stakeholders who deal with child neglect issues in Ghana with the knowledge of what neglect means in our Ghanaian culture. It will further provide psychologists insight to how child neglect affects people psychologically. The development of a child neglect scale will provide a cultural specific tool that can be used to screen and identify adolescents who are experiencing neglect. The study will also help open up research opportunities for individuals interested in child neglect issues to broaden their scope of research. Finally, the study will contribute to existing literature on issues concerning child neglect.
CHAPTER TWO

Literature Review

Introduction

This chapter examines relevant theories that explain the concept of child neglect and reviews various relevant studies that help in explaining the study.

Theoretical Framework

The Parental Investment Theory by Trivers (1972) and the Socio-Ecological Model of Neglect by Bronfenbrenner and Ceci (1994) both explain the nature of the relationships that exist among children and their caregivers and provide insight into how neglect occurs and how it affects children.

Parental investment theory

Parental Investment as defined by Trivers (1972) refers to any expenditure or investment by a parent for an offspring that benefits the offspring and increases the chance for survival at the cost of the parent’s ability to invest in themselves or in other offspring. The concept of parental investment has over the years been expanded to include all other caregivers other than the biological parents. It includes all kinds of behaviours that increase the survival of an offspring while reducing the parent’s resources available to invest in themselves, in other offspring, for future reproduction and for self-maintenance (Shenk, 2011; Woodward & Richards, 2005).

The theory proposes that parents are naturally predisposed to maximize the differences that exist between the benefits and the costs of parental investment. This is usually done by making tradeoffs in the care given to each offspring or the number of offspring they have (Shenk, 2011). This means that when the parents maximize the differences between the
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benefits and cost of parental investment, they either reduce the amount of care given to the offspring they have or reduce the number of offspring they intended to have. Owing to this nature, they decrease or cease all investments in their children when the opportunity costs involved in raising them outweigh parental benefits (Friedman, 2010). Major ways by which parents manage the tradeoffs is through neglect and infanticide (Hrdy, 1992; Shenk, 2011). When parents identify that the cost involved in raising a child far outweighs the benefits they are more likely to trade off caring for the child by either reducing their inputs in caring for the child or by totally neglecting the needs of the child. Also, if parents identify a greater benefit in the use of their finances in different areas than in investing in their children, they are more likely to take advantage of that option with more personal gains (Friedman, 2010). When the parent’s tradeoffs usually occur in the form of neglect it tends to affect the parent child attachment bonds that have been formed between the caregiver and the child. These children therefore experience various negative physical and emotional effects leading to poor psychological health and quality of life.

Despite the usefulness of the Parental Investment theory to the present study, it has been critically examined by other researchers such as Spencer and Masters (1999) and Barrett, Dunbar and Lycett (2002). Spencer and Masters (1999) criticized the theory by noting that the parental investment theory is quite obviously untestable. They maintained that various experiments that had been done to test and to establish the theory had failed to eliminate alternative explanations to the choices that are made by individuals. Barrett et al. (2002) argued that the theory did not take into consideration the effect of culture in the choices made by individuals when they were faced with the decision to make tradeoffs in their parental investment towards their offspring. The theory fails to explain and establish situations in collective cultures where an entire family raises and caters for the child instead of the parents alone, therefore, lacking culture sensitivity.
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Despite the problems raised by various studies, the parental investment theory is still useful as it explains the dynamics behind parental decisions to reduce the amount of care they give to their offspring. However, it can be adapted to suite the culture dynamics of the Ghanaian community which is predominantly collective. The Ghanaian parent will therefore be expected to make tradeoffs considering his or her collective support system.

The socio-ecological model of neglect

The social-ecological model of neglect developed by Bronfenbrenner and Ceci (1994) stated that neglect is not just a function of parental characteristics, but a function of a broader social context and characteristics of the child as well. The child is seen as being at the centre of a series of concentric circles with the child’s immediate family being the most influential and closest circle. The child’s extended family, friends, neighbours, school are seen as having proximal influence on the child, and the media, health, governmental family policies and current cultural believes and values having distal influence on the child (Bronfenbrenner & Ceci, 1994).

Watson (2005) asserted that sometimes society does not offer adequate support to parents who need help, thus, laying a foundation for feelings of insecurity and alienation. These parents, usually single mothers are poor, have very little social support from friends and family and live in unsafe neighbourhoods, a condition that further heightens their insecurities. Their problems are compounded with limited education and intelligence. At this point the presence of various parental characteristics (experiencing neglect or abuse) and child characteristics (difficult or demanding), increases the probability of neglect or abuse occurring. When the child’s needs are ignored, the child learns to give up making demands for his or her needs and becomes apathetic and quiet. Further, lack of physical care may then result in the child appearing unkempt thus, increasing the probability of the neglect pattern.
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being repeated outside the home. The constant experience of neglect increases the chances of negative outcomes for the child who experiences it. The negative effects of neglect usually escalate with time because the existence of one risk factor usually increases the probability of another risk factor occurring in the wider circles of the child’s life (Watson, 2005).

The theory therefore explains that neglect is not only a factor of parental decisions or tradeoffs as explained by the parental investment theory but has a range of risk factors that predisposes a parent to engage in it and a child to experience it.

**Review of Related Studies**

Various studies in the field of child neglect have been reviewed to help explain further the relationships that exist between the variables being considered in the present study (e.g. Chahine, 2014; Harkness, Bruce & Lumley, 2006; Leeb, Lewis & Zolotor, 2011). Most researchers have investigated child neglect together with other child maltreatment problems such as child physical abuse, psychological abuse and sexual abuse and very few of them have investigated child neglect as a phenomenon on its own (Brown et al., 1999; Nyarko et al., 2014; Spinhoven et al., 2010; Watson, 2005). Although the negative impact of neglect have been established as one of the biggest threat to children’s development and wellbeing in general, studies investigating this impact is still sparse (Hildyard & Wolfe, 2002; Kuntson, DeGarmo & Reid, 2004; Sameroff, 2000).

**Child neglect, psychological health and quality of life**

Harkness, Bruce and Lumley (2006) focused on the effects of child neglect by studying 103 depressed and non-depressed adolescents from Ontario, Canada. They examined the role that childhood neglect and/or abuse play in lowering the threshold of stress prior to the onset of depression in adolescents. They conducted clinical interviews to aid in identifying
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participants who met the criteria for depression. Participants who did not meet the criteria for depression were used as controls and those who met the criteria for depression were divided into two groups. Further interviews were conducted by the researchers to obtain demographic characteristics of the participants and their childhood history. This was done to assess the quality of parental care the participants received (Harkness et al., 2006).

Harkness et al. (2006) showed that childhood neglect/abuse caused adolescents to develop a lower threshold of stressful life events prior to the onset of their first depressive episode and as such subsequent depressive episodes. In other words, it was identified that the history of childhood neglect/abuse experienced by these adolescents might have sensitized them to the effects of stressful life events such that a lower level of threat was enough to precipitate their very first depressive episode. These findings as obtained by Harkness et al. (2006) were consistent with previous studies (Hammem, Henry & Daley, 2000; Kendler, Kuhn & Prescott, 2004).

The relationship that exists between specific negative childhood experiences and depression and anxiety later in life has also been investigated by Spinhoven et al. (2010). They employed a retrospective study design and used existing data from the Netherlands Study of Depression and Anxiety, which was an ongoing 8-year longitudinal study. 2288 participants were enrolled in the study. Interviews and questionnaires were conducted and administered respectively to obtain data for the study. The researchers established that depression was primarily linked to childhood emotional neglect (e.g., lack of support, attention and empathy from caregivers). Emotional neglect overall, was identified as characteristic of people with anxiety, depression and/or dysthymia later in life. Further, results showed that individuals who presented with more than one anxiety and depressive disorder frequently reported a history of emotional neglect and sexual abuse. Although the findings were consistent with others (Gibb, Butler & Beck, 2003; Gibb, Chelminski & Zimmerman, 2007; Gibb & Abela,
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2008; Wright, Crawford & Del Castillo, 2009), the use of a retrospective study design affects the nature of causal relationships established for the study.

Chahine (2014) examined the link between child abuse (physical abuse, psychological abuse and neglect) and the quality of life of children living with abusive parents. Operating on the assumption that child abuse (physical abuse, psychological abuse and neglect) affects all dimensions of children’s quality of life, Chahine (2014), sampled 30 students and assessed their quality of life and abuse history. Participants completed the Child Abuse Scale (covering physical abuse, emotional abuse and neglect) and the Quality of Life Questionnaire. Results showed that the three types of abuse that was considered in the study affected the dimensions of children’s quality of life differently. Emotional abuse was identified as having the most negative effects on children’s quality of life. Taking the various aspects of quality of life as measured by the Quality of Life Questionnaire (i.e. Self-esteem & autonomy, family life, social life, and recreation & wellbeing), family life was the most affected.

Dion et al. (2015) investigated the impact of child maltreatment and friend support on psychological distress trajectory. Using a sample of 605 adolescents involved in a longitudinal study, they evaluated the psychological distress experienced by the adolescents at ages 14, 16, 18 and 24. Participants completed a self-administered questionnaire at all these age points. Findings revealed that the average psychological distress trajectory increased in adolescence and decreased following transition into adulthood (Dion et al., 2015). Further, findings revealed that the psychological distress of maltreated participants were higher at baseline and remained higher over the ten years of study than that of non-maltreated adolescents. These findings were confirmed in situations where the various forms of maltreatments were assessed separately or together as a cumulative index. Findings of this study confirmed previous studies that have established higher levels of psychological.
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symptoms in adults who were maltreated in childhood (Fergusson, Boden & Horwood, 2008; McGloin & Wisdom, 2001; Trickett, Noll & Putnam, 2011b).

Leeb, Lewis and Zolotor (2011) reviewed the physical and mental health consequences of child abuse and neglect and looked at its implication for practice. In doing this, they reviewed various studies on the long-term physical and mental health outcomes of child maltreatments in children, adolescents and adults. They further discussed the impact it has on the lives of survivors. According to Leeb et al. (2011), the most common form of childhood mental health outcomes identified in literature were behavioral disorders (including externalizing behaviours, aggressive behaviours, and antisocial behaviours among others), attachment disorders, posttraumatic stress disorder and mood disorders (including depression, anxiety and withdrawn behaviour).

Further findings showed that children who experienced maltreatment are more likely to show higher levels of internalizing (that is, showing depression and anxiety) and externalizing behaviour such as acting out and being aggressive (Bolger & Petterson, 2001; Hazen, Connelly, Roesch, Hough & Landsverk, 2009; Johnson, Kotch & Catellier et al., 2002; Manly, Kim, Rogosch & Cicchetti, 2001). Manly et al. (2001) stated that children who experience severe physical neglect at the preschool level exhibited greater internalizing symptomatology and withdrawn behaviour compared with other maltreated children.

A study by Kotch, Lewis, Hussey et al. (2008) related to children who experience only child neglect and not other forms of maltreatment prior to age 2 years showed that these children exhibit more aggressive behaviour in early childhood and middle childhood. It was identified that as the number of child maltreatments experienced by the child increases, there is a linear increase in depression and aggression making it necessary to consider the specifics of the maltreatment a child goes through when dealing with the outcomes (Leeb et al., 2011). Of all
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the outcomes documented, depression and deliberate self-harm were the most commonly discussed internalizing behaviours exhibited in maltreated adolescents (Martin, Bergen, Richardson, Roeger & Allison, 2004; Croyle & Waltz, 2007; Goldstein, Flett, Wekerle & Wall, 2009; Gratz, 2006; Gratz & Chapman, 2007; Haatainen, Tanskanen & Kylma, 2003; Logan, Leeb & Barker, 2009; Oates, 2004; Whitlock, Eckenrode & Silverman, 2006).

Studies with adults have also revealed that adults who experience childhood abuse and neglect exhibit a wide range of mental health problems. These problems include the high probability of being diagnosed with clinical disorders such as personality disorders, mood disorders (mostly depression and anxiety) and posttraumatic stress disorder. Further investigations revealed that most adult victims report various symptoms of anxiety, depression, trauma, somatisation, hostility and paranoia. Other symptoms include increased risk of suicidal attempts, cognitive distortions and dysfunctional attachment styles (Arnow, 2004; Hazen et al., 2009; Higgins & McCabe, 2000; Kaplow & Widom, 2007; Springer, Sheridan, Kuo & Carnes, 2007).

Studies considering the impact of maltreatment on the quality of life of individuals revealed that child maltreatment may actually impact the life expectancy and the quality of life experienced by survivors of abuse and neglect (Corso, Edwards, Fang & Mercy, 2008; Edwards, Anda, Felitti & Dube, 2003; Leeb et al., 2011; Prosser & Corso, 2007). Leeb et al. (2011) reported that although there was limited work in this direction findings reveal that individuals who were victims of child abuse and neglect reported poorer quality of life than those who were not victims. The reduced quality of life found in these individuals translated into a significant loss in days per year of good health (Corso, Edwards, Fang & Mercy, 2008; Edwards, Anda, Felitti & Dube, 2003; Prosser & Corso, 2007). Corso et al. (2008) further found out that younger adults within that ages of 19 to 39 years who had a history of maltreatment reported lowest perceived quality of life in relation to others adults.
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Rationale for the Study

The literature reviewed has shed light on the impact of child neglect on adolescents. The review by Leeb et al. (2011) revealed significant issues that persist among individuals who experience child neglect and any other child maltreatment. Consistently, depression and anxiety were the main psychological health issues that reflected in all the maltreatments that were reviewed (Martin, Bergen, Richardson, Roeger & Allison, 2004; Croyle & Waltz, 2007; Goldstein, Flett, Wekerle & Wall, 2009; Gratz, 2006; Gratz & Chapman, 2007; Haatainen, Tanskanen & Kylma, 2003; Logan, Leeb & Barker, 2009; Oates, 2004; Whitlock, Eckenrode & Silverman, 2006). Leeb and his colleagues further established that studies on the impact of child maltreatment on quality of life are scarce thus, the need to explore the extent and effects of maltreatment on the quality of life of individuals who experience child neglect (Leeb et al., 2011).

Majority of studies done on child maltreatment (child physical abuse, sexual abuse and neglect) in recent times used a quantitative research design focused on the prevalence, causes, effects and prevention of these issues (e.g. Chahine, 2014; Harkness, Bruce & Lumley, 2006; Leeb, Lewis & Zolotor, 2011). The need to understand the concept of child neglect and other child maltreatment issues has declined over the years leaving researchers to rely on early studies that have been done (e.g. Chorn & Parekh, 1998; Straus et al., 1997).

None of the studies reviewed were done in Ghana or sub-Saharan Africa as efforts made to obtain any proved futile. This may demonstrate the lack of literature on the issue of child neglect and its impact on individual’s psychological health and quality of life in these areas. To add, there are variations in child rearing practices in different cultures. Thus research findings and recommendations from the west may not necessarily apply to people in non-western cultures. It is therefore necessary to explore the concept of neglect from different
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cultural perspectives to enhance its understanding and enable relevant recommendations and polices to be made.

Child neglect as defined by various researchers is dependent on the culture or population that was studied (Dilillo, Perry & Fortier, 2006; Thomas, 2013). It is therefore, necessary to explore issues pertaining to neglect in Ghana in order to understand how it presents and to expand the literature base of child neglect research. This present study will enhance the understanding of neglect from different cultural perspectives. Definitions of child neglect are varied (Dubowitz, 2004), and cultural background may play a role in such definitions (Watson, 2005). Thus, the present study will first use the qualitative research method to explore how child neglect is perceived in the Ghanaians context and then use the quantitative research method to assess the effect of child neglect on the Ghanaian adolescent. The study will therefore employ the exploratory sequential mixed method design using both qualitative and quantitative methods respectively in achieving its aims (Creswell, 2014).

Research Questions and Hypotheses

As stated above the study will be done in two phases. The first phase will constitute the qualitative study and the second phase will constitute the quantitative study. The qualitative study will make use of interviews to explore the understanding of child neglect from the Ghanaian’s view point. The interviews will be designed to address the following research questions;

1. What is the Ghanaian’s understanding of child neglect?
2. What do Ghanaian’s believe constitutes child neglect?
Child Neglect and Psychological Wellbeing

The quantitative study will assess the relationship that exists between child neglect experiences, psychological health and quality of life of adolescents. The following hypotheses will be tested to establish these relationships.

1. A negative relationship will exist between child neglect and psychological health.

2. A negative relationship will exist between child neglect and quality of life.

3. There will be a significant difference between males and female in the effect of child neglect on their psychological health and quality of life.

4. Adolescents who experience neglect will have poorer psychological health compared to adolescents who have not experienced neglect.

