

**THE PSYCHOLOGICAL FUNCTIONING AND EXPERIENCES FOLLOWING
PLACEMENT IN ORPHANAGES: AN EXPLORATORY STUDY OF
ORPHANHOOD IN ACCRA, GHANA**

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Declaration

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I have the sole authorship thereof (unless to the extent explicitly otherwise stated) and that I have not previously, in its entirety or in part, submitted it for obtaining any qualification.

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Abstract

Parental loss and orphanage placement can be stressful and can negatively influence the well-being of children. However, few studies have been conducted on the psychological well-being of Ghanaian orphans placed in orphanages. As a result, the impact of orphanage placement following parental loss in Ghana is not well understood. The present study aimed to explore the psychological functioning and experiences of orphaned children placed in orphanages in comparison to non-orphaned children in Accra, Ghana.

A mixed-method design with elements of both quantitative and qualitative approaches was used. For quantitative data, questionnaires were used to source information pertaining to quality of life, stress (symptoms of depression and anxiety), problems experienced during the month, coping strategies, perceived social support, perceived self-efficacy and resilience. For qualitative data, follow-up interviews with selected orphaned participants were used to delve into participants' experiences of placement in an orphanage. Purposive sampling was used to select participants who were aged between seven and 17 years. The sample comprised 100 orphaned children, placed in four orphanages, and 100 non-orphans sampled from two public schools in Accra. The quantitative data were analysed using the t-test, the chi-square test, Pearson product-moment correlation analyses, one-way analysis of variance (ANOVA) and regression analyses. The qualitative data were analysed through content and thematic analyses.

The results revealed that orphaned children showed more anxiety symptoms than non-orphans but both groups of children presented with high levels of depressive symptoms. The predominant problems for both groups of children were problems with school and relationship problems with peers and caregivers. However, for orphaned children, relationship problems with peers were commonly cited whereas for non-orphans, problems cited were relationship difficulties with caregivers. Despite the heightened emotional distress, orphaned children

reported high levels of self-efficacy and resilience as well as stronger perceptions of available support from friends than non-orphans. Non-orphaned children perceived significantly stronger support from families than orphaned children. Regression analyses also revealed that for orphaned children, anxiety and support-seeking coping emerged as significant predictors of quality of life whereas depression emerged as a significant predictor of quality of life for non-orphaned children. Self-efficacy emerged as a significant positive predictor of resilience for orphaned children whereas self-efficacy and perceived social support emerged as significant positive predictors of resilience for non-orphans.

The results of the thematic analyses of the follow-up interviews with selected orphans also revealed that orphanage placement evoked both negative and positive experiences. While orphanages provided structure, nurturance, a safe home environment and avenues for positive peer relationships that engendered a sense of belonging, they were also associated with financial constraints and relationship problems with peers and caregivers. In addition, the Christian-religious orientation of the orphaned children appeared to foster orphans' well-being.

The present study provided evidence that both the orphaned and non-orphaned children were vulnerable to psychological distress. Therefore, interventions should be effected to both groups of children. Furthermore, the study showed that orphanages provided sanctuary and nurturance to orphans who lack parental care and could be considered as a viable form of orphan care in Ghana.

Opsomming

Ouerverlies en weeshuisplasing veroorsaak stres en kan die welstand van kinders negatief beïnvloed. Min navorsingstudies is egter gedoen oor die psigologiese welstand van Ghanese weeskinders wat in weeshuise geplaas word. Die gevolg is dat die impak van weeshuisplasing ná ouerverlies nie goed in Ghana verstaan word nie. Die studie is daarop gemik om die psigologiese funksionering en ervarings van kinders wat ouerloos gelaat en in weeshuise in Accra, Ghana, geplaas word, te ondersoek en dit met dié van niewesgelate kinders te vergelyk.

’n Gemengdemetode-ontwerp met elemente van beide kwantitatiewe en kwalitatiewe benaderings is gebruik. Vraelyste is vir die kwantitatiewe data gebruik ten einde inligting te bekom oor lewenskwaliteit, stres (simptome van depressie en angs), daaglikse streswekkers of stressors, behartigingstrategieë, waargenome sosiale steun, waargenome selfbedrewendheid en veerkrug. Vir die kwalitatiewe data is opvolgonderhoude met geselekteerde weesgelate deelnemers gevoer ten einde die deelnemers se geleefde ervarings van plasing in ’n weeshuis indringend te bekijk. Doelgerigte steekproefneming is gebruik om deelnemers tussen die ouderdom van sewe en 17 jaar oud te selekteer. Die steekproef het bestaan uit 100 weesgelate kinders wat in vier weeshuise geplaas is, en 100 niewesgelate kinders wat as steekproef uit twee openbare skole in Accra geneem is. Die kwantitatiewe data is ontleed met gebruikmaking van die t-toets, die chi-kwadraattoets, Pearson-produkmomentkorrelasieontledings, asook eenrigting-variansie- (VARO) en regressieontledings. Die kwalitatiewe data is aan die hand van inhouds- en tematiese ontledings geanaliseer.

Volgens die resultate toon weesgelate kinders meer angssimptome as niewesgelate kinders, terwyl beide groepe kinders met hoë vlakke van depressieve simptome presenteer. Die oorheersende daaglikse stressors by beide groepe kinders is probleme by die skool, asook

verhoudingsprobleme met die portuurgroep en sorggewers. Wat die weesgelate kinders betref, word verhoudingsprobleme met die portuurgroep egter as die mees algemene probleme aangevoer, terwyl nieweesgelate kinders verhoudingsprobleme met sorggewers aandui. Afgesien van die verhoogde emosionele nood, toon weesgelate kinders hoë vlakke van selfbedrewendheid en veerkrag, asook sterker persepsies van beskikbare bystand deur vriende, as wat die geval is by nieweesgelate kinders. Nieuweesgelate kinders neem beduidend sterker bystand van families waar as wat die geval is by weesgelate kinders.

Regressieontledings dui ook aan dat angs en bystandsoekende behartigingsgedrag by weesgelate kinders as beduidende voorspellers van lewensgehalte presenteer, terwyl depressie as 'n beduidende voorspeller van lewensgehalte by nieweesgelate kinders presenteert.

Selfbedrewendheid presenteert as 'n beduidende positiewe voorspeller van veerkrag by weesgelate kinders, terwyl selfbedrewendheid en waargenome sosiale bystand as beduidende positiewe voorspellers vir veerkrag, by nieweesgelate kinders presenteert.

Volgens die resultate van die tematiese ontledings van opvolgonderhoude met geselekteerde weeskinders, ontlok weeshuisplasing beide negatiewe en positiewe ervarings. Weeshuise skep struktuur, koestering, 'n veilige tuisomgewing en kanale vir positiewe portuurgroepverhoudings, en gevvolglik 'n gevoel van samehorigheid, ofskoon hierdie instansies ook met finansiële beperkings en verhoudingsprobleme met portuurgroepe en versorgers verbind word. Verder blyk dit dat die Christengeloof-oriëntasie van die weesgelate kinders die welstand van die weeskinders bevorder.

Die aangebode studie lewer bewys dat sowel die weesgelate as die nieweesgelate kinders kwesbaar is vir psigologiese nood. Gevolglik word intervensies vir beide groepe kinders aangedui. Die studie toon verder dat weeshuise 'n toevlugsoord en versorgingsplek bied vir weeskinders wat nie ouerlike sorg ontvang nie, en dat dit as 'n lewensvatbare vorm van weeskindsorg in Ghana beskou kan word.

Statement Regarding Bursary and Manuscripts in the Dissertation

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It should be noted that the manuscripts presented in Chapters 5, 6 and 7 of the dissertation have been accepted for publication, respectively in *Children and Youth Services Review* (Salifu Yendork & Somhlaba, 2014), the *Journal of Loss and Trauma* (JLT; Salifu Yendork & Somhlaba, *in press-a*) and *Child Care in Practice* (Salifu Yendork & Somhlaba, *in press-b*) and are included in the list of references. The manuscripts presented in Chapters 4 and 8 are, as of November 2014, are under review. There is some duplication in the dissertation, publications and manuscripts pertaining to the literature review, methodology and results sections.

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Dedication

I dedicate this dissertation to my husband and daughter. The two of you have always been there, loving, supporting and encouraging me.

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List of Abbreviations

CDI	Children's Depression Inventory
DSM-IV	Diagnostic and Statistical Manual of Mental Disorder
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorder, Text Revision
DSW	Department of Social Welfare
GAD	Generalised anxiety disorder
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Services
GSS	Ghana Statistical Services
HIV/AIDS	Human immunodeficiency virus / acquired immune deficiency syndrome
ICD-10	International Classification of Diseases, Tenth Revision
JHS	Junior High School
MESW	Ministry of Employment and Social Welfare
MMYE	Ministry of Manpower, Youth and Employment
NGO	Non-governmental Organisation
PTSD	Post-traumatic Stress Disorder
QoL	Quality of Life
RS	Resilience Scale
SAD	Seasonal Affective Disorder
SESRTCIC	Statistical Economic and Social Research and Training Centre for Islamic Countries
SHS	Senior High School
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund

USAID United States Agency for International Development

WHO World Health Organisation

WHOQOL World Health Organisation Quality of Life

Chapter 1: Introduction

Orphanhood can be a stressful experience and can adversely affect the well-being of children. However, globally, the psychological well-being of orphans has received little attention (Li et al., 2008). Similarly, although orphans who reside in orphanages face multiple challenges, and can be at risk for developing poor mental health (Johnson, Browne, & Hamilton-Giachritsis, 2006), yet, little is known about their well-being (Hermenau et al., 2011). This is due to the scarcity of studies done on the subject and the inconsistent results that existing studies have reported. It is against this background that there is a continued need for research enquiry on the well-being of orphaned children placed in orphanages. The present study, therefore, aimed to explore the psychological functioning and experiences of orphaned children following their placement in orphanages in Accra, Ghana in comparison to non-orphaned children who live with their parents.

In the current chapter, the following aspects of the present study are discussed: parental loss and psychological well-being, orphanage placement and psychological well-being, problem statement and significance of the study, aims and objectives of the study, scope and limitations of the study, and the chapter outline.

1.1. Parental Loss and Psychological Well-being

In the international literature, orphanhood is generally defined as the position in which a child is placed when he/she loses a parent, or both, through death by any cause during childhood (United Nations International Children's Emergency Fund [UNICEF], 1999; UNICEF/Joint United Nations Programme on HIV/AIDS [UNAIDS], 2006). This definition depends on the biological parental status and the chronological age of a child. However, the African cultural conceptualisation of orphanhood goes beyond the death of a parent and the age of a child to include parental neglect and -abandonment as well as lack of social support. As a result, the mere absence of the parents or lack of social support has been argued as

constituting enough reason for abandoned children to be regarded as orphans in the African context (Meintjes & Giese, 2006; Skinner et al., 2006). The present study, therefore, will adopt both the biological and social definition of orphanhood. Thus, an orphan is defined in the present study as a child who is below 18 years, who has lost a parent, or both, through death or abandonment, and who resides in an orphanage in Accra, Ghana.

In Africa, orphanhood through parental death is mostly caused by Aids (UNICEF & UNAIDS, 2006), whereas orphanhood through abandonment occurs mostly due to poverty (Uzodike, 2000). Generally, orphanhood, whether caused by parental death or neglect, can have both short-term and long-term negative impact on children's well-being. In the context of childhood parental loss through death, research has highlighted that, children, due to their intellectual immaturity, can potentially be at risk of developing poor mental health (Lin, Sandler, Ayers, Wolchik, & Luechen, 2004). This is due to their inability to understand the general concept of death, to accept the loss and to sustain emotions associated with parental death (Clark, Pynoos, & Goebel, 1996; Lin et al., 2004). As a result, orphaned children are prone to experiencing unresolved negative feelings related to parental death. Children are also dependent on their caregivers for satisfaction of their basic needs, as well as for both their physical and emotional support (Lin et al., 2004). As a result, the death of a parent deprives them of sustenance. Also, depending on the cause of parental death, children might be stigmatised, and might even lose out on developing meaningful relationships with their peers (Manuel, 2002). Additionally, the death of a parent comes with numerous social disruptions, such as changes in the home, the community, their education, possible separation from siblings, having to live with relatives, and possibly even living on the street (Thompson, Kaslow, Price, Williams, & Kingree, 1998). Such changes can be stressful as they pose new demands and constraints on children. All of the above-mentioned factors can be detrimental to the psychological well-being of children. Given the potential risk posed by parental death on

children's mental health, it is not surprising that previous studies have found the presence of dysphoria, anxiety, and depression among orphaned children (Chase-Lansdale, Cherlin, & Kiernan, 1995; Dowdney, 2000; Van Eerdewegh, Bieri, Parrilla, & Clayton, 1982).

Parental loss through abandonment has also been noted as having potential negative effects on children's sense of emotional and psychological well-being. Similarly to parental death, abandonment separates children from their primary caregiver. Such separation can deprive children of the affection and security that they need for positive development. Abandoned children might feel unwanted by their parents (Burnstein, 1981), possibly respond to the rejection with difficult behaviours, incontinence, anxiety or depression (Bowley, 1947). Abandonment also increases the likelihood of children being raised in institutions (Burnstein, 1981). Institutions have been found to harbour conditions that can adversely affect children's mental health (Bowlby, 1951; Ellis, Fisher, & Zaharie, 2004; Goldfarb, 1943; MacLean, 2003; Spitz, 1949; Zeanah et al., 2009). Uzodike (2000) also highlights the fact that abandoned children are likely to get into the 'wrong hands', potentially resulting in their death or subjection to slavery.

Of note, parental loss by itself is also argued as possibly not resulting in psychopathology, but, rather, the situations preceding and following the loss are the risk factors for the development of psychopathology in children (Rutter, 1995). For example, it has been found that parental loss initiates a series of negative events that have persistent effects on children (Maier & Lachman, 2000). Maier and Lachman found that loss through parental death and divorce can result in such secondary stressors as reduction in the amount of financial resources and social support, diminished parent-child involvement, a low level of education, negative health behaviours (such as substance abuse and risky sexual behaviours), the lack of access to health care, and poor health (both physical and mental). Such factors can lead to the possibility of orphaned children dropping out of school, being malnourished and

vulnerable to conditions of child labour, as well as to physical and/or sexual abuse (Getachew, Ambaw, Abebe, & Kasahun, 2011; Smart, 2009; Thompson et al., 1998; UNICEF, 2003). All of these adverse consequences can serve as risk factors for the development of poor psychological well-being in the children involved (Dowdney, 2000; Luecken, 2008; Nyamukapa et al., 2006; Sengendo & Nambi, 1997).

Another consequence of parental loss that has received relatively little attention in Africa is the issue of care and living arrangements. In the past, African children who lost their parents were integrated into the extended family system. The extended families provided social security, and helped to ensure that orphaned children were cared for even when the ‘adoptive’ family lacked sufficient resources for its own members (Foster, 2000). The system shielded children who had lost their parents from the adverse effects that might otherwise have been suffered from the loss of the primary caregivers. However, recent reports suggest that extended families tend to lack the full capacity to care for orphans (Foster, 2000), due to recent trends in disease (mainly AIDS) and other factors, including westernisation, rural–urban labour migration, formal education, and changes in locations, thus weakening the extended family ‘safety net’ for orphans (Foster, 2000; Seeley et al., 1993). Against the background mentioned, the potential for orphaned children ending up on their own, as part of a child-headed family, of living on the street, and of being used as child labour, or of landing up in an orphanage is increased (Sengendo & Nambi, 1997).

In Ghana, the prevalence of orphans due to all causes in 2011 was estimated to be about 970 000 and, of that total, 180 000 were due to Aids (UNICEF, 2012a). Although Ghana does not have a disproportionately high prevalence rate of orphans when compared to other sub-Saharan African countries (UNICEF, 2012b), the mere fact that the country has a recorded high number of orphans is still a concern. This is because, the majority of the Ghanaian population are young with 41 per cent being under the age of 15 years, whereas a mere 5 per

cent were 65 years and above (Ghana Statistical Service, Ghana Health Service, & ICF Macro, 2009). The concern often raised about the well-being of orphans is that the elderly people are mostly the ones who traditionally care for orphans (Deters, 2008). Concerns about the long-term sustainability of orphan care by the elderly have been raised because of the emotional and financial consequences on the elderly (Alden, Salole, & Williamson, 1991). The elderly (grandparents) often have to deal with the loss of their children and also have limited financial resources to give adequate care to orphaned children. Additionally, Ghanaian orphans are at risk for lacking care due to few available aged to care for a large number of orphans (Deters, 2008). Orphans in Ghana are, therefore, likely to lack care after the loss of their parents and can be at risk of developing poor mental health.

Additionally, other traditional means of orphan care, which include the traditional inheritance system and fosterage practices that provide avenues for orphans to be cared for and raised by the extended families, have been diminished (Ansah-Koi, 2006; Kuyini, Alhassan, Tollerud, Weld, & Haruna, 2009). This is due to rural-urban migration trends, financial constraints on families and increased in the rate of orphanhood due to HIV infection (Ansah-Koi, 2006; Apt, Blavo, & Wilson, 1998; Deter, 2008; Voyk, 2011). As a result of the diminished capacity of the traditional means of orphan care, placement of orphans in orphanages has become an alternative care arrangement for orphans in Ghana.

1.2. Orphanage Placement and Psychological Well-being

In the past, orphanages in the developed world were found to have a good history of caring for children whose parents were deceased, for abandoned children or for children whose parents were unable to care for them due to poverty (Freundlich, 2005). However, concerns about the health of children placed in orphanages began when it became apparent that the children who had been placed in orphanages were showing signs of negative cognitive, physical and psychosocial development (Lee & Fleming, 2003). Studies regarding

the effect of early deprivation, due to institutionalisation on children's development began in the 1940s and the 1950s (MacLean, 2003). Early studies (Bowlby, 1951; Goldfarb, 1943; Spitz, 1949) consistently reported that children who were raised in institutions presented with severe developmental, emotional, behavioural and intellectual delays. The findings concerned were blamed on emotional deprivation resulting from the absence of a maternal figure in the institutions during early development (Ellis et al., 2004; Rutter, 1979). However, the findings involved should be interpreted with caution, due to early scholars being criticised for failing to report details of the conditions in the orphanages, information about the children concerned, and the measures used to assess children in their studies (MacLean, 2003). MacLean also states that early studies were descriptive, anecdotal and short-term, thus making them difficult to evaluate.

Subsequent to the early studies, later studies (Johnson et al., 2006; MacLean, 2003; The St. Petersburg–USA Orphanage Research Team, 2005; Zeanah et al., 2009), using more rigorous methodologies, have also reported similar negative findings. The later studies also reported developmental, intellectual, academic and language delays, problems with social competence, quasi-autistic behaviour, poor emotional attachment and poor mental health following the institutionalisation of children. Children raised in institutions were also found to present difficulties in terms of economic, family and personal adjustments after they left the orphanage and attempts were made to reintegrate them into the community (Smith, 1995). Of note is the fact that the studies concerned mostly examined infants placed in institutions from birth. Although the severity and duration of the difficulties encountered varied across studies (Browne, 2009), one key finding was that early institutionalisation and long-term placement could negatively impact on all aspects of children's development and mental health (MacLean, 2003; Rahman et al., 2012).

Whereas studies of the effects of institutionalisation on early childhood development have consistently highlighted the negative results found, studies that examine the psychological effects of the placement of orphaned children in orphanages have yielded inconsistent results. Some studies (Ahmad & Mohamad, 1996; Ahmad et al., 2005a, 2005b; Erol, Şimşek, & Münir, 2010; Fawzy & Fouad, 2010; Fisher, Ames, Chisholm, & Savoie, 1997; Hermenau et al., 2011) have highlighted the presence of poor psychological well-being, in the form of depression, anxiety and poor quality of life. In contrast, other scholars (Emond, 2009; McKenzie, 1997, 1998; Whetten et al., 2009) have highlighted the existence of positive mental health.

Studies in the developed world have associated the poor developmental and psychological well-being found in orphanage children to adverse conditions in the orphanages. These include poor stimulating environment, poor caregiving, strict routines, frequent absence of caregivers, stigma and administration restraints (Browne, 2009; Daunhuaer, Bolton, & Cermak, 2005; Wolff & Fesseha, 1999; Zhao et al., 2007). Especially when children are placed in an orphanage at an early age and stay there for too long, they are likely to develop developmental delays and to experience poor psychological well-being (Browne, 2009; Daunhuaer et al., 2005). The symptoms of poor mental health have been found to persist even when the orphans concerned leave the orphanage (Sigal, Perry, Rossignol, & Ouimet, 2003; Wiik et al., 2011).

As already highlighted, the weakening of the extended family system in Africa has left a number of orphans with no option but institutionalisation. Orphanages emerged in Africa to provide care for orphans who would otherwise have been vulnerable as a result of not receiving care from their extended families (Akpalu, 2007). However, little is known about the effects of placement in orphanages on children's mental health, due to the scarcity of research regarding the issue (Hermenau et al., 2011; Leyenaar, 2005). Additionally, the few

existing studies have documented inconsistent results, with some studies highlighting positive mental health of the children concerned (Aboud, Samuel, Hadera, & Addus, 1991; Kodero, 2000; Zimmerman, 2005), whereas others have highlighted negative mental health (El Koumi et al., 2012; Fawzy & Fouad, 2010; Hermenau et al., 2011; Wolff & Fesseha, 1999).

Orphanage placement in Africa has also been argued as being culturally inappropriate, because orphanages are unable to provide authentic African family, tribal and village setting (Beard, 2005). As a result, when the children leave the orphanages, they are not well-prepared for reintegration into African society. Beard also claims that African orphanages are only able to provide help to a small percentage of children and that they have age restrictions, thus leaving some children (older orphans) no alternative but to live on the street. Furthermore, orphanage placement has been found to cause increased stigmatisation and struggle over belongings, as well as the disruption of ties between the community and the family (Freidus, 2010).

The contradictory findings obtained in international and African studies have led to different recommendations with regards to placement in orphanages. Some scholars (Christiansen, 2005; McKenzie, 1997, 1998; Whetten et al., 2009) have argued that institutional placement should be considered as a viable option for orphan care, and might even be more suitable than kinship care (Kodero, 2000). In contrast, some scholars (Wanat et al., 2010) have also argued that institutional placement should be used as a last resort while others (Ahmad et al., 2005a; Beard, 2005; Johnson et al., 2006; Smith, 1995) have argued against institutional placement and have promoted alternative methods that include adoption and foster care. Despite the arguments against institutional placement and the potential adverse effect of orphanages on children's mental health, children continue to be placed in orphanages.

Some reasons for orphanage placement include the inadequate parental socio-economic status resulting from poverty; parental loss, either through death or abandonment; family conflict, such as that which results in divorce; abuse; parental problems that might have genetic or behavioural implications for the child, such as parental mental illness, parental incarceration, drug or alcohol abuse; the loss of parental right to children; the experience of violence or abuse; and war (Akay, Miral, & Baykara, 2006; MacLean, 2003; The St. Petersburg–USA Orphanage Research Team, 2005). In the present study, only children who were placed in orphanages due to parental loss (through death or abandonment since birth) and the effects of such placement on their mental health are emphasised.

Currently in Ghana the evidence suggests that the living arrangement of orphaned children include family care (in terms of which single orphans reside with their surviving parents), kinship care, residential care, formal foster care, adoption and the streets of urban areas (Ministry of Employment and Social Welfare [MESW] & UNICEF, 2010). In 2008, the GDHS reported that 18 per cent of children below 18 years were foster children (living with neither biological parent) and, out of this figure, 8 per cent were single orphans and less than 1 per cent were double orphans (GSS, GHS, & ICF Macro, 2009). The figure represents the percentage of orphans in kinship care, with the remaining orphans being spread across other living arrangements. In Ghana, formal foster care by a non-relative is rare, and the only foster care programme is situated in the Manya Krobo District, in the Eastern Region of Ghana. However, the foster care programme concerned, which is not a national programme, is minimally used. The Ministry of Employment and Social Welfare in Ghana and the UNICEF (2010) reported that, in 2004, only 13 foster care orders were drawn up, and most of the foster parents used were found to be related to the orphans involved. The finding suggests that orphans who are without relatives are less likely to be taken up into foster care.

Residential care is used as a last resort for the care of orphaned children in Ghana (Department of Social Welfare [DSW], 2008; MESW & UNICEF, 2010). However, in recent times, Ghana has witnessed a vast increase in the number of orphanages for orphans and vulnerable children (Ansah-Koi, 2006). The increase has resulted as a response to the Aids pandemic and poverty (Deters, 2008). In 2006, the Ghana Department of Social Welfare reported that there were only five legally operating orphanages. Out of the five, three were government-run (Osu, Kumasi and Tamale) and two others (Jirapa and Mampong) were privately owned. The report further highlights that that as many as 148 privately owned and managed residential care centres for orphaned children operate illegally in Ghana. These orphanages concerned are estimated to provide care for about 4 500 children (MESW & UNICEF, 2010).

In Ghana, poverty is the main reason for the existence of orphanages (Adu, 2011). Adu noted that the majority of children in the Ghanaian government orphanages at the time of her research were from the rural areas, where poverty rates were higher than in the urban areas. In addition, the author highlighted the fact that the surviving parent or family members were not able to care for children of whom at least one parent was deceased. Some children were also abandoned by their mothers after their birth, and others were abandoned by their family after the death of their mother from childbirth. Currently, no data exist on the regional distribution of orphanages in Ghana.

In general, very few studies have been undertaken into Ghanaian orphanages and, of the studies, several structural problems have been reported. Some of the documented studies have reported that many of the orphanages are operating illegally (DSW, 2008), have insufficient facilities pertaining to accommodation, toilet, recreational and academic activities (Simons & Koranteng, 2012), lack of qualified staff, inadequate medical care and high caregiver to child ratio (Ministry of Manpower, Youth and Employment [MMYE] & DSW,

2008), evidence of corruption on the part of the orphanage administrators (Colburn, 2010) and the exploitation of visitors and the misuse of funds by orphanage administrators (Pyper, 2010). The range of adverse living conditions in the orphanages, the discovery of which led to the shutting down of 14, with three others on the waiting list to be closed down in 2010 (DSW, 2010). To date, there is no information regarding the status of the orphanages that were scheduled to be closed down.

