

METHODIST UNIVERSITY COLLEGE GHANA

**THE EMOTIONAL DIFFERENCE BETWEEN CHILDREN LIVING WITH
BIOLOGICAL PARENTS AND CHILDREN LIVING WITH CAREGIVERS IN
INSTITUTIONAL HOMES**

IN ACCRA

BY

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
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DECLARATION AND APPROVAL

This thesis “The Emotional Difference between Children Living with Biological Parents and Children Living with Caregivers in Institutional Homes in Accra” is a dissertation undertaken as a student of the Faculty of Social Sciences of the Methodist University College, Ghana and Submitted in partial fulfilment of the requirement for the award of Master of Philosophy Degree in Guidance and Counselling.

I hereby declare that except for references to other people’s work, which have been duly acknowledged the work presented in this research has never been submitted in part or completely for any degree in this university or elsewhere.

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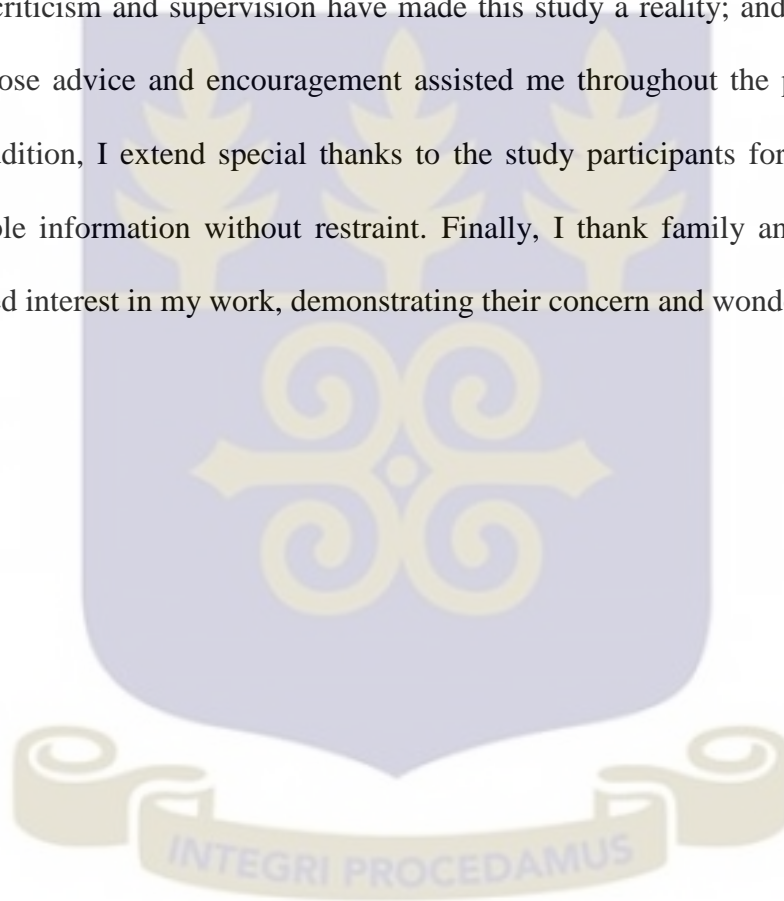
DEDICATION

To the Lord God, Almighty; Father, Son and Holy Spirit; Blessed Three-in-One God;
in whom alone all wisdom is found; and in whom alone I always put my trust.



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Most of all, I offer my indebted thanks and gratitude to the Almighty God, my Father, who has been with me all throughout my course and in this research work, granting me the strength, wisdom and knowledge to accomplish my task. I am especially grateful also to my supervisors, Mr. Gladstone F.K. Agbakpe and Mr. Peter Abomah, whose advice, constructive criticism and supervision have made this study a reality; and to Prof. S. A. Danquah, whose advice and encouragement assisted me throughout the process of this project. In addition, I extend special thanks to the study participants for providing me with invaluable information without restraint. Finally, I thank family and friends who have expressed interest in my work, demonstrating their concern and wonderful support.



ABSTRACT

The general objective of this study is to compare the emotional difference between children living with their biological parents and those living with caregivers in selected institutional homes in Accra. Quantitative data was gathered through the administration of a demographic questionnaire and emotional scale instruments to selected children, parents and caregivers. Qualitative data was gathered through one-on-one interviews of selected children, caregivers and workers of the institutional homes and government representatives. Results show that children living in institutional care are far more likely to experience emotional distress. The Pearson's Product Moment produced negative scores when correlating the ratio of parents/caregivers per child and the caregiver's/parent's attachment to the child; and the same is true when correlating this ratio with the child's attachment to the parent/caregiver. These substantial negative scores indicate the high potential for children's insecure attachment when the ratios become unmanageable either for the child or for the parent/caregiver. Hence, ratios of adults to children and vice versa adversely affect levels of attachments in both directions of the adult/child relationship. The inductive thematic analysis of the qualitative study revealed that children living in the institutional homes suffer from lack of attachment to their caregivers. They experience feelings of hopelessness, low self-esteem, emotional distress, a low sense of wellbeing and no clear sense of cultural identity. From this study, it becomes clearer that institutional homes are not an environment suitable for the wellbeing of children, and should be a last resort only. If such homes must exist as a necessity, measures must be taken by caregivers, workers in the field and government to meet children's emotional and physical needs for the sake of their wellbeing.

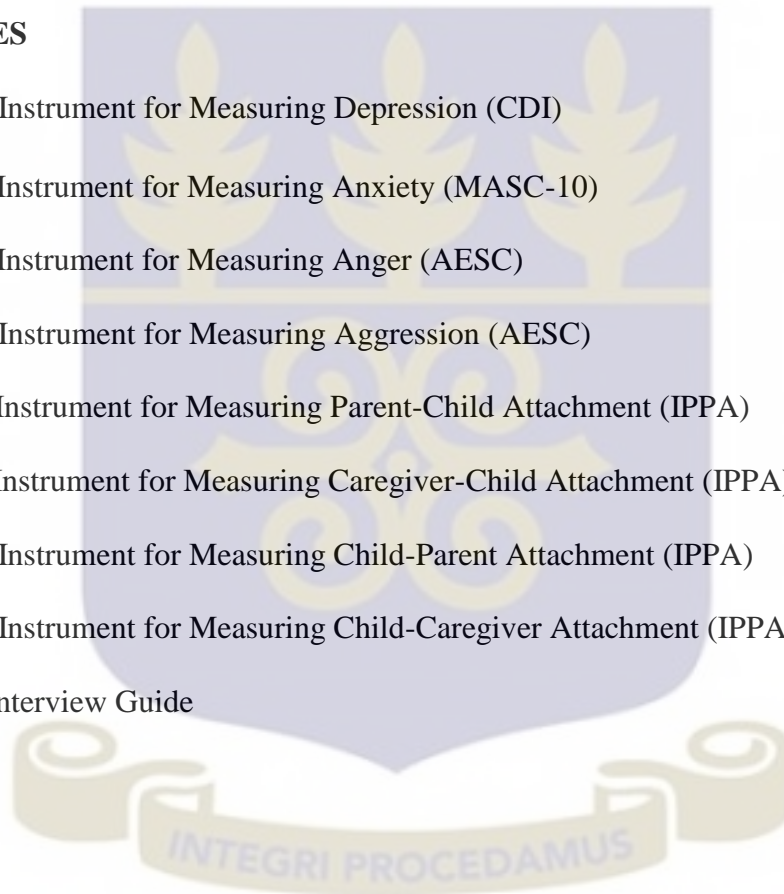
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CRI	Care Reform Initiative
DSW	Department of Social Welfare
HIV	Human Immunodeficiency Virus
OVC	Orphan Vulnerable Children
NCG	News Crusading Guide
PTSD	Post Traumatic Stress Disorder
R-CMAS	Revised Child's Multi-Anxiety Scale
JHS	Junior High School
NGO	Non-governmental organization
CDI	Children's Depression Inventory
MASC	Multidimensional Anxiety Scale for Children
AESC	Anger Expression Scale for Children
IPPA	Inventory of Parent and Peer Attachment
US	United States
BBC	British Broadcasting Corporation
UN	United Nations
USAID	United Nations Program for HIV and AIDS
UNAIDS	United Nations Agency for International Development
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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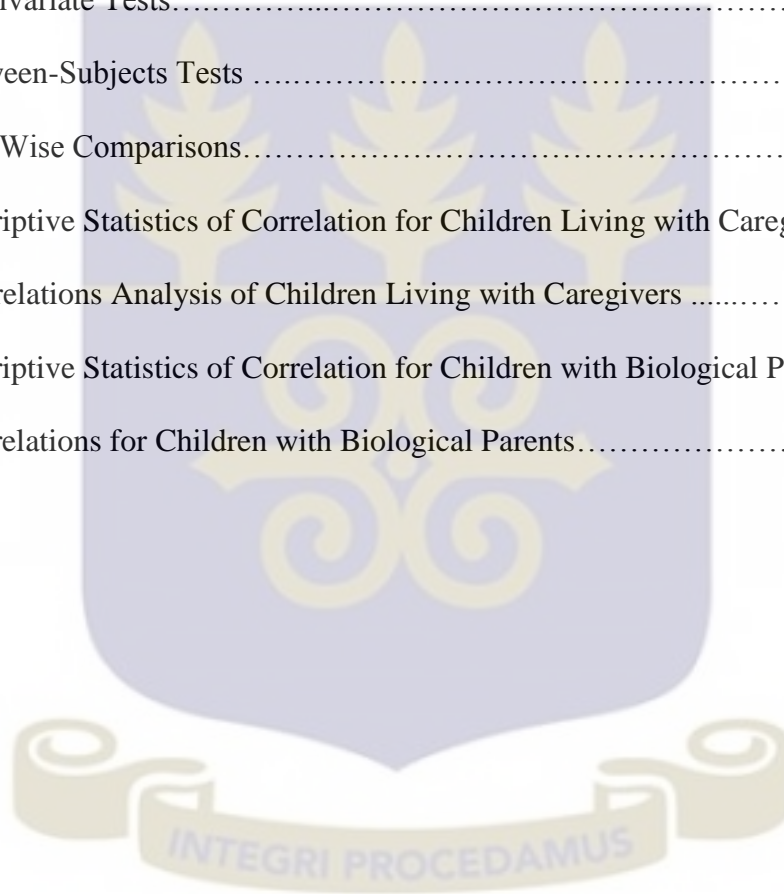
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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

1.1.1 Brief History of Institutional Homes and the Treatment of Orphans

A brief, modern history of orphanages and the treatment of orphans in England, America and the developing world show just how difficult life has been for orphaned children. The story of English society's treatment of orphans passes through the unfortunate practices of bond and apprenticeship, by which orphans and the children of the poor were placed as servants in the charge to the wealthy. (Bullock & McSherry, 2009)

In time, with the horrible conditions of the Industrial Revolution evident to all, many devout Christians with evangelical sympathies, such as George Muller of Bristol (d. 1898), created orphanages to protect children from hard labour throughout the 1800s. Children of the wealthy classes also experienced life away from their parents but they were committed to the boarding school. The practice of sending children to boarding school made the idea of the institutional home for the poor seem reasonable. Thus, by 1948, the Children Act required a children's department in every local authority (Bullock et al., 2009 p.20–21).

John Bowlby in particular studied children from countries such as Germany, Japan, Italy and Poland, who were displaced by World War II and sent to adoptive homes; such as Great Britain, the United States (US) and several Scandinavian countries to be cared for (Wutke, 2012 in Bergquist, 2009). He learned just how important it is for children to have a secure attachment to an adult caregiver.

American society's response to orphans provides a version of the story that leads to current opinion on the matter in favour of mothers' pension, adoption and foster care in private homes. The American experience produced three types of residential home based upon three primary factors. The three types of residential home were the isolating home, which kept poorly behaved children from society; the protective home, which raised children according to particular cultural and religious customs; and the integrative home, which allowed residents to attend public schools during the day. All types of home are connected in some way to urbanization and to external crises such as epidemics or the Civil War, which created many orphans (Hacsi, 1997, p.29).

Americans thought institutional homes were not the best way to care for orphan children. Thus in 1909, the White House Conference on Dependent Children took the view that mother's pension should be instituted to keep families together, and foster care should be organized to imitate family life. Between 1920 and 1950, the institutional home moved from being at a distant third option for orphans to an option only for the most antisocial children (Hacsi, p. 38, 46–49).

From the history of the treatment of orphans in England and America, it becomes clear that children who have needed supportive adults have not always received the help that they need to adjust to the independent life of an adult. The kind of help provided was based less on the needs of the destitute and more on the desire to reduce costs or even to benefit from the situation.

Sometimes orphans are even victims of organized abuse or excessively hostile discipline that results in violent injury inflicted by caregivers who behave like oppressors. For example, in 2003 the British Broadcasting Corporation (BBC) aired the tragic story

of the self-centred motivation of some caregivers when it reported organized sexual abuse at CasiaPia orphanage in Portugal, a reputable state-owned, long-running institutional home. Perpetrators of the abuse of orphaned boys included caregivers and prominent people, such as TV stars, doctors and lawyers (BBC News, 2015). An Egyptian video further showed the manager of Dar Mecca Al-Mokarama Orphanage on Al-Haram Street in Giza beating young children by kicking them, hitting them with a stick and spanking them for opening a fridge and turning on the television (Egypt News August 3, 2014)

In today's world, most orphans are not found in Europe or America, but in Africa and Asia. Many American and European missionaries during the colonial era brought the idea of institutional homes with them in their efforts to improve the lives of those they instructed. Many African states adopted the legal framework established in the UK during the 1930s and the 1940s, when the British public was concerned primarily about the protection of property and control of crime, homelessness and prostitution. They established institutions that have created a strong pulling effect, drawing children who might have been fostered by relatives into institutions (Tolfree, 1995 p. 29-34).

In rural Ghana, extended family members, and occasionally non-kin neighbours, foster orphan vulnerable children (OVC). However, increased urbanization has forced families to move away from their ancestral homes, where the security of extended family existed (*The Child Cannot Wait*, 1992). In urban areas of Ghana, alternatives to traditional fostering were established in the 1940s, when the Ghana Hostels Association began with the objective of finding foster parents for such children. In 1962, the National Trust Fund helped to build the first institutional home, called the Osu Children's Home, to provide permanent shelter for such OAC. The government assumed full responsibility

for the maintenance and operation of various homes of this kind. This responsibility was given legal sanction by an Act of Parliament (the Criminal Procedure Code/Act 30 of 1960 amended by Act 177/section 30 cited by *The Child Cannot Wait*, 1992 p. 18). The objective is to provide near-equivalent natural homes either for children whose parents cannot fulfil their duties, because they are deceased or for other reasons.

1.1.2 The Importance of Children for Nation-Building

A country's greatest resource is its people – especially its children – because tomorrow's world is secured only when society invests in those who will become tomorrow's workers and leaders of the various sectors of society. Both the World Health Organization (WHO) and the United States, understand the economic value of investing in children. In 2004, the WHO identified the need for nations to provide adequate organizational and financial support to promote effective interactions between child and caregiver. A good relation with care giving adults is a fundamental condition for children to survive and to thrive. In 2004, the WHO expressed the concern that all nations should rethink the meaning of shared responsibility for the survival of children and should make a strategic investment in their future. In 2012, the United States Government Action Plan on Children also affirmed the importance of children for nation building. It demonstrates that child development is the cornerstone for all development and investment in children leads to social and economic progress while failure to invest in children undermines social and economic progress.

Although investment in children secures the future of nations, there is a crisis in Africa and Asia where millions have lost one or both parents for one reason or another. War, death, famine, disease, and economic circumstances have led to an enormous

number of orphans and abandoned children (OAC) in Africa and Asia. Though frontline factors vary from country to country, the leading cause of orphan hood in African countries is the HIV/AIDS pandemic. (UNICEF Joint U.N. Programme on HIV/AIDS, cited by USAID, 2011).

Researchers at Duke University's Centre for Health Policy and Inequalities Research (Positive Outcomes for Orphans) estimate that the number of OAC stands about 143 million worldwide. They report that about half of them reside in South and East Asia (72 million). The same researchers also estimate that 12% of African children became orphans by 2010 (POFO, 2012). UNICEF (2006), quoted by Adu, (2011) also indicated that fourteen million children have lost one or both parents worldwide and out of this number, 90% are residing in sub-Saharan Africa.

Ghana, one of the Sub-Saharan African country has a population exceeding 24.6 million; out of this number almost 4.8 million are under the age of 15 (Ghana Census, 2010); and nearly 1.1 million are orphans (Colburn, 2010).UNICEF has reported that the number of AIDS orphans in Ghana has increased dramatically in recent years, from 132,000 in 2004 to 225,000 in 2009. It expects the number to reach 291,000 in 2015 (UNICEF, 2011 cited in *Telling the Untold Story*, 2005).

A child's vulnerability in orphan hood can be described in various ways. UNICEF in *Telling the untold story* (2011), citing Skinner and Davids 2004 identified three core areas of concern. The first area is material or economic: access to money for food, clothing, shelter, health care and education. The second area is emotional: loving support and space to grieve. The third area is social: a supportive peer group, role models to guide them in different situations and assistance through risks in their immediate environment.

Adu's (2011) findings noted that poverty, homelessness, child labour and trafficking, domestic violence, gender discrimination and early marriages are all factors involved to the vulnerability of OAC, which compromise orphans in all of the areas mentioned here.

1.1.3 The Situation of Institutional Homes in Ghana

Colburn (2010) drew attention to the Care Reform Initiative (CRI) programme sponsored in 2006 by Ghana's Department of Social Welfare, which shows that there are 148 institutional homes operating in Ghana; however, only five are registered.

Telling the untold story (2011) attributes this sudden irruption of Institutional Homes in Ghana to the lack of response from the government and the non-existence of policy and regulation. Although lists of criteria were made for the standards of opening children's homes (which includes physical buildings, the environment and the qualifications of the caregivers), these criteria are not met because orphanages are running with no approval and supervision (*Ghana Child and Family Welfare Policy*, 2014). Telling the untold story (2011), analyzing the implementations of the CRI (2006) plan for OVC and family in Ghana, says, "The plan has never seen the day of implementation." Out of the estimated 4,000 orphans who are living in these unregistered orphanages throughout the country, majority of them are not orphans, but children with parents who cannot afford to keep them (www.ovcghana.org). The CRI has affirmed that 90% of residents in orphanages do have living parents.

The original aim of institutional homes for children is that they should be temporary shelters that take responsibility only after making inquiries about a child's background and family. However, present investigation shows that many orphanages are

taking in and keeping children without any background survey and with little facilities to provide for them (UNICEF, 2010: i).

UNICEF's further analysis associates children in such environment with problems of neglect caused by poor care standards and suffering from poor nutrition, life-threatening unhygienic practices and chronic lack of physical and emotional attention. Explaining the motives behind the establishment of new institutional homes, UNICEF indicates that they exploit and abuse rather than support the welfare and wellbeing of vulnerable children (UNICEF, 2010: i). As well, one of UNICEF's child-protection workers during an interview said, "Running an orphanage in Ghana has become a business enterprise; a highly lucrative and profitable venture" (Feb. 2015).

In 2013, the WHO Regional Office for Africa reported that only ten (10) mothers ran an over-filled home outside Accra at Bawjiase, which housed 126 children from infants to 17-year-olds. When the WHO first visited the home in 2001, seventy-three (73) children of the same age range lived there. In 2013, at the time this report was released, 126 children are registered with the home, with twenty-eight (28) of them under one (1) year old. According to the proprietor's statement, fourteen (14) non-salaried staff members have dedicated themselves to run the home.

As stated by UNICEF (2010), although the National Standard ratio between caregiver and child for residential homes in Ghana is supposed to be one to seven children (or eight including one's own child) Unfortunately, OVC are kept in these overcrowded accommodations, including infants exposed to hazardous living. The Care Reform Initiative Ghana reports that most institutional homes do not meet basic requirements of social welfare and that the conditions of care are pitiful. Nearly 80% of

the staff is unqualified, unpaid or part-time workers. Living conditions are poor; and children receive insufficient attention from caregivers because of the inadequate child-to-caregiver ratio.

To cushion their shortcomings, these institutional homes invite foreign volunteers to assist the overworked Ghanaian staff and to give children much needed attention, planning and organizing activities that teach and entertain the OVC (www.orphanageafrica.org). However, the impact of exposing these children to short-term relationships with strangers at a tender age is not considered. It can be unwise to have people who do not know their language or cultural norms teach them, and to have people who will not stay long become attachment figures. At the end, such children are very likely to become confused and feel abandoned.

Smart and Smart (1972, p. 175) elucidated on how children with multiple mother figures become disadvantaged emotionally. In addition, their in-depth study also proves the complex difficulty that babies faces as they learn to adjust their motor and social responses to several adults rather than simply to one.

Based upon these facts, one can predict the kind of future that is waiting for the OVC, and the emotional hazards that they will be exposed to during their early developmental stages. In this regard, global policy-makers have associated institutional care for OVC with poor health and well-being (Ghera, 2009). Because of this, they strongly suggest that orphans abandoned children living in institutional homes be moved as quickly as possible to a residential family setting and that institutional care be used only as a last resort (*Ghana Child and Family Welfare Policy*, 2014). Researchers have also suggested that the authorities' response towards orphans' policy should favour

fostering orphans within the extended family rather than keeping them in institutional homes (Ansell & Young, 2004).