5. Adolescents who experience neglect will have poorer quality of life compared to adolescents who have not experienced neglect.

The study will further develop a child neglect questionnaire based on the information obtained from the interviews. The questionnaire will then be validated using the study participants to serve as a culture specific measure of child neglect for the population being studied. The following hypotheses will therefore be tested:

6. There will be a correlation between the Child Neglect Questionnaire (CNQ), the Neglect Scale (NS), the Multidimensional Anxiety Scale for Children (MASC), the Children’s Depression Inventory (CDI) and the World Health Organization Quality of Life (WHOQOL)-BREF scale.
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Operational Definition of Terms

Child Neglect: Child neglect will be defined based on scores on the child neglect measure.

Psychological Health: Psychological health is defined by an adolescent’s depression, anxiety and self-esteem levels.

Quality of Life: Quality of life is defined based on scores on the WHOQOL-BREF scale.
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Conceptual Model

Figure 1: Proposed Conceptual Model

From Figure 1, it was hypothesized that child neglect will affect adolescent’s psychological health and quality of life. Specifically, child neglect is expected to lead to high levels of depression and anxiety and low self-esteem and quality of life.
CHAPTER THREE

Qualitative Study: Conceptualization of Child Neglect

Introduction

This chapter explores the understanding of child neglect from the viewpoint of respondents as obtained from their one-on-one interviews. Content analysis specifically, the directed content analyses approach was used in the analysis of text obtained from the respondents (Hsieh & Shannon, 2005). The chapter begins with a description of the population used in the study and the socio-demographic information of interviewed respondents. This is followed by the measures and procedures used in the data collection, the data presentation of interview responses and the process of developing the new Child Neglect Questionnaire (CNQ).

Methodology

Participants

The participants engaged for the qualitative study comprised ten (10) adults and six (6) adolescents living in the Tema Metropolitan Assembly and Ashaiman Municipal District of the Greater Accra Region of Ghana. The population considered was made up specifically of 5 adults working in the Domestic Violence and Victim Support Units (DOVVSU) of the Ghana Police Service, 5 parents and 6 adolescents living in Tema and Ashaiman.

The purposive sampling technique was used to obtain key informants (workers who deal with child neglect cases from the Tema and the Ashaiman DOVVSU units) and the convenient sampling technique was used to obtain adults (Parents) and adolescents from the general population who were available and willing to participate in the study.
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Sex, age and employment distribution of respondents

Sixteen (16) individuals were interviewed for the study. This sample size was based on the
principle of saturation of data where the researcher obtains data to the point where no new
significant information is being obtained (Mason, 2010). Five (5) respondents of the sixteen
(16) were officers at the Tema and Ashaiman DOVVSU Units (Key informants), five (5)
were adults (parents) and the final six (6) were adolescents living in Tema and Ashaiman.

Of the five (5) officers interviewed, two (2) were males and three (3) were females. Of the
five (5) adults interviewed, three (3) were males and two (2) were females and of the six (6)
adolescents interviewed, two (2) were males and four (4) were females. A total number of
seven (7) males and nine (9) females were interviewed. The age distribution of interviewed
participants ranged from 15 years to 54 years ($M = 30.06, SD = 12.60$). The adolescents age
ranged from 15 years to 17 years ($M = 16.33, SD = .82$), whiles the adult respondents
including the DOVVSU officers ranged from 30 years to 54 years ($M = 38.30, SD = 7.96$)
(See Table 3).

The employment status of interview respondents included: five (5) Police Officers (Officers
at Tema and Ashaiman DOVVSU Units), one (1) Teacher, one (1) Pastor, one (1)
Hairdresser, one (1) Banker, one (1) Public Health Officer and six (6) Students. The age and
employment distribution of respondents helped provide a diversified view on child neglect as
it presents in the Tema and Ashaiman communities. Below is a table showing the
demographic characteristics of the participants.
Table 2: Demographic characteristics of interviewed participants (N= 16).

<table>
<thead>
<tr>
<th>Participants</th>
<th>Sex</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOVVSU Officer A</td>
<td>Male</td>
<td>39</td>
<td>Senior High School</td>
</tr>
<tr>
<td>DOVVSU Officer B</td>
<td>Female</td>
<td>32</td>
<td>Senior High School</td>
</tr>
<tr>
<td>DOVVSU Officer C</td>
<td>Male</td>
<td>39</td>
<td>Tertiary</td>
</tr>
<tr>
<td>DOVVSU Officer D</td>
<td>Female</td>
<td>34</td>
<td>Senior High School</td>
</tr>
<tr>
<td>DOVVSU Officer E</td>
<td>Female</td>
<td>43</td>
<td>Tertiary</td>
</tr>
<tr>
<td>Parent Respondent A</td>
<td>Male</td>
<td>48</td>
<td>High School</td>
</tr>
<tr>
<td>Parent Respondent B</td>
<td>Male</td>
<td>54</td>
<td>Diploma</td>
</tr>
<tr>
<td>Parent Respondent C</td>
<td>Female</td>
<td>32</td>
<td>High School</td>
</tr>
<tr>
<td>Parent Respondent D</td>
<td>Female</td>
<td>32</td>
<td>Tertiary</td>
</tr>
<tr>
<td>Parent Respondent E</td>
<td>Male</td>
<td>30</td>
<td>Tertiary</td>
</tr>
<tr>
<td>Adolescent Respondent A</td>
<td>Male</td>
<td>17</td>
<td>Senior High School</td>
</tr>
<tr>
<td>Adolescent Respondent B</td>
<td>Female</td>
<td>16</td>
<td>Senior High School</td>
</tr>
<tr>
<td>Adolescent Respondent C</td>
<td>Male</td>
<td>17</td>
<td>Senior High School</td>
</tr>
<tr>
<td>Adolescent Respondent D</td>
<td>Female</td>
<td>17</td>
<td>Senior High School</td>
</tr>
<tr>
<td>Adolescent Respondent E</td>
<td>Female</td>
<td>15</td>
<td>Senior High School</td>
</tr>
<tr>
<td>Adolescent Respondent F</td>
<td>Female</td>
<td>16</td>
<td>Senior High School</td>
</tr>
</tbody>
</table>

Table 3: Mean age and standard deviation of participants (N=16).

<table>
<thead>
<tr>
<th>Range</th>
<th>Mean Age</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants Age</td>
<td>15 years - 54 years</td>
<td>30.06</td>
</tr>
<tr>
<td>Adolescent Age</td>
<td>15 years - 17 years</td>
<td>16.33</td>
</tr>
<tr>
<td>Adult Age</td>
<td>30 years - 54 years</td>
<td>38.30</td>
</tr>
</tbody>
</table>
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Inclusion/exclusion criteria

Key Informants: Key informants used for the study were workers at the DOVVSU unit of the Ghana Police Service. They had been working there for at least 3 years and were working in the department that deals with child neglect cases. This was to ensure that participants had adequate knowledge and experience in the nature of child neglect issues in the country.

Adults: Participants were at least 30 years old and were parents of at least one child.

Adolescents: The adolescent participants were within the ages of 12 and 17 years of age.

Measures

A semi-structured interview guide based on adequately reviewed literature on child neglect was used. Separate semi-structured interview guides were developed for the adult sample and the adolescent sample (Appendix 3). The guides differed in language use and focus to aid in understanding for the two separate groups and the attainment of adequate information from the two groups. This was done to ensure that questions asked were relevant and understood by each group. The interview guides had 9 open-ended questions with probes for optimal and in-depth understanding of responses (Creswell, 2007).

Procedure

Ethical clearance was sought from the Ethics Committee for the Humanities, University of Ghana after which official letters of introduction were obtained from the Department of Psychology University of Ghana and sent to the Regional DOVVSU Office at the Regional Police Head Quarters, Accra. An approval letter was obtained and sent to the DOVVSU units of the Ghana Police Service in the Tema Metropolitan Assembly and Ashaiman Municipal District.
Permission was then sought from the units to enable a section of their staff to be enrolled in the study. After approvals were given, informed consent was sought from the eligible staff and one-on-one interviews were conducted with them to obtain an in-depth knowledge of child neglect as it occurs in the Ghanaian context. During the briefing, specific information regarding the purpose of the study and voluntary participation were communicated to the participants. Participants were made aware that there was no foreseeable risk, discomfort or adverse effect associated with the study if they chose to participate or decline to participate in the research.

A sample of five (5) adults in the general population were conveniently sampled and interviewed after informed consent was sought from them. Finally, six (6) adolescents in the general population were conveniently sampled and interviewed one-on-one after informed consent and assent from parents had been sought. Permission was sought from all interviewed participants with the assurance of confidentiality in order for their interview sessions to be recorded and for notes to be taken during the interview session. All interviews were conducted one-on-one to ensure confidentiality. To ensure anonymity of responses, participants had the option of not mentioning their names during the interview recording period. Each interview session lasted about thirty minutes to one hour. Recorded interviews were transcribed and analyzed using content analysis. A new neglect questionnaire was developed based on the themes that were identified from the qualitative data analysis and information obtained from existing literature.
**Child Neglect and Psychological Wellbeing**

**Content Analysis Results (Interview Data Presentation)**

The transcribed data was analyzed to gain an understanding of the Ghanaian’s view of child neglect and what the Ghanaians believe constitutes child neglect. In exploring this understanding from the respondents, three (3) main themes were developed. These are *Knowledge of child neglect; Categories of child neglect; Causes of child neglect.*

**Knowledge of child neglect among respondents**

Enquiring about the knowledge respondents had on child neglect, it was identified that the basic idea of child neglect among the Ghanaian population studied (people living in Tema and Ashaiman) has to do with the inability or refusal of parents to provide the needs of their children. Also, it included the inability or refusal of parents to provide the necessary or adequate care the children need. Asked to define child neglect with their personal understanding and in their own words the issue of inadequate or lack of care, denial of basic needs or not providing basic needs and abandonment of children were the main key issues provided by the adult sample and the DOVVSU officials. For instance, one DOVVSU official when asked to define child neglect said;

“I cannot say children who have been abandoned by their parents” asked why, she stated that “...because some children even live with their own parents and are not properly taken care of and they are also abused. So I will say it’s a situation where the children are not properly taken care of by either parents or guardians” (Officer “B”, 2015).
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In contrast to this another DOVVSU official who defined child neglect by defining who a neglected child is said;

“It can be defined as a child who has been abandoned by their parents or foster parents” (Officer “A”, 2015).

Another respondent who was a banker simply said;

“It is the ongoing failure to meet a child’s basic needs” (Parent Respondent “D”, 2015).

It can be deduced from the general viewpoint of respondents that child neglect always has the feature of parental omissions as has been identified by previous researchers (Hicks & Stain, 2013; Hornor, 2014; Thomas, 2013). It was identified that child neglect in the Ghanaian community is mostly seen as the crime of fathers especially when it happens in situations where parents do not living together as a result of conflicts. This was evident in the statements of the respondents as seven (7) (4 DOVVSU officers and 3 adults) out of ten (10) adult respondents mentioned the higher probability of men or fathers neglecting children together with their mothers. The DOVVSU officers confirmed that about 95% of the neglect cases reported to the units were against fathers. For example; one DOVVSU officer stated that;

“Sometimes some of the men get annoyed and because of the anger they have for the woman, they refuse to take care of the child” (Officer “A”, 2015).
“Child neglect is where the father refuses to pay school fees and pay money for housekeeping to take care of the children. We have been receiving such cases a lot here” (Officer “C”, 2015).

And yet another officer stated with much confidence that;

“Mostly the women bring the men here as they are the bread winner of the house for them to look after the children as you know our culture says or demands. And at times they don’t like to compromise with us or they don’t bring the money as required of the law so you see the children being stranded, some ending up being street children, some going into hard labour and all sought of things” (Officer “D”, 2015).

Responses from parents interviewed did not differ much from the views of the DOVVSU officials. Examples of responses from interviewed parents include;

“When a woman and a man live together for some time and the marriage does not work out, the man does not marry the woman. And if they have a child and the man claims the child is not his, he leaves the child for the mother. The mother might not be working or does not live in a good environment to enable the child live there, it could lead to child neglect” (Parent Respondent “C”, 2015).

“With the little knowledge I have, child neglect comes from so many ways. Divorce that is when both parents are not together and one parent is taking care of the child sometimes there is neglect because the father will not do his part as a parent so in that way the child is being neglected by the father to the mother” (Parent Respondent “E”, 2015).
From the adolescent respondents, issues relating to lack of or inadequate care, irresponsibility of parents, leaving children without help and rejection by parents were the main issues identified. Below are some of the responses obtained when they were asked to share their knowledge on child neglect.

“I think child neglect is about parents refusing to take care of their children. The parents decide not to take responsibility to do his work or maybe pay school fees and all that. They leave the child to go and find his own job and to live his own life” (Adolescent Respondent “C”, 2015).


“I think it is when the parents of the child do not take responsibility for their children and leave the children to do whatever they want. This makes the children go wayward and do stuff that are not acceptable in society” (Adolescent Respondent “E”, 2015).

Categories of child neglect

Under this theme all respondents mentioned or identified various acts of omissions and commissions that they believed constitute acts of neglect in their community. From their responses 5 main sub-themes or categorizations of child neglect were identified. They include:

**Physical neglect**: “Not thinking about the needs of the child; not providing shelter for the child; not giving the child enough food; not providing proper clothes for the child to wear; not providing appropriate sleeping place for the child”.

**Educational neglect**: “Not paying the child’s school fees; not buying books for the child; refusal to take the child to school; not caring about the child’s education; not caring about what the child does in school; not helping out with homework”.

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Supervisory neglect: “Not correcting the child when he/she is wrong; not monitoring the child’s movement; not caring the kinds of friends the child has; allowing the child to go out and come back at anytime they want; not protecting the child; leaving the child at home alone with house helps at infancy”.

Emotional neglect: “Not making time for the child; not showing the child tender love and care; not spending time and interacting with the child; not commenting on what the child does whether good or bad; denying the child of his/her psychological needs (love, warmth, emotional needs)”.

Medical neglect: “Not caring for the child’s medical needs; not taking the child to the hospital when sick; not providing medical care for the child”.

Most responses from respondents were directed towards physical neglect followed by educational neglect, supervisory neglect, emotional neglect and medical neglect. Below is a table of frequencies and percentages of the various categories.

Table 4: Summary of Frequencies and Percentages of Child Neglect Categories (N=16).

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Neglect</td>
<td>44</td>
<td>49</td>
</tr>
<tr>
<td>Educational Neglect</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Supervisory Neglect</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Emotional Neglect</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Medical Neglect</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

As can be identified, responses geared towards medical neglect were the least. Other concerns raised involved parents not teaching the children good moral values and not
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bringing them up in a good way. These views were raised by a teacher and a hairdresser as they passionately shared their knowledge and views on child neglect.

“We’ve talked about the moral aspect of it. I believe strongly that as you bring up a child the moral values should be included. The moral aspect is very important. For instance, how to train a child to respect and to be responsible. When I talk of the moral aspect, for instance your moral values, when you don’t bring up the child with that moral values it can also be termed as neglect” (Parent Respondent “A”, 2015).

“Also being able to take care of the child, in feeding, clothing and bringing up the child in a good way to grow up to be responsible” (Parent Respondent “C”, 2015).

These views on good moral values and good upbringing did not occur again in any of the transcripts.

Causes of child neglect

Under this theme, findings indicated that the most common cause of child neglect in the Ghanaian community were marital conflicts leading to divorce or separation and economic or financial hardships. Most respondents mentioned that children who found themselves living in homes with parental conflicts were at higher risks of being neglected as compared to children living in homes without conflicts. For instance some of the key informants mentioned that:

“Mostly what I have observed is that it normally comes under this broken home.”... So will you agree that just as you said the basic cause has to do with broken homes... most of them, because the cases we receive here, before you ask the child “where is your mother and they say am staying with my mother, where is your father, my father
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is somewhere”. Some of them don’t even know their father. Some of them too the woman just left them at a tender age with the father and the woman left. Before you ask the person doesn’t even know the mother, where the mother is or where she stays. It is mostly based on the broken homes” (Officer “A”, 2015).

“You see, the men think the children are not with me. Mostly the cases that come here are children not staying together with both parents…, more of broken homes… yes more of broken homes” (Officer “C”, 2015).

One parent respondent also mentioned significantly that;

“With the little knowledge I have, child neglect comes from so many ways, divorce that is when both parents are not together and one parent is taking care of the child sometimes there is neglect because the father will not do his part as a parent so in that way the child is being neglected by the father to the mother” (Parent Respondent “E”, 2015).