Pertaining to the well-being of orphans who are placed in Ghanaian orphanages, very little is known given that very few studies could be traced in the literature. The few existing studies have highlighted incidence of malnutrition (Ribeira, Brown, & Akuamoah-Boateng, 2009; Sadik, 2010), stigmatisation from community members and ill treatment from school children have been found (Voyk, 2011). With regards to the psychological well-being of orphans placed in Ghanaian orphanages, little is known due to the few studies that could be traced in the literature. One study (Kristiansen, 2009) compared the quality of life (QoL) of orphans, with respect to the satisfaction of their needs, in three orphanages in Accra. The other study (Adu, 2011) examined the subjective well-being of orphans who were placed in one particular government orphanage. The studies mentioned used a very small sample and measured a very limited aspect of mental health. They also failed to yield substantial information regarding the psychological well-being of the orphans who are placed in orphanages in Accra, Ghana. Given the gap in research on the mental health of orphans placed in Ghanaian orphanages, studies are therefore warranted.

1.3. Problem Statement and Significance of the Study

From the above discussion, it is worth noting that orphanhood and placement in orphanages can have negative consequences on the psychological well-being of orphans. African orphans are also at added risk due to the rising rate of orphanhood, the breakdown of the extended family's capacity for orphan care and the impact of poverty. However, little is

known about the mental health of orphans and, more specifically, little is known about the psychological effects of placing orphans in orphanages. The few existing studies have also yielded inconsistent results. Within the Ghanaian context, and specifically in Accra, little is known on the subject, because only two studies (Adu, 2011; Kristiansen, 2009) could be traced in this regard. Both studies used small sample sizes and were not comprehensive. Against this background, a study investigating the psychological well-being and the experiences of orphans following their placement in an orphanage within the African context therefore appears to be warranted. With the above in mind, the present study aimed to explore the nature of the psychological functioning and the experiences of orphans placed in orphanages, and the impact of such placement on the psychological well-being and overall quality of life of orphanage-placed children in Accra, Ghana.

The results and findings of the current study were anticipated to yield several impacts. The strength of the present study lie in its strong methodology, including the use of a large sample size across four orphanages in Accra, the use of a control group, the assessment of comprehensive psychological well-being using both standardised measures and follow-up interviews. In this regard, the results of the present study would yield a substantial amount of information that could inform the design of interventions aimed at promoting the mental health of orphans in general. Also, given that little was known, prior to the study, about the psychological effect of orphanage placement on the mental health of orphans in Africa, the study would provide information on the current nature of the issue in the Ghanaian setting.

Additionally, since no study of the kind had yet been undertaken in the Ghanaian context, the results of the present study would provide information on the general stress levels of orphans in orphanages in comparison to non-orphans who resided with their parents. Such results are hoped to form the basis for the consideration of the placement of orphans in orphanages in Accra, Ghana. Additionally, the results of the present study would reveal the

nature of psychological distress involved in such placement, which would help to inform policy-makers, clinicians and non-governmental organisations (NGOs) on the need for psychological interventions for the orphans concerned. Furthermore, given the on-going debate on the psychological effect of placement in an orphanage on the mental health of the orphans involved, with some studies having already highlighted the negative effects of such placement, whereas others have highlighted the positive effects thereof, the present study would contribute to the debate globally and throughout Africa, by providing information on the issue within the Ghanaian context.

1.4. Aims and Objectives of the Study

The main aim of the present study was to explore the psychological functioning and experiences following placement in orphanages and the impact the functioning had on the psychological well-being and overall quality of life of the orphans in comparison to non-orphaned children in Accra, Ghana. To achieve this aim, eight objectives were formulated and are presented below:

1. To determine the overall quality of life of the population of orphans in Accra orphanages in comparison to non-orphaned children in Accra, Ghana. This objective was achieved by measuring the quality of life of participants.
2. To determine the levels of stress of orphans placed in orphanages in Accra in comparison to non-orphaned children in Accra, Ghana. This objective was achieved by screening for symptoms of depression and anxiety.
3. To determine the subjective distress in orphans in comparison to non-orphans, the coping strategies that participants used to manage the distress and the efficacy of the strategies used. This objective was achieved by screening for problems experienced by participants during the month of the data collection period as well as the coping strategies used by participants to manage the problems.

4. To determine the differences between orphans and non-orphans on the stress moderating variables. This objective was achieved by measuring participants' coping strategies, perceived self-efficacy, perceived social support and resilience.
5. To ascertain whether participants' perceived social support, perceived self-efficacy and resilience predict their stress levels.
6. To determine whether participants' stress levels and coping strategies predict their quality of life.
7. To explore whether perceived social support and perceived self-efficacy predict resilience in the participants.
8. To delve into the subjective experiences of placement in the orphanages of the Accra orphans, from their vantage point. This objective was achieved by asking follow-up interview questions on orphans' experience of living in orphanages.

1.5. The Scope of the Study

Given that few studies have been carried out on the psychological well-being of Ghanaian orphans, a study aimed to explore the well-being of orphans placed in varied care arrangements (notably, foster care, kinship care and institutions) in all the ten regions in Ghana would be beneficial. However, due to time and financial constraints, it was not feasible for the present study to accomplish such aim. As a result, the present study aimed to explore the psychological functioning and experiences of Ghanaian orphans placed in four orphanages in Accra. Psychological functioning was operationally defined as overall quality of life, stress (symptoms of depression and anxiety), coping strategies, perceived social support, perceived self-efficacy, resilience and the subjective experiences about placement in an orphanage. Depression and anxiety, regarded as some indicators of stress, were included in the present study because they are the common mental health problems that have been reported by previous studies in orphanage-placed children. The other variables (quality of life, coping

strategies, perceived social support, perceived self-efficacy and resilience) were included because very few studies have explored them in orphanage-placed children. The present study excluded orphans placed in foster care and kinship care, children who were not orphans but lived in an orphanage, and other indicators of psychological functioning besides those listed above (e.g., externalising behaviours, loneliness, self-esteem and self-worth).

1.6. Chapter Outline

The present dissertation consists of nine chapters. The first chapter is the introduction and background of the study. In this chapter, I introduce the study by discussing the general overview of the existing literature on the consequences of parental loss and orphanage placement on the psychological well-being of orphans, the problem statement and the outcome of the study, the aims and objectives of the present study, as well as the scope and limitations of the present study.

The second chapter is the literature review chapter where I discuss the background of the variables and operationally define terms used in the study, discuss the theoretical frameworks employed in the study, the African context of orphanhood, orphan care in Ghana, as well as the review of international and African literature on the psychological well-being of orphans placed in orphanages.

The third chapter is the methodology chapter where I discuss the methods that were used in the present study. In this chapter, I discuss the philosophical assumptions underlying the study, the research design, research settings, participants' information, a summary of the measuring instruments, ethical considerations, procedure and the methods of data analyses of the data. The findings of the study will be presented as five separate manuscripts in five separate chapters. The outline of these chapters is presented in the next five paragraphs.

The fourth chapter is a conceptual manuscript where I discuss the lack of research on the subject of orphanhood in the African context and the need for psychological research on

the well-being of orphaned children in Africa. In this chapter, I also discuss the social context of orphanhood in Africa, the psychological effects of parental loss on well-being, the impact of poverty, little governmental involvement in orphan care, the merits and demerits of foster care and institutionalisation of orphan in the context of the prevailing socio-cultural African child-rearing practices and outline the implications thereof in orphanhood research, policy making, and possible avenues for intervention, regarding orphan care.

The fifth chapter is an empirical manuscript where I explore the statistical relationship between stress (as indicated by the symptoms of both depression and anxiety), coping and the overall quality of life of orphaned children placed in orphanages, in comparison to the non-orphaned controls. Guided by the theoretical perspectives on stress, coping and quality of life, I discuss the findings of the vulnerability of both orphaned and non-orphaned Ghanaian children to depression, and especially the heightened vulnerability of the orphaned children to anxiety, and the implications of these for their overall quality of life and psychological well-being. I also discuss the implications of the findings for research and intervention.

The sixth chapter is an empirical manuscript where I used both qualitative (content analysis) and quantitative (t-test, chi-square and One-way ANOVA) data analytic techniques to explore the nature of the statistical relationship between problems, coping and coping efficacy in the Ghanaian orphaned children placed in orphanages, in comparison to their non-orphaned controls. From the theoretical perspectives under consideration and prevailing research trends, I discuss the findings of the vulnerability of orphaned children to distress associated with problems with peers, caregivers and school, their coping with the distress, as well as how efficacious such coping were. I also discuss the adverse effects of problem-saturated accounts of the relationship with peers on their psychological functioning and the implications of the findings for intervention and future research.

The seventh chapter is an empirical manuscript where I explore the statistical relationship between stress (as indicated by the symptoms of both depression and anxiety), perceived social support, perceived self-efficacy and subjective evaluation of personal resilience in the Ghanaian orphaned children placed in orphanages, in comparison to the non-orphaned controls. Using the theory and literature on social support, self-efficacy and resilience, I discuss the findings of the orphaned children's perception of social support from friends, the protective role of perceived self-efficacy and social support on resilience in the orphaned children, and the implications of these for their overall psychological well-being. I also discuss the implications of the findings for research and intervention.

The eighth chapter is an empirical manuscript where I used qualitative data obtained from follow-up interviews with selected orphaned participants to delve into the subjective experiences of Ghanaian orphaned children, in order to draw on their experiences on their orphanhood status and overall psychological functioning following placement in orphanages. Deriving the themes identified from the thematic analyses of data (and using the prevailing socio-cultural context from which the subjective meanings of the placement in Ghanaian orphanages take place), I discuss orphans' experiences and overall sentiments about placement in an orphanage and how religion and spirituality enhanced the well-being of the Ghanaian orphaned children. I also discuss the implications of the findings for their overall psychological well-being, intervention and future research.

The ninth chapter is a summary and concluding chapter of the dissertation where I discuss how the findings discussed in the preceding sections of the dissertation all come together. This discussion encompasses an articulation of the confluence of the quantitative- and qualitative data in respect of the overall psychological functioning and experiences of Ghanaian orphaned children placed in orphanages. I discuss the implications of all my findings for intervention, policy making and future research.

Chapter 2: Literature Review

In the current chapter, the review of literature pertaining to the background and operational definition of variables, the theoretical frameworks within which the present study was grounded, the African context of orphanhood, orphan care in Ghana, as well as the review of studies examining the psychological functioning and experiences of orphans placed in orphanages are discussed.

2.1. Background and Operational Definition of Variables

Each variable (depression, anxiety, coping, perceived self-efficacy, perceived social support, resilience and QoL) that was considered in the present study plays a significant role in the understanding of the psychological functioning and experiences of orphans placed in orphanages. What the variables are, the rationales for choosing each variable and the role the variables play in the phenomenon studied is, thus, discussed below.

2.1.1. Stress

In order to understand how parental loss and placement in orphanages can affect the psychological well-being and experiences of orphans, stress and its relation to mental health require definition. The term ‘stress’, which was first coined by Hans Selye (1974, 1983), tends to be used without clear definition (Goodnite, 2014), and has been defined in a number of different ways by a range of scholars (Robson, 1999; Rutter, 1988). Stress has been defined as a response, as a stimulus or as a process (Dewe, O’Driscoll, & Cooper, 2012; Kagan, 1988; Robson, 1999).

The response model of stress views stress as “the nonspecific response of the body to any demand made upon it” (Selye, 1974, 1983, p. 1). To Selye, stress is the body’s non-specific response to pleasant or unpleasant demands that are placed on it, and to which it must adapt. Selye further emphasises that constant exposure to stressors and the process of adaptation (due to limited resources) result in the ‘wear and tear’ of the body over time.

The stimulus model of stress views stress as a class of events that can result in undesirable outcomes (Compas, Grant, & Ey, 1994; Holmes & Rahe, 1967; Kagan, 1988). These events, also known as stressors, have been grouped in terms of their severity and duration (Aldwin, 2011) and they can either occur in isolation, or they can co-occur (Cowen & Work, 1988). Severe stressors are classified as trauma, as they involve the threat of witnessing death, the possibility of experiencing death or severe bodily injury (Aldwin, 2011). Such events are rare, occur unexpectedly within a relatively short period of time, involve little or no individual control, and can affect many people at any one time (Aldwin, 2011; Almeida, 2005). These events require significant adjustment on the part of the individual and they have cumulative adverse effects on psychological as well as physical health (Almeida, 2005). They include natural disasters such as tornadoes or earthquakes, and major life events such as bereavement or divorce. In children, although events such as the loss of, or separation from, a parent or caregiver, sexual abuse, war, hospital admission, the birth of siblings or parental divorce have been identified as severe stressful events (Aldwin, 2011; Garmezy, 1988; Rutter, 1988; Stroebe, 2002), parental loss is viewed as the significant factor that increases a child's vulnerability to stress and/or psychopathology, or which acts to provoke stress and/or psychopathology (Costello, 1982).

In contrast to severe stressors, minor stressors associated with everyday hassles are often located in the social environment. These events involve the day-to-day challenges such as concern with work, meeting deadlines and arguments with peers (Aldwin, 2011; Almeida, 2005). Compared to trauma, the effect of minor stressors on well-being is relatively direct and immediate, however, such effect can accumulate over a period of time to create persistent adverse effects that can result in a negative stress reaction such as depression and anxiety (Almeida, 2005; Zautra, 2003). Similarly, in children, daily stressors have been noted to have

more adverse effects on their psychological well-being than do the major stressors (Aldwin, 2011; Cowen & Work, 1988).

Stress has also been viewed as a process. Proponents (Allen, 1983; Lazarus, 1966; Lazarus & Folkman, 1984) of the process model view stress as a total process that involves how stressful events, individual reactions and environmental factors interact to result in mental health outcomes. The current dominant theory of the process model is the transactional model of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984), which has been found to be able to explain how events interact with individual appraisal and coping to result in good or poor psychological well-being (Scherer, 1999; Siemer, Mauss, & Gross, 2007). The transactional model of stress and coping was adopted for the present study given that it is able to explain how stressful life events such as parental loss and orphanage placement can result in mental health outcomes such as depression, anxiety and quality of life that were explored in the present study. The transactional model of stress and coping is explained in Section 2.2.2 of the present dissertation.

Although stress is generally viewed as an undesirable experience that can result in poor well-being, the literature on the relationship between stress and mental health has been inconsistent (Rutter, 1988). Rutter notes that the difficulty in dealing with such a subject can be blamed on methodological problems regarding the operationalisation of stress and psychiatric disorder, the problem of meaning that is ascribed to the findings of correlation studies, and the paucity of related research. Additionally, some factors have been found to moderate the effect of stressful encounters (Beasley, Thompson, & Davidson, 2003; Mäkikangas & Kinnunen, 2003). Some identified stress-moderating factors include: individual resilience; perceived and effortful control; coping; self-related concepts, such as optimism, self-esteem and self-efficacy; and social support. Such factors can be protective

against the negative impact of the stress concerned (Muris, 2007). The present study examined coping strategies, perceived social support, perceived self-efficacy and resilience.

2.1.2. Depression

The challenges associated with the conceptualisation of childhood depression started with the early psychoanalytic thinking that children do not experience depression because, in their pre-adolescent state, they lack a matured super ego to create the experience of depression (Bemporad, 1994; Cicchetti, Rogosch, & Toth, 1994; Cytryn, 2003). The state of sadness was also considered to form part of everyday experience and not necessarily to be a disorder (Poznanski & Mokros, 1994). The psychoanalytical perspective was, however, later criticised since it was noted that children, prior to adolescence, manifested some form of depressive symptoms (Nurcombe, 1994). When depression was later found to exist in children, it was diagnosed in terms of adult criteria (Nurcombe, 1994; Poznanski & Mokros, 1994).

The difference and similarity between depression in adults and that in children was the next debate that arose with two major perspectives emerging from the debate (Nurcombe, 1994; Poznanski & Mokros, 1994). On one side of the argument were those who held that the experience of depression in children was different from that in adults, as the expression of dysphoria was absent in children. On the other side of the argument were those who held that the experience of depression in children was similar to that in adults, although there were additional symptoms that were unique to children. This controversy is still currently unresolved, as evidence has emerged to support both sides of the argument (Poznanski & Mokros, 1994). However, these debates have influenced the way in which childhood depression is measured. Presently, depressive syndrome and disorders in children are diagnosed with adult criteria, both in terms of the fourth revision of the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV-TR) and in terms of the tenth revision of the International Classification of Diseases (ICD-10). However, depressive symptoms in children

are assessed with measures that are specifically adapted to children. That perhaps the debates have influenced the different categorisation of childhood depression stands to reason.

Presently, childhood depression can be conceptualised as mood/symptoms, as a syndrome, and as a disorder (Carlson & Cantwell, 1980; Compas et al., 1994; Compas & Hammen, 1996). Depressed moods or symptoms in children, which are emphasised in the present study, are concerned with emotional symptoms or feelings that include inappropriate and unrealistic feelings of sadness, worthlessness, emptiness, dejection, hopelessness, unhappiness, or blue feelings that are experienced by children for an undefined time period (Castiglia, 2000). Regarding the depressive syndrome, Compas and Hammen (1996) state that it “. . . refers to a set of emotions and behaviours that have been found statistically to occur together in an identifiable patterns at a rate that exceed chance, without implying any particular model for the nature or causes of these associated symptoms” (p. 227). Depressive disorder reflects a categorical diagnostic approach that is based on the assumption of a disease model of psychopathology (Compas et al., 1994; Compas & Hammen, 1996). Depressive disorder in children is diagnosed in consideration with the duration of illness, the familial pattern of illness, testing and the individual’s response to treatment (Carlson & Cantwell, 1980).

Six major theories exist that explain the occurrence of depression in children. The first theory is the cognitive behavioural model (Kaslow, Brown, & Mee, 1994), which asserts that depressed children tend to have distorted thoughts and interpersonal problems. The second theory is the interpersonal conflict model (Garber, 2006), which asserts that higher levels of interpersonal problems are associated with depression in children. The third theory is the biological model (Emslie, Weinberg, Kennard, & Kowatch, 1994), which implicates hereditary abnormalities in the brain structures that cause depression in children. The fourth theory is the developmental psychopathology perspective (Cicchetti et al., 1994), which

asserts that the unsuccessful resolution of developmental issues increases the child's vulnerability to the development of depression in childhood and in later life. The fifth theory is the stress model (Lazarus & Folkman, 1984), which asserts that children can experience depression when they experience stress that is beyond their coping ability. The sixth theory is the bio-psychosocial model (Compas et al., 1994), which incorporates findings from the various models that might provide the strongest explanation of the causes and the development of depression in children. Of particular interest to the current study is the stress model, because parental loss and placement in an orphanage are considered so stressful and are known to lead to instances of poor psychological well-being, such as depression (Fawzy & Fouad, 2010; Hermenau et al., 2011).

Proponents (Brown, 1993; Lazarus & Folkman, 1984) of the stress model argue that continuous exposure to stress that is beyond the individual's coping abilities can result in poor mental health. Stress is regarded as a general risk factor for internalising disorders in children (Compas et al., 1994). As a result, it is predicted that children who experience stress will be more likely to become depressed than those who do not (Abela & Hankin, 2008; Brown, 1993; Garber, 2006). In this regard, major life events such as the loss of or absence of a parent have been found to be mostly related to depression in children (Compas et al., 1994; Cytryn, 2003).

Parental loss is associated with depression for several reasons. The experience of such loss is generally associated with sadness (Eppler, 2008), and thus tends to precipitate depressive symptoms in children (Klerman, 1979). Sengendo and Nambi (1997) also state that the immature cognitive abilities of children prevent them from dealing effectively with the loss of their parents. This immaturity increases the chance of children growing up with unresolved negative emotions that can be expressed in the form of depressive symptoms. It is, therefore, not surprising that depression is reported to be the most common mental health

problems in bereaved children (Dowdney, 2000). Symptoms of depression have been reported in children who have lost their parents both in the short run (Gray, Weller, Fristad, & Weller, 2011) and in the long run (Van Eerdewegh et al., 1982), although the levels are differentiated by the age and gender of the child. Given the highlighted association between parental loss and depression in children, the present study assessed depression in order to ascertain whether depressive symptoms would be present in the present sample of Ghanaian orphans due to their status of orphanhood and placement in orphanage.

2.1.3. Anxiety

The terms ‘anxiety’ and ‘fear’ in relation to children are usually used interchangeably, although the two concepts are distinct. Childhood fear is characterised by an increase in heart rate, respiration and tension in the muscles (Muris, 2007). It occurs as a reaction to threat, and usually serves to alert and to prepare the body for action. In contrast, anxiety, which is characterised by tension, apprehension, worry and general distress, may manifest in the absence of actual danger (Albano, Causey, & Carter, 2001; Muris, 2007).

Fear and anxiety in children can be viewed as normal or abnormal childhood experiences. Normal fear and anxiety are common, are usually short-lived and are considered part of the usual pattern of childhood development (Muris, 2007). Additionally, normal fear and anxiety are age-specific, in that the complexity, intensity and the source of the fear changes with children’s developmental stages (Albano et al., 2001). Fear and anxiety become abnormal and problematic when, they become severe, chronic, focused on harmless situations, spontaneous, interfere with children’s functioning, and result in reactions that lead children to escape the anxiety-provoking situation (Albano et al., 2001; Beesdo, Knappe, & Pine, 2009; Kingery & Walkup, 2005). Additionally, abnormal fears and anxieties are not age-specific, can develop into a psychological anxiety disorder, and, if left unchecked, can

trigger other mental health disorder in children (Albano et al., 2001), as well as persist into adulthood (Muris, 2007).

How normal anxiety develops into abnormal anxiety (or anxiety disorder) has been explained by several theories (Muris, 2007; Prins, 2001). Of particular interest is the contribution of stressful life events to the development of anxiety in children. Negative life events of all kinds have been found to relate to anxieties in children (Compas et al., 1994; Muris, 2007; Phillips, Hammen, Brennan, Najman, & Bor, 2004), with parental loss being one of the most significant (Eppler, 2008). Parental loss can cause anxiety disorder in children by resulting in the sudden removal of the protection that children receive from parents (Vasey & Dadds, 2001), given that parental figures often play a protective role in the lives of their children (Moore, Kinghorn, & Bandy, 2011; Rosenberg & Wilcox, 2006). Such loss can also elicit fear (Muris, 2007), and lead to the recurrence of childhood fears that children might have learned to overcome (Adam & Chase-Lansdale, 2002; Vasey & Dadds, 2001). It was against this background that anxiety was assessed in the present study.

Anxiety disorder in children can be viewed as a disorder or as a symptom. Anxiety as a disorder is based on the disease-oriented model of psychopathology and follows a categorical diagnostic approach, notably according to the fourth edition of the DSM-IV or the ICD-10 classification of anxiety disorders. Anxiety disorders are usually diagnosed by trained mental health professionals, such as a psychologist or a psychiatrist. Such disorders are diagnosed by means of clinical diagnostic interviews in which questions are asked relating to the DSM-IV or the ICD-10 classification and direct observation (Muris, 2007).

Anxiety as symptoms, the view that will be emphasised in this study, is characterised by prolonged worry about current or future events that involve behavioural (in the form of escape and avoidance), cognitive (in the form of negative self-appraisals), and physiological (in the form of involuntary arousal, increased heart rate, rapid breathing, tremors, and muscle

tension) response patterns (Wilmshurst, 2005). These symptoms pertain to global anxiety distress or to specific anxiety problems. Anxiety symptoms can easily be assessed by means of self-report instruments and/or the parent-rated equivalent, clinical rating scales and direct observation (Muris, 2007).

2.1.4. Quality of life (QoL)

Although the well-being of children have received much attention, the use of QoL to assess the overall well-being for this age group has only recently been considered relevant, specifically in the context of health in general (Park, 2004; Wallander, Schmitt, & Koot, 2001). In the past, the conceptualisation of well-being was based on the absence of disease, and psychological research on well-being was mainly focused on psychopathology, psychological treatments and risk-based prevention programmes (Park, 2004). Research on subjective well-being developed as a reaction to what seemed as over-emphasis on negative state in psychological research (Diener, Suh, Lucas, & Smith, 1999). Moreover, against the background of positive psychological states (such as happiness) co-occurring with challenges and stress, scholarly work on children's well-being has focused on the conceptualisation and measurement of QoL (Park, 2004).

In recent times, the assessment of QoL has become important and frequently required in the evaluation of health outcomes (Becker, Shaw, & Reib, 2003). For example the measurement of QoL provides information on how life events (e.g., stressful experiences and illness) and treatments of these impact on the well-being of individuals, and specifically provides useful information for the identification of children in need of psychological intervention (Eiser, 1997). Moreover, information obtained from the assessment of QoL is used for policy decision making regarding the allocation of public resources (e.g., education, housing, health care and transportation) to the population (Wallander et al., 2001). For a vulnerable population such as orphans placed in orphanages, the assessment of QoL will

provide a meaningful insight into the impact of parental loss, general life stressors and experiences in the orphanage on their overall well-being, hence the need for the inclusion of QoL in the present study.

Generally, individual QoL consists of both objective and subjective aspects (Camfield & Skevington, 2008; Cummins, 1996; Ruggeri, Bisoffi, Fontecedro, & Warner, 2001). Regarding the objective dimension, aspects of the individual's lives are used as indicators of quality of life. Some of the identified objective indicators of quality of life include, but not limited to, medical history, health risk behaviours, educational and financial attainment, social involvement (Atkinson, Zibin, & Chuang, 1997) as well as employment, income and living conditions of the individual (Ruggeri et al., 2001).

Subjective aspect of QoL, which is emphasised in the present study, is the subjective evaluation of the individual's well-being. This concept fall into a broad category of phenomenon that included individuals' emotions, domain satisfaction and the global assessment of life satisfaction (Diener et al., 1999). Subjective QoL is conceptualised as a multi-dimensional construct made up of discrete domains that include physical health, psychological well-being, social relationships, environment, functional roles and perceptions of life satisfaction (Becker et al., 2003; Cummins, 1996, 1997; Rapley, 2003). However, these domains can be uni-dimensional as they can be assessed or analysed as stand-alone domains (Fallowfield, 2009).

In the past, the assessment of subjective quality of life in children was based on the reports of parents, given that children, given their young age, were considered as unreliable respondents (Eiser & Morse, 2001). Other developmental concerns regarding children's rating of QoL include doubts about children's competence in receptive and expressive language, their understanding and use of time frame, developmental differences in QoL markers and the identification of QoL markers that are relevant to children (Wallander et al., 2001). Despite

these concerns, the children's ratings of their own QoL are now considered also valid (Eiser, 1997; Eiser, & Jenney, 1996; Eiser & Morse, 2001), given that what children value the most (i.e. the availability of basic needs and positive peer relationships) is as much important indicator of QoL as adults' value of personal accomplishments and independence (Eiser, 1990, 1997; Millstein & Irwin, 1987).