Ghana is the first country to ratify the world summit convention for children 1990. The country has formulated workable policies, strategies and programmes that could lead to the implementation of the affirmed pledge of children's needs by the World Summit. In this regard, the government has paid much attention to three major reform areas:

1. Education
2. Health care with emphasis being given on primary health care and
3. Nutritional problems of children (*The Child cannot wait, 1992*).

The Ghana Child and Family Welfare Policy Revised Draft, (2014, pp.25-30) described the roles of the key ministerial offices, departments and agencies in caring for the wellbeing of Ghanaian children. This document sheds more light on issue of living conditions and pays less attention to the protection and care of children's emotional wellbeing. The focus on physical conditions also occurs in researchers' works that study the problematic condition of orphans in the other parts of Africa (Family Welfare et al., UNICEF, 2010). The findings of Behrendt and Mbaye (2008) and Tsegaye (2013) affirmed that most African research on OVC are focused on health and nutrition, with only few studies mentioning the psychological and emotional wellbeing of OVC.

Since the founding of the nation, orphaned children always have required support for their physical needs, for protection against abuse and for guidance to become responsible adults in society. However, the focus on the physical needs of OVC cannot be the best way of meeting their needs holistically. As Dennis Coon (2005), the writer of

Psychology a Journey, argues, the child's significant need for love and affection is as important as the obvious needs for food, water and physical care.

As *The Child Cannot Wait* (1992) shows, the government of Ghana in collaboration with local and international organizations is putting measures in place to protect children from all kinds of harm. However, as good as this document is, a fully informed response to the crisis of OVC must address emotional and relational as well as physical needs in order to give them a better future.

1.2 Statement of the Problem

During numerous visits to institutional homes in Accra and in the surroundings, the researcher has noticed a greater degree of anger, depression, inattention, theft and lying among orphans than has been observed among children of the same age group who live with their biological parents. The researcher believes that such negative moods and behaviours result from the low level of attachment that they receive from their caregivers. Johnson cited by Wutke (2012) said the attachment cycle begins early and agrees with Freud that the mother/child bond becomes the basis of all future relationships. Bowlby's attachment theory clarifies the importance of the mother/child bond by noting that securely attached children develop a sense of self that serves as a guide for social interaction and contributes to positive experiences in their relationship with others.

In Ghanaian institutional homes, the story of caregiver-child attachment is heart-breaking. Electronic and print media investigational reports have brought to light what is happening in some of the Ghanaian orphanages/institutional homes for children (both in private and public orphanages). Anas, the Ghanaian undercover investigative journalist

for the *New Crusading Guide* (NCG), reports serious mistreatments, including sexual and physical abuse that vulnerable orphaned children have endured under their caregivers at Osu Children's Home, which is the only public institutional home for children ([http://www.modernghana.com/news/294971/1/more-drama-osu-childrens-ome.html](http://www.modernghana.com/news/294971/1/more-drama-osu-childrens-home.html)). Full coverage of similar occurrence at Bawejiase in a Country Side Children's Welfare Home also disclosed orphans' physical and emotional abuse at the home and the school, poor feedings and forced fasting and the most horrible aspect of it: an SHS graduate 'doctor' injecting sick orphans (*The Crusading Guide*, 2nd Feb. 2015)

Along this line, the Care Reform Initiative reports that children with disabilities do not receive appropriate care; and babies are neglected because of understaffing (www.ovcghana.org). The crisis concerning orphans in sub-Saharan Africa not only jeopardizes their rights and wellbeing but also compromises the overall development prospects of their countries (UNICEF, 2013 cited by Telling the Untold Story 2011). From this literature, one can understand that what happens to children at their early stages affects their future as adults

Afrifa (2009) explained that abuse leads to increased aggression and anger, low self-esteem, depression, poor academic achievement and drug abuse as well as emotional problems involving self-injurious and suicidal behaviours, which will also lead to adulthood aggressiveness towards a spouse.

This study examines the emotional difference between children living with their biological parents and children living with caregivers in institutional homes; and evaluates whether poor level of attachment between child and parent/caregiver leads to higher levels of depression, anxiety, anger and aggression.

1.3 Purpose of the Study

The purpose of this study is to compare the emotional difference of Ghanaian children living in institutional homes and that of Ghanaian children living with their biological parents in Accra.

1.4 Objectives of the Study

The researcher identifies the following objectives that will assist her in this task:

1. To describe the relationship between children's attachment level and emotional and relational wellbeing;
2. To examine the parent/child and the caregiver/child attachment level;
3. To observe the child caregiver /parent attachment level.
4. To examine the difference in the level of anxiety, depression anger and aggression between children living with their biological parents and children living with caregivers in institutional homes; and
5. To find out the difference in wellbeing between children living with their biological parents and children living with caregivers in the institutional homes

1.5 Significance of the Study

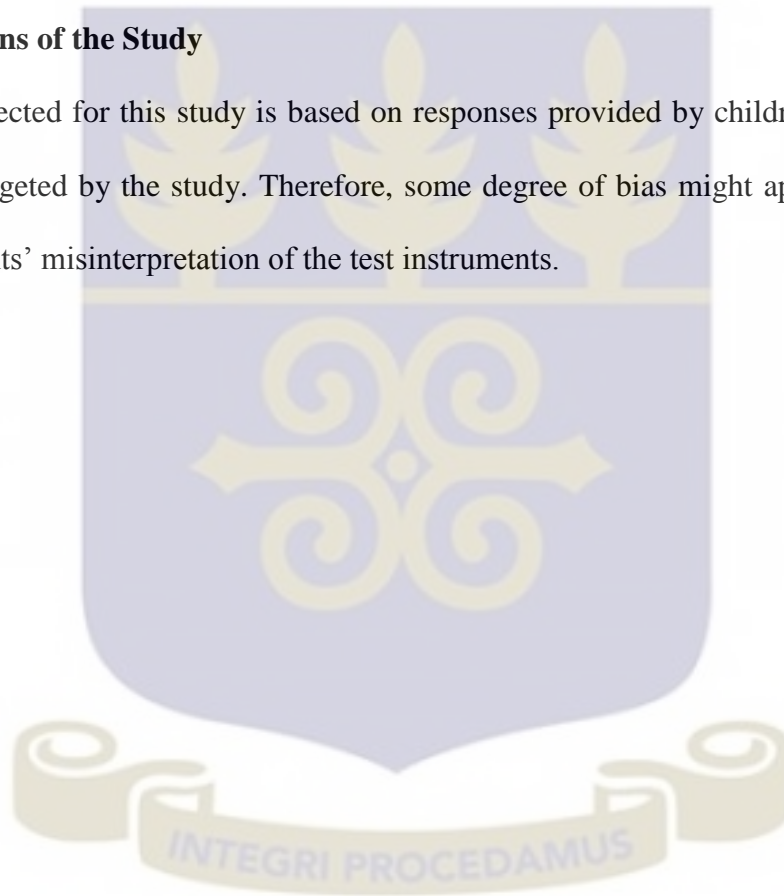
The researcher identifies at least six benefits of this study; that as a result this study will:

- Create the urge in to the need for children to be raised up in a conducive environment.
- Draw the reader's attention to the emotional and relational problems of children living in the institutional homes;
- Provoke advocacy for the emotional and relational wellbeing of OVC;

- Guide policy-makers who can protect children by drafting informed laws;
- Bring to light the crucial need of having trained counsellors and psychologists at every institutional homes;
- Encourage further research leading to better structuring of institutional homes for use as a last resort.

1.6 Limitations of the Study

The data collected for this study is based on responses provided by children, parent and caregivers targeted by the study. Therefore, some degree of bias might appear based on the respondents' misinterpretation of the test instruments.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter is a review of the current and past works on the emotional differences, attachment, the impacts of good child caregiver attachment and the impacts of poor attachment and neglect on the emotional wellbeing, behaviour and psychosocial life of children. In this study the explanations of three major theories are presented below accordingly.

2.2 The Explanations of Psychodynamic Theory and Learning Theory

The earliest theories of human developments are built upon the idea that fixed realities guide the process of life. Sigmund Freud's psychodynamic theory explains human development in terms of unconscious inner urges, which he describes as irrational, invisible and uncontrollable pleasure seeking drives. According to him, they influence patterns of thought and behaviour. Freud states these drives are foundational motives that explain the experiences of human development at each stage. The theory holds that innate sexual drives facilitate human bonds in infancy and lead to emotional and sexual fulfilment in adulthood (Berger, 2005). Since the gratification of biological drives guide human development for Freud, he proposes five stages that are linked to different parts of the body (Freud, 1923 in Sharf, 2008). These stages are known as 1) the oral stage, 2) the anal stage, 3) the phallic stage, 4) the latency stage and 5) the genital stage.

Sharf (2008) explained Freud's belief that "infants receive a general sexual gratification in various parts of the body that gradually become more localized to the genital area in the development of the child" (Sharf, 2008 p. 33). According to the logic

of this theory, stimulation of the mouth, tongue or lips brings pleasure in the oral stage, such as when infants find contentment in sucking the breast. Kathleen Berger says that “the baby through breast sucking gets not only physical nourishment but also experiences sensual pleasure and becomes emotionally attached to the mother as she is providing this oral gratification” (Berger, 2005 p.33). Likewise, Smart & Smart (1972) also agreed that sucking brings both the mother and the infant together and causes pleasant sensation.

Freud’s theory goes on to presume that adults who may not have passed through each stage properly, leaving them dissatisfied and prone to problems related to a particular body part. Thus, cigarette smoking is connected to a problem arising in the oral stage of development. Intense orderliness, such as strictness with money is connected to troubles in the anal stage. Romantic attachment to significantly older persons is linked to difficulties in the phallic stage. To illustrate the kind of problem that might arise, one might consider the on-going effect in adulthood of over-stimulation and under-stimulation in the oral stage at infancy. Illustrating this, Sharf says, “Too much of the breast causes a child to linger in the oral stage and to develop psychological dependency as an adult; on the other hand, if a child experiences anxiety through irregular feeding and lack of attention the child will feel insecure during childhood and adulthood” (Sharf, 2008, p.34). Therefore, psychodynamic describes the relationship between the mother and the child to be as an archetype for all future relationships (Smart & Smart, 1972).

One of Freud’s most influential ideas is that each stage includes its own potential conflicts. Conflicts occur, for instance, when an adult tries to wean a baby from the bottle (oral stage) or when society tries to direct adolescent sexual urges (genital stage). According to Freud, how an individual experiences and resolves these conflicts

determines the individual's life-long personality and behavioural patterns, especially those conflicts related to weaning, toilet training and sexual curiosity. Freud supposes that individuals become anxious, angry or emotionally unstable when early sexual drives are not satisfied and stable when satisfaction is obtained (Berger, 2005).

In this psychodynamic model, the mother/infant bond is primarily physical. Nursing becomes the basis of gratification between the infant and the mother, because the infant sees the mother she who gratifies a physical desire. It overlooks the role of attachment between a child and a parent/caregiver for the child's emotional needs and behaviour formation. In general, Freud's view of human nature is deterministic, closely linked to biological factors. For him, drives developed during the first six years of life guide thoughts and actions throughout life.

Behaviourism, as learning theory focuses on how people learn new ways of behaving in a step-by-step process in the real context of their external environment. The theory holds that people learn from encountering other people in their surroundings. Thus, these theorists believe that people are not born with a specific personality, but become the person they are because of external factors such as training received in childhood (Berger, 2005).

According to this theory, anyone can be trained to become an artist or a scientist, a business icon or a beggar, a banker or a thief, or anything in between regardless of supposedly innate "talents, tendencies, abilities, vocations" or "race" (Watson, 1924/1988 p. 82 in Berger, 2005 p. 38). Learning theorists believe that human development pertains more to a gradual learning process based up on enforcement by significant others than to biological factors, such as the satisfaction of hunger. The mother/child bond, for the

learning theorist, relates to reinforcement of behaviour; such as the smiles a mother and an infant share with one another. Berger writes:

A baby first gives a half smile in response to a full stomach; a mother might smile back. Soon the baby is conditioned by the mother's responsive smile and gives a bigger smile; and the mother encourages the smile by picking the baby up. As time goes on, the baby becomes a smiling toddler, a cheerful child, an outgoing adolescent and a friendly adult (Berger, 2005, p. 39).

Learning theorists believe early operant conditioning and periodic reinforcement form a child's personality, emotional development and social interaction. A person learns through a gradual process what to fear, what to love and how to relate politely to others (*Theories of Psychology*, p.85). Therefore, the basic principle in learning theory is reinforcement and the association of particular people with one's own wellbeing (Wenar & Karig, 2011, p. 46).

Hence, psychodynamic theory and learning theory share in common a kind of deterministic belief that the infant-mother bond is connected to the physical factors involved in breast-feeding, whether through the satisfaction of biological desire or through the environmental reinforcement of the mother's smile when the infant nurses.

2.3 The Explanation of Attachment Theory

Bowlby's (1951) attachment theory has similarity with the psychodynamic and learning theories in granting a significant role to fixed factors in human development. Yet

it credits to the mother a far more significant role in the mother/infant bond than psychodynamic theory and learning theory allow.

Bowlby (1969) defined attachment between a child and a mother/caregiver to be an in-born system in the brain that evolves in ways that influence and organize motivational, emotional and memory processes with respect to significant care giving figures. Attachment theory looks at a mother not as a source of pleasure gratification or as a re-enforcer but as a very important person who nurtures a child's mental development and as the one who serves as a psychic organizer for her child, who needs the mother to make sense of the world. Bowlby writes:

If growth is to proceed smoothly, the tissues must be exposed to the influence of the appropriate organizer at certain critical periods. In the same way, if mental development is to proceed smoothly, it would appear to be necessary for the undifferentiated psyche to be exposed during certain critical periods to the influence of the psychic organizer- the mother (Bowlby, 1951, p.53 in Bretherton, 1992, p.761).

The harmful response of a caregiver or neglect in meeting the infant's need can be difficult for children to develop cognitive models of themselves and their caregivers that can be transferred to other relationships later in their life (Johnson, in *Developmental Psychology*, 1992). The goal of attachment for a child is to maintain proximity to the caretaker in order to build a strong relationship (Wanar & Karig, 2011, p.46). Whereas psychodynamic theorists believe that young children may have unresolved issues between the id, ego and superego that could lead to emotional problems in adulthood; attachment theorists consider that a loving mother herself becomes her child's ego and

superego. She trains her child on how to function in the ego and superego, orienting her child on how, when and where to act until the child becomes a responsible adult (Bowlby, 1951, p.53 quoted by Developmental Psychology, 1992, p. 7).

For the attachment theorist, the loving mother is the environment and the world of the infant through whom he learns, explores, understands and develops. Wanar et al. (2011) said, “The ‘set-goal’ of attachment is to maintain proximity to the caretaker. The child’s behaviour is organized around this goal and is designed to enhance the probability that the relationship with the caregiver will be a strong one” (p. 46). Smart and Smart (1972) also described attachment as an on-going condition of an individual through which he seeks proximity to and contact with another person. Zeanah and Boris, cited by Potter and Sullivan, (2011) explained attachment as an innate system of coordination bio-behavioural system that helps an infant and a child to coordinate the balance between the need for safety in proximity to a caregiver with the tendency for exploration and autonomy.

In the nutshell, Bowlby’s attachment theory views emotional balance in childhood and adulthood to have everything to do with a secure child/parent or principal caregiver attachment in early life. He considers the early child mother/principal caregiver attachment as the means to providing an emotional wellbeing and adjustment in children during adolescence (Buist, Dekovic, Meeus, & van Aken, 2004 in Kacayoruk, 2010).

2.3.1 Empirical Studies on Attachment Theory

Mary Ainsworth, Bowlby’s research assistant, later developed attachment theory by studying feelings of security in the parent/child relationship through an experiment

performed in Uganda called ‘The Ganda Data.’ (Ainsworth, 1963 in Bretherton, 1992; Wenar et al., 2011). She later performed the same experiment, entitling it “The Strange Situation” (Ainsworth & Bell, 1970 in Bretherton, 1992).

Ainsworth placed infants and mothers in surrounding new to both of them in order to observe how each reacted to new people and new toys. When the mothers left, she observed whether the children would continue playing and how each child responded when the mother returned.

Three types of attachments were observed: 1) secure attachment, 2) insecure avoidant attachment and 3) insecure resistant attachment (Main & Weston, in Wenar et al., 2011). Securely attached children are emotionally stable. They relate well to strangers and explore the new environment freely, yet in the presence of their caregiver. In the absence of caregiver, they limit their activities. Upon reunion, they greet the caregiver positively and continue playing. Such caregivers understand their children’s needs and signals, and respond appropriately to them. Children who display insecure avoidant attachment show independence. They relate well to strangers and explore the new environment without the presence of the caregiver. Upon reunion, they show no emotion toward the caregiver, and avoid eye contact as they continue to play. Such caregivers demonstrate behaviour that is insecure, avoidant, uncomfortable and angry. Children who display insecure resistant attachment are fearful. They cling to their caregiver, and resist meeting new people and exploring new environments. Upon reunion, they greet their caregiver with hostility and take a long while to be comforted. Such caregivers behave in irregular ways, close at times and distant at other times. The children respond with protest

to demand the attention needed (Wenar et al., 2011; Ainsworth & Bell, 1970 in Bretherton, 1992).

Along the same lines as Ainsworth, Harlow (1958) performed his popular child/parent experimental study with infant monkeys to show that comforting love which is the emotional bond between mothers and infants to be more significant to infants than feeding and satisfaction of hunger (Berger, 2005).

Harlow arranged for sixty (60) monkeys to be separated from their mothers six to twelve hours after birth; bottle-fed the monkeys under two different conditions. One group received milk through a padded surrogate mother's chest; the other through the chest of a surrogate mother constructed of wire. Those monkeys with the padded mother spent time with it even when they were not hungry; but the monkeys with the wire mother approached only when hungry. Furthermore, the experiment proved that even in times of fear those in group one found immediate comfort by clinging on their padded mother and exploring the object with one hand Smart and Smart (1972); those in group two received no comfort from the wire mother; they were screaming, hiding, getting frightened, frozen, and even urinating (Harlow, 1958 in Berger, 2005).

Consequently, Harlow demonstrates that soft touching or "contact comfort" is the primary function of mothers, not feeding alone (Harlow, 1958 quoted by Berger, 2005, p40; <http://www.psychologytoday.com/blog/spontaneous-emotion>). Hence, Harlow points out that these interactive and communicative socio-emotional challenges correlate with the human children in infancy, childhood and adolescence (Buck, 2010). Therefore, he emphasizes that just as it was impossible for infant monkeys to find comfort from cold, uncomfortable wire mother, so also human infants brought up by cold, neglectful or

rejecting parents/caregivers experience fear, depression and anxiety that damages them later in childhood and adulthood (Barnet & Barnet, 1998, Nelson, 1999 as quoted by Coon, 2005).

Harlow explained the primary factor for infant's basic sense development to come from the sense of trust that is achieved early in life through contact comfort. And he also describes the child's early experiences of abuse and neglect as the main cause of disordered attachment and antisocial behaviour (Buck, 2010). Therefore, in order to develop a sense of wellbeing, all of childhood must be viewed as a sensitive period (Coon, 2005).

According to Collins and Gunnar (1990), children who grow up in overcrowded orphanages suffer lack of attachment. The same can also be true in orphanages that are not overcrowded, yet have caregivers who do not provide contact comfort. Lenore, McVey, Alan and Porter, (1998) stated that children who make more frequent contact with their biological mothers are less likely to experience depression, affirming Bowlby's statement that clinging and following are more important for infants than sucking and crying (Bowlby, unpublished 1962a and 1962b). Harlow addressed the role of a mother as 'contact comfort' or 'love'. He said, "It seems, then, that mothering is not primarily about feeding but about touching, comforting and holding" (Harlow, 1958 in Berger, 2005,p.40).

In general, Bowlby's theory of attachment, coupled with Answorth's and Harlow's empirical studies, teaches the undeniable truth: that a mother's/principal caregiver's love establishes the secure attachment bond between an infant and the primary caregiver that

leads to the well-balanced emotional, behavioural and psychosocial development of a child (Berger, 2005).

2.3.2 The Impact of Secure Attachment on Wellbeing

While children do have physical needs, an essential factor in children's wellbeing is the emotional security. Emotional security comes from feelings of attachment formed in an actively affectionate reciprocal relationship.

Kocayörük (2010) explained the importance of attachment by observing that “it provides the child with autonomy, self-confidence, other emotional and social tools needed to develop relationship within the social world” (719). Afrifa further added that the impact of parent-child and child-parent attachment in infancy is significant because it forms the psychological basis for later family relationships (Afrifa, 2009). In line with this view, Coon (2005) says that the real core of social development is found in the emotional attachment, the close emotional bond that babies form with their primary caregivers.

The attachment theory and several studies agree that failure to form a secure attachment to an adult caregiver during childhood will negatively affect the physical, emotional, social and intellectual scope of a child's life lasting into adulthood. In this regard, Shanthi (2009) described the link between an individual's emotional state and physical health saying that, behind every physical sickness there is a potential drive of emotional imbalance exhibited in the form of anxiety, depression, fear, likes/dislikes and anger. The same study further explained that, whereas courage, good humour, a sense of control and hopefulness can all be beneficial fear, uncertainty, as well as a sense of hopelessness and helplessness, can have a harmful effect on health.