As mentioned above, economic and financial challenges were identified as one prominent cause of child neglect in the Ghanaian communities.

“The most prominent cause of child neglect is financial difficulties. Parents are not able to take care of themselves due to poverty so this pushes some parent to send their children out to sell and do other jobs to provide for the house” (Parent Respondent “B”, 2015).
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“Those that are very prominent these days are economic hardships. Because each and every day parents go and come, go and come because of money and they don’t seek the welfare of their children” (Parent Respondent “E”, 2015).

Other causes outlined by respondents included, unplanned pregnancies, children’s characteristics (bad attitudes, disobedience, not being respectful etc.) and presence of abuse in the home.

The understanding of child neglect among the Ghanaian sample studied as outlined earlier does not differ significantly from documented understandings over the years. The concept of child neglect is seen as a function of parental omissions and/or parental factors as identified by previous studies (Goldman et al., 2003; Hicks & Stain, 2013; Hornor, 2014; Thomas, 2013). To add, fathers or men were identified as the most perpetuators of child neglect in the population studied. Literature has identified that fathers indeed have a role to play in child maltreatment issues (child physical abuse, sexual abuse and child neglect) (Berger, 2000; Dubowitz, Black, Kerr, Starr & Harrington, 2000; Guterman & Lee, 2005; Lee, Bellamy & Guterman, 2009).

Considering the various aspects of child neglect that occurs among the population studied, physical neglect, educational neglect, emotional neglect, supervisory neglect and medical neglect were identified. These forms of neglect have been identified and categorized by other researchers in other places (Doak, 2007; Dubowitz, Pitts & Black, 2004; Erickson & Erickson, 2002; Jenny, 2007; LaMance, 2012; McGuigan & Pratt, 2001). Child neglect was identified as being caused predominantly by economic challenges and marital conflicts mostly leading to divorce or separation of parents.
Table 5: Summary of Key Qualitative Findings (N=16).

<table>
<thead>
<tr>
<th>Themes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of Child Neglect</td>
<td>• Inadequate or lack of care</td>
</tr>
<tr>
<td></td>
<td>• Denial of basic needs</td>
</tr>
<tr>
<td></td>
<td>• Not providing basic needs</td>
</tr>
<tr>
<td></td>
<td>• Abandonment of children</td>
</tr>
<tr>
<td>Categories of Child Neglect</td>
<td>• Physical neglect</td>
</tr>
<tr>
<td></td>
<td>• Educational neglect</td>
</tr>
<tr>
<td></td>
<td>• Supervisory neglect</td>
</tr>
<tr>
<td></td>
<td>• Emotional neglect</td>
</tr>
<tr>
<td></td>
<td>• Medical neglect</td>
</tr>
<tr>
<td>Causes of Child Neglect</td>
<td>• Marital conflicts leading to divorce or separation</td>
</tr>
<tr>
<td></td>
<td>• Economic or financial hardships.</td>
</tr>
</tbody>
</table>

**Questionnaire Development**

A new child neglect scale the Child Neglect Questionnaire (CNQ) was developed based on the responses provided by the interviewed respondents. The various acts of neglect identified by respondents were grouped into five (5) main categories (physical, emotional, educational, supervisory and medical neglect) based on the five main sub-themes identified in the analysis of data (See Appendix 3). After the responses were categorized various questions were developed under each of the five (5) main categories with the help of knowledge obtained from reviewed literature and acts of neglect identified for each category by the respondents (See Appendix 3). An initial pool of 35 questions was developed for the new scale with 8 physical neglect questions, 8 educational neglect questions, 9 supervisory neglect questions, 6
emotional neglect questions and 4 medical neglect questions. After review and revision of all 35 items, 30 final questions were compiled for piloting with 6 physical neglect questions, 8 educational neglect questions, 8 supervisory neglect questions, 5 emotional neglect questions and 3 medical neglect questions (See Appendix 3).

The questionnaire was developed with a five point likert scale with the range of 1 (strongly agree), 2 (agree), 3 (neither agree nor disagree), 4 (disagree) and 5 (strongly disagree). This scale was chosen in order to give respondents 5 possible responses to each question asked as the rate their personal experiences of child neglect. Scoring of the questionnaire required all positively worded items to be reversed scored (thus, items 9, 10, 13, 16, 18) with 1 (strongly disagree), 2 (disagree), 3 (neither agree nor disagree), 4 (agree) and 5 (strongly agree). The highest score that could be obtained on the scale was 150 and the lowest score was 30. Based on the direction of the scale, it is implied that a higher score on the scale shows less experience of neglect and a lower score on the scale shows more experience of neglect. Therefore, a higher score on the CNQ is better than a lower score.

After the pilot study was done, a reliability check revealed that item 8 of the CNQ had an item-total correlation of .069 indicating that it does not correlate well with the overall scale (Field, 2005). Item 8 was therefore removed to help increase and strengthen the questionnaire’s Alpha level from .832 to .836. This resulted in a final 29 item Child Neglect Questionnaire (CNQ).
CHAPTER FOUR

Quantitative Study: Effects of Child Neglect

Introduction

This chapter focuses on the quantitative aspect of the study. It examines the effects of child neglect on the adolescent’s psychological health and quality of life. It further assesses the reliability and validity of the newly developed Child Neglect Questionnaire. The chapter begins with a description of the population and sample used in the quantitative study. This is followed by the measures and procedures used in the data collection and results based on analyzed hypotheses.

Methodology

Participants

The participants for the quantitative part of the study comprised adolescents living in the Tema Metropolitan Assembly and Ashaiman Municipal District of the Greater Accra Region of Ghana. The convenient sampling technique was used in obtaining a total of 230 adolescent participants living in Tema and Ashaiman for the entire study. Thirty (30) of the 230 participants were enrolled for the pilot study and the remaining 200 were enrolled for the main data collection (See Table 6).

According to Streiner (1994), in order to obtain reliable result when considering the use of Principal Component Analysis (PCA), the minimal number of participants that will provide usable data for analysis should be larger than 100 participants and five times the number of variables being analyzed. As the present study sought to employ the use of PCA in the analysis of the new Child Neglect Questionnaire (CNQ), it was therefore necessary to use a sample size that was five times the number of variables being analyzed. The CNQ was made
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up of 29 items, therefore, the minimum sample size that was appropriate for the study was (five times twenty-nine; 5 X 29= 145) one hundred and forty-five (145). Thus, the proposed use of 200 participants was in the right direction to obtain reliable results. A response rate of 172 was obtained at the end of the data collection as some of the questionnaires were not returned and others were not adequately responded to and therefore had missing values rendering them not useful for the data analysis. Despite these challenges the adequate sample size needed was not compromised.

Of the 172 participants obtained for the study, 38% were males and 62% were females. Forty six percent (46%) were in Junior high school and 54% were in senior high school. The ages of the participants ranged from 12 years to 17 years (M= 14.6, SD= 2.04). Identifying the parental figure the participants lived with, it was identified that 79% lived with their biological mother or adoptive mother and 75% lived with their father or adoptive father. Four percent (4%) live with their step mother and 2% lived with their step fathers. Five percent (5%) lived with their grandmothers and 2% lived with their grandfathers. Seven percent (7%) lived with a known female relative and 5% lived with a known male relative. None of the participants lived with a foster mother but 2% lived with a foster father. Four percent (4%) lived with an unrelated female and 4% lived with an unrelated man. Finally, 1% of the participants did not have any female who was responsible for their upbringing and 9% did not have any male responsible for them. This means that these two groups lived in a single parent home with only a mother or only a father. Only 8% of the participants based on their self reports experienced child neglect and the remaining 92% did not experience child neglect. A summary of participant’s demographic characteristics can be found in Table 4 below.
Table 6: Demographic Characteristics of Quantitative Sample (N=172)

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Frequency</th>
<th>Percentages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>66</td>
<td>38</td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>62</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior high school</td>
<td>79</td>
<td>46</td>
</tr>
<tr>
<td>Senior high school</td>
<td>93</td>
<td>54</td>
</tr>
<tr>
<td><strong>Parent Figure Living With</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Figure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother or adoptive mother</td>
<td>135</td>
<td>79</td>
</tr>
<tr>
<td>Step mother</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Grandmother</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Other female relative I live with</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Foster mother</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unrelated woman I live with</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>There was no female responsible for me</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Father Figure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father or adoptive father</td>
<td>129</td>
<td>75</td>
</tr>
<tr>
<td>Step father</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Grandfather</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other male relative I live with</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Foster father</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Unrelated man I live with</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>There was no male responsible for me</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td><strong>Neglect Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglected</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>50</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>50</td>
</tr>
<tr>
<td>Not Neglected</td>
<td>158</td>
<td>92</td>
</tr>
<tr>
<td>Male</td>
<td>59</td>
<td>37</td>
</tr>
<tr>
<td>Female</td>
<td>99</td>
<td>63</td>
</tr>
<tr>
<td><strong>Parent/Guardian Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Primary</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>High school</td>
<td>77</td>
<td>45</td>
</tr>
<tr>
<td>Tertiary</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>Training college/Vocational</td>
<td>43</td>
<td>25</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Primary</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>High School</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>Tertiary</td>
<td>47</td>
<td>27</td>
</tr>
<tr>
<td>Training college/Vocational</td>
<td>42</td>
<td>24</td>
</tr>
</tbody>
</table>
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Inclusion/exclusion criteria

The adolescent participants were within the ages of 12 and 17 years of age, and provide informed assent to participate in the study. They also had the ability to read and write since the questionnaire was in English and demanded the ability to read and to understand. Informed consent was obtained from parents whose wards were recruited from home and teachers whose students were recruited from school.

Measures

A survey questionnaire was developed and used for the quantitative data collection process. The questionnaire was made up of the newly developed Child Neglect Questionnaire (CNQ), the Neglect Scale by Straus, Kinard and Williams (1997), the Children Depression Inventory (CDI) by Maria Kovacs (1992), the Multidimensional Anxiety Scale for Children (MASC) by John March and colleges (1997), the Rosenberg Self Esteem Scale by Rosenberg (1965) and the World Health Organization Quality of Life (WHOQOL)-BREF scale developed by WHO (2004).

Neglect. The Neglect scale developed by Straus et al. (1997) was used to establish the construct validity for the newly developed Child Neglect Questionnaire (CNQ). The scale measures the existence of child neglect in the life of an individual while growing up. It had twenty (20) items and was measured on a 4-point likert scale ranging from “1-stongly agree” to “4-strongly disagree”. Items 5, 7, 15 and 20 were reverse scored. Overall, total scores on the scale range from 32 to 68 with lower scores indicating very high experience of neglect and higher scores indicating very low experience of neglect. The scale had 4 sub-scales (Emotional needs, cognitive needs, supervisory and physical needs). Total scores on each subscale range from 8 to 17 with lower scores indicating very high experience of neglect on that subscale and higher scores indicating very low experience of neglect on that subscale.
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(Straus et al. 1997). A Cronbach alpha of .93 has been reported by the scale developers (Straus et al. 1997) and by Harrington, Zuravin, DePanfilis, Ting and Dubowitz, (2002).

**Psychological Health.** The Child Depression Inventory (CDI) measures depression in children between the ages of seven (7) and seventeen (17) years. It is made up of twenty-seven (27) items and measured on a three (3) point Likert scale ranging from “0 to 2”. The child or adolescent had to choose the statement that best described them. The scores on the entire test were summed up and plotted onto a profile form to obtain the child’s overall level of depression. Kovacs (1992) reported an internal consistency ranging from .71 to .89 for the scale and Ivarsson, Svalander and Lítlere (2006) reported an internal consistency of .86 for the entire scale.

The Multidimensional Anxiety Scale for Children (MASC) is a measure of anxiety among children and adolescents aged eight (8) to nineteen (19) years. It comprises thirty-nine (39) items and it is measured on a four (4) point Likert scale ranging from “0-Never true for me” to “3- Often true about me”. The scores on the entire test were summed up and plotted onto a profile form to obtain the child’s level of anxiety. An internal consistency of .85 has been reported by Ndetei et al. (2008) for the scale.

The Rosenberg Self-esteem scale is used to assess the self-esteem levels of individuals. The scale contains ten (10) items and is measured on a four (4) point Likert scale ranging from “0- strongly agree” to “3- strongly disagree”. Negatively worded items are reverse scored. Possible scores on the scale ranges from 0-30 with scores between 15 and 25 indicating a normal range of self-esteem and scores below 15 indicating low self-esteem. An internal consistency with an alpha coefficient of .83 has been reported by the scale developers. Also Farruggia, Chen, Greenberger, Dmitriexa and Macek (2004) reported an internal consistency with an alpha ranging from .83 to .88.
**Quality of Life.** Participant’s quality of life was assessed using the World Health Organization Quality of Life (WHOQOL)-BREF scale developed by WHO (2004). The scale measures the overall quality of life of individuals. It contained 26 items measured on a five (5) point likert scale ranging from “1-very poor” to “5-very good”. The scale measures four domains of an individual’s life: Physical health, Psychological health, Social relationships and the Environment. Higher transformed scores for each domain indicates higher perceived quality of life for that domain and lower transformed scores indicates lower perceived quality of life. An internal consistency of .82, .81, .80 and .68 has been reported for the domains of physical health, psychological, environment and social relationships respectively (Skevington, Lotfy & O’Connell, 2004).

**Pilot Study**

In order to verify the applicability of the scales used in the study, a pilot study was conducted before the main data collection was done. This was done to help clarify instructions, and to establish the procedures and parameters to be used in the main data collection and to determine the reliability and validity of the scales (Teijlingen van, Rennie, Hundley & Graham, 2001).

For the pilot study, all the scales to be used were put together into one questionnaire. The questionnaires were administered to 30 conveniently sampled adolescents aged 12 to 17 years and lived in Tema and Ashaiman the target setting for the study. The participants during the data collection process complained of the volume of the questionnaire and mentioned the difficulty in understanding some wording of items on some of the scale. For example, on the Neglect Scale item 13, “My parents did not care if I did things like shoplifting”, participants found it difficult understanding the word shoplifting. Reliability analysis conducted for all the
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scales showed that they have acceptable alpha values. Below is a summary of the scales, number of items on each and the corresponding reliability values.

Table 7: Summary of the Scales and Alpha Values (N=172)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of items</th>
<th>Alpha value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect Scale</td>
<td>20</td>
<td>.77</td>
</tr>
<tr>
<td>Child Depression Inventory</td>
<td>27</td>
<td>.75</td>
</tr>
<tr>
<td>Multidimensional Anxiety Scale For Children</td>
<td>39</td>
<td>.82</td>
</tr>
<tr>
<td>Child Neglect Questionnaire</td>
<td>29</td>
<td>.84</td>
</tr>
<tr>
<td>Rosenberg Self Esteem Scale</td>
<td>10</td>
<td>.79</td>
</tr>
<tr>
<td>World Health Organization Quality of Life (WHOQOL)-BREF scale</td>
<td>26</td>
<td>.91</td>
</tr>
</tbody>
</table>

Procedure

After ethical clearance was sought from the ethics committee for the humanities, University of Ghana and all process for the qualitative data collection and analysis was done, the Child Neglect Questionnaire (CNQ) was developed. The scale had a total of 30 items with 5 subscales. All other measures to be used in the study including the CNQ were compiled into a single questionnaire for a pilot study. The pilot study was done to establish the reliability of the scales to be used in the study.

Thirty (30) adolescents were conveniently sampled and enrolled for the pilot study. Each participant was briefed about the study and its significance and was taken through various ethical considerations. They were informed on their rights to participate or to decline participation without any penalty and were also assured of confidentiality of information they
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provided in the questionnaire. Each participant filled and signed an informed consent form before the questionnaire was given out to them. Finally, the researcher’s contact details, that is, name, email address and phone number was provided on the consent form so that participants could contact her in case they wanted to seek clarification or wanted any additional information on the study.

The entire data obtained during the pilot study were compiled and analyzed with the help of the Statistical Package for Social Sciences (SPSS) software. Reliability analyses conducted showed that all the scales (Neglect Scale, CDI, MASC, CNQ, WHOQOL-BREF and Rosenberg Self-Esteem Scale) used had high Cronbach Alpha’s. After analysis had been done for the pilot study and results of reliability had been obtained, the final questionnaire was compiled and administered to 200 conveniently sampled adolescents. Each participant was then given a period of about 1 hour to answer the questions. After the data obtained was compiled a response rate of 172 was realized for the entire data collection. Therefore a total sample data of 172 was analyzed for the study.