The QoL in children is conceptualised as general or health-related (also known as disease-specific; Eiser, 1997; Pal, 1996). General QoL denotes comprehensive subjective well-being that encompasses all domains of human existence, and is measured using generic measures (e.g., WHOQOL-BREF; Pal, 1996). These measures can be used for both healthy children and individuals with a wide range of conditions or diseases (Eiser, 1997). The advantages of the generic measures rest on their suitability for assessing QoL on large samples, with their population norms being often available (Eiser, 1997). However, these measures have been found to lack sensitivity as they are unable to tease out the actual state of the quality of life of individuals with chronic diseases. Moreover, they do not reflect the actual impact of treatments on children's QoL (Eiser, 1997). Eisen, Donald, Ware, and Brook (1990) also note that generic measures of children's QoL tend to be too lengthy for use with sick children, are mostly based on American samples, and may not be culturally appropriate for use in non-American settings.

In contrast to general QoL, health-related QoL refers to the dimensions of overall well-being that include physical, psychological and social domains, which affect either physical or mental health (Eiser, 1997; Pal, 1996). These dimensions are assessed through either generic measures of health-related QoL (e.g., The Short Form 36-item Health Survey Questionnaire, SF-36; Ware, & Sherbourne, 1992,) or disease-specific measures. These measures are sensitive to the impact of treatments on well-being and are appropriate for the evaluation of interventions (Eiser, 1997). For disease-specific measures, questionnaires

specifically designed for use in children with cancer, diabetes and asthma have been developed (Eiser, 1997). Wallander et al. (2001) argue that disease-approach to QoL is misleading and limits the measurement of QoL in children. The authors opine that, theoretically, domains of well-being that are affected by health cannot be separated from other domains of the individuals' existence. Similarly, they argue that individuals who complete a measure of QoL cannot distinguish aspects of their lives that are influenced by disease from the remaining domains. Despite the weaknesses of the general and health-related approaches to QoL in children, both aspects continue to dominate research on children's QoL.

The present study explored general QoL following the approach taken by the World Health Organisation (WHO). WHO defines QoL as:

... [the] individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.”
(WHOQoL Group, 1997, p. 1)

Documented literature shows that psychological concepts predict an individual's perceptions of QoL. Some of the factors that have been found to predict QoL include depression and anxiety (Abbey & Andrews, 1986; Orenius et al., 2012; Stevanovic, 2013), coping strategies (Dheensa & Thomas, 2012), and social support (Abbey & Andrews, 1986; Parker, Baile, de Moor, & Cohen, 2003; Vilhena et al., 2014). Abbey and Andrews (1986) explain that depression and anxiety relate to lower QoL because it leads individuals to feel worse about themselves. In contrast, social support relates to better QoL because the former phenomenon causes people to feel better about themselves, thus decreasing the likelihood of stressful outcome.

Among children, although the studies are few (Stevanovic, 2013), psychological concepts have also been found to predict QoL. For example, Stevanovic, Jancic, and Lalic (2011) found that symptoms of depression and anxiety were significant negative predictors of health-related QoL in children with epilepsy. Al-Fayez and Ohaeri (2011) also reported that anxiety and depression were negative predictors of QoL among Arab children. In a similar vein, Stevanovic (2013) found that symptoms of depression and anxiety were significant negative predictors of perceived QoL among non-referred children and adolescents. Song et al. (2012), in a 30-month follow-up study, found that depressive symptoms negatively predicted QoL subsequent to traumatic experiences. Additionally, the perception of the existence of a negative emotional relationship between children and parents has also been found to predict poor QoL among Arab children (Al-Fayez & Ohaeri, 2011). In the present study, depression, anxiety and coping strategies were assessed as predictors of QoL.

2.1.5. Coping and coping strategies in children

Coping has been cited as an important moderator of the relationship between stress and the short- and long-term adaptational outcome in children (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Holen, Lervag, Waaktaar, & Ystgaard, 2012; Lazarus & Folkman, 1984). The most commonly cited definition of coping is provided by Lazarus and Folkman (1984). The authors define coping as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). This definition was based on Lazarus and Folkman’s (1984) theory of stress and coping in adults, and has been the basis for the definition of coping in children. The key features of the model are that the authors view coping as a dynamic process that changes in response to changing demands in stressful events. Another characteristic of the definition is that coping is a purposeful response that is

directed toward resolving stressful relationship between the self and the environment or toward reducing the negative impact of the stressful encounter (Compas et al., 2001).

Compas et al. (2001) note that attempts to define coping in children have faced two main challenges. The first challenge is the need for the definition of coping to capture the nature of the developmental processes. The second challenge is the problem of distinguishing coping from other stress responses in children. Despite these challenges, four models of definition for coping in children have been identified.

The first model is the control model that is proposed by Weisz and colleagues (Band & Weisz, 1988, 1990; Weisz, McCabe, & Dennig, 1994), who conceptualised coping in children as a two-process model of perceived control. The model differentiates between two general approaches to control, namely primary and secondary control. The second model is the motivational model proposed by Skinner and Wellborn (1994, cited in Compas et al., 2001). The authors define coping in children as “as how people regulate their behaviour, emotion, and orientation under conditions of psychological stress” (p. 112). The third model is the self-regulation model that is proposed by Eisenberg and colleagues (Eisenberg et al., 1993; Eisenberg, Fabes, Guthrie, & Reiser, 2000). The model views coping in children as a subcategory of emotion regulation that is specifically used when the individual is undergoing stress.

The fourth model on childhood coping, which is frequently cited (Holen et al., 2012) and which will be adopted for this study, is the process model proposed by Compas et al. (2001). In terms of this model, coping is defined as “... one aspect of a broader set of processes that are enacted in response to stress” (Compas et al., 2001, p. 89). Compas et al. (2001) argue that coping is volitional effort and can be aided or impeded by the individual’s biological, cognitive, social and emotional development, as well as by the individual’s developmental stage. What differentiates this model from the others previously mentioned is

that the latter views coping as both volitional and involuntary, whereas the former views coping as only volitional and intentional effort. This model was adopted for the current study due to it being consistent with Lazarus and Folkman's (1984) theory of stress and coping that had been adopted for the present study, as is discussed in Section 2.2.2 of the present dissertation.

Coping in childhood has three major characteristics (Compas et al., 2001). The first characteristic of childhood coping is the possibility of coping strategy following a developmental course. In early childhood, children use more behavioural approaches, such as support-seeking from others, behaviour withdrawal and the use of tangible object for soothing. During mid-childhood, as children develop more complex language and metacognitive capabilities, the use of complex emotion regulation skills and cognitive strategies becomes common. Children at the mid-childhood stage use such strategies as cognitive refraining, cognitive representations of absent caregivers, self-talk, the generation of alternative solutions to solve problems, cognitive distractions and self-reassuring statements, problem-focused behaviours, the seeking of social support outside of the family, and rumination. As children continue to develop more metacognitive skills, by early adolescence, they are expected to match coping efforts to the nature of the stress. More problem-solving methods, humour, support-seeking from siblings and friends, as well as maladaptive coping, such as engaging in drugs, are then used.

The second characteristic of childhood coping is changes in the process of coping in relation to developmental and situational changes (Compas et al., 2001). Although some scholars (Losoya, Eisenberg, & Fabes, 1998) have found that the coping process may be relatively stable over time, Compas et al. (2001) suggest that coping processes in children may be influenced by changes in the biological, cognitive and social development, as well as by changes in the immediate social context of children. The third characteristic of childhood

coping is that it includes both overt behaviours and covert cognitive responses that are determined by the stressful context, the child's developmental level and the learned stress response styles (Compas et al., 2001).

Several coping strategies have been identified in children (Compas et al., 2001; Vaillant, 1998). These include problem-solving, information-seeking, cognitive restructuring, the seeking of understanding, catastrophising, emotional release or ventilation, physical activities, acceptance, distraction, distancing, avoidance, self-criticism, the blaming of others, wishful thinking, humour, suppression, social withdrawal, resigned acceptance, denial, alcohol or drug use, the seeking of social and informational support, the use of religion, regression, impulsive acting out, altruism, anticipation, sublimation and religious coping. From such strategies, Donaldson, Prinstein, Danovsky, and Spirito (2000) noted that wishful thinking, problem-solving and emotional regulation are used most frequently across stressors, whereas blaming others, self-criticism, and resignation were least frequently reported. However, the choice of strategies is dependent on the children's temperament, on their developmental level and on the nature and context of the stressor concerned (Holen et al., 2012).

Another issue of concern in the literature of childhood coping is the association between coping strategies and mental health in children. Inconsistencies are present in the results of studies that assess the direction of the relationship between coping and mental health (Compas et al., 2001). Compas et al. reviewed 63 studies (dated from 1988 to 1999) examining the association between coping and mental health. Coping strategies were categorised as problem-focused coping (problem-solving, information-seeking, and problem-focused support), emotion-focused coping (emotional expression, denial, and wishful thinking), engagement coping (problem-solving, emotional expression, and support-seeking), and disengagement (problem and cognitive avoidance and social withdrawal). With regards to

internalising disorders (symptoms of anxiety, depression and somatisation disorders), engagement and problem-focused coping categories were significantly associated with fewer symptoms in most studies, regardless of the sample (children and adolescents) or the statistical method (simple or complex statistical analysis) employed. Problem-solving, cognitive restructuring and the positive reappraisal of the stressor were the specific strategies that were most consistently associated with better adjustments. Compas et al. (2001) explain that the adoption of such strategies might have led to better mental health in the studies reviewed, because they involve “careful analysis of the stressful situation, selective attention to positive aspects of the situation, and generating alternative thoughts that are positive and hopeful” (p. 118). However, the researchers caution that the finding obtained might have resulted from better adjustment capabilities in the samples studied prior to the experience of the stressors.

Compas et al. (2001) also conclude that disengagement and emotion-focused coping were associated with more internalising disorders in most studies, regardless of the sample (children and adolescents) or informants used. Specifically “cognitive and behavioural avoidance, social withdrawal, resigned acceptance, emotional ventilation or discharge, wishful thinking, and self-blame or self-criticism” (p. 119) were frequently associated with negative mental health. The authors concerned argue that poor mental health resulted from the use of the coping strategies employed, due to the lack of engagement with the stressor or emotions involved, negative thoughts that they harboured about themselves and their circumstances, and the inability to control emotions.

Although the review by the Compas et al. (2001) study gives a broader perspective on the relationship between psychological well-being and coping strategies, the review failed to include any study with children who had lost their parents, or with children in institutions. As a result, it cannot be determined from the review whether the relationship between coping and

mental health in orphanage-placed children follows the same pattern. However, the review does give an idea of the nature of the relationship between coping strategies and internalising disorders in children and would thus be used as a guide in the present study.

Also related to the concept of coping in children is that of coping efficacy. Coping efficacy pertains to the belief that an individual can deal with the demands and aroused emotions associated with stressful situation (Sandler, Tein, Mehta, Wolchik, & Ayers, 2000). Documented studies have highlighted that children's perceptions of their coping efficacy play a mediating role in the relationship between coping and mental health. For example, Ayers, Sandler, West, and Roosa (1996) found that higher levels of coping efficacy were associated with lower levels of mental health. Similarly, Sandler et al. (2000) found that coping efficacy was a significant mediator of the relationship between coping and psychological problems in children of divorce. Sandler et al. also found that active coping had a significant positive path to coping efficacy whereas avoidance coping had a significant negative path to coping efficacy. Furthermore, Lin et al. (2004) found that higher coping efficacy was negatively related to children's mental health problems. Lin et al. (2004) also reported a relationship between specific coping strategies and the levels' coping efficacy. They found that active coping strategies relate to greater coping efficacy, whereas avoidant coping relates to lower levels of efficacy.

Given that parental loss and orphanage placement can be stressful experiences that can adversely affect the well-being of children, the ability of orphanage-placed children to manage the demands and aroused emotions associated with the status of orphanhood and placement in an orphanage is crucial to their well-being. Against this background, coping strategies and coping efficacy as well as their relation to the psychological well-being of the present sample of Ghanaian orphans placed in orphanages were assessed in the present study.

2.1.6. Perceived social support

Social support has also been found to be protective against the adverse effects of stressful experiences (Cluver, Fincham, & Seedat, 2009; House, 1986; Kim, Sherman, & Taylor, 2008; Tyler, 2006). This is due to the ability of such support to lead an individual “... to believe that he is cared for and loved, that he is esteemed and valued, and that he belongs to a network of communication and mutual obligation” (Cobb, 1976, p. 300). It is the positive effect of social support that drives people to seek after social relations especially in times of duress. Such support also serves as a means of coping with distress (Kim et al., 2008).

Two types of social support have been identified and differentiated, as are reflected in the definition of social support by Schwarzer, Knoll, and Riechmann (2003). The authors view social support as “the function and quality of social relationships, such as perceived availability of help or support actually received” (p. 2). The definition captures the two aspects of social support, namely received- and perceived social support (Norris & Keniasty, 1996). With regards to the differences between the two types of support, received social support pertains to the supportive behaviour, interactions or received support (Hlebec, Mrzel, & Kogovšek, 2009; Norris & Keniasty, 1996). Hlebec et al. argue that received social support is viewed to be dependent on the availability of support, the individual’s coping skills and the support provider’s perception of the degree of severity of the stress experienced by the individual. On the other hand, perceived social support refers to the individual’s perceptions of the availability and adequacy of social support (Hlebec et al., 2009; Petersen & Govender, 2010).

Of the two sub-constructs of social support, perceived social support has been reported to be consistently linked to good mental health and, more importantly, to the promotion of mental health (Norris & Keniasty, 1996; Petersen & Govender, 2010). It has been asserted that perhaps the problem with received social support has to do with the fact that it is received

(Norris & Keniasty, 1996). In this regard, Norris and Keniasty (1996) state that, “[b]ecause it is received, its levels are associated with severity of stressors and psychological reactions, its merit depends on who provides it and who receives it, its receipt may be threatening to self-esteem, its type may not be appropriate, or its delivery may not be inept.” (p. 3). Perceived social support is, thus, assessed in the present study, given its role in promoting psychological well-being.

The functions of social support in the promotion of positive mental health and in moderating the effects of stressful experiences have been argued in terms of two main perspectives (House, 1986; Tyler, 2006). The first perspective is grounded in the main effect hypothesis, which suggests that the provision of social support directly promotes a sense of positive health and well-being regardless of stressful experiences. The hypothesis concerned also suggests that social support indirectly promotes a sense of health and well-being by reducing people's exposure to stress and other health hazards (House, 1986).

The second perspective, which will be emphasised in the current study, is grounded in the buffer hypothesis (Cobb, 1976; Gore, 1978), which asserts that the provision of social support promotes a sense of positive health and well-being by decreasing the effects of stress and by enhancing coping skills. The theory suggests that individuals who have access to a higher social support network are more likely to cope better in times of stress than do those who have little or no social support network. Studies (Cheng, 1997; Gore, 1978; Norris & Keniasty, 1996) have provided evidence for the buffering effects of social support on mental health outcome. Similar evidence has also been found in children (Cheng, 1997; Okawa et al., 2011).

The literature on social support for children highlights the fact that family support is the primary source of support for children (Decker, 2007; Hong et al., 2010; Zhao et al., 2011). Orphanhood, thus, limits children's sources of social support and increases their sense

of hopelessness (Adamson & Roby, 2011). Additionally, of the various forms of social support (notably, emotional, instrumental, informational and appraisal support), emotional support is the most significant form of support in promoting psychological well-being (Heaney & Israel, 1997, cited in Petersen & Govender, 2010). However, the loss of a parent ends the bond that gives children such emotional support (Bowlby, 1969). Given the African perspective on child-rearing and community bond, it is likely that orphans who end up in the orphanages in the African context are more likely to have lacked social support.

Furthermore, it has been found that orphanages do not provide a caring relationship between the caregivers and the children concerned that promotes secure attachment (Johnson et al., 2006). Orphanages have been cited as having a high child-to-caregiver ratio, multiple shifts and frequent changes in caregivers, thus depriving children of reciprocal interactions with caregivers (Bakermans-Kranenburg et al., 2011). Such deprivation has been found to relate to poor psychological well-being (Johnson et al., 2006; Zeanah et al., 2009). As stated by Cobb (1976), social support is meant to function in such a manner that motivates individuals to perceive that they are loved, cared for, esteemed, and valued and that they belong to a mutually obliging communication network. The availability of such support can, thus reduce the feeling of helplessness among orphans placed in orphanages, hence the exploration of perceived social support in the present study.

2.1.7. Perceived self-efficacy

Another important stress-moderating factor is perceived self-efficacy. Perceived self-efficacy is one of the three forms of human agency (besides proxy and collective agency) that are described by Bandura in his social cognitive theory (Bandura, 1986, 2002). Self-efficacy refers to individuals' belief that they have the capabilities to produce desired outcomes. Bandura emphasises that this form of agency concerned is the most central and pervasive of all the human forms of agency and helps people to persevere in the face of difficulty, thus

helping to regulate the quality of an individual's functioning and sense of emotional well-being. Self-efficacy beliefs are attained by way of personal achievement, vicarious experiences obtained through observation of other people's performances, verbal persuasions, and physiological states.

Bandura (1986, 2002) explains that perceived self-efficacy serves to regulate the quality of an individual's functioning and emotional well-being that is attained through motivational, decisional, cognitive and affective processes. Regarding the motivational process, perceived self-efficacy determines the amount of effort that people put into a task and how much they will persevere when faced with challenges. The above suggests that individuals with high self-efficacy are more likely to exert more effort and to persevere than do those with low self-efficacy.

In regard to decisional processes, perceived self-efficacy determines people's choice of behaviour. People are more likely to pursue tasks that they believe that they have the ability to perform and tend to avoid the tasks that they perceive are beyond their capabilities. Perceived self-efficacy, thus, exerts its influence on an individual's psychosocial functioning by way of the accuracy of the judgement of one's own abilities. Bandura (1986) asserts that if such judgement slightly exceeds one's abilities, it is perhaps the most functional, as it then leads one to undertake realistic challenging tasks. Doing so, in turn, motivates the enhancement of capability. In contrast, misjudgement of one's abilities (whether in the form of overestimation or underestimation) can lead to severe consequences. Those who underestimate their capabilities tend to undertake self-limiting tasks that reduce their exposure to rewarding tasks and that also limit their ability to perform tasks, due to the self-doubt that is engendered thereby. Those who overestimate their capabilities tend to undertake tasks that are beyond their capabilities and to end up experiencing difficulty and failure. Doing so, in turn, causes them to undermine their abilities, possibly leading to irreparable damage.

Cognitively and affectively, efficacy beliefs influence one's ways of thought and emotional reaction during actual or anticipated encounter with situations. Bandura (1986) explains that when people perceive themselves as ineffectual, they tend to focus on their deficiencies and to perceive potential difficulties as more daunting than they actually are. The result is the creation of more stress on the individual and reduction in the use of competences. Such individuals are also more likely to blame their abilities as opposed to their efforts when they fail in challenging situations. In contrast, when people perceive themselves as highly efficacious, they are more likely to exert added effort and to pay extra attention to challenging tasks, being incited by the challenges to achieve. Such individuals are also more likely to blame their effort than their ability when they fail in challenging tasks.

In all, Bandura (1986, 2002) illustrates that efficacy beliefs determine individual psychosocial functioning by exerting influences on the individual's choice of behaviour, as well as on motivation, cognition and affective behaviours, such that those who perceive themselves to be ineffectual are more likely to be stressed and anxious when faced with challenges. In contrast, those who perceive themselves to be efficacious are less likely to be stressed and anxious when faced with stress.

Developmental issues in perceived self-efficacy have also been highlighted. Bandura (1986) emphasises that young children, due to their age, lack knowledge about their capabilities, and are, thus, likely to misjudge their capabilities. At an early age, children depend on adults for judgements about their self-efficacy. As children grow in age and develop mature cognitive abilities, they tend to depend less on external support and more on their internal abilities to judge their own capabilities. During the early phase of the development of self-efficacy, the family becomes the children's primary source of self-efficacy experiences. As the child's social world expands, starting with siblings and then broadening to include peers in the larger community, such as in school, become the source of

efficacy experiences. Peers serve as models for the development of efficacy behaviours, as well as reference points against which children compare the appraisal of their capabilities. As children develop into adolescence, competences in the area of heterosexual relationships and the choice of which lifework to pursue become the competences that they need to pursue. How successful they will become in the areas concerned depends on their prior experiences of mastery.

The theory of perceived self-efficacy has been found to predict a diverse set of behaviours and emotions that includes, but is not limited to, coping behaviours, stress reactions, physiological arousal, depression, anxiety and pain tolerance (Bandura, 1986, 2002). With regard to anxiety, Bandura explains that people can feel anxious when they perceive that they lack the capabilities to cope with potentially aversive events that could make them vulnerable to harm. With regard to depression, Bandura asserts that people can be depressed when they perceive that they lack the capacity to achieve highly valued outcome. Additionally, people who perceive their self-efficacy to be less than their minimal standards are more likely to be depressed, whereas those who perceive their self-efficacy to be close to their standard are less likely to be depressed. Bandura explains that, while the control of harmful outcome is prominent in anxiety, irreparable loss or failure to attain desired rewarding outcome is prominent in depression. Bandura further highlights that, because privation and threat commonly co-occur, certain situations can be highly desirable and also predict future aversive events. In such events, perceived inefficacy can arouse both anxiety and depressive feelings.

With regards to children, Bandura, Pastorelli, Barbaranelli, and Caprara (1999) found that experiencing low self-efficacy can lead to the development of symptoms of anxiety and depression by way of three pathways. Firstly, low perceived self-efficacy can lead to symptoms of depression and anxiety when children face situations requiring highly valued

standards. In such a situation, personal standard of merit that is set above individuals' perception of their capabilities to attain such a standard can lead to self-devaluation that, in turn, predicts depression. Apprehension may also arise when children perceive that they are ineffectual in regard to achieving the set goal.

Secondly, when children have low perceived social self-efficacy, they are less likely to develop positive social relationships that are helpful in giving satisfaction and in enabling stress management (Bandura et al., 1999). The inability to develop such social relationships due to low perceived self-efficacy can, therefore, promote depressive feelings. Additionally, the lack of, or low, social efficacy incites people to believe that they cannot meet the evaluative standards of other people, which can heighten their anxiety in social situations.

Thirdly, children's low perceptions about their capability to control their negative thoughts can also increase their levels of anxiety and depression. Bandura et al. (1999) and Muris (2002) highlight that, although stressors are common experiences, how people deal with daily stressors tends to predict whether they will develop symptoms of psychopathology or not. In this regard, the use of ineffective coping strategies (such as rumination) to deal with negative thoughts can generate subsequent series of such thoughts that can predict the development of negative emotions, such as depression and anxiety.

Besides the role of perceived self-efficacy in the determination of psychopathology during difficulties, documented literature has also linked efficacy beliefs to resilience. In this regard, the possession of high levels of self-efficacy has been viewed by scholars (Brooks, 2006; Cowen & Work, 1988; Rutter, 1987) as being a characteristic of individual resilience that can function as a protective factor against stressful encounters. This is as a result of self-efficacy being able to foster competence and self-worth during adversities, which in turn promote resilience (Hamill, 2003). The present study explored the influence of self-efficacy

on the experience of stress (measured as symptoms of depression and anxiety) as well as the relationship between self-efficacy and resilience.

2.1.8. Resilience

The term “resilience” has been conceptualised differently by different scholars. In a review, Kaplan (2006), noticing several controversies surrounding the conceptualisation of resilience, concluded that “the idea of resilience has different meanings for different people, many of which are vague and contradictory” (p. 40). Resilience has been viewed as an outcome (Naglieri & LeBuffe, 2006; Wright & Masten, 2006), as a process (Rutter, 1987; Wyman, 2003) and as individual capacities or abilities (Brooks, 2006; Wagnild & Young, 1993). The definition of resilience is thus best captured as “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (Masten, Best, & Garmezy, 1990, p. 426), given that it includes all three connotations.

Regarding the outcome model of resilience, resilience is not directly measured, but is inferred, based on the direct measurement of risk and positive adaptation (Luthar & Zelazo, 2003; Wright & Masten, 2006). Resilience is judged by the assessment of the presence of significant threat (risk, adversity or negative life events) to the development of the individual, and by the judgement of positive adaptation, despite adversity. Although this perspective is well used, the requirement of the experience of adversity has been viewed as being too narrow (Brooks, 2006). Brooks (2006) argues that all children continuously experience some adversity during their development, as a result of which the outcome model of resilience is narrow, and does not capture the everyday adversity that children encounter. Brooks further proposes that the concept of resilience should be sufficiently broadened to include all children, and not specifically those who have experienced adversity.

The process model of resilience emphasises the protective mechanism and process that explain how some children adapt successfully despite experiencing adversity (Rutter, 1987;

Wyman, 2003). Rutter identified four main processes of resilience: The reduction of risk impact; the reduction of negative chain reactions; the establishment and maintenance of self-esteem and self-efficacy; and the opening up of opportunities. Wright and Masten (2006) also view the process of resilience as a dynamic process involving the interaction of positive individual attributes, and diverse levels of systems, risks and protective factors, context and developmental levels of the child aimed at modifying the effect of adversity, so as to result in positive outcomes. The process model of resilience exceeds the identification of protective factors to include how the factors function to protect the individual against adversity.

Resilience as capacity has been viewed as consisting of qualities that are embedded in the individual child and which are the focus of the present study. Proponents (Brooks, 2006; Cowen & Work, 1988; Wagnild & Young, 1993) of said perspective hold that resilience, as a set of abilities possessed by children, serves to moderate the negative effects of adversities and to promote positive adaptation. These qualities include an easy temperament, being female, a positive school climate, self-mastery, self-esteem, self-efficacy, problem-solving and planning skills, and a warm, close, interpersonal relationship (Brooks, 2006; Rutter, 1979, 1987); social responsibility and autonomy in a warm, supportive family environment; and extra-familial peer and adult support source and protective identification models (e.g., teachers, the clergy) (Cowen & Work, 1988, p. 599); personal competence and acceptance of self and life (Wagnild & Young, 1993). Individuals with high levels of resilience characteristics are more likely to exhibit indications of psychological well-being in the midst of adversity. In accordance with the perspective, several measures have been developed for the assessment of abilities that are viewed to be resilient characteristics.