Mathias (2007) in Wutke (2012) examining the health conditions of internationally adopted institutionalized children brings to light their increased risk for health-related developmental and behavioural difficulties including cognitive developmental issues and difficulties with attachment to caregiver. On this view, the attachment theory of Erickson describes attachment as an active warm, reciprocal relationship. It is an important determinant of an infant's sense of trust, with the quality of the mother-infant bond being more important especially as it is distinguished from all other persons (Afrifa, 2009). Likewise, Brazelton and Cramer (1990) said that the emotional, physical and intellectual development of young children and infants are derived out of the daily interactions made with their parents/principal caregivers (<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family>). Quoting Bowlby's (1969) presentation on the significance of attachment in shaping a child's life, Mooney says, "Two environmental factors early in life can introduce lifetime challenges: separation from or the death of a mother; and two, the emotional attitude of a parent toward a child has life-shaping effects" (Mooney, 2010 in Wutke, 2012). Therefore, many scholars acknowledge that children form their worldviews based upon their early attachment experiences.

Perry (2002) stated that orphans who lack a stable emotional attachment and touch from primary caregivers are at risk of poor brain development and cognitive limitations. Biemba, Godrey, Beard, Brooks, Bresnahan and Flynn (2010) also observed that there is a high proportion of mental health claims among orphans; which is as a result of experiencing maltreatment, such as neglect or physical or sexual abuse. Kedija (2006) observed that orphans are likely to have low emotional intelligence, thus they do not master life skills such as interpersonal communication, decision-making and negotiation.

Quoted by Tsegaye (2013, p.23,24), Tronick and Beeghly (2011) added that interactive communication between children and parents helps children to develop a sense of self and model various emotional expressions as well as emotional regulation skills, such as self-calming and self-controlling skills. Goswami, (2013) in Wutke (2012) also related parental deprivation to poor academic performance; and intellectual development and knowledge acquisition to motivation and the self-confidence. Goswami described the importance of parental and peer approval in the positive emotional development of a child and the acts of rejection by parent and peers resulting in a belittling self-picture and inferiority feelings. Smart and Smart (1972, p.162) showed how contact through clinging, touching or even looking at a loved person restores the baby's equilibrium; and further shows how holding the baby close can alleviate distress reactions which look like fear caused through loss of support, pain, loud noises and other intense stimuli.

Bowlby and many other researchers look at attachment as a significant dynamic power in regulating infant's safety in the environment, its role in children's development of cognitive and affective model of themselves and their caregivers that is transferred to other relationships when the attachment between the child and the primary caregiver is well established (Bowlby, 1969 in Wutke, 2012). In general, numerous researchers and theorists' acknowledge attachment security as a cornerstone of social development. It provides the child with autonomy, self-confidence, and other emotional and social tools needed to develop relationships within the social world (*Online Journal of Educational Sciences*, 2010).

2.3.3 The Role of a Mother/Primary Caregiver in a Child's Life

Among all other factors in a child's developmental growth, the most fundamental aspect is the role of a mother/substitute mother. For the growing baby, a mother is a role model, a teacher, and source of comfort and security through the means of love, care and a healthy attachment. An applied psychologist, Verial (2009), looked at the role of a mother in a child's life as being a safe base on which children can rely. A mother teaches confidence so that her child will not be afraid of new surroundings. A mother's love is found to be positively related to babies' happiness and calmness behavior, especially between 10 and 36 months (Smart et al., 1972). Furthermore, the real core of social development is found in the emotional attachment that the babies form with their mothers/primary caregivers (Cherry, 2006).

According to UNICEF (2006), cited by Goswami (2013), when children receive the needed attention and love from their parents, they develop an image of themselves as a desirable person, and they develop a positive self-concept. Many studies have regarded the child-mother attachment that occurs during the first year of a child's life as the best source of holistic development. Clothier (1943) stated that a child who encounters lack of motivation from a prominent, loved attachment figure rejects training as a sign of antagonism for the lack of love and attachment he has experienced. If training is accepted, the motivation is most probably fear and may result in wetting and soiling. Mothers who touch and hold infants close form a direct bond with them that can have lasting effects on children. Infants who are securely attached at the age of one year show more resilience, curiosity, problem-solving ability and social skills in preschool (Collins & Gunnar, 1990).

A child's future is determined by the type of attachment/relationship formed with the parents/principal caregivers. A strong child-parent relationship can lead to a healthy essential long lasting health and wellbeing (Doku, in telling the untold story 2011). Deprivation of love and neglect also lead to lifelong crises. Stating a child's maternal deprivation, Ainsworth described that maternal deprivation has three different dimensions: i.e. the lack of maternal care (insufficiency), distortion of maternal care (neglect or mistreatment), and discontinuity in maternal care (separations, or the child being given one mother figure and then another) (Karen, 1998).

Bowlby's profound theory coils around the concept of the mother playing a determinant role in developing a healthy mental growth of the child. In this regard, he says, "The infant and the young child experiences a warm, intimate and continuous relationship with the mother/permanent mother substitute in which both find satisfaction and enjoyment" (Bowlby, 1951, p.13 in Developmental psychology, 1992). NIH-PA Author Manuscript (2010) stressed that children who make more frequent contact with their biological mothers can less likely experience depression that is significantly associated with lower externalized problem. Thus, the close contact and the presence of a mother elevate a child's fear and tension.

2.4 Understanding the Fundamentals of Emotion

Several researchers have defined emotion differently. In general, emotions are understood as representing feelings of long or short-term subjective experiences and expressive behaviors. They are also explained as feelings of being attracted to or repelled by something (www.merriam-webster.com/dictionary/emotion.). Emotions are part of the human evolutionary heritage that serve as a means of expressing feelings and mood and

also that create awareness by adding to general understanding and the facilitation of social communication (*edu/entries/emotion, 2013*).

Psychology Notes HQ (2012) explained emotions in regard to the four theoretical views:

1. *James-Lang's Theory*: This theory supposes that emotions are the way one interprets a physical reaction. For example, a person who is on his own in a dark room, upon hearing a breath nearby, interprets the sound as scary and becomes frightened.
2. *Cannon-Bard's Theory*: According to this theory, an individual first feels the emotion and later experiences the physical reaction, such as sweating and trembling. Using the same illustration, the person first hears the breathing nearby, then his heart rate increases and he begins trembling. While the person is experiencing the physical reaction, he also experiences the emotions of fear at the same time.
3. *Schachter-Singer's Theory*: This theory looks at the displayed emotion and labels it based upon reasoning. When an event occurs, reasoning follows to identify the causes of the physical arousal and labels the emotional behavior as fear, anxiety, panic or whatever other emotion is appropriate.
4. *Schachter-Singer's Two-Factor Theory*: This theory has two strands of explanation. First, physiological arousals are the main factors for emotional responses. Second, all the emotional responses are not the results of physical arousal alone. Cognitive labeling is taken into consideration when it comes to the explanation of emotional response. Thus, the person associates the

physiological arousals to fear, which is immediately followed by the conscious experience behavioral display of the emotion of fear.

All the four theories have associated the emotional responses as having sprung out of a potential entity that could cause the physical arousal leading to the emotional responses that affects both the physical and mental state of the person.

Cherry, the psychology expert on *psychology.about.com*, explains emotion focusing on three basic elements that she calls subjective experience, physiological response and behavioural response. She explains the subjective experience in relation to particular ways of an individual's experiences of emotion. Although there are commonly known emotions around the globe, for example, anger, sadness and happiness the particular way each emotion is experienced differs from individual to individual. The physiological response is associated with the body's response to anxiety or stress such as an increased rate of heart beat, stomach upset and so on. The behavioural response of emotions is the actual response of outward display of the feelings that is exhibited in every individual's day-to-day life.

Emotions are developed from infancy; New born babies are seen displaying a variety of emotions; sadness, anger and, in about 6 to 7 months, fear symptoms. As time passes, they express more complex emotion (Smart et al., 1972). From infancy to adulthood, human beings experience different emotions within the same day. These could be positive or negative emotions that can relate to objects or subjects; to one's future, present or past events. Sometimes emotions can vary depending upon an individual's appraisal and social events (*Psychology Notes HQ, 2012*).

There are two main categories of emotion: primary emotions and secondary emotions. Primary emotions are innate and present from the time of birth. These emotions are love, care, joy, surprise, anger and fear. Secondary emotions are those learnt from experience by modelling and imitations of others. These include, pride, rage, shame, neglect, sympathy, horror and so on.

Mothers/caregivers are models and re-enforcers of emotions in the infant's early life. For example, sometimes mothers/caregivers repeat the infant's facial expressions encouraging the infants to imitate and repeat (Wenar et al., 2012). The work of Wenar and Karig further described how emotions not well integrated with other systems of the body could have maladaptive consequences on an individual's life, producing anger, depression, anxiety and even pathological problems. It is also believed that the development of emotions plays an important role for human understanding of psychopathology and normalcy.

In general, quality of life pertains to the state of an individual's emotions. Emotional health can make a big difference as well as determining life as whether someone feels that life is worth living or ending (www.merriam-webster.com/dictionary/emotion).

2.5 The Emotional Problems of Orphan Vulnerable Children

The emotional problems of children in general are often not considered or understood by the adult caregivers, teachers and members of society at large (Behrendt & Mbaye, 2008). Adults often think that children have no feelings or they can forget their emotional problems and feelings easily. However, this belief is not true to children's experiences. For children, and especially OVC, can have deeply rooted emotional problems.

Fredrikson and Kandours in Tsegaye (2013 p.23, 24) explaining the anguish of parental death on children said, “The impacts of parental death on children are complex and affect the child’s psychological and social development.” Adu (2011) as well described the episodic process for a child to become an orphan not just as an event.

Studies have proved that for children who become orphans as a result of AIDS, the state of their orphan hood starts long before the actual death of their parents. Children get disturbed when they see their parents long term sickness; when a child realizes that the parent is always sick pressure begins to mount in his or her mind (*The Psychological Impact of HIV/AIDS 21*).

Children suffer the fear of losing their parents from HIV/AIDS, become disadvantaged and start experiencing rejection and inappropriate care for their needs (Jackson, 2002 p 257 as cited by UNICEF, 2011 p 17). Across Africa, millions of children are experiencing deepening psychological trauma, hardship, lack of education, poor health care, a deep fear of insecurity and lots of mental stress from witnessing illness and death of their parents, loved ones and a principal caregiver.

Various literature documents that some orphans experience an acute period of both behavioural and emotional symptoms, including dysphoria and anxiety, which typically occurs and then improves during the first 1–2 years following parental death (Dowdney, cited by Sikkema, 2012).

Children are suffering untreated emotional wounds because, at the time of their loss, they are considered not to understand the meaning of death fully (which is true). However, after the occurrence of the death, they are also considered, as they are not experiencing feelings of sadness or emotions about the event (which is wrong). It is true

that since they are young and lack experience at the moment of the actual event, they may not understand the real meaning of death. Nevertheless, as time passes the permanent absence of their parents or loved ones make them understand the clear meaning of death. Unfortunately, they are overlooked and no one helps them through the normal process of grieving and healing that is also required by adults (Brodzinsky, Gormly, & Ambron, 1986 in Sengendo, & Nambi, 1997). Thus, they mourn almost all the time (Getachew, Ambaw, Abebe, & Kasahun, 2011). Subsequently, they become emotionally affected; showing depression, anxiety, anger and aggression (Brodzinsky et al., 1986 as cited by Sengendo et al., 1997).

The experience of losing an attachment figure and separation will likely be distressing and anxiety provoking for children (Kaplan et al. 1999). It is observed that, this distress is manifested in problematic behaviours, such as aggression, delinquency and depression (Howe, Brandon, Hinings & Schofield, 1999). Not only are such emotional displays misunderstood or rejected but also they are even punished earning bereaved children names such as ‘bad boy’ or ‘bad girl’, or even ‘witch’, adding more distress to their untreated pain. UNICEF’s account says, “The emotional suffering of children when parents become sick and die may be not recognized or responded to. Children often become withdrawn and some show antisocial behaviour, for which they are likely to be punished. Particularly, in societies and cultures that devalue children’s needs and rights, children are more likely to internalize their pain” (UNICEF, 2011 p.21).

Tsegaye (2013) explained that most orphan children tend to encounter higher emotional distress, hopelessness, and frustration than non-orphans because of social

deprivation and discrimination, sexual abuse and living conditions (Mbozi, Debit & Munyati, 2006 in Tsegaye, 2013).

2.6 The Plight of Children Living in Institutional Homes

Researchers have proved that orphaned children living in institutional homes/orphanages under the custody of caregivers are prone to having and developing a higher level of emotional and behavioural problems compared to their age counterparts who are living in family settings with their biological parents and relatives. The study of Jonson-Reid (1998); Ryan, Herz, Hernandez and Marshall (2007), cited in Porter, Porter and McWey (2010), stated that the high risk for emotional and behavioural problems among children and adolescents in institutional care has long been documented. Children who are living in some of the orphanages/institutional homes noted to find themselves in very distressed condition because of lack of additional support that they need for the trauma that they are experiencing from the death of their parents or loved ones (Adu, 2011).

Other studies also explain the highest probability of the youth living in orphanages to the use of mental health services more than those who are not under institutional care (UNICEF, 2011). Equally, Amato's findings comparing the difference between family living and institutional or non-traditional ways of living says that, children and adolescents who spend time in institutional homes (which is a non-traditional living type) exhibit lower average levels of wellbeing during both childhood and adulthood than those who spend their entire childhood living with both of their biological parents (Amato 2005, in *Author Manuscript*, Jun 18, 2013). In the report, dissimilarities in behaviour between children living with biological parents and other family type appear and differences with regard to physical health and emotional wellbeing. There is a strong

relationship shown between family structure and adolescent wellbeing, proving that living in a non-family setting with non-biological caregivers robs children of psychological security, physical protection and emotional state of wellness. In this regard, Biemba, Godrey, Beard, Brooks, Bresnahan, and Flynn (2010) had noted the oversized proportions of mental health claims that the majority of children in foster care have, typically experiencing some form of maltreatment, such as neglect, physical or sexual abuse.

Both the short-term and long-term wellbeing of children depends a lot, upon where they live and upon the type of care they receive in those settings. Furthermore, children who grow up in orphanages/institutional homes are observed to lack the experience of a home-like environment. Some are removed from their community of origin and live in a closed environment, which causes them to lack experience in cultural and societal norms.

In its emphasis on the importance of a community in children's life, The Ghana Child and Family Welfare Policy Revised Report say:

An individual's identity is shaped and defined amongst others by his or her belongingness to a family and a community; and as such, an individual cannot be considered in isolation. A sense of belongingness to a family and ethnic group establishes rights and obligations for the members including the children (*Child and Family Welfare Policy*, 2014 p. 21).

Ryan and Testa (2005), in McWey, Acock, and Porter (2010), also explained the relationship between children's removal from their homes and placement in institutional

homes. He points out its increased risk of delinquency, regardless of maltreatment history among boys in institutional homes.

Becoming an orphan leads a child into various developmental disadvantages, such as the likelihood of having stunted development of emotional, intelligence and life skills, including problems of communication, decision-making, negotiation skills and self-esteem (Kedija, 2006 quoted by Tsegaye, 2013, p.23, 24).

2.7 Review of Related Studies

Adu (2011) performed a qualitative study in Accra, Ghana, in light of various theoretical considerations that inform how she interviews orphans. Given her interest in the rights of children to be consulted on matters pertaining to their care, she poses questions to discover how they perceive their own sense of wellbeing. A majority felt that a good childhood means that all of their needs are met. Some of the children formed bonds with either their sponsors or other children, which served as a coping strategy for them.

Colburn (2010) did a comparative study of four orphanages in Accra, Ghana, with the goal of discerning how social work theory informed the practices at each institution. She reported that the institutions studied lacked social work theory, especially counselling services; and that private homes were run more effectively than government homes for two reasons. First, private homes allowed the children to experience a more domestic environment and public homes were subjected to the corruption and bureaucracy of the Department of Social Welfare.

Sengendo et al. (1997) compared the responses of orphans and non-orphans in Uganda, and found that orphans have significantly higher depression scores and a low degree of optimism about the future.

Poulter (1996) interviewed caregivers of three kinds of household in Zambia: those with orphans, those with HIV-positive parents and those with healthy parent's children. The researcher learned by using the Rutter Scale, that orphans were significantly more likely to be distressed than children with HIV-positive parents, and both groups were significantly more likely to be distressed than children in non-affected families.

Makame, Ani and Grantham-McGregor (2002) studied both orphans and non-orphans in urban Tanzania. They found that orphans were three times as likely (12%:34%) to contemplate suicide. Manuel (2002) used the same instrument as Makame (2002) in rural Mozambique, finding that orphans were more likely to be depressed and bullied, and less likely to have a relationship with a trusted adult or to have friends.

Atwine, Cantor-Graae and Bajunirwe (2005) interviewed Ugandans aged 11 to 15 years, orphans and non-orphans in similar numbers. The study found that orphans were more likely to live in an anxious, depressed or angry state of mind, and were significantly more likely to feel hopelessness and suicidal, and excluded other relevant factors, such as past and present living conditions, that might have explained the differences.

Chatterji, Dougherty, Ventimiglia, Mulenga, Jones, Mukaneza, Murray, Buek, Winfrey and Amon (2005) conducted a study in Rwanda and Zambia that compared the level of anxiety in orphans aged six to twelve years to that of children the same age with chronically ill caregivers and to that of children with healthy caregivers. In the end, Zambian orphans scored higher than children with ill caregivers, who scored higher than

other children did. No differences appeared between orphans and children with ill caregivers in Rwanda, but both groups scored higher than other children did.

Cluver and Gardner (2006) interviewed both AIDS-orphans and non-orphans in Cape Town, South Africa. With the aid of the Strengths and Difficulties Questionnaire Goodman, (1997), and the Impacts of Events Scale Dyregrov and Yule, (1995), researchers learned that while both groups scored highly for peer problems and emotional problems, AIDS-orphans were more likely to feel friendless, to lack concentration, and to have frequent somatic symptoms, to have constant nightmares. Interestingly, AIDS-orphans were less likely to lose their tempers. Finally, 73% of AIDS-orphans tested positively for posttraumatic stress disorder (PTSD), even though non-orphans were not tested for PTSD.

Nyamukapa, Gregson, Lopman, Saito, Watts, Monasch and Jukes (2006) conducted a national survey in Zimbabwe, applying factor analysis to compare orphans and non-orphaned children aged 12 to 17 years. The study measured psychosocial disorders with a scale informed by the Child Behavior Checklist and the Rand Mental Health and Beck Depression Inventories. The study found more psychosocial disorders amongst orphans when controlling for poverty, gender, age of household head, school enrolment and adult support.

Gilborn, Apicella, Brakarsh, Dube, Jemison, Kluckow, Smith and Snider (2006) interviewed, Zimbabwean orphans and non-orphaned children, comparing groups by exposure to various psychosocial support programmes. Through qualitative research, researchers developed an instrument to measure six items suggesting depression and two items suggesting poor psychosocial wellbeing. Orphans scored higher in both categories.

Wild, Flisher, Laas and Robertson (2006) completed a study of South African adolescents aged between 10 and 19 years. They compared three groups: AIDS-orphans, non-AIDS orphans, and non-orphans. Using the Revised Children's Manifest Anxiety Scale (R-CMAS) Reynolds and Richmond (1978), the Child Depression Inventory (CDI) Kovacs (1992), items from the Child Behavior Checklist (CBCL-YSR) Achenbach (1991) and items from the Self-esteem Questionnaire DuBois (1996), they reported that non-AIDS orphans complained of more depression and anxiety than non-orphans, with AIDS orphan fitting between the two groups and not differing significantly from either. Similarly, non-AIDS orphans showed lower self-esteem than both non-orphans and AIDS orphans. Greater autonomy from caregivers' neighborhood regulation, peer regulation and connection with caregivers improved depression.

Parikh, Desilva, Cakwe, Quinlan, Simon, Skalicky and Zhuwau (2007) over a period of three years, explored differences in the wellbeing of a cohort of 197 orphans and 528 non-orphans aged 9 to 17 years, who live in KwaZulu Natal in South Africa. After interviewing heads of household, caregivers and children, the study records no significant outcomes, with the exception that paternal orphans are more likely to lag behind academically.

Cluver, Gardner and Operario (2007) interviewed 1061 children; those orphaned fewer than three types of conditions (AIDS, another cause, unknown cause) and those with living parents. Using the Child Depression Inventory Kovacs (1992), The Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978), the Child Behavior Checklist Achenbach (1991) and the Children's PTSD Checklist Amaya-Jackson, Newman and Lipschitz (2000), the study explored potential risk and protective factors

identified through qualitative data and suggested by a range of NGOs and South African government departments. AIDS-orphaned children reported higher levels of depression, post-traumatic stress, relational problems with peers and delinquency than both children did with living parents and children orphaned as a result of deaths from other causes. The difference stood even when controlling for various factors such as age, sex, poverty, migration and household composition. Secure social relationships and school attendance mediated the effect of risk factors such as poverty, stigma, and ill caregivers

Feeney, Passmore and Peterson (2007) compared the relational skills and experience of two groups of Tanzanian adults, one set adopted at birth and the other set that grew up with their parents. The study reported that insecurity was higher among adoptees, and that for adoptees only, relational difficulties predicted insecurity. The study also reported that the quality of attachment during childhood was more important than adoptive status in predicting relationship variables such as loneliness. Secure attachments mediated the effects of adoptive status. The results support the utility of attachment theory in understanding adoptees' relationship concerns.