Statistical Analysis

The statistical package for the social sciences SPSS was used for the analysis of quantitative data. Preliminary analysis was done by computing the descriptive statistics for the demographic data. The Multivariate One-Way Analysis of Variance (MANOVA) was used for the analyses of hypotheses 1 and 2. The Pearson’s product-moment correlation test was used for the analysis of hypothesis 3, 4 and 5.
Results

Preliminary analysis made up of descriptive statistics and frequencies were conducted for participant’s demographic data (age, sex, education, parent/guardian participant lives with and parent/guardian education). Results of the descriptive statistics and frequencies have been summarized in Table 6. Also reliability analysis was conducted for all the scales used in the study and the alpha values obtained ranged from .75 to .91 (See Table 7). Below is the summary of statistics (mean, standard deviation, skewness, kurtosis and alpha values) for participant’s responses on the scales.

Table 8: Descriptive Statistics and Reliability Indices of Scales (N =172)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect Scale</td>
<td>60.98</td>
<td>8.647</td>
<td>-.904</td>
<td>2.030</td>
<td>.77</td>
</tr>
<tr>
<td>Child Depression Inventory</td>
<td>10.67</td>
<td>6.325</td>
<td>.622</td>
<td>-.088</td>
<td>.75</td>
</tr>
<tr>
<td>Multi Dimensional Anxiety Scale for Children</td>
<td>47.16</td>
<td>16.179</td>
<td>-.066</td>
<td>-.346</td>
<td>.82</td>
</tr>
<tr>
<td>Child Neglect Questionnaire (WHOQOL) - BREF</td>
<td>108.22</td>
<td>13.599</td>
<td>-.487</td>
<td>-.129</td>
<td>.84</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>19.60</td>
<td>4.182</td>
<td>-.240</td>
<td>-.286</td>
<td>.79</td>
</tr>
</tbody>
</table>
Testing of Hypotheses

Relationship between child neglect, psychological health and quality of life.

It was hypothesized that a relationship exists between child neglect, adolescent psychological health and quality of life. In that child neglect will affect the adolescent’s psychological health and quality of life negatively. Below is a summary of correlation analysis;

Table 9: Summary of Person’s correlation between Child neglect, Psychological health and Quality of life (N= 172).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CNQ</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Dep</td>
<td>-.240**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Anx</td>
<td>-.037</td>
<td>.080</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Self-Es</td>
<td>.222**</td>
<td>-.236**</td>
<td>-.089</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Phys H.</td>
<td>.212**</td>
<td>-.288**</td>
<td>-.090</td>
<td>.187*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Psych H.</td>
<td>.222**</td>
<td>-.253**</td>
<td>-.066</td>
<td>.289**</td>
<td>.475**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Soc rel.</td>
<td>.166*</td>
<td>-.332**</td>
<td>-.038</td>
<td>.171*</td>
<td>.383**</td>
<td>.417**</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Env</td>
<td>.260**</td>
<td>-.385**</td>
<td>-.148</td>
<td>.135*</td>
<td>.567**</td>
<td>.543**</td>
<td>.480**</td>
</tr>
<tr>
<td>9</td>
<td>QOL</td>
<td>.295**</td>
<td>-.537**</td>
<td>-.152</td>
<td>.292**</td>
<td>.634**</td>
<td>.694**</td>
<td>.626**</td>
</tr>
</tbody>
</table>

**p = .01, *p = .05 Note; CNQ= Child Neglect Questionnaire, Dep= Depression, Anx= Anxiety, Self-Es= Self-esteem, Phys H.= Physical health, Psych H.= Psychological health, Soc. Rel.= Social Relationship, Env= Environment, QOL= Quality of Life.

From the above Table (9), the results obtained showed that there was a significant relationship between all the variables measured (Child neglect, psychological health and quality of life) except for anxiety which did not correlate with any of the variables. Investigating the relationship between child neglect and psychological health, a negative
significant relationship was found between child neglect and depression \( r = -.240, p < .01 \) and a positive significant relationship was obtained between child neglect and self-esteem \( r = .222, p < .01 \). This revealed that adolescents who obtained higher scores on the CNQ which signifies no/low experience of child neglect showed low depression and high self-esteem levels. Adolescents who obtained low scores on the CNQ signifying high experience of child neglect on the other hand, showed high depression and low self-esteem. Interestingly child neglect did not correlate with anxiety, implying that the experience of child neglect did not have any significant effect on the adolescents’ anxiety levels.

The correlation obtained between child neglect and the total quality of life of the adolescents showed a positive significant relationship \( r = .295, p < .01 \) which indicated that adolescents who experienced no/low levels of child neglect showed higher quality of life compared to those who experienced high levels of child neglect. Child neglect was further correlated with specific aspect of the adolescents’ quality of life. Results showed that, a significant positive relationship existed between child neglect and all the QOL domains [physical health \( r = .212, p < .01 \), psychological health \( r = .222, p < .01 \), social relationships \( r = .166, p < .05 \) and environment \( r = .260, p < .01 \)]. The results obtained implied that adolescents who experienced no/low levels of child neglect showed high levels of physical health, psychological health, social relationships and environmental adjustments. On the other hand adolescents who experienced high levels of child neglect had poor physical health, psychological health, social relationships and environmental adjustments.

Furthermore, a relationship was observed between the psychological health and the quality of life of the adolescents. A negative significant relationship was found between the depression levels and quality of life of the adolescents [total QOL \( r = -.537, p < .01 \), physical health \( r = -.288, p < .01 \), psychological health \( r = -.253, p < .01 \), social relationships \( r = -.332, p < .01 \), environment \( r = -.385, p < .01 \)]. This indicated that adolescents who experienced low
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depression levels showed high physical health, psychological health, social relationships, environmental adjustments and overall quality of life. On the other hand adolescents who experienced high depression levels showed poor physical health, psychological health, social relationships, environmental adjustments and overall quality of life. A positive significant relationship was found between the adolescents self-esteem and quality of life [total QOL ($r = .292, p < .01$), physical health ($r = .187, p < .05$), psychological health ($r = .289, p < .01$), social relationships ($r = .171, p < .05$), environment ($r = .135, p < .05$)]. This indicated that adolescents who had high self-esteem showed high physical health, psychological health, social relationships, environmental adjustments and overall quality of life while adolescents who had low self-esteem showed poor physical health, psychological health, social relationships, environmental adjustments and overall quality of life.

Although anxiety showed no relationship with child neglect, it showed a negative significant relationship when it was correlated with overall quality of life ($r = -.152, p < .05$). Specifically, anxiety showed a relationship with the environmental adjustment domain of quality of life ($r = -.148, p < .05$) but did not show any relationship with the other domains of quality of life. This indicated the adolescents’ anxiety levels only impacted their environmental adjustment and as such adolescents who had high anxiety levels showed poor environmental adjustment and those who had low anxiety levels showed high environmental adjustments.

From the above results the hypotheses that there will be a negative relationship between child neglect and psychological health and quality of life were supported.

Gender differences in the effects of child neglect.

It was expected that there will be gender differences in relation to the effects of child neglect on the adolescents’ psychological health and quality of life. A Multivariate Analysis of
Child Neglect and Psychological Wellbeing

Variance (MANOVA) was therefore used to test the expected differences. Below is the summary of results.

<table>
<thead>
<tr>
<th>Construct</th>
<th>Male (n= 66)</th>
<th>Female (n= 106)</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
<th>F</th>
<th>df1</th>
<th>df2</th>
<th>P</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNQ</td>
<td>1.89</td>
<td>1.93</td>
<td>.31</td>
<td>.25</td>
<td>.87</td>
<td>1</td>
<td>170</td>
<td>.35</td>
<td>.005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>48.42</td>
<td>52.17</td>
<td>7.93</td>
<td>10.10</td>
<td>6.55</td>
<td>1</td>
<td>170</td>
<td>.011</td>
<td>.037</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>49.35</td>
<td>52.82</td>
<td>11.53</td>
<td>10.62</td>
<td>4.07</td>
<td>1</td>
<td>170</td>
<td>.045</td>
<td>.023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>19.12</td>
<td>19.91</td>
<td>3.78</td>
<td>4.41</td>
<td>1.44</td>
<td>1</td>
<td>170</td>
<td>.233</td>
<td>.008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health</td>
<td>64.47</td>
<td>64.61</td>
<td>12.12</td>
<td>12.41</td>
<td>.01</td>
<td>1</td>
<td>170</td>
<td>.941</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological health</td>
<td>64.38</td>
<td>63.87</td>
<td>13.88</td>
<td>15.06</td>
<td>.05</td>
<td>1</td>
<td>170</td>
<td>.824</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social relationships</td>
<td>70.23</td>
<td>69.57</td>
<td>18.35</td>
<td>19.17</td>
<td>.05</td>
<td>1</td>
<td>170</td>
<td>.823</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>69.15</td>
<td>67.81</td>
<td>15.35</td>
<td>17.70</td>
<td>.26</td>
<td>1</td>
<td>170</td>
<td>.612</td>
<td>.002</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$p < .007$, Note: $M =$ mean; $SD =$ standard deviation; $df1 =$ degree of freedom (hypothesis); $df2 =$ degree of freedom (error)

The above MANOVA summary report in Table 10 indicated a statistically significant difference between males and females on the effects of child neglect on adolescents: $F (7, 164) = 2.15, p = .041$; Wilks’ Lambda = .92; partial $\eta^2 = .084$. All assumptions for the use of MANOVA were confirmed. In order to reduce the chance of making a Type 1 error, a Bonferroni adjustment was used to set a higher alpha level (Tabachnick & Fidell, 2007). Dividing the original alpha level of .05 by the total number of variables being analyzed, a new alpha level of .007 was obtained (Pallant, 2007). Thus, only a $p$ value less than .007 will be considered as statistically significant. When the effects of child neglect on the psychological health and quality of life of the adolescents were considered separately, it was noted that adolescent males and females did not differ significantly on any of the variables.
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considered. The hypothesis that gender differences will exist in the effects of child neglect on adolescents’ psychological health and quality of life was not supported.

Comparison of neglected and non-neglect adolescents.

The adolescents’ demographic data and scores on the CNQ obtained indicated that only 14 of the 172 participant’s scores fell in the range of child neglect. Judging from the sample size for the two comparison groups, that is, neglected adolescents (N= 14) and adolescent not neglected (N= 158) it can be identified that the disparity between the two groups will be great. This could affect the true reflection of the effects of child neglect on the two groups. Based on the above observation a sample of 14 adolescents whose scores fell out of the range of child neglect were drawn from the larger sample of 158 adolescents not neglected. The 14 non-neglected adolescents were matched to the 14 neglected adolescents on age and educational level. Below is the summary of findings from the matched sample;

Table 11: Summary of Multivariate Analysis for Matched Sample (N=28)

<table>
<thead>
<tr>
<th>Construct</th>
<th>Neglected (n= 14)</th>
<th>Not Neglected (n= 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Depression</td>
<td>58.36</td>
<td>10.10</td>
</tr>
<tr>
<td>Anxiety</td>
<td>52.86</td>
<td>10.15</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>16.50</td>
<td>3.63</td>
</tr>
<tr>
<td>Physical health</td>
<td>55.86</td>
<td>17.23</td>
</tr>
<tr>
<td>Psychological relationship</td>
<td>53.21</td>
<td>18.17</td>
</tr>
<tr>
<td>Social relationship</td>
<td>59.36</td>
<td>18.45</td>
</tr>
<tr>
<td>Environment</td>
<td>53.71</td>
<td>18.94</td>
</tr>
</tbody>
</table>

\( p < .05, \) Note: \( M = \) mean; \( SD = \) standard deviation; \( df1 = \) degree of freedom (hypothesis); \( df2 = \) degree of freedom (error)
Child Neglect and Psychological Wellbeing

The MANOVA results for the matched sample as summarized in Table 11 above shows a statistically significant difference in the psychological health of neglected adolescents and that of adolescents who do not experience neglect: $F (3, 24) = 7.87, \ p = .001$; Wilks’ Lambda = .50; partial $\eta^2 = .496$. Considering the three main components of psychological health, a statistically significant difference still existed between the level of depression and self-esteem of adolescents experiencing neglect and those not experiencing neglect. Adolescents who experienced neglect obtained higher mean scores on depression ($M = 58.36$, $SD = 10.10$) compared to adolescents who did not experience neglect [(($M = 47.79$, $SD = 9.40$); $F (1, 26) = 9.40, \ p = .005$, partial $\eta^2 = .266$]. They again obtained lower mean scores on self-esteem ($M = 16.50$, $SD = 3.63$) compared to adolescents who did not experience neglect [(($M = 20.57$, $SD = 2.82$); $F (1, 26) = 10.97, \ p = .003$, partial $\eta^2 = .297$]. This indicates that adolescents who experience neglect have higher levels of depression and low self-esteem levels compared to adolescents who do not experience neglect.

The two groups did not show any significant difference in their anxiety levels even though a matched sample was used. A comparison of means however showed that adolescents who experienced neglect had slightly higher mean scores ($M = 52.86$, $SD = 10.15$) compared to adolescents who did not experience neglect ($M = 50.14$, $SD = 12.01$).

Assessing the effect of child neglect on the quality of life of adolescents using the matched sample revealed that adolescents who did not experience neglect consistently obtained higher mean scores on the quality of life measure as compared to those who experienced child neglect. The MANOVA results obtained indicates that statistically significant difference exist between the quality of life of neglected adolescents and their matched controls: $F (4, 23) = 3.89, \ p = .015$; Pillai’s Trace = .404; partial $\eta^2 = .404$. The results indicated that adolescents experiencing neglect and those not experiencing neglect differed statistically on all the
components of quality of life. Specifically, neglected adolescents reported poorer physical health \((M = 55.86, SD = 17.32)\) compared to adolescents not neglected \((M = 68.93, SD = 11.66)\); \(F (1, 26) = 5.49, p = .027, \text{partial } \eta^2 = .174\). They also obtained lower scores in the psychological domain of quality of life \((M = 53.21, SD = 18.17)\) than adolescents who did not experience neglect \((M = 65.36, SD = 10.43)\); \(F (1, 26) = 4.70, p = .039, \text{partial } \eta^2 = .15\).

The neglected adolescents obtained lower scores on the environmental domain of quality of life \((M = 53.71, SD = 18.94)\) compared to adolescents not neglected \((M = 72.07, SD = 17.71)\); \(F (1, 26) = 7.02, p = .014, \text{partial } \eta^2 = .212\). They also obtained lower mean scores on the social relationship domain of quality of life \((M= 59.36, SD= 18.45)\) compared to adolescents not neglected \((M= 81.29, SD= 11.21)\); \(F (1, 26) = 14.45, p = .001, \text{partial } \eta^2 = .357\). This indicates that neglected adolescents have significant problems with their physical health, and psychological state. They further show problems with social relationships and environmental adjustments. The hypothesis that adolescents who experience neglect will have poorer quality of life compared to adolescents who have not experienced neglect was therefore supported when matched samples were used.

**Validation of CNQ**

As stated in chapter three (pg. 42), a 29-item child neglect measure named the Child Neglect Questionnaire (CNQ) was developed from the responses obtained from the interviewed participants. The CNQ was administered to the study participants together with the Neglect Scale to assess their experience of child neglect at home and to help validate the CNQ. Three hypotheses were therefore developed to help validate the CNQ. The first hypothesis (Hypothesis 3) stated that there will be a positive correlation between the new Child Neglect Questionnaire (CNQ) and the Neglect Scale (NS). Below is the summary table for the first hypothesis.
Table 12: Summary of Pearson’s Correlation Coefficient between the new and old child neglect scales and their subscales (N=172).