In the present study, the Resilience Scale (RS), which was developed by Wagnild and Young (1993), was used. RS is based on Wagnild and Young's (1993) conceptualisation of resilience as a personality characteristic that is multidimensional and which comprises self-

reliance, independence, determination, invincibility, mastery, resourcefulness and perseverance. It is, thus, suggested that the said characteristics moderate the effect of stress and promote adaptation. The RS yields two factors. The first factor is personal competence, which comprises self-reliance, independence, determination, invincibility, mastery, resourcefulness, and perseverance. The second factor is acceptance of self and life, which comprises adaptability, balance, flexibility, and a balanced perspective of life. Individuals with high levels of the factors are considered to be highly resilient and are expected to report positive mental health, despite the experience of adversity. In contrast, individuals with low levels of the factors are not considered as resilient, and are thus expected to report a high degree of mental health problems, following the experience of adversity.

Despite the fact that the concept of resilience is used in various ways, there is a general consensus that the measurement of resilience requires the experience of risk or adversity and positive adaptation, despite the amount of adversity that is experienced (Kaplan, 2006; Masten & Obradović, 2006; Wright & Masten, 2006). In the present study, risk was conceptualised as parental loss and placement in an orphanage and positive adaptation was conceptualised as higher scores on the Resilience Scale and the lower levels of mental illness (symptoms of depression and anxiety).

2.2. Theoretical Frameworks

The attachment theory (Bowlby, 1969) and the transactional model of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984), which were used to guide the current study, are discussed below.

2.2.1. Attachment theory (Bowlby, 1969)

Bowlby's (1969) attachment theory emphasises the importance of having a close relationship between an infant and the primary caregiver to help ensure normal childhood development. The theory posits that an infant is born with a range of attachment behaviours

that are aimed at seeking and maintaining proximity with the attachment figure (i.e. the caregiver). Bowlby proposed that the first three years of an infant's life is the critical period for attachment and further outlined four phases of attachment.

The first phase is the pre-attachment phase (birth – 2 months). At this stage, infants use behaviours such as grasping, crying, smiling and gazing into adult's eyes as a means of seeking and maintaining proximity with the primary caregiver. The proximity-seeking behaviour engaged in by infants, in turn, helps them to regulate their emotions, protect them from harm and reduce any associated distress (Bowlby, 1969). At this stage, although infants have not yet formed attachment to the primary caregiver, they are able to recognise the smell, voice and face of the mother and they are not afraid of strangers.

The second phase is referred to as 'attachment-in-the-making' (2 – 7 months). At this stage, infants respond differently to familiar caregiver than strangers. Infants learn the basic rules of interaction, in that they learn that their actions affect the behaviours of those around them. Infants at this stage use babbling and smiles to engage with the primary caregiver. When the caregiver is responsive to the infant's bid for proximity, a sense of trust is built in the infant and the infant does not protest when separated from the caregiver.

The third phase is the 'clear cut' attachment period (7 – 24 months). At this stage, the infant develops attachment to a familiar caregiver and display signs of separation anxiety when separated from the familiar caregiver. Bowlby notes that despite the increase in separation anxiety between 6-15 months, the occurrence depends on the infant's temperament, context and the primary caregiver's behaviour. For example, Bowlby found that when the primary caregiver is supportive and sensitive to the infant's bid for proximity, separation anxiety in the infant becomes short-lived. In addition, Lester, Kotelchuck, Spelke, Sellers, and Klein (1974) note that when the infant has not developed the concept of object

permanence, he or she would not exhibit signs of separation anxiety when separated from the primary caregiver.

The fourth phase is the formation of reciprocal relationship (24 months onwards). At this stage, the relationship between the child and parent is two-sided. The child is able to understand the caregiver's need as well as the factors that influence the presence and absence of the primary caregiver, hence, the decline in separation associated protests. This understanding results from growth in representation and language, which are usually attained by two years of age. The child is then able to negotiate with the primary caregiver through request and persuasions that are aimed at altering the goals of the caregiver. As the child continues to develop cognitively and with age, he or she become less dependent on the caregiver and is more confident about the accessibility and responsiveness of the caregiver.

Throughout the four phases of attachment formation, attachment figures become a source of attachment security when they serve as the target for maintaining proximity and as the provider of physical and emotional safety for infants who use the figure as a secure base for the exploration of the environment. Bowlby further explains that the attachment system and a positive formation of attachment security is facilitated when the attachment figure is available, sensitive to the infant's needs and responsive to the infant's bid for proximity. The theory further emphasises that, when a child is successful in regulating affect through proximity-seeking, a sense of attachment security is created. However, when the attachment figure is not available or is unresponsive to the infant's need and bid for proximity, a sense of attachment insecurity develops.

Bowlby (1977) explains that psychopathology results from a disruption in the affectionate bond between infant and caregiver, from deviation in the development of attachment behaviour or from a failure to develop secure attachment. Regarding the well-being of orphans placed in orphanages, the theory is able to explain the effects of parental loss

on children, such that parental loss (either through death or abandonment) disrupts the attachment bond between the child and the caregiver, which, in turn, can result in psychopathology. For example, research shows that children who experience maternal deprivation before the age of five years are more likely to become ‘affectionless psychopaths’ than children who have not experienced maternal deprivation (Bowlby, 1946). Research also shows that the nature of a child’s early attachment style has implications for the individual’s later emotional well-being. For example individuals who developed secure attachment during infancy were found to have good psychological well-being during adolescence and adulthood (Sroufe, Coffino, & Carlson, 2010; Sroufe, England, Carlson, & Collins, 2009). Moreover, disorganised attachment in infancy was found to predict later dissociative symptoms (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997). Against this background, the loss of a parent which results in the disruption of the attachment bond can be argued to be a factor that can result in psychopathology in orphaned children. Studies have also reported that orphanages fail to provide the one-on-one interaction between caregivers and infants that promotes secure attachment formation, thus resulting in poor mental health of infant following their placement in orphanages (Johnson et al., 2006).

2.2.2. The transactional model of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984)

The transactional model of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984) has been found to offer a sound explanation of how the interaction of stress and coping can result in a sense of either good or poor psychological well-being (Scherer, 1999; Siemer et al., 2007). The theory views affect (emotion) or morale (either positive or negative) as the adaptational outcome of a long-term stressful relationship between a person and the environment, with the relationship concerned being mediated by two processes: cognitive appraisal and coping.

Cognitive appraisal, which is viewed as the process by which people categorise their encounters with the environment and its effect on their well-being, is made up of both primary and secondary appraisals (Lazarus, 1999). Primary appraisal, which occurs when an individual evaluates an encounter as being irrelevant or benign, on the one hand, or stressful, on the other, is necessary for the emotions. Stressful appraisal can take the form of a challenge (i.e. a difficult demand that people feel that they can overcome by effective coping), a threat (i.e. anticipation of harm that has yet to take place, but which is imminent), or harm/loss (i.e. psychological damage that has already been done). Secondary appraisal, in contrast, is the evaluation of one's coping capacity. When conducting such an appraisal, the benefits and consequences of specific coping strategies are evaluated in terms of the person's aims and challenges. Notably, both patterns of appraisal are necessary for affect (Lazarus, 1999; Lazarus & Folkman, 1984).

According to the transactional model of stress and coping, affect is an adaptational outcome of a stressful encounter that reflects an individual's evaluation of the encounter as it impacts on his or her well-being, and the appraisal of the coping resources available. Positive affect results when a situation is appraised as either beneficial or challenging, or when the situation is appraised as harmful and threatening, but the individual reckons that they possess the coping resources to manage it. In contrast, negative affect results when a situation is appraised as threatening or harmful, or when it is appraised as challenging, and the individual reckons that they lack the coping resources to manage it (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) also differentiate between short-term and long-term emotions. They explain that short-term emotions must be seen from a process-oriented viewpoint, in that emotion and appraisal are dynamic and change at each stage of the encounter. Thus, a person might experience a variety of contradictory positive and negative emotions during the process. Also, in the short-term, coping becomes the mechanism through

which a positive sense of well-being can be sustained during adverse conditions. In the long-term, how emotions are experienced depend on the consistency of appraisal and coping capabilities employed. Hence, positive affect results from a consistent tendency to appraise situations as challenging or as harmful and threatening, but manageable. Negative affect, in contrast, results from the consistent appraisal of a situation as harmful or the appraisal of the situation as threatening or challenging, and the perception that the individual lack the resources to cope with it. The transactional model has been reported as explaining how appraisal and coping predict negative affect, such as depression, anxiety and poor QoL (Folkman, Lazarus, Gruen, & DeLongis, 1986; Lazarus & Folkman, 1984).

Coping is defined as “on-going cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus, 1993, p. 237). Coping has been reported as shaping emotion through regulating emotional responses to the distress (emotion-focused coping) or as managing the stressor (problem-focused coping). Emotion-focused coping is more likely to occur when an appraisal is made that nothing can be done to change the stressful situation, whereas problem-focused coping tends to occur when an appraisal is made that a situation is manageable (Lazarus & Folkman, 1984), thus leading the individual to take action towards solving the problem at hand. Lazarus and Folkman further explain that both coping strategies can be used in the same situation and that neither is considered more adaptive than the other. They view the outcome of coping as depending on the person, on the situation and on the short- or long-term nature of the problem concerned. Coping strategies have been found to predict emotions, such that emotion-focused coping has been found to relate positively to depression and anxiety, whereas problem-focused coping has been found to relate negatively to both affective states (Takaki et al., 2005).

2.3. The African Context of Orphanhood

From the international and African literature on parental loss, it would seem that a distinction is made between biological orphanhood (when a child below 18 years has lost either or both parents through death; UNICEF, 1999; UNICEF/UNAIDS, 2006) and social orphanhood (when loss is due to parental neglect and -abandonment; Dillon, 2009; Foster, 2000; McCall et al., 2010; Meintjes & Giese, 2006; cf. MESW & UNICEF, 2010; Skinner et al., 2006). Whether it is the biological- or social orphanhood that predominates in the discourse of, and research on, parental loss in Africa has been a subject of enquiry within social science. For example, Foster (2000) notes that social orphanhood was previously thought to be non-existent in the African context (for example, in Zimbabwe) due to the supportive role of the extended families in caring for orphans (thus highlighting that orphanhood in Africa is seen as only biological).

Following biological orphanhood (i.e., when a child loses a parent through death) in the African context, uncles and aunts, as members of the extended family, are often morally and culturally obligated to assume a parental role to orphaned children (Drew, Makufa, & Foster, 1998), especially when no other caregiver is available. Traditionally, the extended familial networks involve mutually supportive relationships and connections among relatives and members of the same clan and kinship, and spanning several generations (Foster & Williamson, 2000). The extended family functions as the social security that ensures that orphaned children are cared for even when the ‘adoptive’ family lacks enough resources for its own members (Foster, 2000). It is against this background that African orphans are thought to be shielded from adverse effects of losing a parent (Foster, 2000; Van der Brug, 2012).

However, recent reports suggest that extended families lack full capacity to care for orphans, due to the recent trends of westernisation, rural–urban labour migration, changes in the economy, formal education, and change in location, thus weakening the extended family

safety net for orphans (Foster, 2000; Seeley et al., 1993). Foster, for example, also reports that the extended family safety net tends to be better preserved in rural communities (because of strong child-rearing practices and family traditions), but has become relatively weak in urbanised communities. In the urban setting, such practices and traditions receive less emphasis owing to, inter alia, competing financial constraints that bear on the livelihoods of relatives.

Also cited as contributing to the lack of extended family networks' capacity to care for orphaned children's needs is when grandparents – who are already burdened by old age and lack the financial resources—assume the role of adoptive parents to the orphans, thus replacing the 'unavailable' or 'incapable' uncles and aunts as adoptive parents. Against said background, the likelihood of the potential for the orphaned children either ending up having to fend for themselves or landing up in orphanages is increased, especially if there are no other available caregivers. Sengendo and Nambi (1997) have cited vulnerability to being in child-headed families, to living on the streets, and to being victims of child labour as consequences of children growing up in broken homes.

The limited capacity of some extended families in providing care to orphaned children notwithstanding, the placement of orphans with their extended families is still internationally recognised as the preferred living condition for orphaned children in Africa (UNICEF, UNAIDS, & USAID, 2004; Zimmerman, 2003). However, it has been found that even in situations where such avenues are available, there are problems associated with such placement (Pillai & Sharma, 2013; Morantz et al., 2013), which adversely affect the psychological well-being of children (Van der Brug, 2012). For example, problems such as poverty, stigma, abuse, problems with peers including bullying, teasing, and lack of friend (Cluver & Gardner, 2007), incidence of material and school neglect, child labour, exploitation

as well as abuse (e.g., emotional, sexual and physical) (Morantz et al., 2013) have been found in studies on orphans who live with extended families.

The emergence of orphanages in Africa has served to provide care for orphans who once were vulnerable as a result of not receiving care from their extended family (Akpalu, 2007). These institutions provide care to orphans through the provision of basic needs such as food, shelter, health care and education (UNICEF, 2011; Zimmerman, 2005), although they have been found with problems. Orphanages in Africa, especially those run by government, have been noted to be poorly equipped and staffed, as well as lack educational, nutritional and health services (Preble, 1990). It is also worth noting that research has also highlighted that problems with placement in orphanages do exist in numerous other contexts apart from Africa: For example non-stimulating environment, unfavourable caregiver-to-child ratio (Browne, 2009; Daunhuaer et al., 2005) as well as abuse and neglect (Johnson et al., 2006). Against this background, developmental and intellectual delays, problems with social competence, as well as poor mental health have been found in children following institutionalisation (Johnson et al., 2006).

With regards to the psychological impact of orphanage placement in Africa, although there have been documented positive mental health outcomes in some African context (Aboud et al., 1991; Zimmerman, 2005), the negative mental health impacts of such placements have also been documented in other African studies (Fawzy & Fouad, 2010; Hermenau et al., 2011; Wolff & Fesseha, 1999). The negative mental health outcomes suggest that placement in an orphanage might result in the development of negative mental health among orphans. Despite the findings by some studies of the potential adverse effect of orphanages on orphans' mental health in the African setting, orphanages continue to be a viable option for orphan care on the continent (Fawzy & Fouad, 2010), given that other options, such as adoption and formal

foster care, are either unfeasible or culturally unacceptable in Africa (Freeman & Nkomo, 2006).

2.4. Orphan Care in Ghana

The Ghanaian culture, since time immemorial, has supported traditional means of caring for orphaned children. Orphan care is, thus, practised through the traditional inheritance system, fosterage and marriage practices (Ansah-Koi, 2006; Kuyini et al., 2009). Through the traditional inheritance system, clan members are selected to inherit the obligations of deceased family members (Ansah-Koi, 2006; Apt et al., 1998). The successor inherits the property (if any) of the deceased parent and care for orphaned children. In situations where no property is inherited, it is still expected of the successors to care for orphaned children. In terms of the system, orphaned children are retained within the ambit of extended families and are cared for by members of their own families.

The system of fosterage is also used as a means of orphan care. Crisis fostering is a typical example of such a situation that has been identified among the Gonjas, which is one of the tribes in the northern part of Ghana (Goody, 1982). In terms of such a system, children are placed in fostering due to a crisis, such as the death of a parent, when care by the surviving parent or by the extended family is inadequate or is totally unavailable (Ansah-Koi, 2006; Kuyini et al., 2009). Unlike the traditional inheritance system that involves only close family ties, the fosterage of orphaned children does not involve only such ties. Within said system, orphaned children may be fostered by people who are not related to them. Most of the community members who foster orphans are sympathisers, who might not necessarily have the need to foster orphans but who are willing to care for them. Also cited is the Queen Mother's Orphans Care Initiative, in terms of which queen mothers of some regions take it upon themselves to care for orphaned children (Ansah-Koi, 2006). Such fosterage is known to be common in the Manya Krobo District in the Eastern Region of Ghana.

Non-related people foster orphans for different reasons. Some of the reasons include the belief that children belong to the community and the religious belief that those who foster orphans will be blessed (Ansah-Koi, 2006; UNDP & Ghana Aids Commission, 2003). In the foster care system, Ansah-Koi cites that double orphans are more likely to be fostered than are single orphans, due to the expectation that the surviving parent should care for the orphan child. The system concerned places some single orphans at a disadvantage, because the situation of some single orphans might be worse than that of double orphans. Other traditional practices that provide some avenue for orphan care include remarriage and polygyny that provide avenues for step-parents to assist surviving parents to care for orphans after the death of a spouse (Ansah-Koi, 2006).

Research has highlighted that these traditional means of orphan care in Ghana are not as functional as they used to be. The breakdown of the traditional means of orphan care has resulted from the increase in modernisation, increased financial burden on families and the growing number of orphans resulting from the AIDS epidemic (Ansah-Koi, 2006; Apt et al., 1998; Deter, 2008; Voyk, 2011). Fostering families are also financially strained and sometime abuse orphans (Kuyini et al., 2009). Ghana also lacks formal governmental welfare policies for the care of orphaned children. These problems have resulted in some orphans lacking support following the loss of their parents. As a result, when the various avenues of orphan care that provide orphans with a family setting are not available or are inadequate, institutional care is considered. The breakdown of the traditional means of caring for orphans has led to an increase in the amount of institutional care for orphans (Ansah-Koi, 2006), which seems to be the easier choice for most families (Voyk, 2011).

Although the orphanages have been noted to care for quite a number of orphans, some concerns regarding the orphanages' activities have been raised. While very few studies have been conducted into the activities of orphanages in Ghana, concerns such as negative

relationship between the children and their caregivers (Kristiansen, 2009), corruption by orphanage administrators (Colburn, 2010), physical and sexual abuse (MESW & UNICEF, 2010), the exploitation of visitors and the misuse of funds by orphanage administrators (Pyper, 2010) have been cited as some of the adverse activities that occur in some orphanages. All of these adverse conditions in the orphanages can negatively affect the mental health of orphans, yet the psychological well-being of orphans has received little attention. Although very little has been done in this regard, studies (Adu, 2011; Kristiansen, 2009) have found that some orphaned children in some Ghanaian orphanages present with poor psychological well-being. It is, thus, important that more attention is given to the psychological well-being of orphans who are placed in Ghanaian orphanages. It was against this background that the present study aimed to explore the psychological functioning and experiences of orphaned children following placement in an orphanage.

2.5. Literature Review on the Psychological Functioning and Experiences of Orphans Placed in Orphanages

In the current section, studies examining the psychological well-being of orphans placed in orphanages are discussed. As highlighted earlier, many of the studies are international literature as only a few could be found in Africa. However, an overview of the findings of the few existing African studies and of those that were undertaken in the Ghanaian setting are included.

2.5.1. The experience of depression, anxiety and quality of life

Depression is one of the common mental health problems that is found among orphanage-placed children (Fawzy & Fouad, 2010; Hermenau et al., 2011; Wolff & Fesseha, 1999). Studies that were conducted in several countries outside of Africa have reported symptoms of depression among orphans placed in institutions. For example, in a Turkish-based research, Hortaçsu, Cesur, and Oral (1993) found that orphans in the orphanage studied

reported significantly higher symptoms of depression than did non-orphans residing with their parents. Similarly, Margoob et al. (2006), through DSM-IV-TR diagnostic interviews diagnosed major mood disorders among orphans living in an orphanage for girls in Kashmir. Additionally, a Palestinian study found that 49 per cent of paternal orphans in two orphanages scored above the clinical cut-off scores for depression (Thabet, Thabet, Hussein, & Vostanis, 2007). Furthermore, a Chinese study (Hong et al., 2010) found that Aids orphans in orphanages presented higher symptoms of depression than did those in group homes. Also, Damnjanovic, Lakic, Stevanovic, and Jovanovic (2011), in a Serbian study, found that children who had lost their parents and who lived in institutions had significantly higher depression scores than did those in foster care. Moreover, an Indian study (Kumar, Dandona, Kumar, Ramgopal, & Dandona, 2014) also found high prevalence of depression among orphanage-placed children. These findings in the international studies suggest that placement in an orphanage might be related to symptoms of depression in orphaned children.

In Africa, although few studies have been undertaken on the set topic, there is evidence that orphans in orphanages present with symptoms of depression. For example, Fawzy and Fouad (2010), in an Egyptian study, found that 21 per cent of 294 orphans reported symptoms of depression. Similarly, Hermenau et al. (2011), in a Tanzanian study also found that 5 out of 38 orphans met the criteria for a major depression episode at baseline. The presence of depression reported in the African studies suggests that placement in orphanages might be related to symptoms of depression in orphaned children.

Besides depression, symptoms of anxiety disorders have also been reported among children in orphanages. Several international studies have reported the presence of anxiety symptoms in orphanage-placed children. For example, in a Kashmir-based study, Margoob et al. (2006), using the DSM-IV, found that 16 out of 38 orphans suffered from (PTSD) and panic disorder. In addition, Thabet et al. (2007), in a Palestinian-based study, found that 28.5

per cent of the orphans in their study met the criteria for anxiety. Additionally, Damnjanovic et al. (2011), in a Serbian-based study, found that institutionalised children had significantly higher anxiety scores than did those in foster care. Findings from the above-mentioned international studies have to be interpreted with caution, bearing in mind the degree of violence encountered in the environment. Symptoms of anxiety are acknowledged as possibly not having resulted specifically from orphanhood and placement in institutions, but also from the experience of frequent violence in the environment. However, the fact that a Chinese-based study (Hong et al., 2010) found that Aids orphans in orphanages reported higher symptoms of anxiety than did those in group homes also suggests that orphanhood and placement in orphanages can be related to anxiety.

Similar findings were reported in one African study undertaken by Fawzy and Fouad (2010). The Egyptian study concerned found that 45 per cent of 294 orphans in their study showed symptoms of anxiety. The finding suggests that placement in orphanages might be related to the development of anxiety symptoms in orphaned children.

In contrast to the above findings on the presence of anxiety symptoms in orphanage-placed children, Kodero (2000), in a Kenya-based study, assessed the effect of residential destination (orphanage, guardian homes and extended families) on the psychological and educational status of orphans. Kodero found that orphans living in orphanages had lower levels of anxiety than did those living in extended families and in guardian homes. Such findings suggest that orphanage placement might not necessarily lead to symptoms of anxiety in orphans.

Some international studies examined symptoms of general internalising disorder (depression, anxiety and somatic disorders) in orphanage-placed children. The findings from some of the studies have provided evidence for the presence of internalising disorders. For example, in a one-year follow-up study, Ahmad and Mohamad (1996), in a Kurdistan-based

study, reported finding a significant increase in the number of symptoms of internalising disorder in children placed in an orphanage in comparison to the number of such symptoms found amongst children in foster care. Similarly, Ahmad et al. (2005a), in a two-year follow-up Kurdistan-based study, compared orphans in orphanages with orphans in foster care. The authors reported that, during the first year, the children in foster care were found to improve in terms of scores of internalising disorder more than did the children in orphanages. During the second year, the children in foster care continued to improve, while the children in orphanages showed no improvement in their psychological problem scores. Furthermore, Erol et al. (2010), in a Turkish-based study, found that orphans in institutions presented a higher score on symptoms of internalising disorders than that of youth in the community. Moreover, Rahman et al. (2012) in the city of Dhaka found high prevalence of emotional disorders among orphans placed in institutions. These findings suggest that placement in orphanages might be related to symptoms of internalising disorders in orphans.

In contrast to the international studies that found the presence of internalising disorders, some international studies found evidence to the contrary. For example, Şimşek, Erol, Öztop and Özcan (2008) found that children in institutions reported experiencing fewer symptoms of internalising disorders than did children living with their families. Additionally, Whetten et al. (2009), in a study of six study sites (Kenya, Tanzania, Ethiopia, Cambodia, and Hyderabad in Andhra Pradesh, India, as well as Nagaland in India) found that (as reported by caregivers) orphans placed in institutions presented lower scores of internalising disorder than did orphans living in the community. Findings from these studies also suggest that placement in orphanages might not be related to symptoms of internalising disorders in orphans.

As was previously discussed (in the background on the variables), an individual's psychological state, such as the experiencing of depression and anxiety, can affect their overall quality of life. However, similar to the inconsistent findings made with regard to the

experiencing of depression and anxiety, the findings of studies that examined the quality of life of orphans placed in orphanages have also been inconsistent. Regarding negative findings, for example, Van Damme–Ostapowicz et al. (2007), in a Polish study, found that the children placed in institutions tended to have a significantly lower quality of life than those living with their families. Additionally, Damnjanovic et al. (2011), in a Serbian study, found that children in institutional care presented with significantly lower quality of life compared to the presentation of children in foster care. Similarly, Damnjanovic et al. (2012), in another Serbian study, found that children in institutions (irrespective of their gender and age) presented with significantly lower quality of life scores than did those in foster care and those living with their families. The findings suggest that placement in orphanage can negatively impact the quality of life of the orphans concerned.

In contrast to the poor quality of life reported in the above-mentioned studies, He and Ji (2007), in a Chinese study, did not find a significant difference between the quality of life of orphans living in institutions in comparison to that of those living with extended families. The authors, however, cautioned of the small sample size involved when interpreting the findings. Although the contradictory finding was made in connection with a single study that used a small sample size, it raises the possibility that placement in orphanages might not negatively impact the quality of life of some orphans.

The quality of life of children in orphanages can be predicted in terms of their psychological state. Studies examining predictors of the quality of life of institutional children are scarce, but the few existing studies have reported that the presence of symptoms of depression and anxiety (Damnjanovic et al., 2011; He & Ji, 2007), as well as of material needs (Kristiansen, 2009), are significant predictors. However, only psychological variables are emphasised in the current review. For example, He and Ji (2007) found that depression was a significant negative predictor of quality of life. Also, in the above-mentioned Serbian

study, Damnjanovic et al. (2011) found that depression and anxiety were significant negative predictors of quality of life among institutionalised children.

Given the inconsistencies in the results of studies examining depression, anxiety and quality of life in orphans placed in orphanages, there is the need for further research inquiry into the psychological well-being of orphans placed in orphanages with respect to the experience of depression, anxiety and the overall quality of life. It was against this background that the present study aimed to explore symptoms of depression and anxiety as well as overall quality of life of orphans placed in Ghanaian orphanages. Studies in this regard would provide an overview of the psychological well-being of Ghanaian orphans placed in orphanages and would provide information on the need for psychological interventions for orphanage-placed children in the Ghanaian context.