Ghera, Marshall, Fox, Zeenah, Nelson and Smyke (2009), conducted a study of how foster care interventions might affect orphans, aged between 30 and 42 months, who were institutionalised in Romania. After examining footage of children performing emotional tasks, the study concludes that family-based intervention significantly improves the overall mood and attention levels.

Whetten, Ostermann, Whetten, Pence, O'Donnell, Messer and Thielman (2009) conducted a study of OVC between 2006 and 2008 entitled, "A Comparison of the Wellbeing of Orphans and Abandoned Children ages 6-12 in Institution and Community-

Based Care Settings in 5 Less Wealthy Nations”. It compared orphanage life in three African countries (Ethiopia, Kenya, & Tanzania) and two Asian countries (Cambodia, India) to life in foster care outside the orphanage. The study concludes that, in poor countries, a co-operative institutional setting such as an orphanage is not worse for children than life in foster care outside an institution. It proposes that in places where the number of orphans is increasing at a quick rate, the locally run orphanage can be an adequate community response that is less problematic for children. One important reason for this finding is that children in foster care may have to work for adoptive families as domestic labour, or as wage earners (even in prostitution!), but children in institutional care are free to focus on their own education. This study found that institutional caregivers tended to devote longer hours while earning less, sometimes just room and board; and that they tended to be younger (35 rather than 42) and more educated (10th grade rather than 5th grade). Finally, over the course of the study, three factors were found to increase the distress of orphans in whatever setting they were living: 1) loss of parents, 2) loss of the mother and 3) loss of a parent at an early age. In the end, while institutional care may not be a good solution for orphans in poor countries, it can be much better than finding oneself subject to a foster parent without resources or a sense of fiduciary responsibility.

McWey, Acock and Porter (2010) studied the impact of regular visitation with birth parents on children placed in foster care in the United States. It found that visitations that are more frequent resulted in lower levels of depressions and reduced problematic behaviours in both boys and girls, and children of both sexes exposed to violence. Furthermore, the study noted higher levels of depression for girls. In the end, the study

recommended that biological parents visit their children in foster care on a frequent and consistent schedule.

Hermenau, Hecker, Ruf, Shauer, Elbert and Schauer (2011) conducted a study in Tanzania, which considered the difference between orphans violently mistreated in their birth families and orphans violently mistreated in an institution. The study confirmed the relationship between violent mistreatment and poor mental health, between violent mistreatment and aggression, and the value of quality caretaking to minimize the effects. The study further concluded that violence inflicted in an orphanage causes more damage than violence inflicted within a birth family. The researchers and others recommend a zero-tolerance policy for violence in orphanages, the promotion of strong bonds of attachment between children and their primary caregivers, training for caregivers on dealing with grief, the bias against contact with HIV-orphans, developmental psychology, as well as sensible parenting strategies that include clear directions, age-appropriate rules, positive reinforcement, monitoring for cooperation, and reasonable discipline. Finally, narrative exposure therapy was taught as a means for children to express painful memories through storytelling and art and for caregivers to learn empathic understanding and active listening skills.

Goswami (2013) compared institutionalised orphans aged 12 to 18 years to orphans of the same age who lived with parents or guardians. The study reported that institutionalized boys and girls performed better in school; yet had lower self-esteem. However, higher academic performance did improve a child's sense of self-esteem. The study lamented that non-institutional children who live in homes other than their birth home do face second-class status, but having relatives near them moderates the impact of

this second-class status. The institutional care and educational environment make them independent, disciplined and self-sufficient. These qualities have some positive impact on academic achievement. The study recommended that house-mothers must be chosen well, and provided proper training, secure employment and an attractive salary.

Tsegaye (2013) conducted a qualitative and quantitative study comparing psychological wellbeing of orphan and non-orphan children in Addis Ababa in order to explore conditions that promote the psychological wellbeing for orphans. The study concluded that non-orphans display a greater sense of wellbeing than orphans; and that gender and age were not significantly related to psychological wellbeing. From the analysis of the qualitative data, orphans report that contexts that allow individuality and independence in which adults respect and care for their comfort improved their sense of wellbeing.

2.8 Hypotheses

This study proceeds with the aim of discerning the validity of the following hypotheses:

1. Children living with caregivers in the Institutional homes will exhibit higher levels of Depression compared to their age counterparts of children living with their biological parents.
2. There will be a higher level of anxiety among children living with caregivers in the institutional homes compared to children living with their biological parents.
3. The level of anger among children living with caregivers in the Institutional homes will be higher than the anger level of children living with their biological parents.

4. Children living with caregivers in orphanages exhibit more signs of aggression than children living with their biological parents do.
5. Children who are living with their biological parents at home would have a better level of wellbeing than the children living with caregivers in the institutional homes would have.
6. There would be a significant correlation between the ratio of children to caregivers/parents and the attachment levels of the caregivers/parents to the child and vice versa.
7. Children living with caregivers in the institutional homes would have difficulties of developing attachment with their caregivers than children living with their biological parents could have.
8. There would be a significant relationship between the degree of children's attachment to their caregivers/parents and their emotional condition.

2.9 Operational Definitions

For the purpose of this study, several terms take specific meanings as used by agencies of the United Nations or the government of Ghana. Unless indicated otherwise, sources for definitions include the following: United Nations Convention of the Rights of the Child; Ghana's Department of Social Welfare; and Ghana National Commission on Children. Words used throughout this study are defined as follows.

Caregivers: This term refers to the individuals who are directly taking care of children living in the institutional homes /orphanages.

Parents: The biological mother and father who are taking care of their child/children.

Child: a person up to the age of 18 (Convention on the Right of the Child/ Article 28; and the Children's Act/section 1) (Ghana revised draft 2014)

Children under caregivers: Orphaned children living in institutional homes /orphanages.

Children under biological parents: Children living with their biological parents in a home environment.

Institutionalized Children: Children kept in orphanages/institutional homes.

Institutional Home: A residence, sometimes called an orphanage, in which children live in a dormitory-style arrangement, with unrelated adults serving as guardians

Orphan: Any person below the age of 18 years who has lost one or both parents, and who is exposed to moral, physical and psychological danger as a result of neglect and or abuse or incapacity whether or not a parent is alive (department of social welfare). Orphans can be categorized as follows:

Single orphan: A child who has lost one parents.

Double orphan: A child who has lost both parents

Maternal orphan: A child whose mother has died (including double orphans)

Paternal orphan: A child whose father has died (including double orphans)

Vulnerable: The official definition of a vulnerable as indicated by the Ghana National Commission on children (GNCC) is a child below the age of 18 who has been abandoned, orphaned or exposed to extreme physical or moral danger

Emotion: a complex psychological state that involves a subjective experience, a physiological response, and a behavioural or expressive response (Hockenbury & Hockenbury, 2007)

Wellbeing: It includes the individual's social, economic, psychological, spiritual, emotional, intellectual and physical stat of being happy, healthy or prosperous (Ghana Revised draft, 2014).

Emotional wellbeing: Children with a secure attachment to their parents/caregivers.

Lack of Wellbeing: For the purpose of this study the term refers to children who score high on the negative emotional status test (depression, anxiety, anger, and aggression.)

Postgraduate: Studies beyond a bachelor's degree

In this study, children under caregivers, orphans, institutionalized children; caregivers, caretakers; institutional homes, orphanages, children's homes or residential cares are used interchangeably to mean the same thing.



CHAPTER THREE

METHODOLOGY

The chapter describes the research design the population, the sampling procedures, the research instruments, the procedure of data collection and the statistical methods used in the analysis of data.

3.1 Research Design

This study adopts a research design that is descriptive by being comparative and correlational study.

The researcher used both qualitative and quantitative approaches in data collection because together they provide a fuller description. The quantitative approach assesses the emotional wellbeing of children living in the two kinds of environment through structured questionnaires that supply numerical values revealing the degree to which types of caregivers produce the same or different results in children of the same age groups, sex or grade level, but residing in different circumstances. The qualitative approach adds greater depth to the project by discovering more information about the conditions or situations of the two target groups of children than questionnaire can quantify. The reason is that personal contact between an interviewer and a person being interviewed can yield information that might not appear outside conversations that allow for the unexpected.

3.2 Study Area and Target Population

The research was conducted in Accra Metropolitan Assembly of the Greater Accra Region of Ghana. Accra was selected because it accommodates more institutional homes for children than the other parts of the country. The target population consisted of children between the ages of 8 to 18 years old. The reason for this age range is, because, UNICEF and the Ghana Social Well-fare Department defines a child to be any one who is between the ages of 0-18 years old.

3.3 Sampling

Children living in the institutional homes for children were selected to represent children living under caregivers. According to UNICEF Ghana Draft Report 2011, the population of OVC living in the institutional homes for children in Accra is estimated to be 400. The sample size of 100 children is used in this study, which is a significant proportion of the total. This number was arrived at using Krejcie and Morgan as cited by Atindanbila (2013). A corresponding number of schoolchildren living with their biological parents were also respondents in the study.

Stratified random sampling was the technique used to determine the subjects of the quantitative part of the study. The researcher selected representatives of child participants from both sexes age 8 to 18. Since no study has been done to show the number of caregivers from the same selected institutional homes and primary schools, a randomly selected number of 43 caregivers and 93 biological parents (especially mothers) were used to determine the caregiver/child and parent/child as well as the child/caregiver and child/parent attachment levels. Institutionalized children used in this study reside at Osu Children's Home, Al Zahawi Children's Home, Shekina Children's Home and Islamic

Counsel for Development and Humanitarian Service (ICODESH) Children's Home. Children living with biological parents used in this study attend Osu Presbyterian Primary and Junior Secondary School (a semi private school located at Osu), the Morning Star Primary and Junior Secondary School (an average standard private school located at Osu) and God's Grace Abide Primary and Junior Secondary School (a lower class semi private school located at Alajo). The reason for selecting the schools from different environment was to get the respondent's view that can address the different socio economic and family background lifestyle. Naturally, the caregivers and parents of the children selected in the sample are those representing the adult component of the target population.

The researcher also conducted interviews with representatives of the Department of Social Welfare (DSW), UNICEF Ghana; the workers and caregivers of Osu Children's Home, Shekina Children's Home, Islamic Counsel for Development and Humanitarian Service (ICODESH) Children's Home and with randomly selected institutionalized and non-institutionalized children. The adult respondents were chosen on the assumption that their experience working with matters concerning OVC makes them aware of the conditions and needs of institutionalized children. Their age span ranged from 28 to 56 years old. Children interviewed were randomly selected from the target population in order to provide the researcher with thorough information concerning the needs of every child, whether orphaned or living with parents. From this group of people, the findings of the study were generalized.

3.4 Inclusion and Exclusion Criteria

The study included children aged between 8 and 18 years, who presently live in the institutional homes named earlier and children who are living with their own parents,

while presently attend the schools selected. It also included the caregivers and the parents of included children. Those children aged below 8 years were excluded from this study.

3.5. Research Variables

The six dependent variables in this study are six dimensions of the studied children's emotional status and attachment level about which the research seeks to know:

Depression level of the child

- Anxiety level of the child
- Anger level of the child
- Aggression level of the child
- Attachment level of the child
- Attachment levels of the parent/caregiver

These variables are dependent because their numerical values may change between the two target populations when these recorded values are correlated to values linked to fixed realities common to both groups. These fixed realities over which the respondents have no control, also called independent variables are listed as follows:

- Age
- Sex
- Grade level

As a concrete illustration of the kind of information generated by indexing dependent variables to independent variables, one might consider what the researcher can learn about 8-year-old boys living in institutional homes under caregivers. She can compare their level of aggression to that of 8-year-old boys who live with parents;

3.6. Data Collecting Instruments

3.6.1 Demographic Questionnaire

Respondents were asked to provide information regarding their age, sex and school grade/ educational level in order to attach them to independent variables. Information is also acquired concerning the ratio of children to parents/caregivers and the ratio of caregivers/parents to children.

3.6.2 Attachment and Emotional Difference Scales

The researcher used four different scales in assessing the variables that are described as follows. The first scale used in this study is a version of the Inventory of Parent and Peer Attachment (IPPA) developed by Armsden and Greenberg (1987) but modified to address parent/child, child/parent, child/caregiver and caregiver/child attachment. It is a five-point Likert-type self-report questionnaire that assesses adolescents' perceptions of the positive and negative aspects of relationships with their parents, particularly how well they act as sources of psychological security. Respondents mark values ranging from 1 to 5 indicating the degree to which a statement is true of them: never true, not very often true, sometimes true, often true, and always true. The scale assesses the degree of mutual trust and the quality of communication as well as the extent of anger and alienation. Although geared to people aged between 16 and 20, the scale can be used with adolescents as young as 12. The original version yields two attachment scores. One score quantifies attachment to parents based on 28 items; the other quantifies attachment to peers based on 25 items. The revised Mother, Father, Peer Version is comprised of 25 items in each of the mother, father, and peer sections, yielding three attachment scores. The IPPA is scored by reverse-scoring the negatively worded items and then summing

the response values in each section. This is in accordance with directions provided by (Armsden & Greenberg, 1987).

Armsden and Greenberg (1987) reported good internal consistency for two samples of undergraduate students who ranged in age from 16 to 20 years, with Cronbach's alpha coefficients ranging between 0.72 and 0.91 for the sub-scales across both the parent and peer scales. Good test-retest reliability for a sample of 18–20-year-olds over a three-week period have also been confirmed, with correlation coefficients ranging between 0.86 for peer attachment and 0.93 for parent attachment (<http://www.researchgate.net/publication/229567918>).

The second scale is the Children's Depression Inventory (CDI), designed by Kovacs (1992). It consists of 27 items quantifying symptoms, such as disturbed mood, hedonic capacity, vegetative functions, self-evaluation, and interpersonal behaviours. It also covers the consequences of depression as they relate to children as they function in school and with peers. The instrument comes with applications designed for parents to assess children at home and for teachers to assess children at school.

The CDI has two forms: The original 27-item version, and the 10-item short-form version, which takes between 5 and 15 minutes for the child to complete. Each item has three statements, and the child is asked to select the one answer that best describes her/his feelings over the past two weeks. It is a three-point Likert-type self-report scale that measures depressive symptoms in the young in order to aid caregivers in social services, education and paediatric medicine to develop an appropriate treatment plan. It is an instrument that has children hear administrators read simply-worded questions, and allows them enough time to answer. Taking only 15 minutes to complete (or 10 minutes

for the abbreviated version), the test asks respondents to choose between three similar options that might describe their experience in the past two weeks. The options differ only with respect to the frequency, intensity or duration of their experience of some emotional state and manner of functioning. Scoring is recorded on a scale registering values of 0, 1 or 2, with the higher scores reflecting the more severe responses. The total score is the sum of all the separate item scores.

Oster and Caro (1990) reported a high internal consistency score for the CDI of Cronbach's alpha of greater than 0.80. Nelson and Politano (1990) confirmed its test-retest reliability in a study of 96 psychiatrically hospitalized children aged 6 to 15 with tests completed after 10 and 30 days. Stability coefficients for the overall group ranged from 0.62 for the shorter interval and down to 0.47 for the longer one. In addition, the test-retest reliability coefficients in 108 normal 7-12 year old children ranged from 0.82 over 2 weeks to 0.66 for longer intervals of 4 and 6 weeks (Finch, Saylor, Edwards & McIntosh, 1987). In the end, the CDI has proven itself as a useful tool for measuring depression in children accurately and reliably, when used properly. Hodges (1990) also found evidence for its convergent and discriminant validity ([wmich.edu .wlacefie/Papers and Articles/CDI files/htm](http://wmich.edu/~wlacefie/Papers%20and%20Articles/CDI%20files/htm)).

The third scale is the Multidimensional Anxiety Scale for Children (MASC 10), created by March. It is a 39-item, four-point Likert-type self-report scale that presents the structure of various factors contributing to anxiety in children aged 8 to 18 years. The MASC seeks to reveal values pertaining to several factors, namely, physical symptoms such as tension/restlessness and somatic/autonomic disposition; social anxiety, such as the sense of humiliation/rejection or public performance fears; harm avoidance manifest

in anxious coping and perfectionism; separation anxiety; and anxiety disorders. In addition, it contains a total anxiety index and an inconsistency index to ensure validity. Scoring is recorded on a scale registering values of 0 (never), 1 (rarely), 2 (sometimes) or 3 (often), with the higher scores reflecting the more severe responses. T-scores are separated into three age groups (March, 1998).

The MASC contains two other empirically-derived subscales for particular purposes. The first is a 10-item short form (MASC-10) that takes only five minutes to complete. It is intended for use in epidemiological and treatment outcome studies. The other is a 12-item anxiety disorder index with a high degree of diagnostic efficiency (March, 1998). It distinguishes between important anxiety symptoms and dimensions that broadband measures do not capture. Its sensitivity to symptom type and level makes it useful for focused treatment and monitoring progress.

The MASC factor structure is valid and reliable in community and clinical samples (Grills-Taquechel, Ollendick, & Fisak, 2008; March et al., 1997; Rynn et al., 2006). The MASC has good, and possibly excellent, test-retest reliability (March, Sullivan, & Parker, 1999; March et al., 1997). It also has good internal consistency (March, 1997; March & Parker, 1999) and air predictive power with respect to the diagnosis of anxiety and social phobias (Dierker, 2001). Thus, the MASC discriminates between anxious children, normal children, and children with other types of psychopathology (March, 1999).

The last scale is the Anger Expression Scale for Children (AESC), which is a 26-item measure that utilizes a four-point Likert-type self-report instrument that measures trait anger (overall tendency toward an angry personality), anger expression, anger in (anger suppression), and anger control in children aged 7 to 17 years. The options on the

scale reflect the frequency of which statements are true of respondents: almost never, sometimes, often and almost always. Higher values are keyed to the more problematic levels and handling of anger. The instrument asks respondents to quantify how well a series of ten statements describes them by circling a number on the scale, with the higher values representing greater trait anger. To measure anger expression, anger suppression, and anger control, respondents perform the same actions with respect to sixteen statements in total. Six pertain to anger expression, four to anger suppression and six to anger control. Before answering the latter portion, however, the respondents are informed that everyone feels angry from time to time, but that people differ in how they act when they are angry. The purpose of setting the context in this way is to remove the sense of judgment in order to ascertain how respondents tend to handle feelings of anger, whether by explicit articulation of feelings or acting out, or by suppression, or by employing strategies to manage the severity of anger and to express it in a tempered way.

Steele (2009) conducted tests for internal consistency, yielding favourable results for the four subscales of the AESC, with scores for Trait Anger of 0.84, for Anger Expression of 0.69, for Anger In of 0.71; and for Anger Control of 0.79. These Cronbach's α scores were calculated using the combined data set ($n = 803$). To examine the test-retest reliability of the instrument, the AESC subscales were re-administered to a subset of the sample that included children on treatment for cancer ($n = 130$). Measures were administered at the initial assessment shortly after diagnosis, and at 6 months, and 12 months following the initial assessment, and showed that the Trait Anger subscale demonstrated the highest test-retest stability across both the 6- and 12-month intervals.

This is consistent with expectations. The other subscales also showed moderate and statistically significant consistency over time.

3.6.3 Semi-Structured Interview

A qualitative semi-structured interview was designed to explore the conditions and situations that could promote the orphaned children's emotional wellbeing. The aim is to allow the respondents to inform the study from their point of view, using their own words (Lofland, 2006).

The first questions focus on the adult respondents' education and work experience. These questions demanded general evaluation of their knowledge and experience in the field. In asking about the psychological aspects of children's experience, information is gathered about the children's psychological needs and how caregivers and children perceive, handle, and understand them.

The interview moves on to discuss emotional support in order to find out what caregivers know about the emotional aspects of the children's lives. The questions refer to the group of children with whom the respondent works or is associated, eliciting general information about them and not information about particular children. Finally, the interviewer rounds off the discussion with questions regarding what could and should be done to address the matters discussed. Before the end of the interview, the respondents get the opportunity to add unsolicited information or ask questions.

3.7. Pilot Testing

The aim of the pilot test is to resolve doubt that may be present in the data collection instruments, as well as to check their validity, reliability and feasibility. In the present

study, the instruments were administered to 35 children: 15 orphans from Osu Children's home and 20 non-orphans attending Osu Presbyterian Primary and Junior Secondary School. No time limit was imposed for the completion of the questionnaire.

3.8. Data Collection Procedure

For the quantitative aspect of the study, the researcher distributed informed consent form to the appropriate authorities and to children, parents and caregivers before administering the structured questionnaire that relate independent demographic variables (orphaned children, non-orphaned children, parents, caregivers) to dependent variables (emotional difference, wellbeing and secure attachment).

For the qualitative aspect of the study, the researcher received consent from respondents before proceeding to interview them using the semi-structured guide at a time most convenient for them. Each interview began with an explanation of its purpose; and payment was neither offered, nor requested. The duration of the interviews varied from 25 to 90 minutes and interviews were terminated when information began to repeat itself. All interviews occurred at the respondents' place of work, school and the institutional home. Data were collected from interviews of children, their biological parents, current caregivers and child protective service agencies. Great care was taken during the interviews since sensitive data were gathered from older children and adults concerning exposure to violence, maltreatment, risky behaviors, and delinquency. Children were asked to report the frequency of contact and daily routines pertaining to the relationship with caregivers. Inquiries addressed the issues of direct physical contact (touching, hugs and kisses) and quality time spent together. Respondents were asked about harsh methods of correction, such as beating, shouting or use of insulting words;

and about their choice of living circumstances, that is, whether they preferred living at home with parents and family, or in the institutional homes with caregivers. Finally, children were asked to discuss what they know about extended family members, culture and traditions. Adhering to standard practice, follow-up questions were used to clarify vague responses, and all interviews were audio-recorded for transcription. At the end of each interview, the researcher made sure that the recorded interviews were audible. After this, respondents received thanks for their participation.