<table>
<thead>
<tr>
<th></th>
<th>CNQ (Physical)</th>
<th>CNQ (Educational)</th>
<th>CNQ (Medical)</th>
<th>CNQ (Supervisory)</th>
<th>CNQ (Emotional)</th>
<th>Total CNQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>NS - Emotional</td>
<td>.127*</td>
<td>.015</td>
<td>.164*</td>
<td>.281**</td>
<td>.459**</td>
<td>.314**</td>
</tr>
<tr>
<td>NS - Cognitive</td>
<td>-.030</td>
<td>-.016</td>
<td>.019</td>
<td>.149*</td>
<td>.265**</td>
<td>.133*</td>
</tr>
<tr>
<td>NS - Supervisory</td>
<td>.143*</td>
<td>.029</td>
<td>.014</td>
<td>.214**</td>
<td>.218**</td>
<td>.195**</td>
</tr>
<tr>
<td>NS - Physical</td>
<td>.078</td>
<td>.032</td>
<td>.145*</td>
<td>.203**</td>
<td>.307**</td>
<td>.225**</td>
</tr>
<tr>
<td>Total NS</td>
<td>.103</td>
<td>.018</td>
<td>.120</td>
<td>.286**</td>
<td>.430**</td>
<td>.295**</td>
</tr>
</tbody>
</table>

**p < .01; *p < .05  Note: NS=Neglect Scale; CNQ=Child Neglect Questionnaire.

From the above table, the results indicated a positive significant correlation existing between the CNQ and the NS ($r = .295$, $p < .01$). The results further showed that there was a significant positive correlation between the physical neglect Subscale of the CNQ and the emotional neglect ($r = .127$, $p < .05$) and the supervisory neglect ($r = .143$, $p < .05$) subscales of the NS. There was also a significant positive correlation between the medical neglect subscale of the CNQ and the emotional neglect ($r = .164$, $p < .05$) and the physical neglect ($r = .145$, $p < .05$) subscales of the NS. The supervisory neglect subscale of the CNQ correlated positively and significantly with all the subscales of the NS; emotional neglect ($r = .281$, $p < .01$), cognitive neglect ($r = .149$, $p < .05$), supervisory neglect ($r = .214$, $p < .01$), and physical neglect ($r = .203$, $p < .01$). Finally the emotional neglect subscale of the CNQ also correlated positively and significantly with all the subscales of the NS; emotional neglect ($r = .459$, $p < .01$), cognitive neglect ($r = .265$, $p < .01$), supervisory neglect ($r = .218$, $p < .01$) and physical neglect ($r = .307$, $p < .01$).
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Contrary to the above the physical neglect subscale of the CNQ did not correlate with the cognitive neglect ($r = -.030$) and the physical neglect ($r = .078$) subscales of the NS. Also the medical neglect subscale of the CNQ did not correlate significantly with the cognitive neglect ($r = .019$) and the supervisory neglect ($r = .014$) subscales of the NS. The educational neglect subscale of the CNQ did not correlate with any of the subscales on the NS. This can be attributed to the fact that the NS did not include items specifically addressing educational neglect which the CNQ did. On the whole the subscales of the two neglect scales correlated at a point showing that the hypothesis stating that “there will be a positive correlation between the new Child Neglect Questionnaire (CNQ) and the Neglect Scale was supported.

The second hypothesis (Hypothesis 4) stated that there will be a negative correlation between the Child Neglect Questionnaire (CNQ) and the Multidimensional Anxiety Scale for Children (MASC) and the Children’s Depression Inventory (CDI). Result for the second and third hypotheses is summarized below.

Table 13: Summary of Person’s Correlation between the CNQ, MASC, CDI and WHOQOL-BREF (N=172).

<table>
<thead>
<tr>
<th></th>
<th>CNQ</th>
<th>MASC</th>
<th>CDI</th>
<th>WHOQOL-BREF</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNQ</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MASC</td>
<td>.045</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDI</td>
<td>-.298**</td>
<td>.119</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>WHOQOL-BREF</td>
<td>.436**</td>
<td>-.165*</td>
<td>-.541**</td>
<td>-</td>
</tr>
</tbody>
</table>

**$p = .01$, *$p = .05$ Note; CNQ = Child Neglect Questionnaire; MASC = Multidimensional Anxiety Scale for children; CDI = Children’s Depression Inventory and the WHOQOL-BREF = World Health Organization Quality of Life scale.

From the above Table (13) the results obtained indicated that the CNQ correlated negatively but significantly with the Children’s Depression Inventory (CDI) ($r = -.298$, $p < .01$) but did not correlate with the MASC ($r = .045$). Therefore, higher scores on the CNQ resulted in
lower scores on the CDI and lower scores on the CNQ resulted in higher scores on the CDI. This means that adolescents who experienced lower levels of child neglect reported lower depression levels and those who experienced higher levels of child neglect reported higher levels of depression but this relationship was not observed in relation to the adolescents Anxiety levels. The above hypothesis was therefore partially supported.

The third hypothesis (Hypothesis 5) stated that there will be a positive correlation between the Child Neglect Questionnaire (CNQ) and the World Health Organization Quality of Life (WHOQOL)-BREF scale.

Results from table (13) showed that the CNQ correlated positively and significantly with the WHOQOL-BREF scale \((r = .436, p < .01)\). This indicates that higher scores on the CNQ resulted in higher scores on the WHOQOL-BREF scale and lower scores on the CNQ resulted in lower scores on the WHOQOL-BREF. This means that adolescents who experienced lower levels of child neglect reported higher quality of life and those who experienced higher levels of child neglect reported lower levels of quality of life. The above hypothesis was therefore supported.

Additionally, it was noted from the results that the WHOQOL-BREF negatively correlated with the MASC \((r = -.165, p < .05)\) and the CDI \((r = -.541, p < .01)\) but the MASC and the CDI did not correlate with each other \((r = .119)\). This implies that higher scores on the WHOQOL-BREF resulted in lower scores on the MASC and the CDI. This means that adolescent who had higher quality of life reported lower anxiety and depression levels and those who had lower quality of life reported higher levels of anxiety and depression.
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Principal Component Analysis

The Child Neglect Questionnaire that was developed was subjected to factor analysis specifically principal component analysis to identify the factors that make up the scale and the various items of the scale that load onto these factors.

29 items of the Child Neglect Questionnaire were subjected to Principal Component Analysis (PCA). To ensure that the data obtained by the scale was suitable for a factor analysis, the correlation matrix of the entire scale revealed that there were many coefficients of .3 and above thus satisfying the criteria for conducting a factor analysis. Also the Kaiser-Meyer-Okin (KMO) value was .83 which is higher than the recommended value of .6 by Kaiser (1974). The Barlett’s Test of Sphericity was also statistically significant (.000) showing that the data obtained by the scale was suitable for factor analysis.

The PCA showed that there were 8 components of the scale which had eigenvalues exceeding 1. Therefore, the analysis generated 8 factors to be analyzed. The screeplot generated showed a clear break after the second component. Even though some breaks can be seen between the third and forth components only the first two components show visibly a clear break. From the initial Component Matrix table, 15 items loaded onto Factor 1 (Items 6, 7, 8, 12, 14, 17, 19, 22, 23, 24, 25, 26, 27, 28 and 29), 3 items loaded onto Factor 2 (Items 10, 13 and 16), 2 items loaded onto Factor 4 (Items 2 and 4) and only 1 item each loaded onto Factors 3 and 5 (Items 15 and 5 respectively). Items 1, 3, 9, 11, 18, 20 and 21 did not load onto any factor. It can be identified that majority of items loaded onto component 1 and 2 at .5 and above (> .5), thus the decision to retain the first two components (See Appendix 6). According to Stevens (2002), the significance of a factor loading depends on the sample size being used. Stevens (2002) recommended that for a sample size of 200 a factor loading greater that 0.364 should be considered as significant. Thus for larger sample sizes smaller factor loadings could be considered as significant and for smaller sample sizes larger factor loadings should be
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considered as significant. Despite this criterion Stevens (2002) further argued that to obtain factor loadings which explain much variance in the variable, loadings greater than 0.4 should be considered. Based on these recommendations, a much higher factor loading of 0.5 was chosen as the cut-off point for this study.

To aid in interpretation of the two components retained, a Direct Oblimin Rotation was done. After rotation was done the factor loadings increased and items 8 and 14 were dropped because their factor loadings fell below .5 (.440 and .429 respectively). The final two factors obtained explained a total of 44.15% of variance; with Component 1 (Negligence) contributing 34.79% and Component 2 (Care) contributing 9.36%.

After the principal component analysis was done, 13 items out of 29 loaded onto factor 1 and 3 items loaded onto factor 2 leaving out 13 items (See Table 14). The factors extracted were labelled Negligence and Care for factors 1 and 2 respectively. Examples of items under negligence are; “My parents/guardians do not care about what I do outside the home” and “My parents/guardians do not care if I stay out of school without permission”. Items that loaded on this factor yielded a good internal consistency with a Cronbach’s Alpha of .89. Examples of items on care includes; “My parents/guardians take time off to care for me when I am sick.” and “My parents/guardians usually want to know what went on in school each day”. Items on this factor also yielded a good internal consistency with a Cronbach’s Alpha of .62.
Child Neglect and Psychological Wellbeing

Table 15: Factor Analysis for Child Neglect Questionnaire

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Content</th>
<th>Item Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor I: Negligence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>My parents/guardians do not care if I went to school or not.</td>
<td>.53</td>
</tr>
<tr>
<td>7</td>
<td>My parents/guardians do not provide proper clothes for me to wear.</td>
<td>.56</td>
</tr>
<tr>
<td>12</td>
<td>My parents/guardians do not care about what I do outside the home.</td>
<td>.65</td>
</tr>
<tr>
<td>17</td>
<td>My parents/guardians do not correct me when I do something wrong.</td>
<td>.53</td>
</tr>
<tr>
<td>19</td>
<td>My parents/guardians do not care if I stay out of school without permission.</td>
<td>.63</td>
</tr>
<tr>
<td>22</td>
<td>My parents/guardians do not care if I get into trouble.</td>
<td>.64</td>
</tr>
<tr>
<td>23</td>
<td>My parents/guardians do not care about where I go.</td>
<td>.79</td>
</tr>
<tr>
<td>24</td>
<td>My parents/guardians do not show me love.</td>
<td>.65</td>
</tr>
<tr>
<td>25</td>
<td>My parents/guardians hardly interact with me.</td>
<td>.65</td>
</tr>
<tr>
<td>26</td>
<td>My parents/guardians do not encourage me.</td>
<td>.66</td>
</tr>
<tr>
<td>27</td>
<td>My parents/guardians do not praise me when I do well in school.</td>
<td>.56</td>
</tr>
<tr>
<td>28</td>
<td>My parents/guardians do not take me to the hospital when I am sick.</td>
<td>.63</td>
</tr>
<tr>
<td>29</td>
<td>My parents/guardians do not ensure I take my drugs when I am sick.</td>
<td>.71</td>
</tr>
</tbody>
</table>

Table 16: Factor Analysis for Child Neglect Questionnaire

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Content</th>
<th>Item Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor II: Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>My parents/guardians take time off to care for me when I am sick.</td>
<td>.68</td>
</tr>
<tr>
<td>13</td>
<td>My parents/guardians always buy me books I need for school.</td>
<td>.74</td>
</tr>
<tr>
<td>16</td>
<td>My parents/guardians usually want to know what went on in school each day.</td>
<td>.69</td>
</tr>
</tbody>
</table>
Child Neglect and Psychological Wellbeing

After conducting the PCA, two main components were obtained from the developed CNQ. The components obtained were the components of negligence and care respectively. The CNQ was therefore reduced from a 29 item questionnaire to a 16 item questionnaire with a Cronbach’s Alpha of .87. The Cronbach’s Alpha obtained for the 16 item CNQ was higher than that of the 29 item CNQ. This implies that using the 16 item CNQ will yield more reliable results that the 29 item CNQ.
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Observed Model

From Figure 2, after the analysis of data was done it was noted that child neglect significantly affected the depression, self-esteem and quality of life of adolescents. Specifically child neglect indicated high depression levels and low self-esteem and quality of life. A significant relationship was also found between adolescent’s psychological health and quality of life. Specifically high depression levels and low self-esteem levels indicated low quality of life. Anxiety only related with the environmental adjustment domain of quality of life such that high anxiety levels indicated poor environmental adjustment and low anxiety levels indicated good environmental adjustment.
CHAPTER FIVE

Discussion

Introduction

The main focus of the present study was to explore the understanding of child neglect from the Ghanaians viewpoint and to identify how child neglect presents in our Ghanaian communities. It also sought to assess the effect of child neglect on the psychological health and quality of life of adolescents. Furthermore, a culture specific questionnaire was developed for the measurement and screening of child neglect situations among adolescents based on the qualitative responses obtained from the one-on-one interviews. A mixed method design was therefore used to help achieve these goals.

Discussion of Qualitative Findings

The introduction of the study sheds light on diverse definitions of child neglect given by various researchers based on the setting of their study and the population they studied (Dubowitz, 2007; Erickson & Egeland, 2011; Mennen et al., 2010). The main aim of the study was to explore the understanding of the concept of child neglect from the Ghanaians viewpoint. Findings from participant’s interviews revealed that the basic idea people have about child neglect is the inability or refusal of parents or guardians to provide the necessary or adequate need or care or both for their children. This finding is consistent with the findings of other researchers who have tried to understand the concept of child neglect from the perspectives of their target populations (Dubowitz, 2007; McSherry, 2007). For example, Hornor (2014) after trying to define child neglect in the United States mentioned that child neglect basically involves acts of omissions by caregivers and parents and is repeated
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Specific to the sample studied, the issues of lack of care, irresponsibility of parents, denial of basic needs and abandonment were the main key issues that persistently came up as participants were being interviewed. It was also identified that child neglect in the Ghanaian community is mostly seen as the crime of fathers especially when it happened in homes with various parental conflicts. As made clear by the DOVVSU officials most cases they received in their units were of mothers or children reporting the fathers for shirking their responsibilities. Due to the high numbers of fathers being reported for neglecting their children most mothers get away with neglecting their children.

Consistent with this finding is the work of Dubowitz, Black, Kerr, Starr and Harrington (2000) as they tried to examine the relationship that exist between father involvement and child neglect in the United States of America. They obtained a neglect rate of 11% to 30% associated with fathers. Their finding revealed that the father’s absence from the home alone was not associated with and did not significantly influence child neglect. Rather it was the nature of the father’s involvement in the home that did influence child neglect, in that, fathers who felt more effective at home were less likely to neglect their children. Therefore it can be deduced that various social (poverty, unemployment, underemployment), psychological (substance abuse, low self-worth, high levels of distress) and family dynamics (divorce, marital issues) all contribute to increasing the odds of fathers neglecting their children (Dubowitz & Black, et al., 2000; Wilcox & Dew, 2008). Linking this to the findings from the sample studied, most cases that were reported to the DOVVSU units were evidently from broke and disorganized homes where there were constant conflicts between the mother and
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father of the child involved. This therefore explains the high rates of child neglect in such homes.

Exploring how child neglect presents in the Ghanaian community, five (5) main key areas were of major concern to the respondents. These five areas cover the child’s physical needs (includes need for food, clothing, appropriate sleeping place, being left at home alone or with house helps among others); educational needs (includes paying of school fees, buying educational materials, enrolment in school among others); emotional needs (includes spending time together, showing love to the child, interacting with the child among others); medical needs (includes taking the child to the hospital when need be, taking time off to care for the child when sick among others) and supervisory role of parents (includes caring about what the child does, monitoring of child’s movements, paying attention to the kinds of friends the child keeps among others). It can therefore be deduced that these five areas are the most common areas Ghanaian parents or guardians usually ignore or neglect in relation to children in their care. These five areas have also been identified among others consistently in research as basic areas of need that tends to be neglected by parents (Doak, 2007; Dubowitz, Pitts & Black, 2004; Straus, Kinard & Williams, 1997). Of all the above named areas of neglect, physical, educational and supervisory neglect were identified as the most prominent types of neglect that occurs within the sample that was studied.

Findings on the cause of neglect in the Ghanaian population revealed that marital conflicts leading to divorce or separation and economic or financial hardships were the main factors that influence child neglect. This implies that children who find themselves in homes with consistent conflicts and in homes with high levels of financial or economic hardships are at higher risks of being neglected at one point or another in their life as children. As explained by Dubowitz et al. (2000) the presence of these factors among others influences the presence
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of neglect in various families. Other researchers have also identified specifically poverty and unemployment as having a strong correlation with child neglect (Goldman, Salus, Wolcott & Kennedy, 2003; Stith, et al., 2009), thus affirming the findings of the present study.

Discussion of Quantitative Findings

In trying to assess the effect child neglect on the psychological health and quality of life of adolescent participants, the researcher tested various hypotheses. The relationships that exist between all the dependent variables were first established. From the results shown in table 7, a statistically significant relationship was found among all the variables except for anxiety.