2.5.2. The influence of stress-moderating variables

Although orphanhood and placement in orphanages can be stressful, and can result in negative mental health, it is argued that the presence of certain protective factors can moderate the negative effects of such experiences and provide protective influences (Cluver & Gardner, 2007; El Koumi et al., 2012; Haine, Ayers, Sandler, & Wolchik, 2008; Şimşek, Erol, Öztop, & Münir, 2007). Of the identified protective factors, those that are salient to the present study and will be discussed below are the kind of coping strategies, perceived social support, perceived self-efficacy and the individual resilience characteristics. These factors have been reported as correlating with the levels of depression, anxiety and quality of life among orphans placed in orphanages. The various influences of these factors are, thus, reviewed below, arranged in the order of coping strategies, perceived social support, perceived self-efficacy, and resilience.

The kind of coping strategies used by orphans is an important factor in determining the effect of parental loss and orphanage placement on the mental health of those concerned.

Although very few studies have been done in this regard, some studies (Erol et al., 2010; Mohangin, Ebersöhn, & Eloff, 2011; Şimşek et al., 2008; Wanat et al., 2010) have identified several coping strategies that are used by orphans placed in an orphanage. The strategies include: support-seeking; problem-solving; cognitive restructuring; spiritual connectedness or religion; fantasy; fatalistic thinking; denial; detachment; and mental disengagement.

Children in orphanages have also been found to use both internal and external coping strategies (Wanat et al., 2010). With regard to external strategies, Wanat et al. (2010), in an Indonesian study, found that orphans tend to use support-seeking (both instrumental and emotional) from friends and family. With respect to internal coping, the children reported using restructuring of thoughts to disengage mentally from the stress, or focusing on inspirational topics or people. The authors also reported that religion was a strong and viable coping strategy that was used by children in their study. Wanat et al. (2010) also found that some children reported using crying as a coping strategy, whereas other children reported that they used no coping strategy. Additionally, orphanage-placed children have been found to use spiritual connectedness (in the form of embracing God and of a sense of optimism) and social responsive behaviour towards others to engage with the stressful life in the institution (Mohangin et al., 2011). Such strategies as fantasy, denial and detachment, in contrast, were used to disengage from the stress. Although the current study did not examine how the strategies used relate to the children's mental health, the literature (Compas et al., 2001) on childhood coping has established that engagement coping is related to psychological well-being, whereas disengagement coping is related to negative mental health. Thus, the kind of coping strategies used by children in managing stressful experiences has an impact on their mental health.

With regards to the relationship between the coping strategies and the mental health of children placed in orphanages, very few studies have been done. Two Turkish studies (Erol et

al., 2010; Şimşek et al., 2008) reported that fatalistic thinking (as defined as the acceptance of the endorsed belief that all events are predetermined and inevitable) was associated with symptoms of mental health problems. Lower levels of problem-solving skills have also been found to be associated with increased problem behaviours (Erol et al., 2010). Given the gap in the literature on coping and its influence on orphanage-placed children's well-being, and considering the lack of research in this regard in the Ghanaian context, the present study aimed to explore the kinds of coping strategies employed by Ghanaian orphanage-placed children to manage distress and how the various copings strategies influence their well-being.

Another important factor that has been found to moderate the adverse effect of parental loss and placement in an orphanage is perceived social support. Social support in orphanage-placed children has been measured differently by different researchers. For example, social support has been examined in terms of attachment scores (Aboud et al., 1991), the relationship between peers and caregivers (Adu, 2011; Kodero, 2000; Kristiansen, 2009), the level of warmth and love (Emond, 2009), the ability to confide in caregivers (Çaman & Özcebe, 2011), and with scores on standardised measures of perceived social support (Erol et al., 2010; Şimşek et al., 2007).

Studies of the nature, and the perceived availability, of social support in orphanage-placed children have, so far, only rendered inconsistent results. With respect to negative findings, Aboud et al. (1991), in an Ethiopian study, found that orphanage-placed children reported having weaker attachment to adults compared to non-orphaned children who resided with their parents. Additionally, orphanage-placed children have reported receiving less warmth and love in the orphanages when they compared their experiences in the orphanage to their memories of family life and to the situation in which their friends found themselves in the community (Emond, 2009).

Similar negative findings have been found in studies that examined the perceived availability of social support in Ghanaian orphanage-placed children. For example, Kristiansen (2009) compared caregivers' and volunteers' attitudes towards children and peer relationships in one government-owned orphanage to those of children in two privately owned orphanages. Kristiansen found that, in general, the attitudes of the caregivers towards the needs of children in the government-owned orphanage were negative. The children reported that their relationship with their caregivers was characterised by a general lack of trust between themselves and their caregivers, as well as by the caregivers treating them unfairly, ignoring and abusing them (both verbally and physically), in addition to which the caregivers had a prevailing negative attitudes towards the orphaned children. With regards to the volunteers, some children reported that the volunteers had a positive relationship towards them, whereas others reported that the relationship was negative. In comparison, children in the private-owned orphanages reported the existence of a general positive relationship between themselves and their caregivers. With regards to the peer relationship, Kristiansen (2009) reported that the children in the government orphanage expressed the lack of close ties with one another, instead of which there was frequent fighting and stealing among them. In contrast, children in the private institution reported the existence of a positive peer relationship among the children.

Similarly, Adu (2011) studied the availability of social support for orphanage-placed children in a government orphanage in Accra, Ghana. Consistent with findings by Kristiansen (2009), Adu (2011) observed that the children in the orphanage lacked adequate attention from the caregivers. Adu explained that such emotional neglect might have resulted from the high ratio of children-to-caregivers, thus giving less room and time for developing a one-on-one relationship between the caregivers and the children. The negative findings suggest that

orphanage placement might not provide positive and adequate social support for orphaned children, which could negatively impact on their mental health.

In contrast to the above-mentioned negative findings, some studies found that orphans placed in orphanages reported positive relationships and adequate social support in the orphanages. For example, Kodero (2000), in a Kenyan study, found that, compared to orphans in extended families and in a guardian's home, orphans living in orphanages enjoyed a better quality relationship between themselves and their caregivers. Additionally, some children in Emond's (2009) study reported the presence of positive peer relationships. Emond argues that the positive peer relationships were protective and helped to buffer the children from the challenges that they experienced both within and outside the orphanage. Similarly, Adamson and Roby (2011), in a South African study, found that orphaned children in institutions had diverse sources of support that promoted a sense of hope to levels that were similar to that among non-orphaned children in the community. Furthermore, children in Wanat et al.'s (2010) study reported that placement in institutions had offered them the possibility of having a positive peer relationship. One child reported how friends in the orphanage made him happier than he was before being placed in the orphanage. In Ghana, Adu (2011) also observed the existence of a positive peer relationship among children in an orphanage. The children reported that their peers helped them to cope with adverse conditions in the institution. Such positive findings suggest that placement in orphanages might provide avenues for positive relationships and adequate social support for orphaned children that could have a positive impact on their sense of psychological well-being.

The relationship between social support and psychological well-being in orphanage-placed children has also been examined. For example, Erol et al. (2010), in a Turkish study, found that higher levels of perceived social support from caregivers and peers were related to a decrease in internalising problem scores in orphans placed in orphanages. Similarly, Çaman

and Özcebe (2011) also reported that adolescents who were unable to share their problems with the orphanage staff reported higher depressive scores, whereas having a positive relationship with a roommate did not significantly relate to the existence of general distress levels.

The above finding suggests that the perceptions of social support available to orphanage-placed children can influence their well-being. Against this background, studies have also established that the perceived social support can predict the state of orphans' mental health. For example, Şimşek et al. (2007), in a Turkish study, found that perceived social support was a significant negative predictor of orphans' total problem scores. Şimşek et al. (2007) concluded that social support was a protective factor against the development of poor mental health in orphanage-placed children. Although the influence of social support on orphans' well-being has seemingly gain momentum globally and in the African context, there is minimal research in this regard in the Ghanaian context. Hence, the present study aimed to explore orphans' perception of the availability and adequacy of support and the influence of such perceived support on their well-being.

Another factor that can moderate the effect of parental loss and orphanage placement that has received relatively little attention is perceived self-efficacy. Generally, children who had lost their parents had been found to present with relatively low levels of self-efficacy (Worden, 1996). A study that was conducted among orphaned youth also found that perceived self-efficacy reduced the adverse effect of distresses on the psychological well-being of orphans (Kiyiapi, 2007). However, in terms of the present study, no study so far could be traced in the literature that examined the levels of perceived self-efficacy and its relationship to orphanage-placed children's mental health. Given the significance of perceived self-efficacy on the psychological well-being of children, there is the need for research inquiry on how the said variable influence orphanage-placed children's well-being. It was against this

background that the current study aimed to assess perceived self-efficacy and its influence on the well-being of Ghanaian orphans placed in orphanages.

Resilience is also another important factor that can moderate the adverse effects of orphanhood and placement in an orphanage, yet has received relatively little attention. Subsequent to parental loss, studies (Adamson & Roby, 2011; Chase, Wood, & Aggleton, 2006; Nyamukapa et al., 2010; Wild, Flisher, & Robertson, 2011) have documented that some orphans functioned optimally, despite the adversities that they encountered. Orphans placed in orphanages have also been found to demonstrate individual resilience, despite the adversities that they encountered (Adu, 2011; Mohangin et al., 2011). The authors concerned have associated the children's positive adaptation to certain individual characteristics, such as self-efficacy and self-care (Mohangin et al., 2011), as well as intelligence levels (Adu, 2011).

Children in orphanages have been found to show individual resilience. For example, Mohangin et al. (2011), in a South African study, found that orphans demonstrated resilience through their understanding of the role of self-efficacy and the need to show responsibility for themselves. Additionally, Adu (2011) in a Ghanaian study found that besides the presence of significant others (sponsors) and peer support, which might have helped the children to cope, the perception of individual intelligence levels was also significant in the orphans' abilities to thrive. Adu found that children who saw themselves as intelligent and who, therefore, received praise from the adults (caregivers and teachers) concerned were more happy and confident, and were found to cope better than did the other children. Given the gaps in research on resilience in orphanage-place children, the present study aimed to contribute to the literature by exploring resilience (as measures by scores on the Resilience Scale, which captures personal competence and acceptance of self and life) and its influence on the well-being of Ghanaian orphanage-placed children.

2.5.3. Subjective experiences about placement in orphanage

There are some qualitative studies that have explored the ‘lived’ experiences of orphaned children about placement in orphanages from participants’ perspectives. These studies aimed to ascertain orphans’ narratives about their experiences and sentiments about orphanage placement. Although few of these studies exist, it is noteworthy that both positive and negative experiences have been highlighted by these studies. With regards to positive experiences about placement in orphanages, some studies have highlighted that orphanages provide material and non-material resources that include food, shelter, clothing, health care and access to education (Adu, 2011; Emond, 2009; Freidus, 2010; Wanat et al., 2010; Zimmerman, 2005), a sanctuary and a safe home environment (Gibbons, 2005; Kristiansen, 2009), avenues for love and affection from caregivers that foster emotional well-being (Gibbons, 2005), as well as the avenues for positive peer relationship and social support (Adu, 2011; Emond, 2009; Gibbons, 2005; Kristiansen, 2009; Wanat et al., 2010; Zimmerman, 2005).

These positive experiences have been found to foster a sense of belonging, broaden social networks, enhance social support and augment a sense of safety in the orphanage (Kristiansen, 2009). In addition, the positive experiences associated with orphanage placement have been found to foster emotional well-being especially considering that some orphans consider orphanage placement as a blessing (Emond, 2009). For example, Emond found that some orphans in her study expounded the view that the orphanage saved them from the adverse effects of poverty, violence and abuse that they had experienced when they lived with their families. The above highlighted positive experiences following placement suggest that, orphanages are able to serve the purposes for which they exist, which are, to provide a home environment where the presence of parental care, love, security and a sense of

belonging are available to orphans and vulnerable children who lack care (Licursi, Marcello, & Pascuzzi, 2013).

In contrast to the above positive experiences associated with orphanage placement, several negative experiences have been reported. For example, in an Egyptian study, Gibbons (2005) found that orphans placed in the orphanages studied experience stigma from their peers at school and from members of the communities at large. In addition, Gibbons highlighted that orphans in mismanaged orphanages often had poor and unvaried diet due to pilfering of materials on the part of orphanage employees as well as persistent relationship problems among peers in the orphanage. Additionally, in an Indonesian study, Wanat et al. (2010) found that orphans cited insufficient access to educational resources (notably, stationary and trained teachers) and basic necessities (notably, food and shelter), lack of affection on the part of the caregivers and relationship problems with peers as the sources of their distress in the orphanage.

Furthermore, documented studies in Ghana have highlighted that orphans in orphanages often have negative sense of emotional well-being, due to their emotional needs not being met in the orphanages. The poor emotional well-being of orphans has been attributed to the negative attitudes of caregivers towards orphans (Kristiansen, 2009) and the lack of affectionate relationships between orphans and caregivers (Adu, 2011). Moreover, orphans in Ghanaian orphanages have been found to experience relationship problems with their peers (Adu, 2011; Kristiansen, 2009), neglect (Adu-Agyem, Enti, & Peligah, 2009), stigma (Adu, 2011) and lack a sense of belonging (Osei, 2013) following placement in the orphanage. All of these negative experiences could adversely affect the psychological well-being of the orphans following their placement in the orphanages.

2.6. Summary of the Literature

From the above discussion on studies that examined the psychological well-being of orphans who live in an orphanage, three main conclusions could be drawn. Firstly, there is an inconsistency in the findings of studies that assessed the mental health of orphanage-placed children. For example, whereas some studies have highlighted good mental health in orphanage children, other studies have reported poor mental health with depression, anxiety and low quality of life being the common mental health problems. These inconsistencies may be attributed to differences in individual characteristics of the orphans, such as the coping strategies that they use to manage distress and their individual resilience. Additionally, differences in orphanage structure and environments might have contributed to the inconsistencies. Positive findings are more likely to be obtained in orphanages characterised by positive caregiving, adequate social support and positive structural conditions, whereas negative findings are more likely to be obtained in orphanages with poor structural conditions, lack of social support and poor caregiving. Furthermore, differences in pre-institutional experiences might be significant. For example, orphans who had positive and stimulating experiences before the loss of their parents are more likely to perceive the orphanages as threatening. These orphans are more likely to report poorer psychological well-being than are those orphans who had adverse pre-institutional experiences. Moreover, the orphanage environment might also be influential given that different orphanages present different environments that can have varying effects on children. Due to the inconsistencies, conclusive associations could not be drawn between parental loss, orphanage placement and psychological well-being of children. Thus, there is the need for further research enquiry into the well-being of orphanage-placed children.

Secondly, the review of scholarly work revealed that very little is known about the nature of coping, perceived social support, self-efficacy and resilience as well as the influence

of these variables on the well-being of orphanage-placed children. This is due to the paucity of research that included these variables in studies on well-being in orphanage-placed children. Thirdly, few studies have been conducted on the psychological well-being of Ghanaian orphans placed in orphanages and the few available studies used small sample sizes and did not study broader aspects of psychological well-being in orphanage-placed children.

Given the gaps identified in the literature, the effects of orphanage placement on the well-being of orphans are not adequately understood and thus point to the need for research inquiry into the well-being of orphanage-placed children. Against this background, the present study aimed to explore the psychological functioning and experiences in Ghanaian orphans following placement in orphanages in Accra through the use of a rigorous methodology that include a large sample size across four orphanages in Accra, the use of a control group, as well as the assessment of comprehensive psychological well-being using both standardised measures and follow-up interviews. Moreover, given the inconsistent results that both international and African studies have yielded, the present study aimed to provide information on the nature of the current well-being of Ghanaian orphanage-placed children. Furthermore, the results and findings of the present study would provide significant information that could aid in the design and implementation of interventions.

Chapter 3: Methodology

In the current chapter, the methodology used for the present study will be discussed. Specifically, the philosophical assumptions underlying the study, the research design, the research settings where the study was conducted, information about the participants, the measuring instruments, ethical considerations, the procedure for data gathering and the methods of data analyses are discussed.

3.1. Philosophical Assumptions and Research Design

The present study used a sequential mixed-method approach, which incorporates elements of both quantitative and qualitative approaches (Creswell, Plano Clark, & Garrett 2008). The quantitative approach drew on the postpositivistic philosophical position, which holds that there is an objective world in which causes determine the effects of outcomes. Ideas can be tested in discrete sets, and knowledge can be produced from a careful observation and measurement of objective reality (Creswell, 2009). Research based on this philosophical position begins with a theory, followed by collection of data that either support or refute the theory, and subsequently, the revision of the theory before additional tests are carried out. The qualitative approach drew on the social constructivist philosophical position, which holds that individuals seek to understand the world in which they live through the formation of subjective meanings of personal experiences (Bryman, 2012; Creswell, 2009). Research based on this worldview relies as much as possible on the research participants' views of the phenomenon under investigation, uses open-ended questions to source information pertaining to the phenomenon under study and asks broad and general questions so that participants can construct the meaning of their experiences.

The use of either a quantitative or a qualitative design alone was considered inadequate for obtaining a complete understanding of the psychological functioning and experiences of Ghanaian orphans following placement in an orphanage. As a result, a mixed-

method design was used for the present study due to the ability of such a design to provide a comprehensive understanding of the phenomenon under study through providing insight from both qualitative and quantitative approaches (Johnson & Onwuegbuzie, 2004). The mixed-method design also helps to minimise the limitations and maximise the strengths of each approach. In line with the recommendations of Yoshikawa, Weisner, Kalil and Way (2008), the use of follow-up interviews was also suitable for the present study because of the importance of orphans' subjective experiences in the understanding of their stress levels. Moreover, the follow-up interviews catered for cultural and contextual factors that were not accounted for by the quantitative findings (Leech & Onwuegbuzie, 2007).

Following the sequential mixed-method design, quantitative data were collected by means of questionnaires whereas qualitative data were gathered by means of follow-up in-depth interviews with selected orphaned participants. Regarding the integration of data, the quantitative data were connected to the qualitative data in that the participants' information and scores on the questionnaires were used to select orphans for the follow-up interviews. In the present study, priority was given to data from both quantitative and qualitative approaches.

The quantitative method was used to explore the nature and magnitude of the statistical relationships among different variables under investigation (while also reducing error and bias). Participants were interviewed using questionnaires that assessed symptoms of depression, symptoms of anxiety, overall quality of life, coping strategies, perceived self-efficacy, resilience and perceived social support. The qualitative data were used to delve into orphans' subjective experiences of orphanage placement in order to ascertain their personal narratives, which were not accessible through the use of established statistical procedures. The selection of participants for the follow-up interviews was based on their age, gender, time since parental loss, duration of stay in the orphanages and the scores on the measures. The

selection along these variables was done in order to include both younger and older participants, both male and female, those who had recently lost their caregivers and those whose loss had taken place in the distant past, those both recently and ‘temporal distantly’ placed in orphanages, those who scored high and those whose scores were low on the measures.

3.2. Research Settings

The study was conducted in Accra, Ghana, with a population of nearly four million people (Ghana Statistical Services, 2011). The institutions that were selected for the present study, also known as ‘Children’s homes’ or orphanages, consisted of both private and government-run institutions for orphans and vulnerable children in Accra. The orphaned children (experimental group) were selected from four orphanages, namely Savers Foundation, Paradise Foster Home, God Saves Orphanage and Haven for Orphans Foundation. The names used here are pseudonyms in order to protect the identity of the participating orphanages and the orphans who lived in the orphanages. All four institutions were under the supervision of the Department of Social Welfare; therefore, before access to the orphanages was obtained, permission had been sought from the Director of the Department of Social Welfare, after which permission was sought from the administrators of the orphanages that had been approved by the said director.

The Director of the Department of Social Welfare granted permission for five orphanages; however, the administrator of one of the orphanages was not available to grant permission for access to the orphanage and the orphans who lived therein. As a result, the research could not be conducted in that orphanage. The administrators of the four remaining orphanages granted access to the orphanages and orphans who resided therein; therefore, the research was conducted in the four above-mentioned orphanages.

On the first day of visit to the government orphanage, after permission had been granted, the administrator introduced the researcher to the social welfare personnel who in turn introduced the researcher and explained the purpose of the study to the children who lived in the orphanage. However, on the first day of visit to the private orphanages for data gathering, the administrators introduced the researcher and explained the purpose of the research directly to the children who lived in the orphanages.

The schools that were selected for the present study were public schools based in Accra. The non-orphaned children (control group) who were compared to the orphaned children were selected from Dynamic Senior High School and Good Starters Basic School. The names used here are pseudonyms in order to protect the identities of the participating schools and the children therein. Dynamic Senior High School had three grades, and Good Starters Basic School had six grades in the primary school and three grades in the junior high school. These schools were chosen because they had different grade levels, which gave the researcher access to children in diverse age groups and grades that were comparable to the orphans who lived in the orphanages. Both schools were under the supervision of Ghana Education Services in Accra; therefore, permission was sought from the Regional Director of Ghana Education Services for access to the schools. On the first day of visit to the schools for data gathering, after permission had been granted, the head teachers introduced the researcher to one of the teachers in the schools who in turn introduced the researcher and the purpose of the study to the learners in the schools.

3.3. Participants

Purposive sampling technique was used to select children aged between seven and 17 years for the present study. For the orphaned children, the orphanage administrators were the sources of access. For selection of participants in the government-run orphanage, the administrator assigned two social workers who selected children within the age group of

seven and 17 years for participation in the study. Regarding the selection of participants in the three private orphanages, the administrators introduced the researcher directly to all children in the orphanages who were aged between seven and 17 years. Following the introduction, the researcher explained the purpose of the study and details of ethical issues to the children. Children were then invited to participate in the study. Of note, no child within the age group in the private orphanages refused to participate in the study.

Orphaned children were included in the study if they were between the ages of seven and 17 years, had lost one or both parents through death or abandonment (the latter criterion – abandonment – was used to rule out the inclusion of children who, although also staying in orphanages, had indicated that their parents were still alive, even when their whereabouts were unknown), resided in an orphanage and were willing to participate in the study. An original pool of 104 children was drawn from the orphanages to participate in the survey. Based on the inclusion criteria outlined above, four children (3.8%) were excluded from the data analyses on the basis that, although they also lived in the orphanages, their residence status was due to their parents (both were alive) being caregivers or administrators of the orphanages. After excluding four children, 100 orphaned children placed in orphanages (96.2% response rate) were included in the study. Of the 100 children, 43 (22%) were taken from Savers Foundation, 26 (13%) were from God Saves Orphanage, 20 (10%) were from Haven for Orphans Foundation and 11 (6%) were from Paradise Foster Home. The demographic information of the orphaned children is presented in Table 3.1.

Consistent with the international research trends on orphans in which the psychological well-being of orphanage-placed children was compared with that of the non-orphaned children in the family set-up (Damnjanovic et al., 2011; Damnjanovic et al., 2012; Fawzy & Fouad, 2010; Hermenau et al., 2011; Thabet et al., 2007; Wolff & Fesseha, 1999; Van Damme-Ostapowicz et al., 2007), the present study compared orphans placed in

orphanges with non-orphaned children who resided with their parents. The non-orphaned children were identified through the assistance of the head teachers and a teacher in each school. In both the basic- and senior high schools, the head teacher assigned a teacher who introduced the researcher to school children. At the Basic school, the teacher selected children who were aged between seven and 17 years for participation in the study. At the high school, the researcher and research assistant approached children during their break period and invited them to participate in the study. Those who agreed to take part in the study were included.

The non-orphaned participants were included if both of their parents were alive, they were between the ages of seven and 17 years, they attended public schools in Accra, they lived with their parents and they were willing to participate in the study. The original sample comprised 115 children. Following the inclusion criteria outlined above, 15 children (13.05%) were excluded from the data analyses for various reasons: six participants were orphans and of these, two were single orphans (had lost either a father or a mother) and four were double orphans (had lost both parents). The remaining nine participants were also excluded because they were above the cut-off age of 17 years. After the exclusion of the 15 children, the non-orphaned sample was reduced to 100 participants (86.95% response rate). Of the 100 non-orphans, 45 (45%) were taken from Dynamic Senior High School and 55 (55%) from Good Starters Basic School.

Taken together, the combined number of participants in the study was 200, with the experimental group consisting of 100 participants and the control group also comprising 100 participants. Data were collected over a five-month period spanning from September 2012 to February 2013.

For the purpose of analyses, participants in the study were divided into children (7-12 years) and adolescents (13-17 years), in order to ascertain if there were any differences

between the two groups of participants. Theories of human development point to different developmental milestones for these two groups (notably, Berk, 2002; Craig, 1996; Louw & Louw, 2007). The demographic information of the non-orphaned children is presented in Table 3.2.

Table 3.3.

Demographic Characteristics of Orphans in the Present Study

		n (%)
Age groups	Children	41 (41)
	Adolescents	59 (59)
Sex	Males	60 (60)
	Females	40 (40)
Religious affiliations	Christianity	96 (96)
	Islam	3 (3)
School attendance	Yes	97 (97)
	No	3* (3)
School grade	Primary	40 (40)
	JHS	35 (35)
	SHS	22 (22)
No of siblings	None	25 (25)
	One	13 (13)
	Two	18 (18)
	Three	11 (11)
	Four or more	33 (33)
Working status	Yes	5 (5)
	No	95 (95)
Parental status	Maternal orphans	7 (7)
	Paternal orphans	41 (41)
	Double orphans	14 (14)
	Don't know	38 (38)
Duration of parental loss	Don't know	89 (89)
	4–11 years	11 (11)
Age at admission	Birth–7 years	46 (46)
	8–16 years	24 (24)
	Don't know	30 (30)
Duration of orphanage stay	Less than 1 year	9 (9)
	1–3 years	12 (12)
	4–6 years	14 (14)
	More than 6 years	44 (44)
	Don't know	21 (21)

Note. JHS = Junior High School; SHS = Senior High School.

* The three participants had completed JHS and were awaiting the results of their final exams.

Table 3.4.