3. 9. Ethical Considerations

To safeguard the dignity of participants, they were advised concerning the strictly voluntary basis of their participation and the purpose of the study. Their explicit verbal consent was received before being admitted to the study. Furthermore, measures were taken to ensure that the participants received respectful treatment, including their freedom to express themselves and their freedom from embarrassment or reprisals, which has been secured through absolute confidentiality. Participants have been informed that the information provided will be kept confidential, not to be disclosed to anyone else – including anyone in the schools or the institutional homes.

3.10. Procedure of Data Analysis

The data collected from the respondent was analyzed with the use of the Statistical Product and Service Solutions (SPSS) version 22 Software. The questionnaires were assessed through the descriptive statistical measures of mean and standard deviation to see general patterns of emotional status pertaining to the respondents from the two populations according to sex, age and grade level. The General Liner Model Multivariate test and the Pearson Product-Moment correlation was deployed to determine whether

there is a significant mean difference in the results between the two populations. The goal is to discern the relationship between independent variables and dependent variables, that is, to figure out how and to what degree they correlate to each other; and to discern whether living arrangements in the care of caregivers or parents makes any difference in the outcome. Data collected through semi-structured interviews were analyzed using inductive thematic analysis, a procedure that takes several steps. In the first place, data is transcribed and reviewed carefully. Afterward, the data is re-read with the aim of recording initial perceptions. Finally, after themes appear, a report is produced to express them.



CHAPTER FOUR

RESULTS

4.1 Overview: Types of Result Presented

This chapter presents the results of data collected on the research field and analyzed in line with the research questions presented in earlier chapters.

4.2.1 Descriptive Statistics

The descriptive statistical test involved summarizing the demographics of the respondents as well as conducting the normality test and scale reliability of the measures of the survey instruments. Cramer (1994) indicated that a 95% confidence interval for skewness and kurtosis score is appropriate for evaluating the variability of estimates. Fiddell and Tabacknick (1996) further stated that normality of a variable is established when skewness and kurtosis values fall within the acceptable range for psychometric purposes of ± 2 .

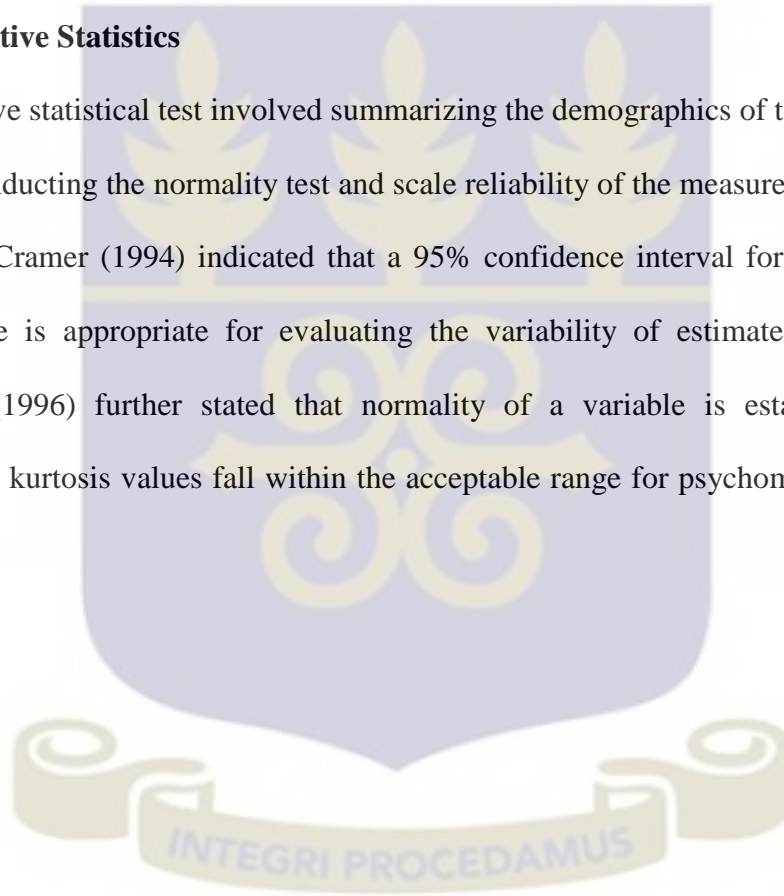


Table 1: Statistical Summary of Participants Regarding Variables Studied (N=343)

Dependent Variables	Mean	Std. Deviation	Skewness	Kurtosis
Children's Depression	13.96	9.446	.419	-.814
Anxiety of Children	15.20	4.593	-.406	-.055
Anger of Children	14.27	6.106	.260	-.436
Aggression of Children	22.76	8.067	.139	-.563
Attachment of Parent/Caregiver to child	107.56	16.238	-.333	-.595
Attachment of Child to Parent/Caregiver	97.96	19.398	.266	-.938

From Table 1, one observes that skewness and kurtosis scores lie within the acceptable range of ± 1 . Therefore, the data fulfilled all the assumptions used in parametric testing, including assumptions regarding regression analyses.



Table 2A: Demographic Characteristics of Child Study Subjects (N=200)

Tables 2A and 2B consist of descriptive statistics describing the socio-demographic characteristics of the participants (age, sex, grade, caregiver/parent ratio to child and children's ratio to parent/caregiver).

Variables		Children under parents		Children under caregivers	
		N	%	N	%
Sex	Male	47	23.5	61	30.5
	Female	53	26.6	39	19.5
	Total	100	50	100	50
Age	8-12	58	28.8	46	22.9
	13-18	42	20.9	54	27
	Total	100	50	100	50
School Grade	1-5	50	25	55	27.5
	6-9	50	25	45	22.5
	Total	100	50	100	50
Parent or caregiver ratio to child	1	29	14.5	15	7.5
	2	71	35.5	45	22.5
	7	0	0	40	20.0
	Total	100	50	100	50

Table 2A provides the socio-demographic characteristics of the study's participants, identifying the relative numbers and percentages of child study subjects who live with parents and who live with caregivers according to sex, age and grade level. There are 47 (23.5%) males and 53 (26.5%) females who live with parents; and 61 (30.5%) males and 39 (19.4%) females who live with caregivers in the institutional homes. Of those living with parents, there are 58 (29%) children aged 8–12 years, and 42 (21%) aged 13–18 years old. Of those living with caregivers, 46 (23%) are 8–12 years old, and 54 (27%) are

13-18 years. The number of children residing with parents is divided evenly between students in grades 1–5 and grades 6–9, that is, 50 participants each. However, 55 (27.5%) of the students residing in institutional homes are in the lower grades 1–5, while 45 (22.5%) are in the higher grades 6–9. Finally, the number of parent or caregivers, available to children varies. There were 29 (14.5%) children living at home with one parent (the mother) and 71 (35.5%) children living with both parents available to them. The situation for children in institutional care differs, with 15 (7.5%) having one (1) caregiver to share with all of the other children, 45 (22.5%) having two (2) adults taking care of them and 40 (20%) who had seven (7) different adults taking shifts to look after them.

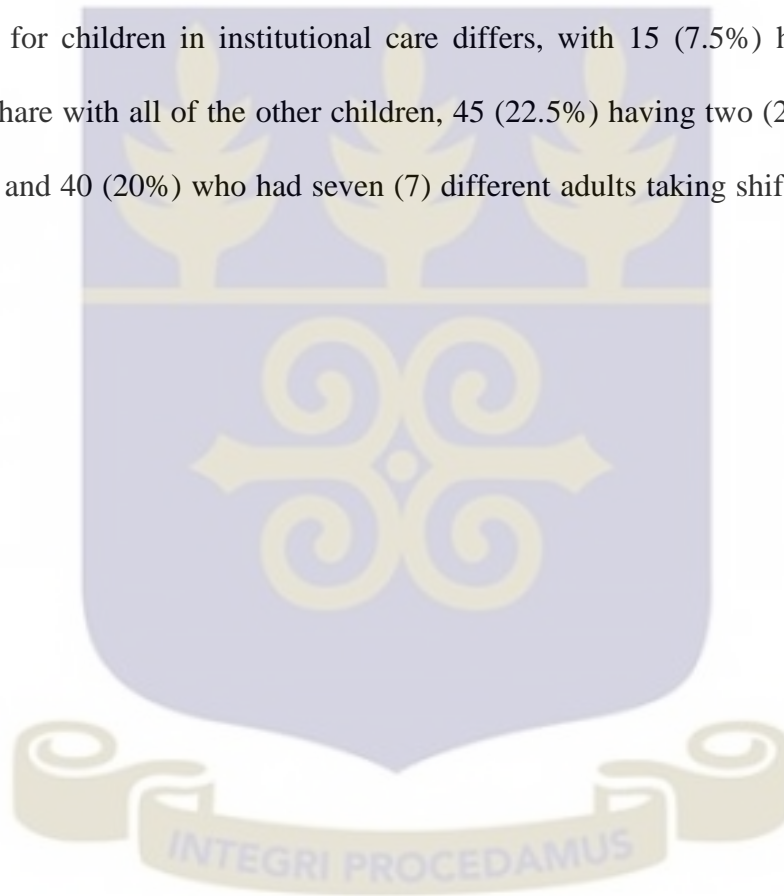


Table 2B: Demographic Characteristics of Adult Study Subjects (N=143)

Variables	Parents		Caregivers		
		N	%	N	%
Sex	Male	30	14.9	3	1.5
	Female	70	34.8	40	20
	Total	100	50	43	21.5
Age	28-40	42	21	24	12
	41-60	58	29	19	9.5
	Total	100	50	43	21.5
Level of Education	JHS – BA	84	42	43	21.5
	Post graduate	9	4.5		
	Total	93	46.5	43	21.5
Child to parent/caregiver ratio	1–4	81	40.5	0	0
	5–9	19	9.5	0	0
	29–35	0	0	2	1.0
	36–45	0	0	41	20.5
	Total	100	50	43	21.5

NB: seven (7) parents did not indicate their level of education

Table 2B reflects the relative proportion of all 143 adults who participated in the study. There were 30 (14.9%) male parents and 3 (1.5%) male caregivers who participated in the study; whereas, 70 (34.8%) female parents and 40 (20%) female caregivers participated. Furthermore, there were 42 (21%) parents aged 28–40 years and 58 (29%) aged 41–65 years old. The caregivers were generally younger, with 24 (12%) aged 28–40 years and 19 (9.5%) aged 41–65 years old. Concerning the level of education attained, 84 (42%) parents completed studies ranging from junior high school to the first degree at university and 9 (4.5%) completed studies beyond the first degree. (There were 7 (3.5%) out of the 100 parents who did not indicate their level of education.) By contrast, all 43 (21.5%) caregivers have studies ranging from junior high school to the first degree but

none (0%) have studies beyond the first degree. Concerning the load of responsibility, 81 (40.5%) parents care for 1-4 children, with only 19 (9.5%) caring for 5-9 children. The burden of caregivers was far higher, with 2 (1.0%) caring for 29-35 children and 41 (20.5%) caring for 36-45 children.



Table 3: Descriptive Statistics Pertaining to Emotional State and Types of Children

The table below provides the mean, standard deviation and respective totals for the four dependent variables, which have been split by the independent variables

Dependent Variables	Types of Children	Std.		N
		Mean	Deviation	
Children's depression	Under biological parents	6.73	4.809	100
	Under caregivers	21.20	7.105	100
	Total	13.96	9.446	200
Children's anxiety	Under biological Parents	12.59	4.229	100
	Under Caregivers	17.80	3.288	100
	Total	15.20	4.593	200
Children's anger	Under biological Parents	10.44	4.477	100
	Under Caregivers	18.10	5.026	100
	Total	14.27	6.106	200
Children's aggression	Under biological parents	17.55	5.844	100
	Under Caregivers	27.97	6.467	100
	Total	22.76	8.067	200

Table 3 indicates the scores for depression N=100 (M=6.73, SD 4.81) for children living with parents. By contrast, children under caregivers scored N=100 (M=21.20, SD=7.11). Anxiety related scores for children under parents were N=100 (M=12.59, SD=4.23); whereas, for the children under caregivers were N=100 (M=17.80, SD=3.29). While anger expression scores for children living with their parents were N=100 (M=10.44, SD=4.77), the scores for the children under caregivers were N=100 (M=18.10, SD=5.03). Finally, the level of aggression for children with biological parents was scored at N=100

(M=17.55, SD=5.84) and for children residing with caregivers in the institutional homes were N=100 (M=27.97, SD=6.47).

4.2.2 Testing of Hypotheses 1, 2, 3, 4 & 5

The first four hypotheses relating to difference in emotional state, and the fifth relating to overall wellbeing, are tested here. Hypotheses 1–4 affirm that children living with caregivers exhibit higher levels of depression, anxiety, anger and aggression than their age counterparts living with their parents. Hypothesis 5 supposes that children living with parents have a greater sense of wellbeing than those living in institutional care on account of lower scores on the various instruments measuring the emotional states identified above. The relevant statistics computed by multivariate, univariate and pair-wise comparisons are displayed on Tables 4, 5 and 6 below.

Table 4: Multivariate Tests

The table below is a summary of multivariate tests that shows the actual results of the computation, as it is statistically significant through the value of “Sig.”

Effect		Value	Hypothesis			Sig.	Partial Eta Squared
			F	df	Error df		
Intercept	Pillai's Trace	.963	1252.045 ^b	4.000	195	.000	.963
	Wilks' Lambda	.037	1252.045 ^b	4.000	195	.000	.963
	Hotelling's Trace	25.683	1252.045 ^b	4.000	195	.000	.963
	Roy's Largest Root	25.683	1252.045 ^b	4.000	195	.000	.963
Type of Children	Pillai's Trace	.652	91.526 ^b	4.000	195	.000	.652
	Wilks' Lambda	.348	91.526 ^b	4.000	195	.000	.652
	Hotelling's Trace	1.877	91.526 ^b	4.000	195	.000	.652
	Roy's Largest Root	1.877	91.526 ^b	4.000	195	.000	.652

a. Design: Intercept + Type of Children

b. Exact statistic

One observes from Table 4 above a Sig. value of .000, which means that $p < .001$. Therefore, given the results attained, one can observe that the levels of depression, anxiety, anger and aggression were significantly dependent on the type of children tested. Children living with biological parents scored differently from children living with caregivers ($p < .001$). This means that there was a statistically significant difference in the levels of depression, anxiety, anger and aggression based up on the type of children tested. $F(4, 192) = 91.53, p < .001$; Wilk's $\Lambda = 0.348$, partial $\eta^2 = .652$.

Table 5: Between- Subjects Tests

Table 5 shows the tests of between-subjects effects that determines how the dependent variables differ from the independent variables.

Dependent Variable		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Children's Depression	Contrast	10469.045	1	10469.045	284.434	.001	.590
	Error	7287.710	198	36.807			
Children's anxiety	Contrast	1357.205	1	1357.205	94.616	.001	.323
	Error	2840.190	198	14.344			
Children's Anger	Contrast	2933.780	1	2933.780	129.500	.001	.395
	Error	4485.640	198	22.655			
Children's aggression	Contrast	5428.820	1	5428.820	142.908	.001	.419
	Error	7521.660	198	37.988			

The F tests the effect of Types of Children. This test is based on the linearly independent pair wise comparisons among the estimated marginal means.

- a. R Squared = .590 (Adjusted R Squared = .588) c. R Squared = .395 (Adjusted R Squared = .392)
 b. R Squared = .323 (Adjusted R Squared = .329) d. R Squared = .419 (Adjusted R Squared = .416)

From the Table 5, it can be observed that living with biological parents or institutional caregivers has a statistically significant effect on the levels of children's depression,

anxiety, anger and aggression. Scores were as follows: for depression ($F(1, 198) = 284.434$; $p < .001$; partial $\eta^2 = .59$); for anxiety ($F(1, 198) = 94.616$; $p < .001$; partial $\eta^2 = .32$); for anger ($F(1, 198) = 129.500$; $p < .001$; partial $\eta^2 = .40$); and finally, for aggression ($F(1, 198) = 142.908$; $p < .001$; partial $\eta^2 = .42$).

Table 6: Pair-Wise Comparisons

A summary of comparisons of the two dependent variables on the difference in the mean scores on the four dependent variables.

Dependent Variables	(I)Type of Children	(J)Type of Children	95% Confidence Interval				
			Mean Difference (I-J)	Std. Error	Sig. ^b	Lower Bound (LB)	Upper Bound (UB)
Depression of Children	Living with Parents	Living with Caregivers	6.730	.481	.000	5.776	7.684
	Living with Caregivers	Living with Parents	21.200	.711	.000	19.790	22.610
Anxiety of Children	Living with Parents	Living with Caregivers	12.590	.423	.000	11.751	13.429
	Living with Caregivers	Living with Parents	17.800	.329	.000	17.148	18.452
Anger of Children	Living with Parents	Living with Caregivers	10.440	.448	.000	9.552	11.328
	Living with Caregivers	Living with Parents	18.100	.503	.000	17.103	19.097
Aggression of Children	Living with Parents	Living with Caregivers	17.550	.584	.000	16.390	18.710
	Living with Caregivers	Living with Parents	27.970	.647	.000	26.687	29.253

Based on observed means

The error term is Mean Square (Error) = 4.074

*The mean difference is significant at the .05 level.

In Table 6, the scores for the two dependent variables (children under biological parents and children under caregivers) shown were statistically significantly different

($p < 0.001$). The comparison relating to depression scores for children living with parents (MD = 6.730, LB= 5.776, UB=7.684) and for children living with caregivers in institutional homes (MD = 21.200, LB=19.790 UB= 22.610); the between-subjects test presented on Table 5 shows a contrast result of ($F=284.43$, partial $\eta^2 = .59$) pertaining to the Children's Depression Inventory. From Table 6, the scores for the Multi Anxiety Scale for Children were statistically significantly different between the two independent variables ($p < 0.001$). The comparison pertaining to anxiety levels between the two group of children were (MD = 12.590, LB=11.751, UB=13.429) for children living with parents and (MD=17.800, LB=17.148, UB18.452) for those in institutional care. The related contrast result from the between-subjects test presented on Table 5 above were ($F=94.616$, partial $\eta^2 = .32$).

From Table 6, there was also a statistically significant difference between the two independent variables ($p < .001$) recorded concerning the Anger Scale for Children. The values recorded for the comparison on anger between the two group were (MD=10.440, LB=9.552, UB=11.328) for children living with parents and (MD=18.100, LB=17.103, UB=19.097) for those in institutional care. The contrast arising from the multivariate test on anger presented on Table 5 above was ($F=129.50$, partial $\eta^2 = .40$).

Finally, the score for the aggression level for children were also statistically significantly different between the two independent variables ($p < .001$). The comparison on the level of aggression was (MD=17.550, LB=16.390, UB=18.710) for children living with parents and (MD=27.970, LB=26.687, UB=29.253) for children in institutional care. The multivariate test presented on Table 5 shows the result of the contrast between the two groups of children pertaining to aggression ($F=142.91$, partial $\eta^2 = .42$).

In all the scores higher scores were obtained by children living with caregivers in the institutional homes than children living with biological parents. This shows that living with biological parents makes a significant difference on lowering a child's level of depression, anxiety, anger and aggression. This implies that the four hypotheses (hypotheses 1-4) which tested the emotional difference between children living with biological parents and children living with caregivers in the institutional homes were supported. The hypotheses are as follows:

1. Children living with caregivers in the Institutional homes will exhibit higher level of depression compared to their age counterparts of children living with their parents.
2. There will be a higher level of anxiety among children living with caregivers in the institutional homes compared to children living with their biological parents.
3. The level of anger among children living with caregivers in the Institutional homes will be higher than the aggression level of children living with their biological parents.
4. Children living with caregivers in the orphanages will exhibit more signs of aggression than children living with their biological parents will.

Since all the scores are showing that higher levels of negative emotions are connected to living in institutional homes, and for greater depression, anxiety, anger and aggression translates to a lower sense of overall wellbeing, the fifth hypothesis that says that children who are living with their biological parents would have a better level of wellbeing than children living with caregivers in the institutional homes was also supported.

4.2.3 Testing of Hypotheses 6, 7 & 8

Hypotheses 6, 7 & 8 pertain to the correlation of the attachment variables. Hypothesis 6 supposes that significant correlation exists between the attachment level of parent/caregiver to children and the number of children cared for. Hypothesis 7 supposes that children living in the institutional homes will have greater difficulty attaching to the caregivers than children living at home with parents. Finally, Hypothesis 8 supposes that there is a significant relationship between children's level of negative emotion and the lower degree of attachment they have with their caregivers/parents. The analyses in table 7 and 8 provide a means to interpret their statistical probabilities.