Assessing the relationship that exists between child neglect and psychological health, it was revealed that child neglect affected only the depression and self-esteem levels of the adolescents studied but did not affect their anxiety levels. Specifically, child neglect had a negative correlation with depression indicating an inverse relationship between the two variables. The results as stated can be interpreted to imply that adolescent experiencing child neglect will most likely show or report higher depression levels and an adolescent who do not experience child neglect all other things being equal will most likely show or report no/low depression levels. Considering self-esteem, the results indicated a positive correlation between child neglect and self-esteem. The relationship established indicates that adolescents who experience child neglect will most likely show or report low self-esteem and adolescents who do not experience child neglect all other things being equal will show or report high self-esteem. The above relationship was confirmed in the MANOVA analysis comparing neglected adolescents to non-neglected adolescent on their psychological health. Adolescents who experienced child neglect showed higher levels of depression and low self-esteem levels compared to adolescents who did not experience neglect.
Child Neglect and Psychological Wellbeing

This finding is consistent with most literature that has investigated the effects of child neglect on individual’s psychological health. These studies have established a link between child neglect and poor psychological health as measured by depression, anxiety and self-esteem levels of individuals (Dubowitz, 2009; Spinhoven et al, 2010). As established in their study, Harkness, Bruce and Lumley (2006) revealed that the experience of neglect subsequently lowers one’s threshold for stressful life events. This lowered threshold in turn makes the neglected individual vulnerable to experiencing depression episodes in the face of minimal life stressors. This finding thus helps to explain the high depression levels identified among neglected individuals. Spinhoven and his colleges (2010) found a link between depression, anxiety and child neglect. Obtaining data from an existing study of depression and anxiety, they identified that most individual who experienced these negative psychological states had histories of neglect especially emotional neglect.

Leeb et al. (2000) documented various physical and mental health outcomes of child abuse and neglect. They identified that children who experienced maltreatment were more likely to exhibit higher levels of internalizing behavioural symptoms which mostly includes depression and anxiety. Furthermore, self-esteem has also been strongly associated with child neglect by various studies in that, children who experience child neglect develop low self esteem and self worth (Hartley, 2002; Holts & Buckley et al., 2008; Horner, 2004). These studies confirm the findings that child neglect indeed affects not just the physical health of the child but most importantly the psychological health of the child which has a strong influence on the child’s physical health. Although the above discussed studies have mentioned the existing link between child neglect and anxiety, the present study did not support that view.
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A positive correlation was found between child neglect and quality of life. The results obtained indicated that child neglect affects one’s quality of life in that adolescents who experienced child neglect reported poor quality of life. On the other hand adolescents who did not experience child neglect reported high quality of life. Considering the domains of quality of life it can be implied that child neglect leads to poor physical health, poor psychological health, inability to form strong and lasting social relationships and poor environmental adjustments. When neglect and non-neglected adolescents were compared in relation to their quality of life, the results showed a significant difference between adolescents who experienced neglect and those who did not experience neglect. Specifically, adolescents who experienced neglect reported poorer quality of life compared to adolescents who did not experience neglect. From the results it was identified that neglected children had significant issues with the physical health, psychological health and the environmental aspect of their quality of lives. This means that neglected children were identified as having problems with physical health, psychological states and with environmental adjustments. Their formation and sustenance of social relationships was also compromised. Thus, the general quality of life as evaluated by the neglected children individually was poor.

As has been established in the literature reviewed, child neglect does not only affect an individual’s psychological health but also their quality of life. Orbuch et al. (2005) established that quality of life is enhanced by the same conditions that enhance psychological health. That is, positive parent-child relationships which is one critical determinants of a child’s development and adjustments. Therefore in the absence of a positive parent-child relationship as well as other compensatory relationships, the child’s quality of life is compromised. This finding is consistent with Chahine (2014)’s findings. Chahien emphasized that family violence and child abuse including neglect could lead to negative consequences regarding the well-being and quality of life of a child. In his study, he found a negative
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relationship between child abuse and neglect and the quality of life of children. Jernbro, Tindberg, Lucas and Janson (2015) affirmed this finding in their study as they established a linear relationship between various types of maltreatments and quality of life. All these researchers including the present research attest to the fact that child neglect affects children’s quality of life negatively. Specifically, child neglect has the potential of reducing the quality of life of children.

Furthermore, the above findings have theoretical implications. The social-ecological model of neglect explains that neglect is not just a function of parental characteristics but also a function of a broader social context and characteristics of the child as well (Bronfenbrenner & Ceci, 1994). In explaining this, the theory makes it clear that neglect usually does not start and remain only in the home. This nature of neglect makes it more detrimental as neglect starts from the home and gradually extends to the child’s broader social environment.

For example, as Bronfenbrenner and Ceci (1994) explained, neglect may start as a result of parents having financial challenges coupled with conflicts and tension in the home. In such a situation if the child in question is difficult and demanding, it could lead to either abuse or the parents ignoring the child’s needs. If on the hand, the child is quiet and placid, he or she may be easily ignored by the parents. As neglect of the child’s needs continue, the child learns to give up and becomes apathetic and soon the lack of care may result in significant physical changes of the child. Here the child becomes timid, unusually quiet and sometimes unkempt even outside the home. Owing to the appearance and nature of the child, he or she tends to receive fewer commendations, is bullied and taunted by his or her peers. This nature of neglect therefore makes its effects very significant in the child’s life. Therefore, the effects of neglect on the child cannot be solely restricted to parental omissions but as explained by the theory to a wide range of factors (Bronfenbrenner & Ceci, 1994).
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From the results it can be established that child neglect indeed has negative effects on children who experience it. It is therefore necessary for various measures to be put in place to help reduce the existence of child neglect in our communities. It is also important to identify children who are experiencing child neglect in the early stages so that they can be helped to reduce the detrimental effects of neglect on their life.

Development and Validation of CNQ

Based on the above findings a 29 item child neglect questionnaire was developed based on the respondents’ responses to the research questions asked, analysis and review of theories and literature. The aim of developing this questionnaire was to obtain a culture specific child neglect questionnaire to help in the general screening of adolescents experiencing neglect. The items of the questionnaire were based on the five main areas identified as the key areas of neglect among the studied population. They include physical, educational, supervisory, emotional and medical neglect.

The Child Neglect Questionnaire (CNQ) had 6 items measuring physical neglect, e.g. “My parents/guardians hardly give me enough to eat” and “My parents/guardians do not provide proper clothes for me to wear”. There were 8 items each measuring educational neglect, e.g. “My parents/guardians do not care if I went to school or not” and “My parents/guardians do not ask me questions about what I study” and supervisory neglect, e.g. “My parents/guardians do not care about what I do outside the home” and “My parents/guardians are always interested in the kinds of friends I have”. There were 5 items measuring emotional neglect, e.g. “My parents/guardians hardly interact with me” and “My parents/guardians do not care what time I went out or came back home” and the final 3 items measured medical neglect eg. “My parents/guardians do not ensure I take my drugs when I am sick” and “My parents/guardians take time off to care for me when I am sick”.

In trying to validate the newly developed Child Neglect Questionnaire, three hypotheses were developed to help tests for the convergent and divergent construct validity of the scale. Convergent validity as established by Campbell and Fiske (1959) is established when the newly developed measure correlates well with other tests believed to measure the same construct and when relationships that are expected to occur if the test is really measuring what it purports to measure is demonstrated (Kaplan & Saccuzzo, 2009). Divergent validity on the other hand is established when the test shows low correlations with measures of unrelated constructs (Kaplan & Saccuzzo, 2009).

The third hypothesis stating that there will be a positive correlation between the new Child Neglect Questionnaire (CNQ) and the Neglect Scale was supported. The correlation of the CNQ and the Neglect scale showed that a positive correlation exist between the two scales. This means that higher scores on the CNQ indicated a higher score on the Neglect Scale. Further finding showed that the supervisory neglect and emotional neglect subscales of the originally developed CNQ positively correlated with all the subscales of the Neglect scale (physical, emotional, supervisory and cognitive). This implies that a relationship exists between the supervisory neglect and emotional neglect subscales of the CNQ and the entire subscales of the Neglect Scale.

The medical neglect subscale of the CNQ on the other hand only correlated positively with the emotional and physical neglect subscales of the Neglect scale. This shows that the medical neglect subscale of the CNQ relates only with the physical and emotional subscales of the Neglect scale.

Finally the physical neglect subscale of the CNQ also correlated positively with the emotional and supervisory neglect subscales of the Neglect scale. This also implies that the physical neglect subscale of the CNQ relates only with the emotional and supervisory...
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subscales of the Neglect scale. All the correlations obtained between the various subtests were weak correlations except for the correlations that existed between the emotional neglect subscale of the CNQ and the emotional and physical neglect subscales of the Neglect scale which were moderate.

The educational neglect subscale of the CNQ did not correlate with any of the subscales of the Neglect scale as the Neglect scale did not measure any construct relating to educational neglect. An observation of the entire correlations shows that most of the items on the Neglect scale related better with the emotional neglect subscale of the CNQ. From the above it can be deduced that the newly developed CNQ subscales relates with specific subscales of the already validated Neglect scale. This can further be interpreted in line with convergent validity that the two scales (CNQ and Neglect scale) both measures the same construct which is neglect (Kaplan & Saccuzzo, 2009).

The fourth hypothesis stating that there will be a negative correlation between the Child Neglect Questionnaire (CNQ) and the Multidimensional Anxiety Scale for Children (MASC) and the Children’s Depression Inventory (CDI) was partially supported. This is because the CNQ only correlated with one of the scales it was hypothesized to correlate with. The CNQ correlated negatively with the CDI. This shows that a relationship exists between the two scales but this time adolescents who obtained higher scores on the CNQ obtained lower scores on the CDI. The above findings imply that adolescents who experienced lower levels of neglect had low levels of depression and those who experienced high levels of neglect had high depression levels. In relation to establishing convergent validity it can be argued that child neglect is expected to have a relationship with one’s level of depression. Therefore the above obtained results show that the relationship expected between the two constructs: neglect and depression has been established as explained by Kaplan and Saccuzzo (2009).
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The results obtained also showed that the CNQ did not correlate with the MASC showing that there is no relationship between the two scales. This means that the adolescent’s scores on the CNQ did not influence their scores on the MASC. Explaining the results in relation to divergent validity it can be said that the CNQ clearly measures neglect and not anxiety (Kaplan & Saccuzzo, 2009).

The fifth hypothesis stating that there will be a positive correlation between the Child Neglect Questionnaire (CNQ) and the World Health Organization Quality of Life (WHOQOL-BREF) scale was statistically supported. A positive significant relationship was found between the CNQ and the WHOQOL-BREF. This implies that adolescents who experienced lower levels of child neglect reported higher quality of life and those who experienced higher levels of child neglect reported lower levels of quality of life. Thus the above convergent validity relationship as explained by Kaplan and Saccuzzo (2009) applies to the relationship between the CNQ and the WHOQOL-BREF. From the above it can be concluded that the newly developed CNQ has construct validity.

The relationship existing between the CNQ, CDI and WHOQOL-BREF is evident in the reviewed literature as it has been established that child neglect does affect the quality of life and psychological health of adolescents (Chahine, 2014; Dion & Matte-Gagne, 2015; Goldstein & Flett, et al., 2009; Harkness & Bruce et al., 2006; Leeb & Lewis, et al., 2011; Martin & Bergen, et al., 2004).

All the items on the CNQ were subject to Principal Component Analysis (PCA) to help verify the various components that make up the questionnaire and how the components relate with each other. From the PCA two main components labelled Negligence and Care were obtained from the entire questionnaire. The first factor was made up of negatively worded items. This factor contained thirteen (13) items that focused on various parental omissions of
care. Examples of items that made up this component are; “My parents/guardians do not care if I went to school or not” and “My parents/guardians do not care about what I do outside the home”. The second factor was made up of positively worded items and contained three (3) items that focused on the care given by parents. Examples of items that made up this component are; “My parents/guardians take time off to care for me when I am sick” and “My parents/guardians usually want to know what went on in school each day”.

The originally developed 29 item CNQ was reduced to a 16 item scale with a strong Cronbach Alpha of .87. After principal component analysis was conducted for the entire CNQ, a Pearson’s correlation was computed between the two components obtained (negligence and care) and the subscales of the Neglect scale. Results obtained indicated that the negligence and care components of the CNQ positively correlated with the entire subscales of the Neglect scale showing that a relationship exists between them. This implies that the two components of the CNQ measures the same construct as the entire subscales of the Neglect scale.

**Limitations of the Study**

The major challenge faced in this study was the difficulty in obtaining adequate adolescents who had experienced neglect for the study. Owing to this challenge, the sample size used in the qualitative part of the study was small and quite skewed as only one adolescent participant met the criteria for neglect. Although the sample obtained provided significant results, a much larger sample size of adolescents who had experienced neglect would have lead to stronger correlations than obtained in the present study. The use of self-report measures in the quantitative part of the study could have lead to inaccurate self reporting or over estimation of non-neglected adolescents thus reducing the number of adolescents identified as being neglected. Furthermore, the research was situated in the Tema...
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Metropolitan Assembly and the Ashaiman Municipal District of the Greater Accra Region. Thus, the findings of the study cannot be generalized to other adolescents living outside the research area.

**Practical Implications and Recommendations**

The present study has added to the existing literature on child neglect and its effect on psychological health and quality of life. The study in its bid to explore the nature of child neglect in the Ghanaian community identified various issues that are important in understanding child neglect and how it presents in the Ghanaian community studied. The main issues were that Ghanaians concept of child neglect was similar to concepts of other Western countries. This suggests that the understanding of child neglect among the studied population is influenced by formal definitions obtained from Western literature. In the light of this finding, it is therefore necessary for more studies to be conducted to indentify specifically the unique trends of neglect in the country so that measures can be put in place to curb it.

It was also identified that physical neglect, educational neglect and supervisory neglect were the most identified forms of neglect in the studied population. This finding hinges on the realization that one of the persistent causes of neglect was identified to be economic challenges. It therefore necessary that structures are put in place by the government, ministries, social welfare and other stakeholders to help provide a source of support for families that are under extreme economic challenges to help in the provision of necessary and important basic needs.

Furthermore, findings in relation to the effect of child neglect on the psychological health and quality of life shows that neglected children need more than just the provision of needs and the care they lack. The Domestic Violence and Victim Support Units (DOVVSU) of the
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Ghana Police Service should include psychological interventions to the physical interventions they provide for neglected children. This should be considered because it has been established overtime that child neglect does not only affect the child physically but also psychologically. The psychological damage done if not rectified goes a long way to affect the child’s life in future.

To add, the development of the Child Neglect Questionnaire has also provided a tool that can be used to screen and identify adolescent who are experiencing some form of neglect in their homes. With the identification of such children, measures can be put in place to help sustain them.

Finally, future researchers interested in studying further the understanding of child neglect in Ghanaian communities should employ a more robust sampling technique to enable them obtain more individuals who have experienced neglect to enable them understand the concept and its effects better. Based on the findings of this present study it can be said that there is more to unravel about child neglect and its occurrence in Ghana. Therefore, rigorous indebt qualitative studies on child neglect in relation to our cultural values are needed to understand the concept of neglect in Ghana. Future researchers are therefore encouraged to take up the area of neglect and conduct more in-depth studies which might lead to important and interesting findings about neglect and also add to literature.

Summary and Conclusion

Child neglect, as has been established, does occur in most homes both consciously and unconsciously and does have significant effects on the children who experience it. Also the concept of child neglect as identified among the studied sample was similar to the concepts of other Western countries. Main findings of the study showed that the understanding of child neglect among the sample studied centred on issues of inadequate or lack of care, denial of
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basic needs or not providing basic needs and abandonment of children. Also the most occurring form of neglect was physical neglect where parents neglected the physical needs of their children, educational neglect where parents did not concern themselves with the child’s educational needs and supervisory neglect which in a way did cut across most physical and educational needs. It was further identified that almost all identified neglect cases were as a result of economic challenges or broken homes. Also, fathers were identified as the culprit in most reported neglect cases among the population studied. Findings on the effect of neglect showed that child neglect, no matter how subtle, could go a long way to affect a child’s psychological health and quality of life.

In conclusion it can be agreed that child neglect just as all other forms of child maltreatments affect children negatively and should therefore not be relegated to the background as secondary to other maltreatments. Just as measures have been put in place specifically to help check and reduce child physical and sexual abuse, similar measures should be put in place to educate the general population on the effects of neglect on children and to help reduce the incidents of child neglect in the country.

Finally, “Children are like flowers that should never cease to grow. Nurture them and they will outlive you. Neglect them and they will wilt away and die” let us all come together to nurture and love the children we are blessed with.
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APPENDIX A

Informed Consent Form for Adults

UNIVERSITY OF GHANA
OFFICE OF RESEARCH, INNOVATION AND DEVELOPMENT
Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A– BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>Title of Study:</th>
<th>Child neglect and psychological wellbeing in adolescents: an exploratory study in the Tema Metropolitan Assembly in Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Investigator:</td>
<td>Anna Gyaban-Mensah</td>
</tr>
<tr>
<td>Certified Protocol Number</td>
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</tbody>
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Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The aim of this research is to explore the understanding of child neglect among the Ghanaian population and to find out the impact it has on the psychological health and the quality of life of adolescents. Participating in the research will take approximately 30 minutes to 1 hour. You will be interviewed extensively on your understanding of child neglect and how it occurs in the Ghanaian community. Your interview session will be recorded and as such your name will not be mentioned or used during the interview session.