Demographic Characteristics of Non-orphans in the Present Study

		<u>n (%)</u>
Age groups	Children	41 (41)
	Adolescents	59 (59)
Sex	Males	60 (60)
	Females	40 (40)
Religious affiliations	Christians	95 (95)
	Muslims	5 (5)
School attendance	Yes	100 (100)
	No	0
School grade	Primary	27 (27)
	JHS	28 (28)
	SHS	45 (45)
No of siblings	None	4 (4)
	One	5 (5)
	Two	36 (36)
	Three	32 (32)
	Four or more	23 (23)
Working status	Yes	0
	No	100 (100)

Note. JHS = Junior High School; SHS = Senior High School.

3.4. Measuring Instruments

Several questionnaires were used to gather the quantitative data. These measures are discussed below.

3.4.1. Demographic Questionnaire

A demographic questionnaire was used to gather information pertaining to the participants' background information that included age, sex, religious affiliation, levels of education, number of siblings, parental status (whether or not they had lost a parent), duration of parental loss and employment status. For orphaned children, further demographic information were gathered pertaining to the types of orphanhood, which were paternal (children who had lost a father), maternal (children who had lost a mother) or double orphans (children who had lost both parents), whether they were attending school or not, age at placement, and the duration of stay in the orphanages.

3.4.2. Children's Depression Inventory

The Children's Depression Inventory (CDI; Kovacs, 1992) was used to screen for participants' depressive symptoms. This 27-item measure is symptom oriented and assesses five domains of depressive symptoms; namely, negative mood, interpersonal problems, ineffectiveness, anhedonia and negative self-esteem (Kovacs, 1992). It uses a child-friendly language that and it is recommended for children aged between 7 and 17 years (Kovacs, 1992). Items have three response options ranging from 0 (absence of symptoms) to 2 (severe symptoms) and the total scores range from 0 to 54. Scores are categorised into non-depressive symptoms (10 or less), mild depression (11–18), and severe depression (19 and above) (Kaslow, Rehm, & Siegel, 1984; Smucker, Craighead, Craighead, & Green, 1986). Good psychometric properties including Cronbach alphas ranging from .83 to .89, split-half reliability of .77 to .81, test-retest reliability of .54 to .87, and concurrent validity of .71 to .84 have been established (Kovacs, 1992; Smucker et al., 1986; Weiss & Weisz, 1988). The

internal consistency based on Cronbach's alpha of the CDI for the present Ghanaian sample was .77.

3.4.3. Revised Children's Manifest Anxiety Scale

The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) was used to screen for participants' anxiety symptoms. This measure is made up of 37 items of which 28 items assess the three domains of anxiety symptoms; namely, physiological symptoms, worry and concentration. The other nine items are used to detect lying on the part of participants in order to reduce social desirability. RCMAS is a 'yes-no' response-type of scale and scores range from 0 to 28, with a score of 19 and above suggesting clinical level of anxiety and recommended for children aged between 6 and 19 years (Reynolds & Paget, 1983; Reynolds & Richmond, 1978; Stallard, Velleman, Langsford, & Baldwin, 2001). Cronbach's alphas ranging from .79 to .85, test-retest reliability of .98 as well as good concurrent and discriminant validity for the RCMAS have been reported (Pela & Reynolds, 1982; Reynolds & Paget, 1983; Reynolds, & Richmond, 1978). The internal consistency based on Cronbach's alpha of RCMAS for the present Ghanaian sample was .82.

3.4.4. Kidcope

The Kidcope scale (Spirito, Stark, Grace, & Stamoulis, 1991) measures subjective distress and coping strategies in children. For subjective distress, this measure has a single-item question – "Write down a problem that you have experienced during the prior month" – that requires children to report on any problem, irrespective of intensity. Subsequently, participants are required to read 15 statements pertaining to various ways of coping with the problem reported or identified, and then answer two sets of questions. The first question – 'did you do this [did you make use of each of 15 listed coping strategies]?' – assesses whether or not the coping strategies listed were used, and uses the 'yes-no' response-type question format. The second question – 'how much did it [coping strategy] help you?' – assesses

coping efficacy, and has three-response options that range from 0 ('not at all' – not efficacious) to 2 ('a lot' – highly efficacious). Sample items on the Kidcope include 'I just tried to forget it' and 'I tried to fix the problem by thinking of answers'. For the younger childhood version, which was used in the present study, the coping strategies of distraction, social withdrawal, problem-solving, emotional regulation and wishful thinking have two items on the scale, whereas self-criticism, blaming others, cognitive restructuring, support-seeking and resignation are coping strategies that each have a single item on the scale.

Psychometric values ranging from .41 to .81 for test-retest reliability in the short time, .15 to .43 for a 10-week period, as well as moderate to high-concurrent validity ranging from .33 to .77, have been reported (Spirito et al., 1991; Spirito, Stark, & Williams, 1988).

3.4.5. 14-item Resilience Scale

The 14-item Resilience Scale (RS-14; Wagnild, 2009b) was used to measure participants' levels of individual resilience. This 14-item, self-report is a shorter scale of the 25-item resilience scale, and assesses personal competence and acceptance of self and life, both of which are positive personality characteristics that enhance individual adaptation (Wagnild, 2009b). The RS-14 is a 7-point Likert scale with scores ranging from 1 (strongly disagree) to 7 (strongly agree). Its total scores are categorised into low (14–64), medium (65–81), and high (82–98) resilience (Wagnild, 2009b). Strong psychometric properties that include Cronbach alphas ranging from .72 to .91, test-retest reliability of .84, and good content and concurrent validity have been reported (Abiola & Udofia, 2011; Wagnild, 2009a). In addition to its child-friendly language, and its wide use for all age groups (Windle, Bennett & Noyes, 2011), this measure seems appropriate for the study. The internal consistency based on Cronbach's alpha of RS-14 for the present Ghanaian sample was. 79.

3.4.6. General Self-efficacy Scale

The General Self-efficacy Scale (GSS; Schwarzer & Jerusalem, 1995) was used to assess participants' general self-efficacy. This 10-item self-report measure assesses the general sense of self-efficacy of coping with daily hassles and adapting after the experience of stressors. The GSS has responses ranging from 1 (not at all true) to 4 (exactly true). Internal consistency values ranging from .79 to .91, test-retest ranging from .55 to .75, as well as good criterion, discriminant and concurrent validity have been established across a wide population including children and orphans (Jerusalem, 1990; Kiyiapi, 2007; Schwarzer, Babler, Kwiatek, Schroder, & Zhang, 1997; Schwarzer & Jerusalem, 1995). The internal consistency based on Cronbach's alpha of GSS for the present Ghanaian sample was .79.

3.4.7. Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farlay, 1988) was used to screen for participants' perceived adequacy of social support. This 12-item measure assesses perceived social support (PSS) from three sources (family, friend and significant others). The MSPSS is a 7-point Likert scale, with scores ranging from 1 (strongly disagree) to 7 (strongly agree), with a higher score reflecting a greater perceived social support. Good psychometric properties for the MSPSS have been reported, including internal consistency values ranging between .69 and .90 for the subscales, and .79 and .89 for the entire scale (Cluver, Gardner, & Operario, 2008; Getachew et al., 2011). The internal consistency based on Cronbach's alpha of MSPSS for the present Ghanaian sample was .87.

3.4.8. World Health Organisation Quality of Life-BREF Version.

The World Health Organisation Quality of Life-BREF Version (WHOQOL-BREF; WHOQOL GROUP, 1998) was used to measure participants' perception of their overall quality of life. This 26-item measure contains four major domains of quality of life; namely,

physical, psychological, social, environment and a global estimate. Items are scored on a 5-point scale, with scores ranging from 1 (low) to 5 (high), and the higher scores denote the higher quality of life. High internal consistency values that range from .66 to .86, test-retest reliability ranging from .66 to .87 as well as good discriminant and construct validity values have been established with wide range of samples across cultures (Garcia-Rea & LePage, 2010; Skevington, Lofty, O'Connell, & WHOQOL Group, 2004; WHOQOL Group, 1998). The internal consistency of the WHOQOL-BREF based on Cronbach's alpha for the present Ghanaian sample was .79.

3.5. Ethical Considerations

Studies involving orphaned children are sensitive and thus require careful ethical considerations at all stages of the research. Ethical considerations guide the researcher against any form of abuse of participants' rights and also help to protect informants (Fraser, Lewis, Ding, Kellett, & Robinson, 2004). In the present study, ethical issues pertaining to informed consent, non-harmful procedure, confidentiality, anonymity and voluntary participation were considered.

The research began after the Research Ethics Committee: Non-Health (Humaniora) at Stellenbosch University had given clearance for the study to be conducted. Permission to access orphanages was obtained from the Department of Social Welfare in Accra, Ghana. Additionally, permission to access public schools was obtained from Ghana Education Services in Accra. Furthermore, permission was obtained from the administrators of the orphanages and head teachers of the public schools used in the present study. Moreover, written informed consent was obtained from the parents of the non-orphaned children as well as from the legal guardians and administrators designated to give 'parental' consent for the orphaned children. Lastly, informed assent was obtained from all children who participated in the study.

The American Psychological Association (1992, 2002) recommends non-harmful procedure when conducting research with participants. Children in the present study were not subjected to any physical risk. Psychologically, the interviews could have induced emotional distress; however, care was taken to eliminate this possibility. Before the interviews began, rapport had been established with the participants in order to make them feel comfortable. Due to the sensitive nature of the research, only the researcher and a trained research assistant (both had experience in conducting interviews with vulnerable individuals) conducted the interviews with the participants. The participants were closely monitored for any signs of emotional distress during the interviewing process. Questions that brought up emotional distress in the children were handled with care, and the children were reminded that they could refuse to answer any question that made them feel uncomfortable. Due to the sensitive nature of the research, counselling services were also made available to participants who might require psychological services following participation in the present study. Despite these plans, however, no participant expressed nor even implicitly displayed (at any time during the course of data gathering) the need for the counselling services that were made available.

To adhere to the ethical principle of confidentiality, questionnaires were securely stored out of reach of unauthorised individuals. To ensure anonymity, codes were used to identify the participants and the children were assured of the confidentiality of their responses and that their identity would remain anonymous. The participants were also assured that their participation was voluntary, that they had the right to decline to participate in the study (even when consent from administrators and legal guardians had been obtained) and that they had the right to withdraw from the study without any consequences to them. More importantly, regarding the orphaned children, the right to decline participation even when the administrators had given consent was emphasised, given that the orphans were identified

through the assistance of the orphanage administrators. Participants and their parents or legal guardians were also encouraged to contact the researchers with any further questions. To show appreciation for their participation, participants were each given a monetary value of Five Ghana Cedis (Ghanaian currency that is equivalent to US\$ 2 or R17 – seventeen South African rands).

3.6. Procedure

After the researcher had obtained permission to access the orphans placed in the orphanages and the school children in the public schools, days were set for data gathering. Quantitative data were gathered, followed by the gathering of qualitative data. The gathering of data was carried out by the researcher and a research assistant who had been trained and had experience in interviewing vulnerable individuals. The research assistant was remunerated for the work done. The data gathering process began with a visit to each research setting, followed by an introduction of the researcher and research assistant, an explanation of the purpose of the research, the seeking of informed consent and assent as well as the establishment of rapport. Of note, data gathering from Saver Foundation, Haven for Orphans Foundation and God Saves Orphanage was carried out by only the researcher, as requested by the administrators of the respective orphanages.

Participants were identified with the aid of the orphanage administrators and the head teachers of the schools. Identified children were approached by the researcher and research assistant, after which the purpose of the research was explained and ethical issues were emphasised. Children who gave informed assent were then interviewed. Some of the older participants opted to fill out the questionnaires by themselves. Those children were given the questionnaires to be completed, and they consulted the researcher and assistant for clarifications when they needed to. Children who did not request to fill out the questionnaire

by themselves were interviewed on the questions in the questionnaires by the researcher or the research assistant.

Upon completion of the quantitative phase of data gathering, the researcher went through the responses of the orphans in order to identify those participants who could be interviewed in order to explore their subjective experiences of placement in an orphanage. Orphans were selected for the follow-up interviews based on their age, gender, time since parental loss, duration of stay in the orphanages and the scores on the measures. The follow-up interviews were conducted exclusively by the researcher and were audio-taped after having obtained informed assent from the participants. The duration of completion of questions in the questionnaire ranged from 40 minutes to an hour, while the follow-up interviews lasted for about 25 to 35 minutes.

3.7. Data Analyses

The quantitative data were analysed using STATISTICA and SPSS (version 20.0 for windows) computer software packages in consultation with Professor Martin Kidd at the Centre for Statistical Consultation in Stellenbosch University. To test for normality of the data for all the variables, descriptive statistics were used to analyse the data for skewness and kurtosis. For skewness, the values ranged from -.92 to 1.10, and for kurtosis, the values ranged from -1.05 to 1.62. These values were within the acceptable range (i.e., from -2 to +2) and thus indicated that the data did not violate the assumption of normality (West, Finch, & Curran, 1995). Moreover, although the study used a non-probability sampling technique for selecting participants, parametric statistics were included in the analyses of data because the data met the criteria for parametric statistical tests (Taylor & Francisco, 2005). These criteria included (1) The use of continuous variables (depression, anxiety, perceived social support, self-efficacy, resilience and quality of life), (2) Large sample size, (3) The groups (orphans

and non-orphans) were independent of each other, and (4) the scores on the variables were normally distributed as indicated by the values for skewness and kurtosis.

The independent sample t-test was used to ascertain the differences between the orphans and non-orphans groups on pertinent variables of the study. The Chi-square test (χ^2) was used to compare differences between orphans and non-orphans on reported problems and coping strategies that were indicated by participants on the Kidcope scale. One-way analysis of variance (ANOVA) was used to compare differences between orphans and non-orphans on overall quality of life, depression, anxiety, perceived social support, perceived self-efficacy and resilience. The Pearson correlation coefficients were used to determine association between depression, anxiety, coping strategies, self-efficacy, resilience, perceived social support and the overall quality of life of the participants. Regression analyses, the included multiple and stepwise regression were used to explore variables that emerged as predictors of quality of life, depression, anxiety and resilience.

The qualitative data were analysed using the 7th version of Atlas.ti (Muhr, 1991). Content analysis was used to analyse and categorise reported problems on the Kidcope scale. Thematic analysis was used to analyse the follow-up interviews in order to identify and report patterns within the data (Boyatzis, 1998).

The results and findings of the study are presented by means of five separate manuscripts in the following chapters: Chapter four presents a conceptual paper in which the findings of the literature review on orphanhood and the psychological well-being of orphans in Africa. Chapter five is an empirical manuscript where the results of the statistical relationship between stress (as indicated by the symptoms of both depression and anxiety), coping and the overall quality of life of the orphaned children, in comparison to the non-orphaned controls are presented. Chapter six is an empirical manuscript where the results of the statistical relationship between problems, coping and coping efficacy of the orphaned

children, in comparison to their non-orphaned controls are presented. Chapter seven is an empirical manuscript where I present the results of the statistical relationship between stress (as indicated by the symptoms of both depression and anxiety), perceived social support, perceived self-efficacy and subjective evaluation of personal resilience of the orphaned children, in comparison to the non-orphaned controls. Chapter eight is an empirical manuscript where I present the results of the thematic analyses of the follow-up interviews regarding the subjective experiences of the orphaned children.

Chapter 4: Manuscript 1

Title: Does it still take the whole community to raise a child? Presenting a case for psychological research on orphanhood in the African context.

Authors: Joana Salifu Yendor & Nceba Z. Somhlaba

Brief Summary: In this conceptual manuscript, the review of literature on the psychological well-being of orphaned children is presented. We discuss the lack of research on the subject of orphanhood in the African context and the need for psychological research on the well-being of orphaned children in Africa. We also discussed the social context of orphanhood in Africa, the psychological effects of parental loss on well-being, the impact of poverty, little governmental involvement in orphan care, the merits and demerits of foster care and institutionalisation of orphan in the context of the prevailing socio-cultural African child-rearing practices and outline the implications thereof in orphanhood research, policy making, and possible avenues for intervention, regarding orphan care.

Status: The manuscript was, as of 27 November 2014, still under review

4.1. Abstract

Given the increasing number of orphans in Africa due to the HIV and AIDS epidemic, orphanhood is becoming a psychosocial challenge. The extended familial system of child care, traditionally the pinnacle of caring for orphans in the African continent has been weakened, with extended families being often unable to cater for orphaned children. The weakening of the extended familial system of child care and the effects of other contextual factors that will be discussed in this paper have led to vulnerabilities in African orphans, but little is known about their psychological well-being. In this paper, we discuss the social context of orphanhood in Africa, the psychological effects of parental loss, the impact of poverty, little governmental involvement in orphan care, the impact of cultural practices and the comparison of foster care and institutionalisation. The paper concludes with an argument for the need for psychological research and psychological contributions to the crisis of orphanhood in Africa.

4.2. Introduction

While the subject of orphanhood (being bereaved following the death of, or neglect by, either or both parents) in Africa has become one of the central issues in academic research in the past few decades (Grant & Yeatman, 2012), it seems that the loss of a parent in the African context is continually a major psychosocial problem (Abebe & Aase, 2007). The growing psychosocial concern regarding orphanhood has resulted mainly from the rise in the HIV and AIDS epidemic, the deaths from which have been the cause of the growing number of orphans in Africa (Abebe & Aase, 2007; Grant & Yeatman, 2012; Matshalaga & Powell, 2002; UNAIDS/ UNICEF, 1999; UNICEF, 2009). Notable studies in Africa that have been conducted on parental loss include those in countries such as Ghana (Doku, 2009), Uganda (Dalen, Nakitende, & Musisi, 2009; Segendo & Nambi, 1997), Kenya (Kiyapi, 2007), Zimbabwe (Nyamukapa et al., 2010), Eritrea (Wolff & Fesseha, 1999), as well as South

Africa (Ntozi, Ahimbisibwe, Odwee, Ayiga, & Okurut, 1999). Research in different parts of the continent has also revealed that factors that include living in conditions of poverty, with limited means of providing for the children's needs, render many parents unable to look after their children. This results in many children being socially orphaned through pervasive parental neglect (Morantz et al., 2013), and the surge of orphaned children closely linked to the weakening of traditional (extended-familial) means of caring for orphans, thus increasing the vulnerabilities of such children (Foster, 2000). These factors highlight the increased susceptibility of African orphans for being at risk for poor mental health – given the lack of nurturance and emotional climate for their social-emotional development. However, a review of the literature reveals that very little is known about the mental health of orphans in Africa due to lack of research on this specific area. This paper argues for the need for psychological research in the area of orphanhood in the African context, highlighting areas that could be areas of social science and psychological research. The emotional needs and overall mental health of the orphaned children in Africa, given the heightened emotional vulnerability, should be the focal point of child development research in the continent.

4.3. Parental Loss and Psychological Well-being

Parents play various roles in children's physical and psychological development; research suggests that, as early as infancy, parents provide care and nurturance to infants through material and emotional resources that are essential for physical growth, survival and health (Shaffer, 1993). As children mature physically and emotionally, and when safety and survival are incorporated into other forms of child rearing, parents incorporate into child rearing the training and socialising skills that are necessary for independent sustainability, status, prestige and self-fulfillment. Parental involvement is thus important for positive child development and has been highlighted to relate to positive social, emotional and cognitive development in children (El Nokali, Bachman, & Votruba-Drzal, 2010; McWayne, Hampton,

Fantuzzo, Cohen, & Sekino, 2004; Miedel & Reynolds, 2000; Shaffer, 1993; Supplee, Shaw, Hailstones, & Hartman, 2004). Given the significant role that parents play in the physical and emotional development of children, the loss of a parent in childhood can adversely affect children's psychological well-being.

The concept of 'loss in childhood' has been used to refer to circumstances that deprived children of the care of primary caregivers, such as the death of parents, neglect and abuse by uncaring parents or surrogates (Garmezy, 1988; Keenana, 2014). The effect of parental loss on children's mental health and well-being has been articulated by several researchers. Studies in the developed world have established that parental loss through death can have potential adverse effects on children's psychological well-being due to children's developmental vulnerabilities (Li et al., 2008). After parental death, the process of grieving is noted to be necessary for the resolution of the loss towards healthy maturation in children (Clark et al., 1996). However, children have been noted to be disadvantaged in this process. In a review, Li et al. (2008) listed factors that can impede children from going through the natural grieving process. These factors include children's intellectual immaturity, inability to sustain emotion, dependency on caregivers, incomplete individuation, loss of primary attachment and secondary loss. These factors prevent children from understanding the finality of the concept of loss, as a result, they are unable to grieve properly and end up with unresolved and complicated grief. Unresolved and complicated grief has been cited as potential risk factors for poor psychological well-being (Lannen, Wolfe, Prigerson, Onelov, & Kreicbergs, 2008).

The presence of supportive adults to help children identify and work through the process of loss is also important. However, it has been noted that there are instances where adults who live with bereaved children assume that children do not understand death and therefore do not grieve (O'Connor & Templeton, 2002). These adults try to shield children

from the direct realities of death, which in turn, worsens the grief process as adults do not help children to identify and work through the grief. Unlike adults, children have been found to react to loss mostly by seeking attention through acting out behaviours, becoming anxious about being separated from their parents, conversing repetitively about the dead, exhibiting sleep problems, difficulties at school, eating problems and somatic reactions (Westmoreland, 1996). As these behaviours are typical behaviours of children, adults who live with bereaved children are unlikely to relate these behaviours to parental loss. The above-mentioned scenarios can result in normal reaction to loss going unrecognized and unaddressed. Children can therefore be at risk of growing up with unresolved emotions that can lead to emotional and behavioural problems (Li et al., 2008).

Although parental loss has been associated with poor psychological well-being in children, it has been argued that such loss alone does not lead to psychopathology. Rather, the personal and social circumstances surrounding the child that precede and follow the loss are risk factors for psychopathology in children (Luecken, 2008; Rutter, 1995). This suggests that parental loss can indirectly lead to psychopathology through exposure to adverse circumstances before and after the loss of the parents. In this regard, several contextual and individual child factors have been highlighted to moderate or mediate the impact of parental loss on children's mental health.

Individual child factors such as the age and sex of children have been reported to influence the emergence and the forms of child psychopathology subsequent to parental loss (Dowdney, 2000; Dowdney et al., 1999), with girls found to show more internalising disorders (e.g., depression, anxiety, and low self-esteem). Boys on the other hand present with more externalizing disorders (e.g., conduct problems, aggression and hyperactivity). Dowdney and colleague also found that bereaved boys show higher psychological distresses than girls. This finding is expected given that boys, due to their genetic disposition and

socialisation, tend to show behaviours that are outwardly aggressive. Hence the higher prevalence of externalising disorders in boys. Girls, on the other hand, are socialised to direct their emotions inwardly, hence the higher prevalence of internalising disorders in girls than boys (Delfos, 2004). Regarding age, Harrington (1994) reported that the rates of depression following parental loss increase with children's age, such that, while the rates of depression are approximately equal between boys and girls in middle childhood, by adolescence depression is more common in girls than in boys. The age and gender disparity in the presentation of depression is not peculiar to the context of loss and has been associated with the interaction of biological, genetic, psychosocial and family factors (Nolen-Hoeksema, 2002; Nolen-Hoeksema & Girgus, 1994; Wichstrøm, 1999).

In addition to the individual child factors, parental loss has been found to initiate a series of negative events that lead to long-lasting changes in children's environment and have persistent effects on children over time (Maier & Lachman, 2000). For example, following parental loss, children are likely to experience secondary stressors such as stigma, social changes, loss of income, the possibility of missing and dropping out of school, poor nutrition, health problems, child labour, physical and sexual abuse (Thompson et al., 1998). In addition, Maier and Lachman have also highlighted that parental loss through death and divorce can result in stressors such as reduction in financial resources and social support (from parents and peers). Such stressors, in turn, set the stage for other stressors, such as low parent-child involvement, low education, negative health behaviours (including substance abuse and risky sexual behaviours), lack of access to health care, and poor health (both physical and mental). Furthermore, the mental health of the surviving parent, the type of care-arrangements (foster care, kinship care, or institutional care), the quality of care received from caregivers, reduced contact with the surviving parent, disruption of daily and social routines and separation from family members have also been cited as impacting the well-being of children after parental

loss (Li et al., 2008; Luecken, 2008). All these factors can detrimentally affect orphans' psychological well-being. In view of the potentially adverse effects of parental loss on children's well-being, studies in the Western settings have found the presence of symptoms of psychological disorders such as childhood dysphoria, depression and anxiety in orphans (Dowdney, 2000; Van Eerdewegh et al., 1982). Similarly in the African context, parental loss has been identified as a risk factor for poor mental health and has been linked to mental health problems such as suicidal ideation (Behrendt & Mbaye, 2008), trauma, school drop-out, inadequate care, child labour, physical abuse, stigma and discrimination (Nyamukapa et al., 2010), poor schooling outcome (school enrolment and completion), and poor socio-economic status (Case & Ardington, 2006).

4.4. Orphanhood in Africa: The Socio-cultural Context

Traditionally in the African context, during crisis circumstances such as parental death, divorce or parental illness that renders the family unable to fulfil their child-rearing roles to children, the extended family bond and the practices of fostering are valuable resources (Goody, 1982; Pillai & Sharma, 2013). An African adage that highlights that it takes the whole village to raise a child (Exil, 2012; Mohamed, 1996) also seems to have gained resonance in other contexts such as the United States of America (for example, Palmer & Gasman, 2008; Tomlin, n.d.). What is of particular interest is when children lose their primary caregiver, the extended family system provides social security and care through the practices of fostering (Goody, 1982). The care for orphaned children was so strong such that orphans were catered for even when the 'adoptive' families did not have enough resources for their existing member. It is therefore not surprising that the concept of social orphans was previously believed to be non-existent in the African context (Foster, 2000). With this system, orphans were shielded from the adverse effects of losing a caregiver.

Recent reports have consistently cautioned that, although the extended families continue to cater for children of deceased family members (George, Govender, Bachoo, Penning, & Quinlan, 2014; Grant & Yeatman, 2012), the safety net provided by extended families for orphans is increasingly getting weak (DeSilva et al., 2008; Foster, 2000) due to the growing number of HIV and AIDS-related deaths. These deaths have overwhelmed the extended families and rendered them unable to care for all orphans (Foster, 2000; Grant & Yeatman, 2012), making the pursuance of the ideal of community involvement in raising an orphaned child increasingly difficult. In addition to the increase in HIV and AIDS infection, Foster noted that the recent trends of Westernisation, rural-urban labour migration, formal education, and change in location are some of causes of the weakening of the extended families' safety net as it has led to less contact among family members, especially in the urban areas. Also highlighted are the effect of starvation, extreme poverty and war that have limited the extended families' resources and have thus limited their ability to cater for all orphans (DeSilva et al., 2008).