Table 7 Descriptive Statistics of Correlation For Children Living with Caregivers

Variables	Mean	Std. Deviation	N
Caregiver: Child ratio	6.60	1.466	43
Children: caregiver ratio	34.59	9.571	100
Depression level of children	21.20	7.105	100
Anxiety level of children	17.80	5.288	100
Anger level of children	18.10	5.026	100
Aggression level of children	27.97	6.467	100
Attachment level of caregiver to children	97.12	10.384	43
Attachment level of children to caregiver	82.88	9.261	100

Table 7 provides the results of the mean, standard deviation and "total" rows of the eight dependent variables: caregiver to child ratio, child to caregiver ratio, depression level of children, anxiety level of children, anger level of children, aggression level of children, children's level of attachment to the caregiver, and the caregiver's level of attachment to children. The table shows the result for caregiver to child ratio of N= 43 (M=6.60, SD=1.466); for the child to caregiver ratio, N= 100 (M=34.59, SD=9.571); for the attachment level of caregiver to children, N=43 (M=97.12, SD=10.384); and for the attachment level of children to caregiver, N= 100 (M=82.88, SD=9.261). Respectively, for children living with caregivers, the table indicates a depression level of N=100 (M=21.20, SD=7.105), an anxiety level of N=100 (M=17.80, SD=5.288), an anger level of N=100 (M=18.10, SD=5.026) and an aggression level of N=100 (M=27.97, SD=6.46).

Table 8: Correlation Analysis

The following table shows the summary of the correlation between various factors pertaining to the experience of children living with caregivers. These correlations include those between secure attachment and emotional wellbeing of children; between the ratios of parent to child and level of parent attachment to children; and between the impact of these factors already mentioned on children's level of depression, anxiety, anger and aggression.

Correlations For Children Living With Caregivers

	Caregiver: child ratio	Child caregiver ratio	Depression level of children	Anxiety level of children	Anger level of children	Aggression level of children	Attachment of caregiver to children	Attachment of children to caregiver
Caregiver: Child ratio	1	-	-	-	-	-	-	-
Children: Caregiver ratio	.204	1	-	-	-	-	-	-
Depression level of children	.181	-.042	1	-	-	-	-	-
Anxiety level of children	.069	.064	.299**	1	-	-	-	-
Anger level of children	.228	-.110	.357**	.354**	1	-	-	-
Aggression level of children	.100	.064	.297**	.285**	.499**	1	-	-
Attachment level of caregiver to children	.005	-.665**	.354**	.181	.520**	.416**	1	-
Attachment level of Children to Caregiver	-.103	-.061	-.273**	-.347**	-.340**	-.241**	-.175	1

** . Correlation is significant at the 0.01 level (1-tailed).

From Table 8 above, it can be observed that the correlation ratio observed between child to caregiver ratio and the attachment level of the caregiver to the child was significant [$f = .665^{**}$, $\rho = 0.001$]. The correlation ratio is negative, which means that when one or few caregivers are caring for too many children, they have difficulty developing a bond of attachment with a child.

The correlation between child to caregiver ratio and the attachment of a child to caregiver was negative [$f = -.061$, $\rho = 0.001$]. This means that when too many children are

trying to seek a caregiver's attention, the competition makes it even more difficult to develop attachment to the caregiver. In other words, the negative correlation coefficients mean that both children and adults will have lower levels of attachment to one another [$f = -.175, \rho = 0.001$] as the number of children in care increases and the numbers of caregivers' decreases the levels of attachment also goes low.

The caregiver to child ratio for institutional homes is far higher, making the place far less conducive to the formation of attachment bonds. Therefore, this affirms the sixth hypothesis, namely, that there would be a significant correlation between the number of children to be cared for and the attachment levels of the caregivers to children and the children to the caregivers.

There is a negative correlation ratio for the correlation between ratio of caregivers to children and the attachment of children to them [$f = -.103, \rho = 0.001$]. This means that the more the child has to deal with multiple caregivers taking shifts, the greater the difficulty for children to identify themselves with a particular figure of attachment. Moreover, the correlation between the ratio of caregivers and the attachment of caregivers to children [$f = .005, \rho = 0.001$]. The implication of this: for the caregivers who are coming to the home on a shift bases will not be difficult to develop attachment with a child as she/he comes to meet the same children whenever they are on duty. But the condition affects the child living him/her in anxiety of developing an attachment with a particular caregiver. Because the less quality time and contact that the children share with the caregiver, the less they develop a bond of attachment. The implication of these correlations is that the more children are exposed to several caregivers and have less or

no quality of time with each of them, the higher the probability of their developing insecure attachment.

The correlation between the ratios of caregiver to children and vice versa was significantly positive [$f=.204$, $\rho=0.001$]. This implies that increasing the numbers of caregivers in situations where many children are under few caregivers can allow the children to develop a bond of attachment with a particular permanent caregiver; which would likely yield a better emotional state of the children.

The correlations between the ratio of caregiver to children and the various scores pertaining to children's emotional states were positive. The score for depression was [$f=.181$, $\rho=0.001$]; and for anxiety [$f=.069$, $\rho=0.001$], for anger [$f=.228$, $\rho=0.001$] and for aggression [$f=.100$, $\rho=0.001$]. These positive scores simply mean that when the numbers of the caregivers are high and they are running shift or when few caregivers are caring for too many children in both conditions the probability of developing an emotional distress would high.

The table also indicates that the correlation between the ratio of children to caregiver; and pertaining to one or another of children's emotional states. The score for depression was [$r=-.042$, $\rho=0.001$]; for anxiety [$f=.064$, $\rho=0.001$], for anger [$f=-.110$, $\rho=0.001$] and finally for aggression [$f=.064$, $\rho=0.001$]. The negative scores imply that when children have to share the attention of one caregiver among too many of them or trying to attach to a particular caregiver who is not on a regular schedule with them but come on shift the probability of them experiencing anxiety and showing aggression would be higher. The positive scores imply that when children are having many

caregivers they may not show anger but, suppress their emotion and express it in aggression than demonstrating their anger in more appropriate ways.

The scores correlating negative emotions and too many children under caregiver are significantly higher than those scores correlating negative emotions and having too many caregivers [$f=.181 > f=-.042$; $f=.069 > f=.064$; $f=.028 > f=-.110$; $f=.100 > f=.064$]. The numbers also indicate that, although children have difficulty with too many different caregivers [$f=-.103$], they do even worse when they must attract the attention of a particular caregiver at a particular time [$f=-.061$]. These results imply that the seventh hypothesis which supposes that children living with caregivers in the institutional homes would have difficulties of developing attachment with their caregivers than children living with their biological parents could have is supported.

In correlating the scores resultant from the Children's Depression Inventory with scores pertaining to Multi Anxiety Score for Children, Anger and Aggression Scale for Children, the following results were obtained. Depression and anxiety correlated positively [$f=.299^{**}$, $\rho=0.001$], depression with anger [$f=.357^{**}$, $\rho=0.001$] and with aggression [$f=.297^{**}$, $\rho=0.001$]. Anxiety correlates with anger positive [$f=.354^{**}$, $\rho=0.001$]; and with aggression [$f=.285^{**}$, $\rho=0.001$]. Anger occurs with aggression [$f=.499^{**}$, $\rho=0.001$], this implies that when children experience one negative emotional state, they are likely to experience others at the same time. Hence, a depressed child will also experience some degree of anxiety and anger and aggression.

The correlation between the four variables of emotion and the two variables of attachment were all positive. Depression correlates with the attachment of caregiver to children [$f=.354^{**}$, $\rho=0.001$], and anxiety correlates to the same variable at [$f=.181^{**}$,

$\rho=0.001$), anger at [$f= .520^{**}$, $\rho=0.001$) and aggression at [$f=.416^{**}$, $\rho=0.001$). In addition, the correlation between depression and the attachment of children to caregiver was [$f= -.273^{**}$, $\rho=0.001$], with anxiety [$f=-.347^{**}$, $\rho=0.001$], with anger [$f= -.340^{**}$, $\rho=0.001$] and finally with aggression [$f= -.241^{**}$, $\rho=0.001$]. These values imply that when the attachment of caregivers to children is low its impact on their own emissions is insignificant in other words it does not affect them. But when the attachment of children to caregivers is low it will directly affect the emissions of the children. They will have increased levels of depression, anxiety; anger and aggression. Relevant to the sixth and seventh hypotheses is that Table 8 shows that children have more trouble developing attachment to caregivers [$f=-.104$] than caregivers have attaching to children [$f=.005$]. Thus, this observation affirms hypothesis eight that says, there would be a significant positive relationship between the emotional state of children and the degree of the attachment they are having with their caregivers was supported.

Table 9 Descriptive Statistics of Correlation for Children With Biological Parents

	Mean	Std. Deviation	N
Parent: Child ratio	1.71	.456	100
Child: Parent ratio	3.16	1.587	100
Children's Depression Inventory	6.73	4.809	100
Multi Anxiety Scale for Anger Level	12.59	4.229	100
Aggression Level	10.44	4.477	100
Attachment of Parent to Children	17.55	5.844	100
Attachment of Children to Parent	116.29	11.226	89
	112.81	14.445	99

Table 9 describes the results of mean, standard deviation and "total" rows of the eight dependent variables: parent to child ratio, child to parent ratio, children's attachment to parent and attachment of parent to children. Thus the table shows that for the parent to child ratio $N=100$ ($M=1.71$, $SD=.456$). For the child to parent ratio, the score is $N=100$ ($M=3.16$, $SD=1.587$), For attachment of parent to children, $N=89$ ($M=116.29$, $SD=11.226$); and for attachment of children to parent, $N=99$ ($M=112.81$, $SD=14.445$). Respectively, for children living with parents the depression level shows that $N=100$ ($M=6.73$, $SD=4.809$); for anxiety scale $N=100$ ($M=12.59$, $SD=4.229$); for anger level $N=100$ ($M=10.44$, $SD=4.477$); and for the level of aggression $N=100$ ($M=17.55$, $SD=5.844$).

Table 10: Correlation Analysis

The following table shows the summary of the correlation between various factors concerning children living with their parents. These correlations include those between secure attachment and emotional wellbeing of children; between the ratios of parent to child and level of parent attachment to children; and between the impact of these factors already mentioned on children's level of depression, anxiety, anger and aggression.

Correlations for Children with Biological Parents

	Parent : child ratio	Child to parent ratio	Depression Level of children	Anxiety Level of children	Anger Level of children	Aggression Level of children	Attachment of parent to Children	Attachment of children to parent
Parent: Child ratio	1	-	-	-	-	-	-	-
Child: Parent ratio	.186*	1	-	-	-	-	-	-
Depression of Children with Parents	-.068	-.043	1	-	-	-	-	-
Anxiety of Children with Parents	-.057	-.037	.140	1	-	-	-	-
Anger of Children with Parents	.197*	-.149	-.267**	.194*	1	-	-	-
Aggression of Children with Parents	-.076	-.051	-.119**	-.193*	.245**	1	-	-
Attachment of Parent to Children	.194*	.123	-.310**	-.146	-.063	-.318**	1	-
Attachment of Children to Parent	.084	.043	-.350**	-.198*	-.284**	-.317**	.309**	1

*. Correlation is significant at the 0.05 level (1-tailed).

** . Correlation is significant at the 0.01 level (1-tailed).

From Table 10 above, it can be observed that the correlation ratio observed between child to parent ratio and the attachment level of the parent to the child was significant [f.123; $\rho = 0.001$]. The correlation ratio is positive, which means that when numbers of the

children that the parent is carrying for is few the bond of attachment that the parent is developing with the child will be higher.

The correlation between child to parent ratio and the attachment of a child to parent was positive [$f = .043, \rho = 0.001$]. This means that as the numbers of children living with biological parents are not many (three in average) their chance of getting the attention that they need from the parent is high; they can easily approach and ask for their emotional and physical needs to be provided for. In other words, the positive correlation coefficients mean that both children and adults will have higher levels of attachment to one another [$f = .309, \rho = 0.001$]. Therefore, comparing this with the institutional homes the caregiver to child ratio for institutional homes is far higher, making the place far less conducive to the formation of attachment bonds. Therefore, this affirms the sixth hypothesis, namely, that there would be a significant correlation between the number of children to be cared for and the attachment levels of the caregivers to children and the children to the caregivers.

There is a positive correlation ratio for the correlation between ratio of parent to children and the attachment of children to them [$f = .084, \rho = 0.001$]. This means that when the child knows feel that he has a parent whom he/she can depend up on; who is there for him to listen, understand, give attention and show love the child would automatically develop a bond of attachment. And the correlation between the ratio of parent and the attachment of parent to children is [$f = .194^*, \rho = 0.001$]. The implication of this: for the parent who shares quality of time with the child and care for few children compared to the institutional homes their chance of developing a bond of attachment would be also high as well as the child's developing secure attachment with them.

The correlation between the ratios of parent to children and vice versa was significantly positive [$f=.186^*$, $\rho= 0.001$]. This implies that the balanced ratio of child to parent and vice versa provides the ground for a positive outcome of the relationship which would likely yield a better emotional state of the children that can allow the children to develop a bond of attachment with the parent.

The correlations between the ratio of parents to children and the various scores pertaining to children's emotional states were as follows. The score for depression was [$f=-.068$, $\rho=0.001$]; and for anxiety [$f =-.057$, $\rho=0.001$], for anger [$f =.197$, $\rho=0.001$] and for aggression [$f=-.076$, $\rho=0.001$]. These scores show that almost all the scores are negative apart from the correlation with anger. These imply that as children are having quality of time with the parents they develop less emotional distress because the ratio allows them to have the full attention of their parents and as a result develop less distressful emotional condition. Even though the correlation between the ratio of parent to children and the level of children's anger is positive when this is compared to the score that is obtained by the children living in the institutional homes the score is far lower [$f =.197$, $\rho=0.001$] < [$f =.228$, $\rho=0.001$]. This means that it is undeniable that children living with biological parents also experience some level of emotional distress but the fact is it does not affect their attachment with their parents [$f =.984$, $\rho=0.001$] as it does with children living with caregivers in the institutional homes [$f =-.103$, $\rho=0.001$].

The table also indicates that the correlation between the ratio of children to parent; and pertaining to one or another of children's emotional states. The score for depression was [$r= -.043$ $\rho=0.001$]; for anxiety [$f=-.073$ $\rho=0.001$], for anger [$f= -.149$ $\rho=0.001$] and finally for aggression [$f=-.051$ $\rho=0.001$]. The negative scores simply mean that the ratio

between the children to the parent does not lead the children to experiencing of emotional distress.

In correlating the scores resultant from the Children's Depression Inventory with scores pertaining to Multi Anxiety Score for Children, Anger and Aggression Scale for Children, the following results were obtained. Depression and anxiety correlated positively [$f=.140$, $\rho=0.001$], depression with anger [$f=-.27^{**}$, $\rho=0.001$] and with aggression [$f=-.119^{**}$, $\rho=0.001$]. Anxiety correlates with anger positive [$f=.194^*$, $\rho=0.001$]; and with aggression [$f=-.193^*$, $\rho=0.001$]. Anger occurs with aggression [$f=.245^{**}$, $\rho=0.001$] the implication of this is that the positive score shows that when children experience one negative emotional state, they are likely to experience others at the same time. I.e. the child that experiences anxiety can also experience anger, aggression or depression. But when these positive scores are compared to those of the institutional children's scores they are significantly less. Depression with anxiety [$f=.140$, $\rho=0.001$] < [$f=.140^*$, $\rho=0.001$], anxiety with aggression [$f=.194^*$, $\rho=0.001$] < [$f=.354^{**}$, $\rho=0.001$] and Anger with aggression [$f=.245^{**}$, $\rho=0.001$] < [$f=.499^{**}$, $\rho=0.001$]. The negative scores imply that there is no correlation between the negative emotions. Therefore, compared to the children living with caregivers in institutional homes children living with their biological parents can experience a better emotional wellbeing.

The scores correlating parent to child ratio and the attachment of parent to children and vice versa are positive [$f=.194^*$, $\rho=0.001$]; the scores for the attachment of children to parent is [$f=.084$, $\rho=0.001$]. And the scores correlating child to parent ratio and the attachment of parent to children and vice versa are positive [$f=.123$, $\rho=0.001$], as well the scores for the attachment of children to parents [$f=-.073$, $\rho=0.001$]. These implies

that although children living with biological parents may also experience some levels of emotional distress as it is stated in the earlier correlations it does not affect the attachment of the children to the parent or vice versa as it does affect the attachment of children to their caregivers. These results imply that the seventh hypothesis which supposes that children living with caregivers in the institutional homes would have difficulties of developing attachment with their caregivers than children living with their biological parents could have is supported.

The correlation between the four variables of emotion and the two variables of attachment were all negative. Depression correlates with the attachment of parent to children [$f=-.310^{**}$, $p=0.001$], and anxiety correlates to the same variable at [$f=-.146$, $\rho=0.001$], anger at [$f=-.063^{**}$, $\rho=0.001$] and aggression at [$f=-.318^{**}$, $\rho=0.001$]. In addition, the correlation between depression and the attachment of children to parent was [$f=-.350^{**}$, $\rho=0.001$], with anxiety [$f=-.198^{*}$, $\rho=0.001$], with anger [$f=-.284^{**}$, $\rho=0.001$] and finally with aggression [$f=-.317^{**}$, $\rho=0.001$]. These values imply that any amount of the emotional distress that is felt by the children it does not affect the level of attachment that the child develops towards the parent or vice versa. Though the child feels angry or anxious he or she will not keep in it will be forgotten easily and at the end the bond of the attachment will remain the same between the child and the parents. [$f=-.309^{**}$, $\rho=0.001$]. Thus, this observation affirms hypothesis eight that says, there would be a significant positive relationship between the emotional state of children and the degree of the attachment they are having with their parents/caregivers was supported.

4.3 Results of the Qualitative Dimension of the Study

To present both sides of the child/caregiver relationship in qualitative perspective, in-depth interviews were conducted with parties representing various sides. On the adult's side, two caregivers working at private institutional homes, two administrators in public institutional homes, one worker with UNICEF Ghana and one employee of the DSW, a total of six (6) were asked about a series of subjects. On the child's side, ten (10) randomly selected children residents of the selected institutional homes and schools offered their comments on the same series of subjects. This was done with the objective of exploring the factors that could potentially contribute to the emotional uplifting and wellbeing of children living under the care of institutional caregivers. Data collected through semi-structured interviews were analyzed using inductive thematic analysis; results are organized by topic as follows.

4.3.1 Poor Living Conditions: Overcrowding and Overworked Caregivers

The first major theme is the living conditions in parental and in institutional homes. School children living with parents were glad that they lived with them. Similarly, orphans wished that they could live with parents in a family. Only one institutionalized child expressed his interest in living in the institutional home, but only until he finishes school. This is not a surprise considering the living conditions of institutional homes. A worker from the DSW asserted:

“No documentation exists showing the condition of orphanages, their history or present activities.”

Oral resources affirm that every orphanage is full beyond its capacity. One of the public institutional home workers said,

“Apart from the listed children, others are added on the daily emergency bases rescued from trafficking, abuse, war, migration and the like without any new staff hired to care for them.”

All the representatives of the authorities and the workers of the orphanages expressed concerns about the burnout of workers.

4.3.2 Low Attachment: Little Trust/Dependency and Quality Time

Attachment is linked to the sense in children of trust for caregivers and enjoyment of quality time with them. Most children expressed the view that they did not trust or depend on their caregivers. A nine-year boy said,

“When I need help with school work, I ask the older children or my friends; mostly I do my work at school.”

On the matter of trust, a twelve-year-old girl said,

“I share my secrets and hopes with my friends. Sometimes I keep things to myself.”

When threatened, a boy of nine year old said,

“I call the older boys to protect me.”

And a girl of eleven year said,

“When I am afraid I call the older children if they don’t come, I just hide.”

By contrast, the respondents of children living with biological parents confirmed that they seek support from their parents and trust them for help to materialize their ambitions. A boy who is thirteen years old said,

“I tell my secrets and desires to my parents; I know that they will help me to become what I wanted to be.”

Likewise, a ten-year-old girl also said,

“I trust my parents they will do everything to help me in my school work. They encourage and support me in to become what I want to be when I grow up.”

The same girl replied by saying to the question of help and protection in times of fear

“I call my parents; even if it is late at night or they are faraway they will come to help me.”

When asked whether they feel attached to caregivers or feel distant, most orphan respondents complained that the caregivers do not spend any time with them. They expressed their desire to be hugged and told that they are loved.

“It makes me happy if I am hugged.” (Eight-year-old orphan girl.)

When asked about which adults do hug and express love to them, a boy of eight year old said,

“My parents, before I came here.”

An eleven years old girl also said,

“The nurses; when I get sick and sent to the clinic the nurse hug me and tell me that I am nice and she loves me.”

A twelve-year-old boy also referred to foreign sponsors when they come to visit from time to time. He said,

“My sponsors when they come to visit me during the holidays, they hug me and tell me that they love me.”

Furthermore, an eight-year old girl replied, pointing to the researcher;

“You!”

A boy of nine years old also pointed to the sky; when asked for explanation he said

“God!”

In contrast, the interview reveals the different experiences that the children living with biological parents are having on the same subject.

“My parents love me, when I was small/younger they used to hug me and rub my head a lot, especially when I do good in school work and other activities they do it more; now they don’t hug me like those days; it is not because they have stopped loving me because I am growing.” (Thirteen-year-old boy)

It became clear to the researcher that the children missed or never enjoyed quality time with their caregivers. To rectify this problem, an interviewed official suggested,

“Caregivers should draw children closer through having meal time together, playing indoor and outdoor games, watching TV and storytelling time.”

By contrast, children living with parents identified them as people who love them and do things with and for them. Thus, a fourteen-year-old boy and twelve-year-old girl sharing similar view said

“I watch movies with my parents and we discuss about it; on weekends and during the holiday we go out for meal, excursion, to visit families and friends.”