Possible Risks of the study

The study will not involve any adverse risks. You might however endure some level of fatigue during the interview period. Adequate steps will be taken to allow for intermittent breaks to reduce or to minimize any of these effects. In case of psychological stress you will be taken though relaxation therapy and referred for appropriate counselling and care.
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Possible Benefits

Your participation in the study will help provide insight into child neglect issues among the Ghanaian population. Your responses will also help in the development of a child neglect scale which can be used to screen for possible neglect situations concerning adolescents.

Confidentiality

Please be assured that any information you provide during the interview will be used solely and purposely for research. Your recorded interview session will be handled only by the principal researcher. The recorded information will be transcribed and written down after which the recorded data will be deleted. Only the transcribed data will be used in the research analysis. You are not required to provide your name during the interview session and your name will not be used or mentioned in any part of the interview to avoid recognition. Any information you provide will be protected as much as possible.

Compensation

There will be no material compensation involved, but your participation will be very much appreciated.

Withdrawal from Study

Participation in this research is completely voluntary. You have the right not to participate. You also have the right to withdraw from participating at any point in time during the study. Doing so will not attract any penalty whatsoever from the researcher. You may also choose not to answer any question you are not comfortable with.

Contact for Additional Information

In case of any doubt or/and for additional information concerning the study you may contact the Principal Investigator; Anna Gyaban-Mensah University of Ghana, Department of Psychology, Legon Telephone: 0270-116-119 or email address: annagmensah@gmail.com

Dr. Margaret Amankwa-Poku
University of Ghana,
Department of Psychology,
Legon
Tel: 0277-545-995

OR

Dr Paul N. Doku
University of Ghana,
Department of Psychology,
Legon
Tel: 0543-209-066
"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

_____________________________   _______________________
Name of Volunteer

_____________________________   _______________________
Signature or mark of volunteer      Date

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____________________________
Name of witness

_____________________________   _______________________
Signature of witness       Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Name of Person who Obtained Consent

_____________________________   _______________________
Signature of Person Who Obtained Consent      Date
**Section A - BACKGROUND INFORMATION**

<table>
<thead>
<tr>
<th>Title of Study:</th>
<th>Child neglect and psychological wellbeing in adolescents: an exploratory study in the Tema Metropolitan Assembly in Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Investigator:</td>
<td>Anna Gyaban-Mensah</td>
</tr>
<tr>
<td>Certified Protocol Number</td>
<td></td>
</tr>
</tbody>
</table>

**Section B – ADOLESCENT CONSENT TO PARTICIPATE IN RESEARCH**

**General Information about Research**

The aim of this research is to explore the understanding of child neglect in Ghana and to find out how it affects the lives of adolescents. Taking part in the research will take about 30 minutes to 1 hour. (You will be interviewed briefly on what you know about child neglect and on your own personal experiences at home/ you will be given a set of questionnaires about your experiences at home and your well-being to fill). You are expected to fill them out as truthfully as possible.

**Possible Risk of the study**

The study will not involve any adverse risks. You might however experience some level of fatigue while responding to the questionnaire. Adequate steps will be taken to allow for intermittent breaks to reduce or to minimize any of these effects. In case of psychological stress you will be taken though relaxation therapy and referred for appropriate counselling and care.

**Possible Benefits**

Your participation in the study will help provide insight into the impact child neglect has on the psychological health and the quality of life of adolescents. Your responses will also help in the validation of a new child neglect scale which can be used to screen for possible neglect situations concerning adolescents.
Confidentiality

Please be assured that any information you provide will be used solely and purposely for research. You are not required to provide your name on any part of the questionnaire.

Compensation

There will be no material compensation involved, but your participation will be very much appreciated.

Withdrawal from Study

Participation in this research is completely voluntary. You have the right not to participate. You also have the right to withdraw from participating at any point in time during the study. Doing so will not attract any penalty whatsoever from the researcher.

Contact for Additional Information

In case of any doubt or/and for additional information concerning the study you may contact the Principal Investigator; Anna Gyaban-Mensah University of Ghana, Department of Psychology, Legon Telephone: 0270-116-119 or email address: annagmensah@gmail.com

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Tel: 0277-545-995

OR

Dr Paul N. Doku
University of Ghana,
Department of Psychology,
Legon
Tel: 0543-209-066
Section C- VOLUNTEER AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

________________________________________________
Name of Volunteer

________________________________________________
Signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

________________________________________________
Name of witness

________________________________________________
Signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

________________________________________________
Name of Person who Obtained Consent

________________________________________________
Signature of Person Who Obtained Consent
Assent Form for Participation of Ward

**Title of Study:** Child neglect and psychological wellbeing in adolescents: an exploratory study in the Tema Metropolitan Assembly in Ghana

**Principal Investigator:** Anna Gyaban-Mensah

**Certified Protocol Number**

---

**Section B– ASSENT FOR WARD TO PARTICIPATE IN RESEARCH**

**General Information about Research**

The aim of this research is to explore the understanding of child neglect among the Ghanaian population and to find out the impact it has on the psychological health and the quality of life of adolescents. Your permission is being sought to enable your ward participate in this study. Your ward will be required to fill out a questionnaire about his or her experiences at home as a child and about his or her psychological health and quality of life. Participating in the research will take approximately 30 minutes to 1 hour.

**Possible Risk of the study**

The study will not involve any adverse risks. Your ward might however experience some level of fatigue while responding to the questionnaire. Adequate steps will be taken to allow for intermittent breaks to reduce or to minimize any of these effects. In case of psychological stress your ward will be taken though relaxation therapy and referred for appropriate counselling and care.

**Possible Benefits**

Giving your assent to allow your ward participate in the study will help provide insight into the impact child neglect has on the psychological health and the quality of life of adolescents. The
Child Neglect and Psychological Wellbeing

responses obtained will also help in the validation of a new child neglect scale which can be used to screen for possible neglect situations concerning adolescents.

Confidentiality

Please be assured that any information provided will be solely and purposely used for research. The home address and contact you provide will only be used for the purpose of following up for additional information to help validate the new child neglect questionnaire to be developed. This information will be handled only by the principal investigator and any information you provide will be protected as much as possible.

Compensation

There will be no material compensation involved, but your assent and your ward’s participation will be very much appreciated.

Withdrawal from Study

Participation in this research is completely voluntary. You have the right not to allow your ward participate in this study. You and your ward both have the right to also withdraw from participating at any point in time during the study. Doing so will not attract any penalty whatsoever form the researcher.

NB: The researcher will be grateful if you will provide your home address and telephone number at the end of the questionnaire to enable the researcher contact your child for a follow up to help validate the new child neglect scale to be developed from this study.

Contact for Additional Information

In case of any doubt or/and for additional information concerning the study you may contact the Principal Investigator; Anna Gyaban-Mensah University of Ghana, Department of Psychology, Legon Telephone: 0270-116-119 or email address: annagmensah@gmail.com,

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"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

________________________________________________
Name of Parent/Guardian
________________________________________________
Signature or mark of parent/guardian Date

If volunteers cannot read the form themselves, a witness must sign here:
I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

________________________________________________
Name of witness
________________________________________________
Signature of witness Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

________________________________________________
Name of Person who Obtained Consent

________________________________________________
Signature of Person Who Obtained Consent Date
Survey Questionnaire

Dear Survey Participant,

I am a student at the University of Ghana conducting a research on the topic “Child neglect and psychological wellbeing in adolescents: an exploratory study in the Tema Metropolitan Assembly in Ghana” as part of the requirement for a Master of Philosophy (MPhil.) degree in Clinical Psychology.

This survey is to obtain your views on how your parents care for you as a child and how this care you receive affect your everyday life at home and at school. Your honest responses will be most appreciated.

Your responses are confidential and will not be seen by anyone else and will be used solely for analysis and academic purposes.

Thank you for your willingness to participate in this study. If you have any questions, comments, or concerns about this project, please contact the Principal Researcher, Anna Gyaban-Mensah (Tel: 0270116119, E-mail: annagmensah@gmail.com) or the Project Supervisors: Dr. Margaret Amankwah-Poku and Dr. Paul Doku, both from the Psychology Department of the University of Ghana.

Sincerely,
Anna Gyaban-Mensah
Child Neglect and Psychological Wellbeing

Neglect Scale

These questions are about what it is like living with your parents. "Parents" refer to the person or people who raised you. If you lived with different parents at different times or if there is a question that applies only to part of the time when you were growing up, you should answer for the parent or the part of the time that you think had the most influence on you.

1. Which of the following "father figures" will you be answering these questions for? (mark only one category):
   1 = Father or adoptive father
   2 = Step father
   3 = Grandfather
   4 = Other male relative I lived with
   5 = Foster father
   6 = Unrelated man I lived with
   7 = There was no male who was responsible for me
   8 = I lived in an institution and will answer for that place

2. Which of the following "mother figures" will you be answering these questions for? (mark only one category):
   1 = Mother or adoptive mother
   2 = Step mother
   3 = Grandmother
   4 = Other female relative I lived with
   5 = Foster mother
   6 = Unrelated woman I lived with
   7 = There was no woman who was responsible for me
   8 = I lived in an institution and will answer for that place
**Child Neglect and Psychological Wellbeing**

For each of the following statements, decide how well it describes your life with your parents. Mark or circle a "1" for "Strongly Agree" if it is a very good description of either or both of your parents or a "4" for "Strongly Disagree" if it does not describe either of them at all. Choose “2” for "Agree" or “3” for "Disagree" if the description falls somewhere between.

1 = Strongly Agree 2 = Agree 3 = Disagree 4 = Strongly Disagree

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My parents did not help me when I had problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. My parents did not comfort me when I was upset.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. My parents did not praise me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My parents did not tell me they loved me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. My parents did things with me just for fun.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My parents did not help me to do my best.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. My parents helped me when I had trouble understanding something.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. My parents did not read books to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. My parents were not interested in my activities or hobbies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. My parents did not help me with homework.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. My parents did not make sure I went to school.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My parents did not care if I got into trouble in school.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. My parents did not care if I did things like shoplifting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. My parents were not interested in the kind of friends I had.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. My parents wanted to know what I was doing when I was not at home.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. My parents did not keep me clean.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. My parents did not make sure I saw a doctor when I needed one.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. My parents did not give me enough clothes to keep me warm.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. My parents did not give me enough to eat.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. My parents kept the house clean.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Children sometimes have different feelings and ideas. This form lists the feelings and ideas in groups. From each group of three sentences, pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this ‘X’ next to your answer. Put the mark in the box next to the sentence that you pick. Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you best.

Example:

<table>
<thead>
<tr>
<th>Item 1</th>
<th>Item 2</th>
<th>Item 3</th>
<th>Item 4</th>
<th>Item 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] I am sad once in a while.</td>
<td>[ ] Nothing will ever work out for me.</td>
<td>[ ] I do most things O.K.</td>
<td>[ ] I have fun in many things.</td>
<td>[ ] I am bad all the time.</td>
</tr>
<tr>
<td>[ ] I am sad many times.</td>
<td>[ ] I am not sure if things will work out for me.</td>
<td>[ ] I do many things wrong.</td>
<td>[ ] I have fun in some things.</td>
<td>[ ] I am bad many times.</td>
</tr>
<tr>
<td>[ ] I am sad all the time</td>
<td>[ ] Things will work out for me O.K.</td>
<td>[ ] I do everything wrong.</td>
<td>[ ] Nothing is fun at all.</td>
<td>[ ] I am bad once in a while.</td>
</tr>
</tbody>
</table>

Remember, pick out the sentence that describes you best in the PAST TWO WEEKS.

<table>
<thead>
<tr>
<th>Item 6</th>
<th>Item 7</th>
<th>Item 8</th>
<th>Item 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] I think about bad things happening to me once in a while.</td>
<td>[ ] I hate myself.</td>
<td>[ ] All bad things are my fault.</td>
<td>[ ] I do not think about killing myself.</td>
</tr>
<tr>
<td>[ ] I worry that bad things will happen to me.</td>
<td>[ ] I do not like myself.</td>
<td>[ ] Many bad things are my fault.</td>
<td>[ ] I think about killing myself but I would not do it.</td>
</tr>
<tr>
<td>[ ] I am sure that terrible things will happen to me.</td>
<td>[ ] I like myself.</td>
<td>[ ] Bad things are not usually my fault.</td>
<td>[ ] I want to kill myself.</td>
</tr>
</tbody>
</table>

Turnover and fill out the other side.
Child Neglect and Psychological Wellbeing

Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.

<table>
<thead>
<tr>
<th>Item</th>
<th>Sentences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 10</td>
<td>I feel like crying every day.</td>
</tr>
<tr>
<td></td>
<td>I feel like crying many days.</td>
</tr>
<tr>
<td></td>
<td>I feel like crying once in a while.</td>
</tr>
</tbody>
</table>

| Item 11 | Things bother me all the time.                                           |
|         | Things bother me many times.                                             |
|         | Things bother me once in a while.                                        |

| Item 12 | I like being with people.                                                |
|         | I do not like being with people many times.                              |
|         | I do not want to be with people at all.                                  |

| Item 13 | I cannot make up my mind about things.                                    |
|         | It is hard to make up my mind about things.                              |
|         | I make up my mind about things easily.                                    |

| Item 14 | I look O.K.                                                               |
|         | There are some bad things about my looks.                                 |
|         | I look ugly.                                                             |

| Item 15 | I have to push myself all the time to do my schoolwork.                   |
|         | I have to push myself many times to do my schoolwork.                     |
|         | Doing schoolwork is not a big problem.                                    |

| Item 16 | I have trouble sleeping every night.                                     |
|         | I have trouble sleeping many nights.                                     |
|         | I sleep pretty well.                                                     |

| Item 17 | I am tired once in a while.                                              |
|         | I am tired many days.                                                    |
|         | I am tired all the time.                                                 |

| Item 18 | Most days I do not feel like eating.                                     |
|         | Many days I do not feel like eating.                                      |
|         | I eat pretty well.                                                       |

| Item 19 | I do not worry about aches and pains.                                    |
|         | I worry about aches and pains many times.                                |
|         | I worry about aches and pains all the time.                              |

| Item 20 | I do not feel alone.                                                     |
|         | I feel alone many times.                                                 |
|         | I feel alone all the times.                                              |

| Item 21 | I never have fun at school.                                              |
|         | I have fun at school only once in a while.                               |
|         | I have fun at school many times.                                         |

| Item 22 | I have plenty of friends.                                                |
|         | I have some friends but I wish I had more.                               |
|         | I do not have any friends.                                               |

| Item 23 | My schoolwork is alright.                                                |
|         | My schoolwork is not as good as before.                                  |
|         | I do very badly in subjects I used to be good                            |

| Item 24 | I can never be as good as other kids.                                    |
|         | I can be as good as other kids if I want to.                             |
|         | I am just as good as other kids.                                         |

| Item 25 | Nobody really loves me.                                                  |
|         | I am not sure if anybody loves me.                                       |
|         | I am sure that somebody loves me.                                        |

| Item 26 | I usually do what I am told.                                             |
|         | I do not do what I am told most times.                                   |
|         | I never do what I am told.                                               |

| Item 27 | I get along with people.                                                 |
|         | I get into fights many times.                                             |
|         | I get into fights all the time.                                          |
Child Neglect and Psychological Wellbeing

Multidimensional Anxiety Scale for Children

<table>
<thead>
<tr>
<th>Name: ..........................................................................</th>
<th>Age: ..................</th>
<th>Gender: Male / Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: ..........................................................................</td>
<td>School level: ..........</td>
<td></td>
</tr>
</tbody>
</table>

This questionnaire asks you how you have been thinking, feeling or acting recently. For each item, please circle the number that shows how often the statement is true for you. If a sentence is true about you a lot of the time, circle 3. If it is true about you some of the time, circle 2. If it is true about you once in a while, circle 1. If a sentence is not ever true about you, circle 0. Remember, there are no right or wrong answers, just answer how you have been feeling recently.

Here are two examples to show you how to complete the questionnaire. In Example A, if you were hardly ever scared of dogs, you would circle 1, meaning that the statement is rarely true about you. In Example B, if thunderstorms sometimes upset you, you would circle 2, meaning that the statement is sometimes true about you.

<table>
<thead>
<tr>
<th></th>
<th>Never true about me</th>
<th>Rarely true about me</th>
<th>Sometimes true about me</th>
<th>Often true about me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example A: I’m scared of dogs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Example B: Thunderstorms upset me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Now try these items yourself. Don’t forget to do the items on the back of the questionnaire as well.