While the weakening of the extended family safety for orphans is of concern, the impact of poverty cannot be ignored. Children growing up in scarce-resource contexts have been noted to be at risk for poor physical and emotional development due to the impact that poverty and material deprivation have on well-being (Richter, Dawes, & de Kadt, 2010). Sub-Saharan Africa is currently the poorest region in the world, with as much as 45 per cent of the population living below the poverty line (Statistical Economic and Social Research and Training Centre for Islamic Countries [SESRTCIC], 2007). The report further highlights that Sub-Saharan Africa is also the only region where the proportion of people who are below the poverty line has been rising over time and where the poor are relatively worse off than their counterparts in other parts of the world (SESRTCIC, 2007). Poverty increases the risks for under-nourishment and illnesses which in turn can negatively affect children's physical

development (Engle & Black, 2008; Richter et al., 2010). Poverty has also been found to serve as a key predisposing factor to sexual risk behaviour such as transactional sex, early marriage and sexual experimentation among orphans in a Kenyan study (Juma, Alaii, Bartholomew, Askew, & Van den Born, 2013). It has also been noted that parents who have limited resources tend to work more as they need to earn a living to cater for their children (Engle & Black, 2008). These parents tend to have little time away from work to attend to their children and such absence can affect children's emotional well-being (Engle & Black, 2008).

Similarly, African orphans are at greater risk for stunted physical and emotional development due to the high rate of poverty. At the policy level, poverty weakens the capacity of the Sub-Saharan African region to provide adequate health care, basic needs, good sanitation and infrastructure for its communities (SESRTCIC, 2007). Due to limited resources, many African countries are unable to provide adequate care in terms of structures and formal systems specifically for orphans. At the family level, poverty has contributed to reducing the capacity the extended families to cater for orphans in Africa (DeSilva et al., 2008; Foster, 2000). Due to poverty, orphans in Sub-Saharan African are at risk of being malnourished, dropping out of school, and lacking access to good health, all of which can be detrimental to their mental health and future (Morantz et al., 2013). The susceptibility for orphans to be trapped in poverty is also increased due to orphans receiving limited education that can have long-term effects on their economic and financial status (SESRTCIC, 2007).

Although parental death and subsequent orphanhood are not new in the continent, the current trend of AIDS in Africa has worsened the condition of orphans (Leyenaar, 2005). Sub-Saharan Africa has the highest prevalence of the disease and account for an estimate of 69 per cent of all people living with HIV (UNAIDS, 2012). The region also stands as mostly affected by the HIV and AIDS epidemic when compared to other continents with nearly 1 in

every 20 adults living with HIV (UNAIDS, 2012). Given that heterosexual intercourse is one of the primary mode of transmission for HIV (UNAIDS, 2012), the probability of both parents getting infected and possibly dying from the infection is high (Leyenaar, 2005). This leads to an increase in the likelihood of children experiencing multiple deaths resulting from the death of both parents (Cluver & Gardner, 2007). The duration of time between HIV infection and possible death from AIDS also exposes children to prolonged trauma of witnessing parental illnesses. The experiences of multiple death and prolonged exposure to parental illnesses can be traumatic for children and can be a source of added risks to their mental health. Additionally, HIV and AIDS often affect young adults who are the working population of a country (Leyenaar, 2005). The illness and deaths resulting from the disease has contributed to the increase in poverty levels as a result of the young adults who form the majority of the working population dying from the disease (Nyambenda, Wandibba, & Aagaard-Hansen, 2003).

Orphanhood in Africa is also compounded by the little involvement of the government in the care for orphaned children. Formal structures and systems such as formal foster care (where orphans are cared for by non-related families) and adoption are either not in existence or are rarely utilised. In the developed world, where formal institutions and structures exist, orphaned children who do not receive support from families are cared for by the governments within their countries (Bailey, 2009). Upon assessment, orphans who do not have support from their family members are integrated into care systems such as foster care, adoption and when necessary institutions. In Africa, however, where traditional kinship or community care used to be the greater source of care, the increased in the HIV and AIDS infection and financial burden on families has weakened the extended families' ability to care for orphans (Bailey, 2009; DeSilva et al., 2008; Ntozi et al., 1999). As a result, in circumstances where orphans do not receive support from the extended families, they are left to fend for themselves

– a factor that increases their vulnerability to end up in child-headed households or living on the streets (Sengendo & Nambi, 1997; UNICEF/ International Social Service, 2004). Despite the problems with the African traditional means of orphan care, many African countries still lack formal structures and systems for the care of orphans.

In addition to the impact of the health crises and poverty on orphanhood, certain cultural practices in Africa, such as inheritance, can be a source of added financial risk to orphans. In patrilineal societies in Africa, children belonged to the husband and his family (Ntozi et al., 1999). After the dead of a parent, clan members (of the patrilineal family) make most of the decisions concerning who cares for the orphaned child(ren) (Ntozi et al., 1999). In a circumstance where the father is deceased, the surviving mother is sometimes prevented from caring for her children. These children are more likely to end up living with paternal relatives (aunts, uncles and other members of the deceased father's family) (Ntozi et al., 1999). It has been noted that children's separation from their mother following their father's death increases the chance of them being isolated, maltreated and discriminated against compared to the biological children in their 'adoptive' home (Cluver & Gardner, 2007).

Moreover, the sex of the deceased parent and the sex of the orphaned child can also be a source of distress to the orphaned child. For example, in an Ugandan study of 1206 households that have experienced death(s) of family members, Ntozi et al. (1999) found that the death of a father in patrilineal societies increases the chance of orphaned children (irrespective of their sex), losing the valued family possessions and assets left by their deceased father, especially when they are dispossessed by the father's relatives. This tends to increase orphaned children's financial burden as a result of them losing their father's possessions. Ntozi and colleagues have also noted that the gender of the orphaned child in these patrilineal societies determines how the relatives relate to the child following parental loss, more value is placed on male children than on female children, due to the males being

considered as those who continue the patrilineal family line. In this context, being a female orphan place the child at a risk of receiving less support or being maltreated compared to the male orphan (Ntozi et al., 1999).

Furthermore, there are certain socio-cultural African belief systems that can also be a risk factor for children becoming orphaned early in their lives and thus losing their caregiver(s). For example, there is a belief that HIV and AIDS are caused by witchcraft or ancestral curse (Seeley et al., 1993). Dalen et al. (2009) found that patients who held such beliefs were more likely to resort to traditional treatments than Western treatments (antiretroviral medications) and were more likely to have died earlier than they would have if they had used antiretroviral medications. They further found that community members who also held such beliefs were more likely to blame the infected parents for getting infected and they limit the amount of support they gave to the patients. Such beliefs also affect the kind of support the surviving children received after the death of their parents. These orphans were less likely to receive social support and more likely to be stigmatised, as a result of them losing their parents from AIDS and the beliefs that they might also be infected (Dalen et al., 2009; Seeley et al., 1993). All of these factors thus increase the likelihood of orphans ending up on the street or in child headed house-holds. Also cited is the cultural belief that children do not experience emotional problems (Segendo & Nambi, 1997). This belief system, although not unique to Africa, also increases the probability of orphans' emotional problems going unnoticed and unresolved. Segendo and Nambi noted that unresolved emotions associated with parental loss can lead children to develop mental problems such as complicated grief and depression.

4.5. Foster Care versus Institutionalisation

The bulk of the Western and African literature on orphanhood suggests that the living conditions of orphaned children following parental loss determine the mental health outcome

of orphans (Bailey, 2009; Foster, 2000; Li et al., 2008). In the Western settings, formal institutions and structures that assess and care for orphaned children are reported to be in place (Bailey, 2009). This system makes orphan care easy and accessible to those children who might be in need of such services. In contrast to the Western setting, child care after parental loss in the African context has traditionally been provided by extended families and the community (Bailey, 2009; Foster, 2000; Goody, 1982). However, due to various factors that include HIV/AIDS epidemic and poverty – which already place considerable burden on the functioning of these extended ('adoptive') families – concerns have been raised that the extended families are often unable to fully integrate orphaned children into their care (Foster, 2000). The absence of alternative care for these children has resulted in them being on the street and placed in institutions of care. Although institutions for orphans provide care for some orphaned children, they have been associated with potentially adverse conditions such as negative relationship between the children and their caregivers (Kristiansen, 2009), corruption (Colburn, 2010), the exploitation of visitors and the misuse of funds (Pyper, 2010), and emotional deprivation resulting from the absence of a maternal figure in the institutions (Daunhuaer et al., 2005; Ellis et al., 2004; Rutter, 1979). All of these factors can negatively affect the mental health of orphaned children and the symptoms of poor mental health persist even when orphans leave the orphanages (Sigal et al., 2003). The results of poor mental health in orphanages have led to the recommendation of deinstitutionalization, adoption and foster care in the Western settings (Johnson et al., 2006). Although foster care is being promoted as the better care arrangement compared to institutionalisation (Ahmad et al., 2005a; Beard, 2005; Johnson et al., 2006; Smith, 1995), studies have found that foster care can also be problematic (Morantz et al., 2013; Thomas & Mabusela, 1991) and that institutional placement can be a tenable option for the care of orphans (Kodero, 2000).

Upon the review of the African literature, it seems that little is known about the psychological effects of placing orphans in institutions of care (Hermenau et al., 2011). The few existing studies have also reported inconsistent results, with some studies reporting positive mental health of orphans placed in institutions (Aboud et al., 1991; Kodero, 2000; Zimmerman, 2005), whereas others have reported negative effects of such placement (Fawzy & Fouad, 2010; Hermenau et al., 2011; Wolff & Fesseha, 1999). Beard (2010) also argued that institutional placement in Africa is culturally unacceptable because institutions only provide help to only a small percentage of children and have age restrictions, thus leaving majority of children with no option than living on the streets. Beard further argued that institutions are unable to provide African traditional family setting, as a result when the children leave the institutions, they are unable to reintegrate into African society. Moreover, institutions in Africa have been reported to be unable to prepare young adults for productive lives outside of the institutions (Mohangi et al., 2011). As result, children placed in institutions are unable to function optimally when they leave the institutions. These problems can lead to financial difficulties and poor social skills following placement and can further contribute to stress in children who live in orphanages.

Documented literature evidence points to several ways in which foster care can also be problematic in Africa. It is worth noting that due to the existence of traditional fostering operated by the extended family system in Africa, fostering practices were informal and did not involve legal processes (Thomas & Mabusela, 1991). However, the breakdown of the traditional family bond, resulting from political unrest and poverty, the traditional fostering practices has been weakened and has resulted in circumstances where some children lack care from their families. The advent of formal fostering has created opportunities for children who lack care from their families to be catered for by families through government support (Thomas & Mabusela, 1991). However, foster care involving a non-relative (a person who is

not related to the orphaned child) is rare in the continent because such practice is culturally unacceptable in some African countries (Wolff & Fesseha, 1999). In some African countries (such as Ghana) that practise formal foster care, people rarely ‘adopt’ foster children whom they are not related to (MESW & UNICEF, 2010). This raises the concern that orphans who do not have surviving relatives are less likely to get foster parents. Moreover, problems of inadequacy and delay of foster care grant, few available foster parents for a large number of children in need of care as well as the old age of the foster parents (who themselves need care) have also been found to rendered some foster families unable to adequately care for children in their care (Thamas & Mabusela, 1991). These factors can adversely impact on the well-being of children in foster care in the African context.

It has also been noted that in instance of informal foster care (that involve extended families), the complication with many foster families is that they also have problems that impact on functioning, and these include large family size and limited resources to sustain their livelihoods (Freeman & Nkomo, 2006; Segendo & Nambi, 1997). Therefore, taking on orphans into these families becomes an additional burden on the adoptive families’ limited resources – a factor that makes adoption of orphaned children unappealing, even when the families would want to help out. Furthermore, it has also been reported that orphans experience abuse and unequally treatment in the foster homes further adding to their distress (Cluver & Gardner, 2007; Morantz et al., 2013). Furthermore, the age of the foster parents is documented as a potential hindrance to the adequate care of orphaned children in the African context, with literature pointing to challenges associated with foster families’ lack of preparedness for caring for the orphans. In some cases, foster families might be too young or too old to offer proper care to orphans, with the result that discipline, routine setting and socialization are not adequately enforced (Hunter, 1990). All of these factors contribute to the stress levels of orphans who are placed in foster care.

It would seem that the issue of whether placement of orphans in orphanages or in foster homes promotes well-being and overall mental health has received attention in African research (albeit in limited studies). For example, in a Kenyan study that compared the psychological and educational status of orphans placed in orphanages, guardian homes and extended families, Kodero (2000) found that of the three groups, orphans in extended families reported the highest psychological distress and lowest educational attainment, whereas orphans in orphanages presented with the least mental health problems and highest educational attainment. Kodero argued that the placement of orphans in orphanages is better than placement with extended families because orphanage placement was associated with good mental health in the orphaned children. Zimmerman (2005), in a Malawian study, also found that orphans living in orphanages fared better in their psychosocial life (with regards to autonomy, concept of the future and relationship with caregivers) than those in foster care. Zimmerman concluded that orphanages were more efficient in providing care for orphans than foster care because orphanages were able to adequately provide basic needs as well as emotional support to the orphaned children. The above findings, although from limited research, suggest that orphanage placement in Africa can be a tenable form of orphan care. Empirical data that compare the psychological functioning of orphaned children placed in orphanages with that of orphans placed in foster homes could offer valuable insights into whether placement in orphanages is inherently linked to better mental health outcomes.

A closer look at the subject of orphan care in Africa brings certain issues to light. It is agreed that the African culture promote placement of orphaned children with relatives as such placement provided orphaned children with family settings. However, the realities of modern life that place huge financial burden on families have made such placement unfeasible and that placement of orphaned children in institutions has become a plausible option. However, the problems that have been identified with orphanages raise concerns about the well-being of

orphaned children who are placed in orphanages and have questioned the consideration of orphanage placement as a viable option of orphan care. The problems identified with orphanages tend to reinforce the notion that orphans are best cared for by relatives, although this option is not always feasible. Given the limited options of orphan care available in African context and that each option has considerable advantages and disadvantages, it is important that attention be given to the limited available orphan care and the potential impact of these care arrangements on the mental health of orphans should be evaluated.

4.6. Contribution of Psychological Research

Having reviewed the literature on the subject of orphanhood in the African context, with the paucity of research on the subject that the review reveals, two major issues that have already been discussed, merit further emphasis. First, as discussed, it is generally acknowledged that parental loss is a stressful experience that in turn potentially leads to poor psychological well-being. Second, there is a growing concern about the weakening of the extended family safety net that traditionally provided support for orphaned children, which has resulted in many extended families unable to care for orphans that supposedly should be in their care – hence our contention that socio-economic living conditions imposed on extended families make these families unable to look after these orphaned children (with the subsequent lack of support having a detrimental effect on the well-being of orphans).

Regardless of the acknowledged impact of parental loss and the weakening of the extended family safety net on African orphans' psychological well-being, the response to the crisis of orphanhood (mainly from the international donors and in their own countries) has mainly been on the provision of material resources to orphans (Drah, 2012), with minimal attention being devoted to their psychological well-being and emotional needs (Dalen et al., 2009). Additionally, relatively little is known about care arrangements and the effects of these arrangements on orphans' mental health. As a result of the factors highlighted above, the

psychological functioning, including the subjective experiences and overall well-being of orphans in Africa, still remain outside the ‘gaze’ of social science research due to limited scholarly work in this specific area. Against this background, research on the subjective experiences and the psychological well-being of orphans in Africa is warranted.

Studies that are devoted to identifying the risk- and protective factors associated with orphanhood in the African context, with the view of informing intervention approaches and guiding policy makers about best strategies for prevention of mental health problems in orphans, are therefore needed. Finally, and as alluded, orphanhood in Africa is seemingly rooted in socio-cultural practices that include child-rearing and orphan care. Against this background, we are interested in also ascertaining the extent to which psychological research on orphanhood could advance via an interdisciplinary approach that includes ‘voices’ from other disciplines (for example, anthropology, sociology, social work) on the subject.

Chapter 5: Manuscript 2

Title: Stress, coping and quality of life: An exploratory study of the psychological well-being of Ghanaian orphans placed in orphanages.

Authors: Joana Salifu Yendork & Nceba Z. Somhlaba

Brief Summary: In this empirical manuscript, we explored the statistical relationship between stress (as indicated by the symptoms of both depression and anxiety), coping and the overall quality of life of orphaned children placed in orphanages, in comparison to the non-orphaned children. Guided by the theoretical perspectives on stress, coping and quality of life, we discuss the findings of the vulnerability of both orphaned and non-orphaned Ghanaian children to depression, and especially the heightened vulnerability of the orphaned children to anxiety, and the implications of these for their overall quality of life and psychological well-being. We also discuss the implications of the findings for research and intervention.

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5.1. Abstract

Previous studies have demonstrated that parental loss and orphanage placement can be stressful and can negatively affect the psychological well-being of children. However, studies on the psychological well-being of orphanage-placed children in Accra, Ghana, are scarce and the impact of parental loss and orphanage placement is minimally understood. The aim of the present study is to explore stress (symptoms of depression and anxiety), coping and the overall quality of life of orphaned children in comparison to non-orphans who resided with their parents. We sampled 200 participants aged between 7 and 17 years, with 100 being orphaned children placed in four orphanages (experimental group) and 100 non-orphans from two public schools in Accra, Ghana (control group). The participants completed the Children's Depression Inventory, the Revised Children's Manifest Anxiety Scale, the Kidcope scale and the World Health Organisation Quality of Life-BREF Version. One-way Analysis of Variance reveals that orphaned children show more anxiety symptoms than non-orphans but there are no significant differences between orphaned children and non-orphans on symptoms of depression and overall quality of life. The Pearson product-moment correlation analyses reveal significant correlations between depression, anxiety, coping and quality of life in the orphaned children and non-orphans. Stepwise regression analyses also reveal that for orphaned children, anxiety and support-seeking coping emerge as significant predictors of quality of life whereas depression emerges as a significant predictor of quality of life for the non-orphaned children. The implications of the results are discussed.

5.2. Introduction

The loss of parents during childhood, also referred to as orphanhood in the present study, has generally been considered as stressful and is deemed a risk factor for poor mental health in children (Daniel, 2005; Lata & Verma, 2013; Luecken, 2008; Morantz et al., 2013). Such loss has been found to lead to situations where children are deprived of basic needs, lack

physical, social and emotional support, decline in educational attainment, instances of food insecurity, substance abuse, risky sexual behaviours, inadequate health care, poor physical and mental health, abuse as well as adverse living arrangements that include child-headed household and orphanages (Clark et al., 1996; DeSilva et al., 2012; Gana et al., 2014; Getachew et al., 2011; Lin et al., 2004; Luecken, 2008; Maier & Lachman, 2000; Marais et al., 2014; Morantz et al., 2013; Smart, 2003; Thompson et al., 1998; United Nations International Children's Emergency Fund [UNICEF], 2003). Moreover, depending on the cause of parental loss (e.g., HIV/AIDS), orphans might be stigmatised, and might even lose out on developing meaningful relationships with their peers (Manuel, 2002). All of these factors can lead to mental health problems such as depression, anxiety and poor quality of life in orphaned children (MacLean, 2003; Tweed, Schoenbach, George, & Blazer, 1989; Zeanah et al., 2009). Despite the risk associated with orphanhood, little is known about the psychological well-being of orphans.

In Africa, orphanage placement has become a viable form of orphan care after the systemic failure in the traditional means of orphan care. In the past, traditional practices that created avenues for orphan care, which was kinship fosterage (Ansah-Koi, 2006; Foster, 2000; Kuyini et al., 2009), provided an opportunity for orphans to be raised in the extended-family setting that protected orphans from the negative effects of losing a parent. However, with documented indications that the surge of HIV-and-AIDS-related deaths, westernisation, poverty, war and rural-urban labour migration has seen many extended families unable to provide care for orphaned children (DeSilva et al., 2008; Foster, 2000; George et al., 2014; Seeley et al., 1993), placement of orphans in orphanages has thus become the next available means of raising orphans.

Ghana has recently witnessed an increase in the number of institutional care for orphans as a response to the increasing number of orphans caused by the HIV and AIDS

epidemic thus, making institutional care the easier choice for most families (Ansah-Koi, 2006; Voyk, 2011). These orphanages are estimated to provide care for about 4,500 children (Ministry of Employment and Social Welfare & UNICEF, 2010). Although the orphanages have been noted to care for quite a number of orphans, some concerns regarding the orphanages' activities have been raised. While very few studies have been done in Accra, Ghana, concerns such as negative relationship between the children and their care-givers (Kristiansen, 2009), corruption (Colburn, 2010), the exploitation of visitors and the misuse of funds (Pyper, 2010) have been cited as some of the adverse activities that occur in some orphanages. All of these adverse conditions in the orphanages can negatively affect the mental health of orphans, yet the psychological well-being of orphans has received little attention.

5.3. Placement in Orphanages

Similar to parental loss, orphanage placement has also been cited as a potential stressor for orphans (Browne, 2009; Daunhuaer et al., 2005; Wolff & Fesseha, 1999). Early studies consistently reported that children who were raised in institutions presented with severe developmental, emotional, behavioural and intellectual delays (notably, Bowlby, 1951; Goldfarb, 1943; Spitz, 1949). The findings mentioned above were cited to be caused by the emotional deprivation resulting from the absence of a maternal figure in the institutions during early development (Ellis et al., 2004; Rutter, 1979).

Subsequent to the early studies, later studies using more rigorous methodologies, have also reported similar negative findings (e.g., Johnson et al., 2006; MacLean, 2003; The St. Petersburg–USA Orphanage Research Team, 2005; Zeanah et al., 2009). The later studies also reported developmental, intellectual, academic and language delays, problems with social competence, quasi-autistic behaviour, poor emotional attachment and poor mental health following the institutionalisation of children. Although the severity and duration of the difficulties encountered varied across studies (Browne, 2009), one key finding was that, early

institutionalisation and long-term placement can negatively impact on all aspects of children's development and mental health.

Whereas studies of the effects of institutionalisation on early childhood development have consistently highlighted negative results, studies that examine the psychological effects of orphanage placement on orphaned children have yielded inconsistent results. Some studies have highlighted the presence of poor mental health in orphanage children with the symptoms of depression and anxiety being the commonly reported mental health problems (e.g., Ahmad & Mohamad, 1996; Ahmad et al., 2005a, 2005b; Fawzy & Fouad, 2010; Fisher et al., 1997; Hermenau et al., 2011; Hong et al., 2010; Wolff & Fesseha, 1999). These studies have associated the poor psychological well-being of the orphanage-placed children to lack social support, inadequate basic need in the orphanage, as well as the absence of problem-solving and social skills in the orphanage children. All of these factors are known risk factors for poor mental health in children. The findings of the studies highlighted above suggest that placement in orphanage can negatively impact on the psychological well-being of the orphans concerned. On the other hand, some studies have revealed positive effects of institutionalisation on orphaned children's mental health (notably, Aboud et al., 1991; Emond, 2009; Kodero, 2000; Whetten et al., 2009; Zimmerman, 2005). The positive findings were associated with factors such as favourable management in some privately-run orphanages as well as the availability of basic needs and social support. The positive findings also suggest that orphanage placement can promote the psychological well-being of orphans.

The contradictory results have raised questions about the true impact of orphanage placement on children's mental health and have led to different recommendations regarding placement of orphans in orphanages. Some scholars have argued against institutional placement and have promoted alternative methods of orphan care such as adoption and foster care (e.g., Ahmad et al., 2005a; Beard, 2005; Johnson et al., 2006; Smith, 1995). Others have

also argued that institutional placement should be considered as a last resort (notably Wanat et al., 2010). In contrast, some scholars have argued that institutional placement should be considered as a viable option for orphan care (e.g., Christiansen, 2005; McKenzie, 1997, 1998; Whetten et al., 2009), and might even be more suitable than kinship care (Kodero, 2000).

Given the background outlined above, it can be argued that parental loss and orphanage placement can negatively impact on children's mental health. Despite these findings, the number of orphans in Africa continues to increase due to the recent increase in HIV/AIDS epidemic. Additionally, given the weakening of the traditional safety-net for orphans in Africa, families and government of nations have resorted to institutional care for orphans who lack support. Although the emergence of orphanages has served to provide care for orphans who once were vulnerable as a result of not receiving care from their extended family, the potential negative impact of such placement cannot be ignored. Additionally, although few studies have been done on the issue in Africa, the results of those studies have been inconsistent, thus, warranting research.

Within the Ghanaian context and, specifically in Accra, very few studies have been done on the mental health orphanage children in general. Notable exceptions are two master's theses that examined the subjective experiences of well-being (Adu, 2011) and the quality of life of orphaned children (Kristiansen, 2009). It can therefore be argued that studies that explore the mental health of children placed in Accra orphanages are warranted. In the present study, we assessed the symptoms of depression and anxiety, quality of life and coping strategies of orphans placed in four orphanages in Accra, Ghana. We examined: (1) The overall quality of life and the level of stress (as measured by depressive and anxiety symptoms) of orphaned children relative to non-orphaned children in Accra, Ghana; (2) The comparative coping strategies used by these two groups of children to manage stress; and (3)

The variable(s) that emerged as significant predictor(s) of quality of life in these two groups of children.

Based on the aims, the following hypotheses were formulated. Firstly, previous studies have found that orphaned children present with significantly lower quality of life scores than non-orphaned children (Damnjanovic et al., 2012; Van Damme-Ostapowicz et al., 2007). Based on this, we hypothesised that orphaned children would present with lower quality of life scores than non-orphaned children.

Secondly, orphaned children are reported to show significantly higher anxiety and depressive symptoms than non-orphans (Damnjanovic et al., 2011; Fawzy & Fouad, 2010; Hermenau et al., 2011; Thabet et al., 2007; Wolff & Fesseha, 1999), hence we hypothesised that orphaned children would evince relatively higher depression scores than non-orphans. We also hypothesised that orphaned children would evince relatively higher anxiety scores than non-orphans.

Thirdly, given that the orphans and non-orphaned children experience different stressors due to their parental status and living arrangements (Cluver, Orkin, Gardner, & Boyes, 2012; Hortaçsu et al., 1993; Hong et al., 2010; Şimşek et al., 2008), we hypothesised that there would be differences between these two groups of children on coping strategies used.