4.3.3 Harsh Treatment as Discipline

The third theme is discipline, with special attention paid to find out if orphans as correctional methods receive harsh treatment. When asked about discipline in institutional homes, first worker of the institutional home said,

“The children here are difficult to handle they often upset the caregivers.”

Second worker in further explanation said that,

“Since biting is not allowed most often caregivers shout at the children in order to discipline them because they disobey a lot.”

A front line worker says:

“To be frank handling these children is not easy. The boys, sometimes they become aggressive and disobedient; there are times when I feel I wish I were not their caregiver. In order to discipline them I assign them work in the compound, if they are really bad, I let them kneel down.” (A male caregiver)

From the other side, an eleven-year orphan girl complained.

“They shout bad words at me. I feel scared; sometimes I get shocked when they shout at me or at others, I am not happy about it; I don’t know why they shout at us.”

Younger respondents claimed that sometimes-older children are assigned to take charge over them after some episode of mistreatment by a caregiver. A nine years old boy said,

“The big boys and girls they are good when they are told to help us; but some of them they beat us just like the mothers”

Looking on at a distance, the UNICEF worker lamented,

“Physical and emotional abuses often occur in institutional homes in the name of discipline.”

When asked about the root of orphans’ strong emotional outbursts, the male caregiver said,

“Most often Children who come to us already have behavioral problems; they are not disciplined.”

A female caregiver and first worker of an orphanage, sharing view that is more similar said,

“The behavior of the children comes from something in the children’s past, such as a parent’s death, family conflict, streetism or war. Some of them they are mostly feeling down and sad; those who came from the street show more aggressiveness and other behaviors such as stealing”

The female caregiver respondent who associated the children’s behavior to their past life experience said,

“They think it is normal to behave the way they do.”

“Children in emotional problem are difficult to handle, but they are really longing for their caregivers’/an adult’s love, we try our best to help and care for them; but, sometimes since caregivers are responsible for many children there are times when they are left to deal with their feelings in their own way.”(Mail caregiver said)

4.3.4 The Importance of Professional Psychological Care

All adult respondents reported their conviction that support for emotional wellbeing is as important as the physical support. Recognizing the importance of emotional care, the worker at the governmental office suggested, Caregivers are essential, but every institutional home also needs a psychologist. However, the answers of respondents working in the institutional home demonstrate just how difficult emotional needs are to understand and to care for.

“It is very difficult to understand a child’s emotional problem like hunger or thirst. People and authorities think that what orphans need is food, water and a place to live they do not realize how important it is for children to have who understands their problem. Caregivers have little or no training in child psychology or in caring for children.” (First worker)

Concerning the availability of professional psychological care in institutional homes, the second worker said

“We don’t have professional psychologist to help with the children’s emotional problem; the little support the children get is from the volunteer religious leaders who come from time to time to organize prayers and other religious service for them”

Eleven-year girl in confirmation to this said,

“Some pastors come to pray for us and tell us to be good children”

A female caregiver respondent also said,

“I have no training as a counselor and we also have no in house or visiting psychologists who counsel the children.”

Therefore, the interview indicates that, orphaned children have no one who is trained to understand their emotional problems.

4.3.5 The Future of Orphans and Prolonged Residency

Every individual has a task to perform at every stage in his/her life. In this regard institutionalized children are not exceptional; they also transit through every developmental stage which at the end determines their adult life. Concerning the preparedness of the orphans to meet their adult life 1st worker said

“Many of the children don’t leave the home when they grow up; they continue living here, because they lack proper training to meet their future.”

Clarifying the reason why children linger, one older child said,

“I have no idea what to do or where to go when I am old enough.”

When asked about their experience of outside world or about the society beyond the orphanage’s walls, children also testified along line with the worker’s report saying that they have little interaction with the surrounding community and cultural way of life,

“I only know about cultural performances and festivals from watching them on T.V.”(Eleven-year-old girl.)

Most children report that they have not been to a country side or a significant cultural event such as “an outdoorings”. While some residents of private institutional homes children did know something about their hometowns and extended families, those children residing in public institutional homes knew nothing even of their own family and place of origin. Twelve-year-old boy said

“I don’t know who my mom or dad is, I don’t know if I have siblings and I don’t also know where my parents are coming from”

The UNICEF worker suggested,

“Institutional homes must be the last resort for children. We must find their extended families so that they have contact with society and a place to belong.”

He went on to say,

“Orphaned children must be exposed to culture and to the community they are living in beyond the premises of the institutional homes in order to integrate them well into adult society.”

When children were asked their preferred place of living while majority of the children expressed their strong desire to living with their biological parents’ one orphan respondent chose the institutional home.

“I want to live here until I finish my schooling” (Twelve-year boy)

The UNICEF worker suggested,

“Institutional homes must be the last resort for children. We must find their extended family so they have contact with society and a place to belong.”

He went on to say,

“Orphaned children must be exposed to culture and to the community
They are living in beyond the premises of the institutional homes in order to integrate them into adult society.”

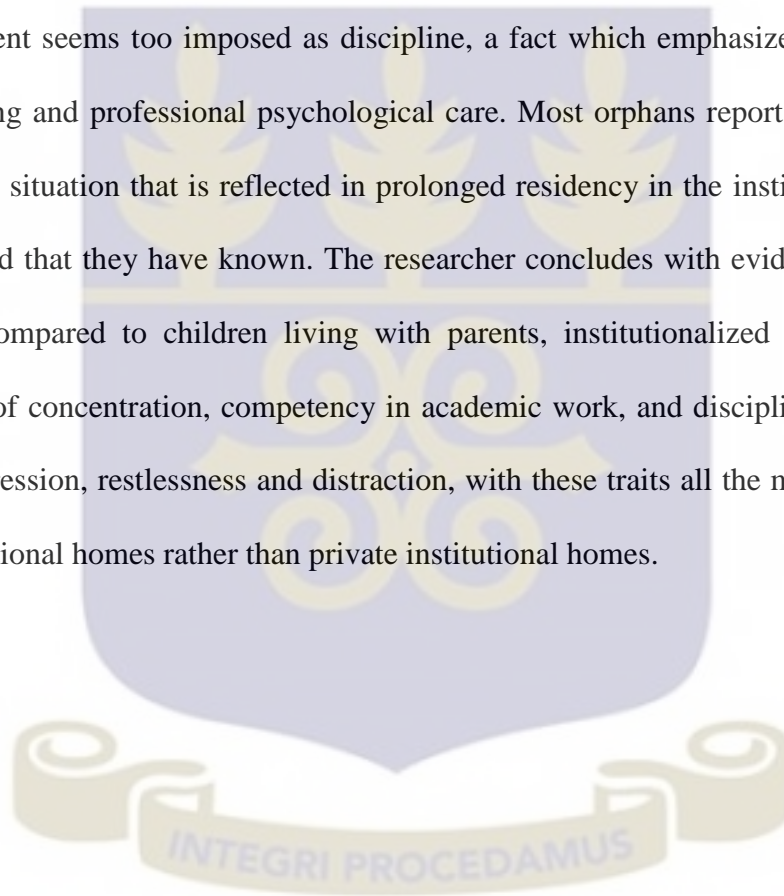
4.3.6 Additional Information:

The last topic is the researcher's own observation of the difference in behaviour between schoolchildren living with parents and orphans living in institutional homes. The schoolchildren demonstrated complete concentration, understanding and discipline. However, the children in institutional homes tended to be aggressive, restless and distracted; and even older orphans had difficulty reading and writing. The researcher also noted that among orphans, problems appeared worse in public institutional homes rather than private institutional homes.

4.5 Summary

To sum up the findings, this chapter has presented and described the results of the quantitative and qualitative aspects of the study. The quantitative data appears in a series of eight tables and a brief account of their content and significance. In the end, the use of inferential statistics has affirmed the validity of the eight hypotheses presented in chapter one. The numbers demonstrate that children living with caregivers exhibit higher levels of depression, anxiety, anger and aggression than their age counterparts living with their parents. The statistics also show that children living with parents have a greater sense of wellbeing than those living in institutional care. In addition, correlated scores also reveal that there is significant correlation exists between the attachment level of parent/caregiver to children and the number of children cared for; and that institutionalized children have greater difficulty attaching to caregivers than children living at home have forming attachment bonds with parents. Finally, correlated scores also communicate that a high level of negative emotion in children is related to a lower degree of attachment to caregivers.

The qualitative data is organized under headings that draw out the significance of the answers collected from adult caregivers and orphans to questions about their experience of working and living in a residential home in Accra. It has come to light that the residential homes studied are overcrowded with children in need of care and that caregivers are overworked, making all parties feel distressed. Low attachment level appeared to be linked too little opportunity for quality time that builds the sense of trust. Harsh treatment seems too imposed as discipline, a fact which emphasizes the need for greater training and professional psychological care. Most orphans report little hope for their future, a situation that is reflected in prolonged residency in the institutional home, the only world that they have known. The researcher concludes with evidence revealing that, when compared to children living with parents, institutionalized children show lower levels of concentration, competency in academic work, and discipline, and higher levels of aggression, restlessness and distraction, with these traits all the more evident in public institutional homes rather than private institutional homes.



CHAPTER FIVE

DISCUSSION

5.1 Introduction

This section of the study discusses the major findings of the research, which are presented in three parts. The two sections bring the findings of the quantitative and qualitative dimensions of the study into dialogue with related studies presented in the literature review. The last section offers a summary, a conclusion and a set of recommendations.

5.2 Quantitative Study Findings

This section of the study discusses the major quantitative findings under three topics for discussion. The first topic is the issue of the emotional impact of the high ratio of caregivers to children and of children to caregivers. The next topic is the higher incidence of all kinds of negative emotion in orphans, showing their emotional world to be problematic. Finally, the last topic is the high rate of negative emotion in orphans as this relates to their low sense of self-esteem and wellbeing that leads to significant problems for their adjustment to life when they are old enough to leave institutional care.

5.2.1 Insecure Attachment and High Ratios in the Child/Caregiver Relationship

The data of the current study confirms that there is a significant problem with the ratios of caregivers and children in institutional homes. UNICEF (2010) stated that the ratio of caregivers to children must be 1:7, or 1:8 when including one's own child. For one adult cannot possibly provide adequate attention to each child's needs when outnumbered by a

wider margin. While the current study found that children living with parent did experience the acceptable ratio, and sometimes a better ratio between 1:1 and 1:3, the findings of the study show that the ratio in the institutional homes of Accra can reach 1:30, and even 1:45. This is a vast difference. The amendment of *World Summit Convention for Children* (1990) and *The Child Cannot Wait* (1992) stated that children must be protected from all kinds of harm, but this becomes impossible in such overcrowded living arrangements.

Two kinds of trouble come from these high ratios when examined from both sides. Even from the perspective of the dedicated caregiver, the responsibility to care for so many children at once is overwhelming. The fact is that such high ratios make it impossible for them to meet the standard of care expected by UNICEF and by Ghanaian law, as the negative correlation between attachment and the caregiver/child ratio shows. For they have so many tasks to complete on each shift, such as cooking and cleaning for so many children, that there is hardly any time left to spend quality time with those in their care. Instead, the children compete and fight amongst themselves for their attention. The time that caregivers do have to spend with children is often spent imposing order on a chaotic, overcrowded environment that creates insecure attachment in children (Collins & Gunnar 1990).

Viewed from the other side, children resident in institutional homes must deal with many different caregivers who take shifts each day. The rotation leaves children unable to bond well with any particular caregiver, even if the caregiver had time to spend with individual children (which time he or she does not have). There is no doubt that the negative correlation between low attachment and a high child/caregiver ratio reveals that

orphans are deprived of loving care needed daily, the affirming touch and listening ear of a trusted adult (Brazelton & Cramer, 1990). In fact, high ratios of children to caregivers correlated to attachment shows a score twice as large as the same when considering the opposite ratio of caregiver to child. It follows that children living in institutional homes suffer insecure attachment directly resulting from unacceptably high ratios of caregivers to children and vice-versa. They must simply have to deal with too many attachment figures. During the sensitive period of childhood (Coon, 2005), a stable relationship with a fixed attachment figure, as would be reflected in a low child to caregiver ratio, is essential. McWey's (2010) findings in the United States are also relevant here. For they found that birth parents who maintained frequent visits with children in foster care increased the child's sense of attachment, reducing problematic behaviours and depressive mood swings. Again, from this study, one learns that when a stable attachment figure takes the initiative to ensure the wellbeing and sense of attachment in children, the relationship between the child and the world improves.

5.2.2 High Correlated Levels of Negative Emotions for Orphans

The data provided by the current study of the emotional difference of children in Accra confirmed that children living in institutional homes with caregivers do experience higher levels of depression, anxiety, anger and aggression compared to children living with biological parents. Poulter's (1996) Zambian study and Wild's (2006) South African study also confirm this result: that orphans are likely to live in an ongoing state of distress characterized by negative emotion. The data also reveals that one negative emotional state increases the likelihood of another. Thus, depressed children are more likely to feel anxious; and anxious children are more likely to exhibit anger and aggression, and so on.

Apparently, the combined effect of so many intense negative feelings makes children feel alone in the world. This sense of isolation acts as a barrier wall between them and the world around them (Gilborn, 2006) and even leads to ill health (Shanti 2009). By contrast, children living with parents experienced much lower levels of negative emotion, showing that parents, even in poor circumstances, are able to calm their children and help them with emotional stability.

While some orphans do express negative emotion toward their caregivers, they are especially likely to express anger and aggression among themselves because there are so many of them. Competition for attention between them makes children become bitter toward each other as fear; anger and aggression come to dominate their lives. The older children bully younger children, and these older children who bully the younger ones lack adult guidance and a sense of meaningful attachment, which increases depression and anxiety. Since circumstances have forced the children together from different backgrounds, they have difficulty understanding one another and building the bond of love, and their lives are full of negative emotion that they do not handle well. The very situation of arriving in a new environment so full of unknown people adds another factor to the orphans' experience of life without the loving care, the listening ear and frequent touch of a trusted adult. Such disruption and deprivation leads them to internalize negative feelings resulting in externalized negative behaviours. The very opposite should be true in their lives: children should live an environment where they can externalize their feelings in relation to caregivers and, as a result, internalize positive ways of behaving (Bowlby, 1951).

5.2.3 Low Level of Wellbeing in Orphans

The data also confirms the low chance that orphans have an adequate sense of wellbeing on account of the confusion caused by so much negative emotion that results from their lack of secure attachment to an adult caregiver, which further results in a sense of not belonging in the world. In line with these results, Nyamukapa (2006) reported that psychosocial disorders are common among Zimbabwean orphans. Even children who fear the loss of gravely ill parents feel the anxiety of potential orphan-hood that results in a low sense of wellbeing (Chatterji et al., 2005). Regardless of the flexibility of children in adapting to changes in their circumstances, and despite their naturally hopeful outlook on life, the loss of a stable relationship with parents is devastating because daily interaction with them provides a sense of belonging in the world. Goswami (2013) commented on low self-esteem in children without parents, and notes that some institutionalized children experience improved self-esteem when caregivers assist them with school work to improve their academic standing.

Intense negative emotions surrounding relationships of mistrust reduce children's sense of wellbeing. However, those caregivers who build relationships of trust and grant children some measure of autonomy find that children in their care experience increased self-esteem and a greater sense of wellbeing (Wild, 2006). In his study of orphan's wellbeing in Addis Ababa, Tsegaye (2013) reported that children who feel controlled and confined in institutional homes have a low sense of wellbeing. He also reported that children allowed individuality and independence by adults experience an improved sense of wellbeing. Tsegaye's results are also confirmed by Adu (2011), which showed that children in Accra who feel respected, loved and accepted by their caregivers also

experience increased levels of attachment and wellbeing the result of this study confirms all of these research which shows that the sense of autonomy and self-confidence provided by the social tools learned within a securely attached relationship to a trusted adult is the cornerstone of wellbeing. Unfortunately, most orphans in Africa do not have this experience. Low self-esteem follows them into adulthood, even affecting the harmony of their marriages (Afrifa 2009). Sadly, orphans are often upset with themselves, upset with others and upset with the world. Their emotional and physical quality of life is so low that they are three times more likely to contemplate suicide (Makame, et al., 2002).

5.3 Findings of the Qualitative Study

The qualitative data collected through semi-structured interviews complements the findings of the hard data collected in the quantitative dimension of the study. Results are presented through three topics of discussion. The first concerns the negative impact of the harsh treatment of orphans. The next topic is about the value and need for professional emotional care. Finally, the last topic to discuss addresses the inadequate preparation of orphans for integration into society.

5.3.1 The Low Quality of Caregiver-Child Relationships

Qualitative data suggest that the quality of caregiver-child relationships is low particularly due to harsh treatment by and task-oriented busyness of frontline caregivers, which makes disciplinary problems worse and destroys the potential for secure attachment. Administrative workers and a UNICEF agent testify that both physical and emotional abuse occurs in institutional homes. Orphans report beatings and complain of

little quality time with caregivers. When considered together, such violence and emotional abandonment leads to hostility in the children. Such harsh treatment by caregivers is not received well by orphans, who feel minimal or no attachment to them. As Hermenau et al., (2011) indicated, violence at the hand of non-parents is far more devastating to children than the same trauma administered by parents.

In line with Hermenau's recommendations, the researcher observes that caring for orphans requires sensible parenting strategies that are not observed in the institutional homes. The reasonable caregiver would calmly give clear directions and patiently monitor difficult children for cooperation, but children report in interviews that caregivers shout at them with abusive language and impose punitive measures, such as extra kitchen duties, without explanation. The researcher also notes that caregivers do not institute age-appropriate rules and appropriate disciplinary measures. For children report that they receive a beating for disobedience that may not even be intended.

Furthermore, rather than reinforce good behavior by engaging children with empathic understanding and active listening skills, the researcher hears from interviews, and sees for herself, that it is older children who listen to the complaints of fellow residents mistreated by a caregiver. Awareness of the need for sensitivity varied among the caregivers interviewed. While one caregiver acknowledged that some unknown trauma might make orphans difficult to handle, another claimed that children simply lack personal discipline from their prior home life. The second view suggests that caregivers have the responsibility to remain inflexible and emotionally distant. A third adult interviewed acknowledge that disruptive behavior is a child's way of seeking needed attention, but also noted that a heavy workload for caregivers means that children have

deal with their own problems without much assistance. With such responses from caregivers, it is not surprising that orphans decide that caregivers are not helpful. Children look to one another for help with schoolwork, and depend upon any source except their caregivers including foreign visitors, the researcher herself who took time to listen to them, or the invisible God of heaven.

While children need daily comfort from caregivers, such as a hug (Harlow 1958), they complain that they have not received affection since they left their parents or since the last visit of the nurse. In place of such emotional abandonment, the advice of one interviewed official is correct. Caregivers could do so much good if they would prioritize relationships rather than tasks. Rather than simply prepare meals, they could share time with the children. Rather than send children to play, they could play with them or tell them stories. As they build relationships, attachment bonds may form that reduce the negative cycle of harsh treatment intended to impose order and hostile emotional displays that cause the return of chaos. As Feeney et al., (2007) observed among adult adoptees in Tanzania, those orphans with a strong sense of attachment to a caregiver, who interacts positively with them, experience a sense of wellbeing that softens the deep hurt and common effects associated with orphan-hood that do last into adulthood.

5.3.2 The Value and Need of Professional Emotional Care

Qualitative data collected from interviews also strongly suggests that the emotional care of orphans is as important as physical care, and that institutional homes should acknowledge its importance by providing the professional emotional care of trained psychologists and counselors. Adults interviewed report that, in practice, there is no evidence that the value or the need of professional care is recognized. For no funds are

designated for such care in the homes selected for study, and workers admit that they themselves have not received any training before or after taking the job. They testify that the emotional care that children do receive comes from the prayers of the volunteer spiritual leaders (who are not trained in developmental psychology and the counsel of children).

While one interviewed government officer did acknowledge the need for a psychologist at every institutional home, literature in the field suggests that devaluing emotional care is common. Unfortunately, many members of society and policymakers in developing countries fail to recognize the importance of emotional health. Many people think that providing food, medicine, housing and education is a sufficient response to orphan-hood. To the contrary, as Adu (2011), Nyamukapa (2006) and Gilborn (2006) have demonstrated, orphans require significant emotional bonds as a way of coping through a difficult childhood. Children with reasonably healthy bodies but a distressed state of mind are still likely to act out in antisocial ways. During her many visits during the data collection, the researcher observed herself how emotionally stable children living with parents were in comparison to orphans. Children living with parents could concentrate on reading and writing, and understand questions asked of them, whereas orphans were more likely to behave in distracted and disruptive ways.

5.3.3 Poor Preparation for Integration into Society

Finally, the data reveals that institutionalized children are poorly prepared for integration into society. This matter of inadequate preparation for life appears in a study of Ugandan orphans by Sengendo and Nambi (1997) who identified in orphans a low sense of optimism and inadequacy commonly felt among insecurely attached children. It follows

that the reason why orphans are likely to linger in the institutional home much longer than expected is this: they have not been trained in the context of a secure adult/child relationship on how to behave in the outside world. Orphans report that they hardly leave the institutional environment. Thus, they have no opportunity to engage in cultural events or visit with people who live outside the orphanage. To address this problem, UNICEF worker suggested that children should be placed in families or community-based foster care so that they can be integrated into the norms of society. Efforts must put into finding orphans' extended families to connect them to society and to culture and give them a basis of belonging, the starting point for self-confidence, autonomy and hope. This is also in line with the findings of (Kocayörük, 2010). Some researchers also believe that the idea of the institutional home is better for children because, in some circumstances in the developing world exceptionally poor foster parents treat orphans as an unwanted burden (Whetten et al., 2009).