1. I feel tense or uptight ................................................. | 0 | 1 | 2 | 3 |
2. I usually ask permission.................................................. | 0 | 1 | 2 | 3 |
3. I worry about other people laughing at me ........................ | 0 | 1 | 2 | 3 |
4. I get scared when my parents go away ................................. | 0 | 1 | 2 | 3 |
5. I keep my eyes open for danger ........................................ | 0 | 1 | 2 | 3 |
6. I have trouble getting my breath ...................................... | 0 | 1 | 2 | 3 |
7. The idea of going away to camp scares me ............................ | 0 | 1 | 2 | 3 |
8. I get shaky or jittery ................................................... | 0 | 1 | 2 | 3 |
9. I try to stay near my mom or dad ....................................... | 0 | 1 | 2 | 3 |
10. I am afraid that other kids will make fun of me .................... | 0 | 1 | 2 | 3 |
11. I try hard to obey my parents and teachers ........................ | 0 | 1 | 2 | 3 |
12. I get dizzy or faint feelings ........................................... | 0 | 1 | 2 | 3 |
13. I check things out first ................................................. | 0 | 1 | 2 | 3 |
14. I worry about getting called on in class ............................. | 0 | 1 | 2 | 3 |
15. I’m jumpy ...................................................................... | 0 | 1 | 2 | 3 |

Please flip the questionnaire over; the items are continued on the back page...
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Never true about me</th>
<th>Rarely true about me</th>
<th>Sometimes true about me</th>
<th>Often true about me</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>I’m afraid other people will think I’m stupid.................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>I keep the light on at night......................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>I have pains in my chest.........................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>I avoid going to places without my family...................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20</td>
<td>I feel strange, weird, or unreal.................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>I try to do things other people will like....................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22</td>
<td>I worry about what other people think of me..................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23</td>
<td>I avoid watching scary movies and TV shows..............................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>My heart races or skips beats....................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25</td>
<td>I stay away from things that upset me..........................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26</td>
<td>I sleep next to someone from my family......................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27</td>
<td>I feel restless and on edge.......................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>I try to do everything exactly right..........................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>I worry about doing something stupid or embarrassing..............................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>I get scared riding in the car or on the bus..............................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31</td>
<td>I feel sick to my stomach..........................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32</td>
<td>If I get upset or scared, I let someone know right away.........................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33</td>
<td>I get nervous if I have to perform in public................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34</td>
<td>Bad weather, the dark, heights, animals or bugs scare me........................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35</td>
<td>My hands shake..................................................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36</td>
<td>I check to make sure things are safe...........................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37</td>
<td>I have trouble asking other kids to play with me..........................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38</td>
<td>My hands feel sweaty or cold........................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39</td>
<td>I feel shy.......................................................................................................................</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Child Neglect and Psychological Wellbeing

Child Neglect Questionnaire (CNQ)

Read each of the following statements carefully and decide how well it describes the care you receive from your parents/guardians. Mark or circle a "1" for "Strongly Agree" if it is a very good description of either or both of your parents or a "4" for "Strongly Disagree" if it does not describe either of them at all. Choose "2" for "Agree" or "4" for "Disagree" if the description falls somewhere between and "3" for "Neither Agree nor Disagree" if you are not so sure the description you agree or disagree with the descriptions.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My parents/guardians hardly give me enough to eat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My parents/guardians refuse to pay my school fees.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am always left at home by myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I was never enrolled in school by my parents/guardians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I am always left at home with house helps.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. My parents/guardians do not care if I went to school or not.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. My parents/guardians do not provide proper clothes for me to wear.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My parents/guardians do not provide appropriate sleeping place for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. My needs always come first for my parents/guardians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. My parents/guardians take time off to care for me when I am sick.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. My parents/guardians do not ask me questions about what I study.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My parents/guardians do not care about what I do outside the home.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. My parents/guardians always buy me books I need for school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. My parents/guardians do not care about my safety when I go out.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. My parents/guardians hardly help me with my homework.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. My parents/guardians usually want to know what went on in school each day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. My parents/guardians do not correct me when I do something wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. My parents/guardians are always interested in the kinds of friends I have.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
## Child Neglect and Psychological Wellbeing

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19. My parents/guardians do not care if I stay out of school without permission.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. My parents/guardians hardly spend time with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. My parents/guardians do not care what time I went out or came back home.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. My parents/guardians do not care if I get into trouble.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. My parents/guardians do not care about where I go.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. My parents/guardians do not show me love.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. My parents/guardians hardly interact with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. My parents/guardians do not encourage me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. My parents/guardians do not praise me when I do well in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. My parents/guardians do not take me to the hospital when I am sick.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29. My parents/guardians do not ensure I take my drugs when I am sick.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**WHOQOL-BREF**

The following questions ask how you feel about your quality of life, health, or other areas of your life. Read out each question along with the response options and **"Please choose the answer that appears most appropriate"**. If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. As you respond to the questions think about your life **in the last four weeks**.

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Neither poor nor good</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>How would you rate your quality of life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>How satisfied are you with your health?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The following questions ask about **how much** you have experienced certain things in the last four weeks.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>A moderate amount</th>
<th>Very much</th>
<th>An extreme amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>To what extent do you feel that physical pain prevents you from doing what you need to do?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>How much do you need any medical treatment to function in your daily life?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>How much do you enjoy life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>To what extent do you feel your life to be meaningful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>A moderate amount</th>
<th>Very much</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>How well are you able to concentrate?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>How safe do you feel in your daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>How healthy is your physical environment?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Mostly</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Do you have enough energy for everyday life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>Are you able to accept your bodily appearance?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>Have you enough</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
### Child Neglect and Psychological Wellbeing

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>How available to you is the information that you need in your day-to-day life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>To what extent do you have the opportunity for leisure activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>How well are you able to get around?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>How satisfied are you with your sleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>How satisfied are you with your ability to perform your daily living activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>How satisfied are you with your capacity for work?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>How satisfied are you with yourself?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>How satisfied are you with your personal relationships?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>How satisfied are you with your sex life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>How satisfied are you with the support you get from your friends?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>How satisfied are you with the conditions of your living place?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>How satisfied are you with your access to health services?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>How satisfied are you with your transport?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The following question refers to how often you have felt or experienced certain things in the last four weeks.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Quite often</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
</table>
Child Neglect and Psychological Wellbeing

26. How often do you have negative feelings such as sad mood, despair, anxiety, depression?  

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any comments about the assessment?
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Rosenberg Self-Esteem Scale

This questionnaire asks you how you have been thinking or feeling recently. For each item, please tick the box that shows how often the statement is true for you. Remember, there are no right or wrong answers, just answer how you have been feeling recently.

Please tick (√) the appropriate box as it applies to you.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel that I am a person of worth, at least on an equal plane with others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I feel that I have a number of good qualities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. All in all, I am inclined to feel that I am a failure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I am able to do things as well as most other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I feel I do not have much to be proud of.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I take a positive attitude toward myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. On the whole, I am satisfied with myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I wish I could have more respect for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I certainly feel useless at times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. At times I think I am no good at all.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Demographic Information

This section is to acquire personal information about the participants to enhance the research by enabling the researcher compare various variables in the study being conducted. You are assured that information given will be treated as confidential, used mainly for academic work and will not be published in the results to breech ethical boundaries. The researcher will be highly grateful if genuine information needed will be provided as requested.

1. Gender: Male ☐ Female ☐

2. Please state your age as at last birthday (in years) ___________

3. Level of education: JHS ☐ Level ________   SHS ☐ Level ________

4. Parent Educational level
   Mother
   Father
   None ☐
   Primary ☐
   High school ☐
   Tertiary ☐
   Training college/Vocational ☐
   Others (Specify) ______________________________

5. Parents’/Guardians’ Occupation
   __________________________________________
   __________________________________________

Home Address
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Tel: ______________________________

Please check that all questions have been answered.

Thank you for completing the questionnaire.
Interview Guide

Semi-Structured Interview Guide for adult sample.

1. Have you heard about the term child neglect?
   a. Tell me what you know about child neglect?
   b. How will you define it?

2. Tell me when you will say a child has been neglected? Why do you think so?

3. How will you identify a child who has been neglected.
   a. Can you explain further?

4. Based on your understanding of child neglect would you say that Ghanaian parents neglect their children? Please tell me more about it.

5. What specific actions or omissions will you describe as an act of neglect among Ghanaian parents /guardians? Tell me more about them.

6. What about.....?

7. What are the circumstances by which parents will neglect their children? Please explain further.

8. Which of the above mentioned circumstances do you find as common in our communities?

9. Do you think that a parent or guardians socioeconomic status can result in child neglect? Why do you think so?
Child Neglect and Psychological Wellbeing


1. Have you heard about the term child neglect? Tell me what you know.

2. Tell me, when will you say a parent or guardian has neglected a child? Why do you think so?

3. I want you to listen to these scenarios and tell me if they count as child neglect.
   a) A (2, 9, 12, 15) years old child is left on his own during the day for about 3 hrs while his mother is out.
   b) A (9, 12, 15) years old child is left to wash her own clothes without help.
   c) A (9, 12, 15) years old child is made to cook all family dinners.
   d) A (2, 9, 12, 15) years old child being fed with takeaways and fast foods.

4. Why do you think a parent will neglect a child? Can you explain further?

5. Can you describe a child or adolescent who has been neglected?

6. What happens to a child when he/she is neglected? Can you explain it more?

7. Do you know of any institution or place where a child or adolescent can go to for help when they are being neglected? Tell me about the ones you know?

8. Based on your understanding of child neglect will you say that Ghanaian parents or guardians neglect their children? Why do you say so?

9. Based on your understanding of child neglect will you say that your parents or guardian neglects you? Please elaborate.
Child Neglect and Psychological Wellbeing

APPENDIX D

Child Neglect Questionnaire Development

### CATEGORIES OF CHILD NEGLECT

<table>
<thead>
<tr>
<th>Physical Neglect</th>
<th>Questionnaire Items</th>
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<td>Abandoning the child</td>
<td>My parents or guardians hardly gave me enough to eat.</td>
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<tr>
<td>Giving the child out without caring about the child.</td>
<td>I was abandoned by my parents or guardians when I was very little.</td>
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<td>Not thinking about the needs of the child. (their feeding, clothing, shelter, health)</td>
<td>Growing up as a child my parents or guardians always provided money for my care and upkeep.</td>
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<tr>
<td>Giving children out to live with others without care.</td>
<td>My parents or guardians did not provide proper clothes for me to wear.</td>
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<td>Not giving children enough care needed to grow.</td>
<td>I am always left at home by myself or with the house helps.</td>
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<td>Not providing shelter for the child.</td>
<td>My parents or guardians did not provide appropriate sleeping place for me.</td>
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<td>Not giving the child enough food.</td>
<td>Growing up my parents or guardians gave me up to fend for myself with caring.</td>
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<td>Not providing proper clothes for the child to wear.</td>
<td>My needs always came first for my parents or guardians.</td>
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<td>Not providing appropriate sleeping place for the child.</td>
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<td>Not taking care of the child.</td>
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<tr>
<td>Not providing the necessary life needs for the child.</td>
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<tr>
<td>Refusal to provide money for children’s care and housekeeping.</td>
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<tr>
<td>Leaving the child on his/her own at a tender age.</td>
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<tr>
<td>Not taking care of the child.</td>
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<tr>
<td>Leaving children on the streets without help.</td>
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</tbody>
</table>
### Child Neglect and Psychological Wellbeing

#### Educational Neglect

- Not paying the child’s school fees.
- Not buying books for the child.
- Refusal to take children to school.
- The child not going to school with the parents not caring.
- Not caring about the child’s education.
- Not asking questions about school.
- Not helping out with home work.
- Denying the child his/her right to education.
- Not caring about what your child does in school.

#### Questionnaire Items

- My parent or guardian refuses to pay my school fees.
- I was never enrolled in school by my parent or guardian.
- My education was always my parent’s or guardian’s priority.
- My parent or guardian did not care if I went to school or not.
- My parent or guardian always bought me books I needed for school.
- Growing up my parents or guardian wanted to know what went on in school each day.
- My parents or guardians hardly helped me with my homework.
- My parents or guardians do not ask me questions about what I study.

#### Supervisory Neglect

- Not correcting the child when he/she is wrong.
- Your child plays truant at school without your concern.
- Leaving the child to bad company.
- Not providing the safety needs of the child.
- Leaving the child on his/her own at a tender age.

#### Questionnaire Items

- My parents or guardians do not correct me when I am wrong.
- My parents or guardians do not care if I was truant at school.
- My parents or guardians are always interested in the kinds of friends I have.
- My parent or guardian does not care what time I went out or came back.
### Child Neglect and Psychological Wellbeing

- Not monitoring the child’s movement.
- Exposing the child to dangers.
- Not protecting the child.
- Not supervising children’s activities.
- Leaving children with care takers.
- Allowing the child to go out and come back at any time they want.
- Leaving children at home alone with house helps at infancy.
- Not caring the kinds of friends the child has.

### Emotional Neglect

- Denying the child of his/her psychological needs (love, warmth, emotional needs).
- Not making time for children.
- Not taking time to care for children.
- Not showing the child tender love and care.
- Not spending time and interacting with the child.
- Not loving the child.
- Not providing the self-esteem needs of the child.
- Not commenting about what the child does whether good or bad.

### Questionnaire Items

- My parent or guardian does not care if I get into trouble.
- My parent or guardian did not care where I went.
- My parent or guardian did not concern themselves with my upbringing.
- My parents or guardians do not care about what I do outside the home.
- My parents or guardians hardly spend time with me.
- My parents or guardians do not show me love.
- My parents or guardians hardly interact with me.
- My parents or guardians do not encourage me.
### Child Neglect and Psychological Wellbeing

#### Medical Neglect

- Not caring for child’s medical needs.
- Not taking the child to the hospital when sick.
- Not providing medical care for the child.

#### Questionnaire Items

- My parents or guardians make sure I receive medical care when I am sick.
- My parents or guardians take time off to care for me when I am sick.
Final Child Neglect Questionnaire

1. My parents/guardians do not care if I went to school or not.
2. My parents/guardians do not provide proper clothes for me to wear.
3. My parents/guardians do not care about what I do outside the home.
4. My parents/guardians do not correct me when I do something wrong.
5. My parents/guardians do not care if I stay out of school without permission.
6. My parents/guardians do not care if I get into trouble.
7. My parents/guardians do not care about where I go.
8. My parents/guardians do not show me love.
9. My parents/guardians hardly interact with me.
10. My parents/guardians do not encourage me.
11. My parents/guardians do not praise me when I do well in school.
12. My parents/guardians do not take me to the hospital when I am sick.
13. My parents/guardians do not ensure I take my drugs when I am sick.
14. My parents/guardians take time off to care for me when I am sick.
15. My parents/guardians always buy me books I need for school.
16. My parents/guardians usually want to know what went on in school each day.
Child Neglect and Psychological Wellbeing

APPENDIX F

Principal Component Analysis Factor Loadings

<table>
<thead>
<tr>
<th>Item</th>
<th>Component 1</th>
<th>Component 2</th>
<th>Component 3</th>
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Ethical Clearance: Ethics Approval Letter

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No. ...

17th March, 2015

Ms. Anna Gyaban-Mensah
Department of Psychology
University of Ghana
Legon

Dear Ms. Mensah,

ECH 041/14-15: EXPLORING THE GHANAIAN CONCEPTUALIZATION OF CHILD NEGLECT AND ITS IMPACT ON ADOLESCENT PSYCHOLOGICAL WELL-BEING

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 3/09/15
On Agenda for: Initial Submission
Date of Submission: 17/02/15
ECH Action: Approved
Reporting: Quarterly

Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Prof. C. C. Mate-Kole, Dept. of Psychology

Tel: +233-30393866
Email: ech@isser.edu.gh
DOVVSU Introduction Letter

My Ref: NS/DOVVSU/66/SF.1/V.2/0  S C

DSP/DOVVSU/TR
GHANA POLICE SERVICE
TEMA

RE - LETTER OF INTRODUCTION
MS. ANNA GYABAN-MENSAH

The bearer of this letter is an M.Phil Clinical Psychology student of University of Ghana Legon, writing her thesis on the topic: "Exploring the Ghanaian Conceptualization of Child Neglect and its Impact on Adolescent Psychology Well-Being", the case of Tema and Ashaiman.

2. Approval has been given for her to gather the information from your outfit for her project. You are kindly requested to give her the necessary assistance, please.

[Signature]

L W AKORLI
Chief Superintendent
For: Ag. COORDINATING DIRECTOR/DOVVSU