5.4 Summary, Conclusion and Recommendations

5.4.1 Summary

The general objective of this study is to compare the emotional difference between children living with their biological parents and children living with caregivers in an institutional home in Accra.

Quantitative data was acquired through a demographic questionnaire and emotional scale instruments, which were administered to both types of children, to parents and to caregivers associated with the selected institutional homes and schools. To analyze the quantitative data, the General Liner Model Multivariate and the bivariate Pearson Product-Moment correlation were employed.

Significant findings were found from the analysis of the quantitative data. Applying the mean-split technique to the question of emotional difference, the study notes that children living in institutional homes scored higher on negative emotion than their counterparts living with their parents. The comparative scores for orphaned children, when compared to those of non-orphaned children shows that children living in institutional care are far more likely to experience emotional distress.

The Pearson's Product Moment produced negative scores when correlating the ratio of parents/caregivers per child and the caregiver's/parent's attachment to the child, and when correlating this ratio with the child's attachment to the parent/caregiver. Similarly, negative scores also resulted from correlating the ratio of children per parent/caregiver and parent's/caregiver's attachment to them; and when correlating this second ratio with children's attachment to the parent/caregiver. These substantial negative scores indicate the high potential for children's insecure attachment when the ratios become unmanageable either for the child or for the parent/caregiver. Hence, ratios of adults to children and vice versa adversely affect levels of attachments in both directions of the adult/child relationship,

5.4.2 Conclusion

While most children living in institutional care scored high on the tests for various negative emotions, most children living with their biological parents scored low on the same tests. This result shows that there is an emotional difference between the two kinds of living arrangement children. Children living in institutional homes are more likely to experience strong negative emotions, a low sense of well-being and insecure attachment,

and a general sense of not belonging in their culture and society that does not look good for future prospects.

5.4.3 Recommendations

Based on the major findings of the study, the researcher proposes six significant recommendations.

1. The ratios of children to caregivers and caregivers to children must be reduced for the sake of children who have already lost so much. Distressed children must not be forced to compete with one another for a caregiver's attention. Frontline caregivers must do what they can to build secure attachment with children in their care by making the conscious effort to share meals with them, to play indoor and outdoor games with them, to watch television with them and to share storytelling time also.
2. Awareness must be created among workers in the field that psychological care is as important in the care of orphaned children as other needs, such as food, shelter and education. One way to act upon this awareness is to ensure that children in institutional care, being emotionally distressed, have access to resident professional psychological services. A trained counselor or child psychologist in residence could raise awareness of children's psychological needs, provide routine psychotherapy to children in care, and diagnose serious psychosocial conditions that prevent children from acquiring benefit from home and school services. Such professionals could also refer particularly difficult cases to those outside the residential home before they become unmanageable.

3. Caregivers and workers in institutional homes must undergo a programme of professional development. They should attend periodic seminars on matters of counseling and child psychology. They should be provided with better payment, have housing on-site and more coworkers with whom to share the load; and they should receive formal recognition for the service they provide for the society.
4. Policy makers, governmental and nongovernmental workers must inculcate policies that protect OVC emotionally/psychologically as well as physically. The DSW must oversee orphanages with periodic visits to track problems and evaluate the implementations of regulations; as well to ensure that well-organized records are kept which document the activities of every home. This practice would assure that caregivers would work under conditions requiring more self-control, so that abuse and emotional outbursts would not be tolerated.
5. Institutional homes should arrange local family sponsorship for children in their care so that these children might have the opportunity to stay with a family during holidays and long vacation. Such sponsors could spend time with the disadvantaged children, providing experience of domestic life, a sense of cultural and linguistic identity, and friendship. If possible, extended families must be traced so that they might have the opportunity to live with them in a family.
6. In-depth qualitative studies should be done in the area of institutional homes in order to gain a more detailed and richer understanding of the orphan's and the caregiver's experience of his or her world, with special attention to how and why each behaves the way that he or she does. This kind of research would help to identify and to explain specific emotional and other problems faced by orphans

and their caregivers suggesting that the ratio of caregivers to children and vice-versa must be children addressed.



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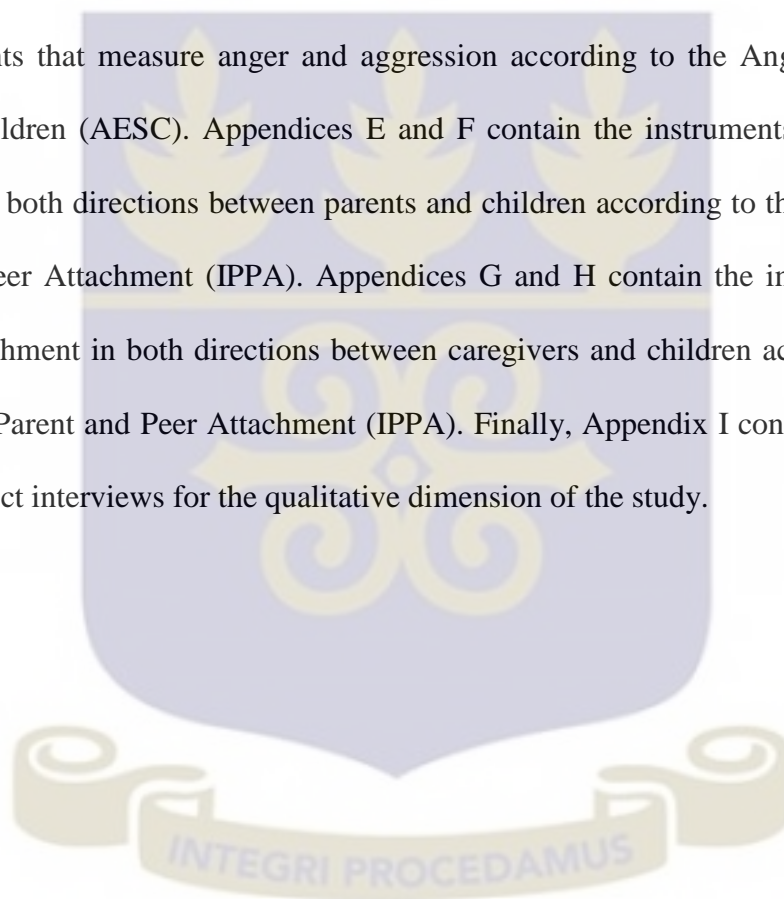
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APPENDICES

In the pages that follow are the actual instruments used in the study to measure various levels of emotion. Appendix A contains the instrument that measures depression according to the Children's Depression Inventory (CDI). Appendix B contains the instrument that measures anxiety according to the shortened form of the Multidimensional Anxiety Scale for Children (MASC-10). Appendices C and D contains the instruments that measure anger and aggression according to the Anger Expression Scale for Children (AESC). Appendices E and F contain the instruments that measure attachment in both directions between parents and children according to the Inventory of Parent and Peer Attachment (IPPA). Appendices G and H contain the instruments that measure attachment in both directions between caregivers and children according to the Inventory of Parent and Peer Attachment (IPPA). Finally, Appendix I contains the guide used to conduct interviews for the qualitative dimension of the study.



Appendix A: Instrument for Measuring Depression (CDI)

CDI-P00

Client ID: _____ Age: _____ Birthdate: _____ <small>mm/dd/yyyy</small> Grade: _____ Gender: Male Female Today's date: _____ <small>mm/dd/yyyy</small>	<h1 style="font-size: 4em; margin: 0;">CDI</h1>	by Maria Kovacs, Ph.D.
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Kids 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 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:

I read books all the time.
 I read books once in a while.
 I never read books.

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

Item 1

 I am sad once in a while.
 I am sad many times.
 I am sad all the time.

Item 6

 I think about bad things happening to me once in a while.
 I worry that bad things will happen to me.
 I am sure that terrible things will happen to me.

Item 2

 Nothing will ever work out for me.
 I am not sure if things will work out for me.
 Things will work out for me O.K.

Item 7

 I hate myself.
 I do not like myself.
 I like myself.

Item 3

 I do most things O.K.
 I do many things wrong.
 I do everything wrong.

Item 8

 All bad things are my fault.
 Many bad things are my fault.
 Bad things are not usually my fault.

Item 4

 I have fun in many things.
 I have fun in some things.
 Nothing is fun at all.

Item 9

 I do not think about killing myself.
 I think about killing myself but I would not do it.
 I want to kill myself.

Item 5

 I am bad all the time.
 I am bad many times.
 I am bad once in a while.

Turn over and fill out the other side.

MHS Copyright © 1982, Maria Kovacs Ph.D., © 1991, 1992, Multi-Health Systems Inc. All rights reserved. In the U.S.A., P.O. Box 950, North Tonawanda, NY 14120-0950, (800) 456-3003. In Canada, 3770 Victoria Park Ave., Toronto, ON M2H 3M6, (800) 268-6011. Internationally, +1-416-492-2627, Fax, +1-416-492-3343 or (888) 540-4484.

Remember, pick out the sentences that describe you best in the past two weeks.

Item 10

- I feel like crying every day.
- I feel like crying many days.
- I feel like crying once in a while.

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 11

- Things bother me all the time.
- Things bother me many times.
- Things bother me once in a while.

Item 20

- I do not feel alone.
- I feel alone many times.
- I feel alone all the time.

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 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 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 22

- I have plenty of friends.
- I have some friends but I wish I had more.
- I do not have any friends.

Item 14

- I look O.K.
- There are some bad things about my looks.
- I look ugly.

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 in.

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 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 16

- I have trouble sleeping every night.
- I have trouble sleeping many nights.
- I sleep pretty well.

Item 25

- Nobody really loves me.
- I am not sure if anybody loves me.
- I am sure that somebody loves me.

Item 17

- I am tired once in a while.
- I am tired many days.
- I am tired all the time.

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 18

- Most days I do not feel like eating.
- Many days I do not feel like eating.
- I eat pretty well.

Item 27

- I get along with people.
- I get into fights many times.
- I get into fights all the time.

Appendix B: Instrument for Measuring Anxiety (MASC-10)

Age _____ Sex (Male / Female) School Grade _____ Date _____

These questions ask you how you have been thinking, feeling or acting recently. For each item please tick inside the box that shows how the statement is true about you.

		Never True About Me	Rarely True About Me	Sometimes True About Me	Always True About Me
1	The idea of going away to camp scares me				
2	I am afraid that other kids will make fun of me				
3	I try to stay near my mum or dad				
4	I get dizzy or faint feelings				
5	I feel restless or on edge				
6	I feel sick to my stomach				
7	I get nervous if I have to perform in public				
8	Bad weather, the dark, height, animals or bugs scare me				
9	I check to make sure things are safe				
10	I feel shy				

Appendix C: Instrument for Measuring Anger (AESC)

Age ____ Sex (Male / Female) Grade _____ Date _____

Below are a number of statements which children and adults sometimes use to describe themselves. Read each statement and tick inside the box that describes you best, or shows how you usually feel.

Never Sometimes Often Always

1	I feel angry				
2	I feel like yelling at someone				
3	I'm easy going and don't let things bother me				
4	I get very impatient if I have to wait for something				
5	I lose my temper easily				
6	I feel like breaking things				
7	I feel grouchy or irritable				
8	I get in a bad mood when things don't go my way				
9	It takes a lot to get me upset				
10	I have a bad temper				
11	I get very angry if my parent or teacher criticizes me				
12	I get in a bad mood easily				

INTEGRI PROCEDAMUS

Appendix D: Instrument for Measuring Aggression (AESC)

Everyone feels angry from time to time, but people differ in how they act when they are angry. Below are some statements that people use to describe themselves and how they act when they feel angry. Read each statement carefully, and decide how often the statement applies to you when you feel angry:

Never Sometimes Often Always

1	I slam doors or stomp my feet				
2	I keep it to myself				
3	I control my temper				
4	I let everybody know it				
5	I show displeasure or be in a mood				
6	I try to be patient				
7	I argue or fight back				
8	I don't talk to anybody				
9	I keep my cool				
10	I hit things or people				
11	I feel it inside, but I don't show it				
12	I stay well behaved				
13	I say mean or nasty things				
14	I stay mad at people but keep it secret				
15	I try to stay calm and settle the problem				
16	I have a temper outburst				
17	I hold my anger in				
18	I try to control my angry feelings				

Appendix E: Instrument for Measuring Parent-Child Attachment (IPPA)

Age _____ Sex (Male / Female) Level of education _____

Today's date _____ Number of children you are having, _____

Below are a number of statements which parents sometimes use to describe their feelings towards their children. Read each statement and tick inside the box that describes you best, or shows how you usually feel towards your child/children.

		Strongly Disagree	Disagree	Sometimes Agree	Agree	Strongly Agree
1	I respect my child's feelings					
2	My child is a good child					
3	I wish I have a different child					
4	I accept my child as he/she is					
5	My child does not come to me to help him/her solve a problem					
6	My child wants to get my view on things that he/she is worried about					
7	My child does not show his/her feelings when he/she is upset					
8	I can tell when my child is upset about something					
9	My child feels ashamed or silly when he/she talks about his/her problems with me					
10	I expect a lot from my child					
11	My child gets upset easily at home					
12	I get upset a lot at my child more than he/she knows					
13	when my child talks about things with me I listen to what he/she thinks					

		Strongly disagree	Disagree	Sometimes agree	Agree	Strongly agree
14	I help my child to understand himself/herself better.					
15	My child tells me his/her problems and troubles					
16	My child is angry with me					
17	My child does not get much attention at home					
18	I support my child to talk about his/her worries					
19	I understand my child					
20	My child knows that he/she can depend up on me					
21	When my child is angry about something I try to understand					
22	My child trusts me					
23	I don't understand my child's problems					
24	My child counts on me when he/she needs to talk about a problem					
25	No one understands my child					
26	If I know that my child is upset about something I ask him/her about it					
27	I listen to my child's opinion					
28	My child does not bother me with his/her own Problems					

Appendix F: Instrument for Measuring Caregiver-Child Attachment (IPPA)

Age _____ Sex (Male / Female) Level of education _____

Number of children under your care _____

Below are a number of statements which caregivers sometimes use to describe their feelings towards the children they are caring for. Read each statement and tick inside the box that describes you best, or shows how you usually feel towards the child/children.

		Strongly disagree	Disagree	Sometimes agree	Agree	Strongly agree
1	I respect the child's feelings					
2	The children are good children					
3	I wish I am not a caregiver of these children					
4	I accept a child as he/she is					
5	The children do not come to me to help them solve a problem					
6	The children wants to get my view on things that he/she is worried about					
7	The children does not show their feelings when he/she is upset					
8	I can tell when a child is upset about something					
9	The children feel ashamed or silly when he/she talks about his/her problems with me					
10	I expect a lot from the children					
11	The children gets upset easily at home					
12	I get upset a lot at the children more than he/she knows					
13	when a child talks about things with me I listen to what he/she thinks					
14	I listen to the child's opinion					

		Strongly Disagree	Disagree	Sometimes Agree	Agree	Strongly Agree
15	I help the children to understand themselves better.					
16	The children tells me their problems and troubles					
17	The children are angry with me					
18	The children do not get much attention at home					
19	I support the children to talk about their worries					
20	I understand the children					
21	The children knows that they can depend up on me					
22	When a child is angry about something I try to understand					
23	The child trusts me					
24	I don't understand the children's problems					
25	The children count on me when they need to talk about a problem					
26	No one understands the children					
27	If I know that a child is upset about something I ask him/her about it					
28	The children do not bother me with their own Problems					

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Appendix G: Instrument for Measuring Child-Parent Attachment (IPPA)

Age _____ Sex (Male / Female) School grade _____

Type of parent you are living with (Mother/ Father or Both)

Below are a number of statements which children sometimes use to describe their feelings towards their parent. Read each statement and tick inside the box that describes you best, or shows how you usually feel towards your parent.

		Strongly Disagree	Disagree	Sometimes Agree	Agree	Strongly Agree
1	My parents respect my feelings.					
2	My parents are good parents.					
3	I wish I had different parents.					
4	My parents accept me as I am					
5	I can't depend on my parents to help me solve a problem.					
6	I like to get my parents' view on things I am worried about.					
7	It does not help to show my feelings when I am upset					
8	My parents can tell when I'm upset about something.					
9	I feel silly or ashamed when I talk about my problems with my parents					
10	My parents expect too much from me.					
11	I easily get upset at home.					
12	I get upset a lot more than my parents know about					
13	When I talk about things with my parents they listen to what I think					

		Strongly Disagree	Disagree	Sometimes Agree	Agree	Strongly Agree
14	My parents have their own problems, so I don't bother them with mine					
15	My parents help me to understand myself better.					
16	I tell my parents about my problems and troubles.					
17	I feel angry with my parents.					
18	I don't get much attention at home.					
19	My parents support me to talk about my worries.					
20	My parents understand me.					
21	I don't know who I can depend on.					
22	When I am angry about something, my parents try to understand.					
23	I trust my parents.					
24	My parents don't understand my problems					
25	I can count on my parents when I need to talk about a problem					
26	No one understands me.					
27	If my parents know that I am upset about something, they ask me about it.					
28	My parents listen to my opinions					

Appendix H: Instrument for Measuring Child-Caregiver Attachment (IPPA)

Age_____ Sex (Male / Female) Level of education _____

Number of caregiver you are having _____

Below are a number of statements which children sometimes use to describe their feelings towards their parents or caregivers. Read each statement and tick inside the box that describes you best, or shows how you usually feel towards your caregivers.

		Strongly Disagree	Disagree	Sometimes Agree	Agree	Strongly Agree
1	My caregivers respect my feelings					
2	My caregivers are good parents					
3	I wish I had different caregivers					
4	My caregivers accept me as I am					
5	I can't depend on my caregivers to help me solve a problem					
6	I like to get my caregivers view on things I'm worried about					
7	It does not help to show my feelings when I am upset					
8	My caregivers can tell when I'm upset about something					
9	I feel silly or ashamed when I talk about my problems with my caregivers					
10	My caregivers expect too much from me					
11	I easily get upset at home					
12	I get upset a lot more than my caregivers know about					
13	When I talk about things with my caregivers they listen to what I think.					
14	My caregivers listen to my opinions					

		Strongly Disagree	Disagree	Sometimes Agree	Agree	Strongly Agree
15	My caregivers have their own problems, so I do not bother them with mine.					
16	My caregivers help me to understand myself better.					
17	I tell my caregivers about my problems and troubles					
18	I feel angry with my caregivers					
19	I don't get much attention at home					
20	My caregivers support me to talk about my worries					
21	My caregivers understand me					
22	I don't know who I can depend on					
23	When I am angry about something, my caregivers try to understand					
24	I trust my caregivers					
25	My caregivers don't understand my problems					
26	I can count on my caregivers when I need to talk about a problem					
27	No one understands me					
28	If my caregivers know that I am upset about something they ask me about it					

Appendix I: Interview Guide

1. Introduction: Present myself, the study and its purpose and approximate length of interview. Tell participants about anonymity, confidentiality, voluntary participation. Ask consent to record the interview, noting that the recording would be destroyed at the end of the analysis. Offer a summary of the interview.

2. Preliminary Question

Is there anything you would like to ask me before we begin?

After answering preliminary question, recording begins.

3. Questions about Background of the Respondent

1. Education: What is your highest level of education? How long was training for the job?
2. Work: In what area do you work, and how long have you held this job position?

4. Questions According to Topic

Topic 1: Social aspects of children's emotional and general well-being

1. What emotional and well-being support do you think children need and are receiving?
2. Is there any emotional problem that children are suffering, how is it identified and treated? (*Question to adults*)

Topic 2: Living conditions

1. With whom do you feel happy to living? (*Question to children*)
2. Is there any documentation concerning the life and conditions of institutionalized children? (*Question to adults*)

Topic 3: Trust and Dependency

1. Whom do you call or go to in time of need for help such as academic, danger or sharing of your secrets?
2. What do you do if you could not get the help you need? (*Questions to children*)

Topic 4: Discipline

1. How do you evaluate the behaviors of the children in the institutional care?
2. How are children's behavioral displays handled? What are the correctional methods employed by caregivers? (*Questions to adults*)
3. How are you corrected for the actions that you are told it is wrong? How often does this happen? What do you feel about it? (*Questions to children*)

Topic 5: Attachment/Quality Time

1. Who are you close to? Who hug you; tell you that you are loved and you are good?
2. What do you want your caregivers do to show you love? (*Questions to children*)
3. What do you suggest caregivers to do in order to draw children close to themselves? (*Question to adults*)

Topic 6: Professional Psychological Care

1. From what kind of psychological and emotional care do children in institutional home benefit from?
2. What are your suggestions concerning this aspect?

Topic 7: The Future of the Orphaned Children

1. Is there any relative who comes to visit you?
2. Do you know where you are coming from and your tribe?

3. Have you seen or participated in any cultural displays?
4. What do you want to be when you grow up and where do you go from here?

(Questions to children)

5. What is the future of the institutionalized children and how are they prepared to meet it?
6. What could be done? What would you like to see done? *(Questions to adults)*

5. Conclusion: Thank you very much for your time and for taking part in the study.