Fourthly, in line with the literature that shows an inverse relationship between anxiety and quality of life (Damnjanovic et al., 2011; Stevanovic, 2013; Stevanovic et al., 2011), we hypothesised that anxiety would emerge as significant negative predictor of the quality of life of the orphaned children.

Fifthly, in line with the literature that shows an inverse relationship between depression and quality of life (Damnjanovic et al., 2011; He & Ji, 2007), we hypothesised that

depression would emerge as significant negative predictor of the quality of life of the orphaned children.

Sixthly, consistent with the literature on the positive associations between seeking human contact in times of duress and overall quality of life (Çaman & Özcebe, 2011; Erol et al., 2010; Hong et al., 2010; Şimşek et al., 2007), we hypothesised that social support-seeking coping would emerge as a significant positive predictor of overall quality of life.

5.4. Method

5.4.1. Research settings

Four orphanages and two public schools in Accra, Ghana were used in the study¹. These orphanages were Savers Foundation, Paradise Foster Home, God Saves Orphanage and Haven for Orphans Foundation, and the schools were Dynamic Senior High School and Good Starters Basic School. Data were collected over a five-month period spanning from September 2012 to February 2013.

5.4.2. Participants

Purposive sampling, using pre-determined criteria, was used to select children for the study. For selection of participants placed in the government-run orphanage, orphans were identified through the assistance of the orphanage administrators and social workers. The orphanage administrator assigned two social workers who selected children within the age group of seven and 17 years for participation in the study. Regarding the selection of participants in the private orphanages, the administrators introduced the researcher (first author) directly to all the children who were between the age group (seven and 17 years) and

¹Pseudonyms were used to name the orphanages and public schools used for the present study. This was in order to protect the names of the orphanages and schools as well as possible identification of children living in these orphanages and attending the schools (and in adherence to the ethical principle of ensuring that no inadvertent stigmatisation of any of the participants). Any interested party may contact the first author for information regarding where the present study was conducted.

encouraged them to participate in the study. For the orphaned children, the inclusion criteria were: the age range of between 7 and 17 years; who had lost one or both parents through death or abandonment; resided in an orphanage and were willing to participate in the study. The latter criterion – abandonment – was used to rule out the inclusion of children who, although also staying in orphanages, had indicated that their parents were still alive, even when their whereabouts were unknown. The original pool of 104 children drawn from the orphanages was sampled to participate in the survey. Following the inclusion criteria, four children (3.8%) were excluded from the data analyses on the basis that both of their parents were alive, although these children were residing in an orphanage. After excluding four children, 100 orphaned children placed in orphanages (96.2% response rate) were included in the study. Of the 100 children, 43 (22%) were taken from Savers Foundation, 26 (13%) were from God Saves Orphanage, 20 (10%) were from Haven for Orphans Foundation and 11 (6%) were from Paradise Foster Home.

Consistent with the international research trends on orphans in which the psychological well-being of orphanage-placed children was compared with that of the non-orphaned children in the family set-up, the present study compared orphans placed in orphanages with non-orphaned children who resided with their parents. The non-orphaned children were identified through the assistance of the head teachers and a teacher in each school. In both basic- and senior high school, the head teacher assigned a teacher who identified and invited school children who were aged between seven and 17 years to participate in the study. The non-orphaned participants were included if: both of their parents were alive, they were between the ages of 7 and 17 years, attended public schools in Accra, Ghana, lived with their parents and were willing to participate in the study. The original sample comprised 115 children who were sampled from the two schools, which included Dynamic Senior High School and Good Starters Basic School. Following the inclusion

criteria outlined above, 15 children (13.05%) were excluded from the data for various reasons: 6 participants were orphans and, of these, two had lost either of the parents and four had lost both parents. The remaining nine participants were also excluded because they were above the cut-off age of 17 years. After excluding the 15 children, the non-orphaned sample was reduced to 100 participants (86.95% response rate). Of the 100 non-orphans, 45 (45%) were taken from Dynamic Senior High School and 55 (55%) from Good Starters Basic School.

Taken together, the combined number of participants in the study was 200, with the experimental group consisting of 100 participants, and the control group also comprising 100 participants.

5.4.3. Measures

Provisions were made to translate the measures into the common spoken local language (Akan) should there be the need. However, participants were fluent in the English language, as a result there was no need for translation. Hence, the English version of the measures was used.

5.4.3.1. Demographic questionnaire

A demographic questionnaire was used to gather information pertaining to the participants' background information that included age, sex, religious affiliation, levels of education, number of siblings, parental status (whether or not they had lost a parent), duration of parental loss and employment status. For orphaned children, further demographic information were gathered pertaining to the types of orphanhood, which were paternal (children who had lost a father), maternal (children who had lost a mother) or double orphans (children who had lost both parents), whether they were attending school or not, age at placement, and the duration of stay in the orphanages.

5.4.3.2. Children's Depression Inventory

The Children's Depression Inventory (CDI; Kovacs, 1992) was used to screen for participants' depressive symptoms. This 27-item measure assesses five domains of depressive symptoms; namely, negative mood, interpersonal problems, ineffectiveness, anhedonia and negative self-esteem (Kovacs, 1992). It uses a child-friendly language that and it is recommended for children aged between 7 and 17 years (Kovacs, 1992). Items have three response options ranging from 0 (absence of symptoms) to 2 (severe symptoms) and the total scores range from 0 to 54. Scores are categorised into non-depressive symptoms (10 or less), mild depression (11–18), and severe depression (19 and above) (Kaslow et al., 1984; Smucker et al., 1986). Good psychometric properties including Cronbach alphas ranging from .83 to .89, split-half reliability of .77 to .81, test-retest reliability of .54 to .87, and concurrent validity of .71 to .84 have been established (Kovacs, 1992; Smucker et al., 1986; Weiss & Weisz, 1988). The internal consistency based on Cronbach's alpha of the CDI for the present Ghanaian sample was .77.

5.4.3.3. Revised Children's Manifest Anxiety Scale

The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) was used to screen for participants' anxiety symptoms. This measure is made up of 37 items of which 28 items assess the three domains of anxiety symptoms; namely, physiological symptoms, worry and concentration. The other nine items are used to detect lying on the part of participants in order to reduce social desirability. RCMAS is a 'yes-no' response-type of scale and scores range from 0 to 28, with a score of 19 and above suggesting clinical level of anxiety and recommended for children aged between 6 and 19 years (Reynolds & Paget, 1983; Reynolds & Richmond, 1978; Stallard et al., 2001). Cronbach's alphas ranging from .79 to .85, test-retest reliability of .98 as well as good concurrent and discriminant validity for the RCMAS have been reported (Pela & Reynolds, 1982; Reynolds & Paget, 1983; Reynolds,

& Richmond, 1978). The internal consistency based on Cronbach's alpha of RCMAS for the present Ghanaian sample was .82.

5.4.3.4. *Kidcope*

The Kidcope scale (Spirito et al., 1991) was used to assess participants' coping strategies. The Kidcope scale has a frequency scale that assesses how often children used a particular coping strategy, and an efficacy scale that assesses the effectiveness of the coping strategy used (Spirito et al., 1991). In addition, this measure also assesses subjective distress and additional questions measuring anxiety and depression. In the present study, only the frequency scale and, for ease of assessment and scoring, only the younger childhood version was used. This 15-item self-report measure assesses 10 general cognitive and behavioural coping strategies in children, aged between 7 and 18 years. These are distraction, social withdrawal, wishful thinking, self-criticism, blaming others, problem-solving, emotional regulation, cognitive restructuring, seeking social support and resignation. Psychometric values ranging from .41 to .81 for test-retest reliability in the short time, .15 to .43 for a 10-week period, as well as moderate to high-concurrent validity ranging from .33 to .77, have been reported (Spirito et al., 1991; Spirito et al., 1988).

5.4.3.5. *World Health Organisation Quality of Life-BREF Version*

The World Health Organisation Quality of Life-BREF Version (WHOQOL-BREF; WHOQOL GROUP, 1998) was used to measure participants' perception of their overall quality of life. This 26-item measure contains four major domains of quality of life; namely, physical, psychological, social, environment and a global estimate. Items are scored on a 5-point scale, with scores ranging from 1 (low) to 5 (high), and the higher scores denote the higher quality of life. High internal consistency values that range from .66 to .86, test-retest reliability ranging from .66 to .87 as well as good discriminant and construct validity values have been established with wide range of samples across cultures (Garcia-Rea & LePage,

2010; Skevington et al., 2004; WHOQOL Group, 1998). The internal consistency of the WHOQOL-BREF based on Cronbach's alpha for the present Ghanaian sample was .79.

5.4.4. Procedure

Questionnaire administration took the form of either researcher-administration (in which researcher (first author) and a research assistant asked questions in the questionnaire) or self- administration (in which participants completed the questionnaires by themselves) depending on the participants' age and their ability to read and understand the English language. Participants who did not require assistance in completing the questionnaires were given the questionnaires to complete by themselves without the presence of their peers or orphanage personnel. These were older participants who were aged between 13 and 17 years old. Those who required assistance were interviewed individually on questions in the questionnaires by the main author and a research assistant. These were younger participants aged between 7 and 12 years. All orphaned children participated in the study during their free periods, which was after school periods and weekends in the orphanages. Non-orphans were interviewed during their break periods at the school premises.

5.4.5. Ethical considerations

Before the research began, ethics clearance was obtained from the Research Ethics Committee: Non-Health (Humanoria), at Stellenbosch, South Africa. As part of her doctoral research under which the present manuscript falls, the first author obtained permission to access the orphanages from the Department of Social Welfare in Accra, Ghana. Moreover, the administrators of all orphanages used for the study gave permission for access to the orphaned children. The Ghana Education Service granted permission to access, and conduct research in public schools. The head teachers of the schools gave permission for access to school children for the surveys.

Additionally, written informed consents were obtained from the administrators of the orphanages for orphaned children who had no legal guardians. For those who had legal guardians, informed consent was obtained from their legal guardians. For non-orphaned children, written informed consent was obtained from their parents. Lastly, informed assent was obtained from all children who participated in the study. The researchers assured participants of confidentiality, anonymity and voluntary participation. Participants and their parents or legal guardians were also encouraged to contact the researchers with any further questions. Due to the sensitive nature of the research, counselling services were made available to participants who might require counselling following participation in the present study. To show appreciation for their participation, participants were each given a monetary value of Five Ghana Cedis (Ghanaian currency that is equivalent to US\$ 2 or R17 – seventeen South African rands).

5.4.6. Data analyses

Statistical analyses were carried out using the Statistical Programme for Social Sciences (SPSS, version 20.0 for windows). The independent sample *t*-test and One-way Analysis of Variance were used to compare the differences on scores on the Children's Depression Inventory, the Revised Children's Manifest Anxiety Scale and the World Health Organization Quality of Life-BREF Version between the orphaned children and non-orphans. Although the study used a non-probability sampling technique, the parametric tests (*t*-test and ANOVA) were used because depression, anxiety and quality of life were continuous variables. The Chi-square (χ^2) test for independence was used to compare the differences on scores on the Kidcope scale given the measure uses a no-yes response type which assessed coping as a categorical variable. The Pearson correlation coefficients were used to determine association between depression, anxiety, coping and quality of life. Regression analyses were used to explore variables that emerged as predictors of the quality of life of the participants.

5.5. Results

5.5.1. Descriptive statistics

Descriptive analyses were carried out to explore the demographic characteristics of the participants in the present study. The participants' demographic information is presented in Table 5.1 below. The age for all children (both experimental and control groups combined) ranged from 7 to 17 years ($M = 13.34$ years, $SD = 3.10$; for orphaned children: $M = 13.31$ years, $SD = 3.14$; for the control group: $M = 13.37$ years, $SD = 3.08$). There was no significant age difference between orphans and non-orphans, $t(198) = -0.136, p > .05$. The age for all boys ranged from 7 to 17 years ($M = 13.01$ years, $SD = 3.29$; for orphaned children: $M = 13.03$ years, $SD = 3.29$; for the control group: $M = 12.98$ years, $SD = 3.34$). There was no significant age difference between orphaned boys and non-orphaned boys, $t(118) = 0.083, p > .05$. The age for all girls ranged from 7 to 17 years ($M = 13.84$ years, $SD = 2.74$; for orphaned children: $M = 13.72$ years, $SD = 2.88$; for the control group: $M = 13.95$ years, $SD = 2.62$). There was also no significant age difference between orphaned girls and non-orphaned girls, $t(78) = -0.365, p > .05$.

Table 5.1.

Demographic Information for Orphans and Non-orphans

		Orphans	Non-Orphans
		(n = 100) n (%)	(n = 100) n (%)
Age group	Children (7-12 years)	41 (41)	41 (41)
	Adolescents (13-17 years)	59 (59)	59 (59)
Sex	Boys	60 (60)	60 (60)
	Girls	40 (40)	40 (40)
Orphanhood status	Maternal orphans	7 (7)	
	Paternal orphans	41 (41)	
	Double Orphans	14 (14)	-
	Abandoned children	38 (38)	
Duration of parental loss	Could not recall	89 (89)	-
	Between 4 and 11 years	11 (11)	
Age at placement (M=12.55 years)	Birth-7years	46 (46)	
	8-16 years	24 (24)	-
	Could not recall	30 (30)	
Duration of orphanage stay	Don't know	21 (21)	
	Less than 1 year	9 (9)	-
	Between 1-3 years	12 (12)	
	Between 4-6 years	14 (14)	
	More than 6 years	44 (44)	

5.5.2. Orphaned children and non-orphans on depression, anxiety, coping and quality of life

One-way Analyses of Variance were carried out to compare orphaned children and non-orphans on anxiety, depression and quality of life scores. The results are presented in Table 5.2. Following the cut-off point, which is a score of 19 and above on the RCMAS for clinical level of anxiety, the prevalence of anxiety symptoms in the orphaned children was as follows; 75 (75%) were non-anxious and 25 (25%) were anxious. For the non-orphaned

group, 89 (89%) were non-anxious and 11 (11%) were anxious. Regarding the symptoms of depression in the orphaned group, 59 (59%) were in the non-depressed range (CDI score of 10 or less), 32 (32%) were in the mildly-depressed range (CDI score of 11-18) and 9 (9%) were in the severely-depressed range (CDI score of 19 and above). The results show that 41% of the orphaned children were mildly-to-severely depressed. For the non-orphaned group, 60 (60%) were in the non-depressed range, 31 (31%) were in the mildly-depressed range, and 9 (9%) were in the severe depressed range. The results show that 40% of the non-orphaned children were mildly-to-severely depressed.

Table 5.2.

Summary of ANOVA Results for the Comparison of Scores on the CDI, RCMAS and WHOQOL-BREF for Orphaned Children and Non-orphans

	Orphans	Non-orphans	<i>F</i>	<i>p</i>
	(n = 100)	(n = 100)		
	M (SD)	M (SD)		
CDI	9.71 (5.69)	9.98 (6.41)	0.091	.76
RCMAS	13.55 (6.44)	11.93 (4.31)	4.285	.040*
WHOQOL-BREF: Total	93.91 (11.02)	95.61 (11.33)	1.148	.29
Physical health	24.96 (3.55)	25.57 (3.66)	1.431	.23
Psychological health	21.86 (3.02)	22.04 (3.02)	0.180	.67
Social relationship	10.73 (2.23)	11.18 (2.36)	1.919	.17
Environment	28.22 (4.72)	28.45 (4.62)	0.118	.73

Note. CDI = Children's Depression Inventory; RCMAS = Revised Children's Manifest Anxiety Scale; WHOQOL-BREF = World Health Organization Quality of Life-BREF.

**p* < .05.

The results indicate that there were no significant differences between orphaned children and non-orphans on scores of depressive symptoms, total quality of life, and the four sub-scales of quality of life measure. However, there was a significant difference between orphaned children and non-orphans on scores of anxiety symptoms, $F(1, 145) = 4.285, p < .05$, with orphaned children ($M = 13.55, SD = 6.44$) showing more anxiety symptoms (score of 19 and above on the RCMAS) than non-orphans ($M = 11.93, SD = 4.31$). The results(illustrated in Table 5.2.) confirmed the research hypothesis:

- *Orphaned children would evince higher anxiety scores than non-orphans.*

Chi-square analyses were carried out to compare orphaned children and non-orphans on coping strategies used to manage stress. The results presented in Table 5.3. revealed that there were no significant differences between orphaned children and non-orphans on the proportion of children who used distraction, social withdrawal, wishful thinking, self-criticism, blaming others, problem-solving, emotion regulation, cognitive restructuring and seeking support. However, there was a significant difference between orphaned children and non-orphans on wishful thinking $\chi^2(1) = 5.023, p < .05$. Non-orphans reported to use wishful thinking more often than orphaned children. The results (illustrated in Table 5.3.) confirmed the research hypotheses:

- *There would be differences between orphaned children and non-orphans on the types of coping strategies use (on the Kidcope scale).*

Table 5.3.

Comparison of Coping Strategies used by Orphaned Children and Non-orphans

	Orphans	Non-orphans	X^2	<i>p</i>
	(n = 100)	(n = 100)		
	n (%)	n (%)		
Distraction	84 (84)	88 (88)	0.37	.54
Social withdrawal	73 (73)	66 (66)	0.85	.36
Wishful thinking	80 (80)	92 (92)	5.03	.025*
Self-criticism	48 (48)	50 (50)	0.02	.89
Blaming others	40 (40)	32 (32)	1.06	.30
Problem-solving	83 (83)	87 (87)	0.35	.55
Emotional regulation	83 (83)	90 (90)	1.54	.21
Cognitive restructuring	70 (70)	82 (82)	3.32	.07
Support-seeking	79 (79)	74 (74)	0.45	.51
Resignation	39 (39)	38 (38)	0.00	1

**p* < .05.

5.5.3. Correlation analyses

The Pearson product-moment correlation analyses were carried out to explore the relationship between depression, anxiety, coping strategies and the overall quality of life of the participants. The results are presented in Table 5.4. There was a strong² significant positive relationship between depression and anxiety in the orphaned children ($r = -.63, p < .001$) and in non-orphans ($r = .42, p < .001$). This suggests that, for the orphaned children and

² The strength of a correlation (of weakness thereof, as reported in the subsequent sections) is based on the value of the Pearson's r , and not on the alpha value (p).

the controls, the more anxious they were, the more they evinced depressive symptoms and *vice versa*.

Table 5.4.

Summary of Intercorrelations for Scores on the Kidcope, CDI, RCMAS and WHOQOL-BREF for Orphaned Children- and Non-orphans

Measures	CDI		RCMAS		WHOQOL	
	Orphans	Non-orphans	Orphans	Non-orphans	Orphans	Non-orphans
CDI	1	1	.63**	.42***	-.34***	.48***
RCMAS			1	1	.32**	-.11
Distraction	.09	-.19	.09	.03	-.04	.16
Social withdrawal	.15	.23*	.34***	.33***	-.05	-.02
Wishful thinking	-.03	-.01	.11	.23*	-.04	.09
Self-criticism	.13	.19	.19	.23*	-.19	-.1
Blaming others	.07	.39***	.11	.26**	-.12	-.22*
Problem-solving	.12	-.09	.13	-.06	-.01	-.08
Emotional regulation	-.06	.09	.08	-.01	.04	.07
Cognitive restructuring	.08	-.12	.12	.10	-.02	.15
Support-seeking	-.04	-.29**	.17	-.05	.13	.24*
Resignation	.07	-.02	.19	.10	.07	.15

Note. CDI = Children's Depression Inventory; RCMAS = Revised Children's Manifest Anxiety Scale; WHOQOL-BREF = World Health Organization Quality of Life-BREF

* $p < .05$. ** $p < .01$. *** $p < .001$.

Regarding stress and quality of life, the bivariate correlation analyses revealed a moderate significant negative relationship between depression and the quality of life for orphans, $r = -.34$, $p < .001$; and non-orphans, $r = -.48$, $p < .001$. This implies that the higher

the participants' depressive symptoms, the lower were their perceptions of their overall quality of life, with depression explaining 23 per cent of the variance in orphans' quality of life. A weak significant negative relationship emerged between anxiety and quality of life in the orphaned group, $r = -.32, p < .05$. This suggests that among orphaned children, the higher their anxiety symptoms, the lower were their perceptions of their overall quality of life, with anxiety explaining 10 per cent of the variance in quality of life. For the non-orphaned group, the negative correlation between scores on anxiety and the perceptions of their overall quality of life scores was not significant.

Further analyses were carried out to examine the relationship between depression, anxiety, coping strategies and quality of life. The results revealed that there were weak significant positive correlations between social withdrawal coping and anxiety in both groups; orphans ($r = .34, p < .001$) and non-orphans ($r = .33, p < .001$). This suggests that the more anxious the participants were, the more they used social withdrawal coping strategy. For the orphans, social withdrawal coping explained 11 per cent of the variance in anxiety, and for non-orphans, social withdrawal explained 10 per cent of the variance in anxiety. Moreover, there was a low positive correlation between social withdrawal and depression in the non-orphaned group ($r = .23, p < .05$). This suggests that the more depressed the non-orphaned children were, the more they used social withdrawal coping, with social withdrawal coping explaining 5 per cent of the variance in depression. The correlation between depression and social withdrawal coping in the orphaned children was not significant.

Wishful thinking was positively correlated (weak relationship) with anxiety in the non-orphans group ($r = .23, p < .05$). This suggests that the more anxious non-orphans were, the more they used wishful thinking coping. Wishful thinking explained 5 per cent of the variance in anxiety in the non-orphaned group. The correlation between wishful thinking and anxiety in the orphaned group was not significant. A weak significant positive correlation

emerged between self-criticism and anxiety in the non-orphaned group ($r = .23, p < .05$). Self-criticism explained 5 per cent of the variance in anxiety in the non-orphaned group. This suggests that the more anxious the non-orphaned children were, the more they used self-criticism coping strategy. The correlation between self-criticism and anxiety in the orphaned group was not significant.

Blaming others coping was significantly positively correlated with depression ($r = .34, p < .001$) and anxiety ($r = .26, p < .01$) in the non-orphaned group. The relationship was weak as blaming others explained 11 per cent of the variance in depression and 6 per cent of the variance in anxiety. This suggests that the more anxious and depressed the non-orphaned children were, the more they used blaming others coping strategy. Blaming others coping was also significantly negatively correlated with quality of life ($r = -.22, p < .05$) for the non-orphaned group. Blaming others also explained 4 per cent of the variance in quality of life. This suggests that the lower the non-orphans perceived their overall quality of life, the more they used blaming others coping strategy. The correlations between blaming others coping and the other measures (depression, anxiety and overall quality of life) in the orphaned children were not significant.

Lastly, seeking social support was negatively correlated with depression ($r = .29, p < .01$) for the non-orphaned group. Seeking social support explained 8 per cent of the variance in depression. This suggests that the more depressed the non-orphaned children were, the less they used seeking social support coping strategy. Moreover, support-seeking coping was significantly positively correlated with perceptions of quality of life ($r = .24, p < .05$) in the non-orphaned group. Seeking social support explained 5 per cent of the variance in quality of life. This suggests that the more the non-orphans used social support coping strategies, the higher they perceived the quality of their lives to be. The correlation between seeking social

support and the other measures (depression, anxiety and quality of life) in the orphaned children was not significant.

5.5.4. Regression analyses

The backward stepwise regression procedures were carried out to explore whether depression, anxiety and the ten coping strategies would emerge as significant predictor(s) of quality of life in the participants. For the orphaned children, the initial model indicated that depression, anxiety and the ten coping strategies explained 22% of the variance ($R^2 = .224$, $F(12, 82) = 1.975, p < .05$). This implies that depression, anxiety and the ten coping strategies predicted 22 % of the overall quality of life of the orphaned children. Only self-criticism coping emerged as a significant predictor of the overall quality of life and remained in the final model ($\beta = -.22, p < .05$). This suggests that the more orphaned children used self-criticism coping, the lesser they perceived the value of their overall quality of life. The backward stepwise regression procedure was then used to eliminate variables that were not predicting quality of life in the orphaned children. The results are illustrated in Table 5.5. In the final model, anxiety, social support and self-criticism coping remained in the model, explaining 16% of the variance ($R^2 = .161, F(3, 91) = 5.815, p < .001$). This suggests that anxiety, social support and self-criticism coping strategies predicted 16 % of the overall quality of life scores of the orphaned children. Anxiety ($\beta = -.33, p < .001$) and social support coping ($\beta = .20, p < .05$) emerged as significant predictors of perceived quality of life in the orphaned children. This suggests that the more anxious orphaned children were, the lesser they perceived the value of their overall quality of life; and the more they used social support coping, the higher they perceived their overall quality of life.

Table 5.5.

Predictors of Quality of Life for Orphaned Children

Variables	β	<i>t</i>	<i>p</i>
Anxiety	-0.36	-3.60	.001**
Self-criticism coping	-0.16	-1.62	.108
Support-seeking	0.20	2.02	.047*

$R = .40; R^2 = .16; F = 5.815$

* $p < .05$. ** $p < .01$

For the non-orphaned children, the initial model explained 32% of the variance in the overall quality of life, $R^2 = .316, F(12, 85) = 3.269, p < .001$. This suggests that depression, anxiety and the ten coping strategies predicted 31 % of the overall quality of life of the non-orphaned children. Only depression emerged as a significant predictor ($\beta = -.43, p < .001$) of the overall quality of life. This suggests that the more depressed non-orphans were, the lesser they perceived the value of their overall quality of life. Through the backward regression analyses, depression emerged as the only significant predictor in the final model, explaining 24% of the variance in the overall quality of life of the non-orphaned children ($R^2 = .238, F(1, 96) = 29.909, p < .001$). This implies that the more depressed non-orphans were, the lesser they perceived the value of their overall quality of life. The results (illustrated in Table 5.5.) confirmed the research hypotheses:

- *Anxiety would emerge as significant negative predictor of the quality of life (on the WHOQOL-BREF) of the orphaned.*
- *Support-seeking coping would emerge as a significant positive predictor of the overall quality of life of the orphaned children.*

5.6. Discussion

Our study aimed to explore stress (symptoms of depression and anxiety), coping and the overall quality of life of orphaned children in comparison to non-orphans who resided with their parents in Accra, Ghana. Findings from the present study indicated that this sample of orphaned children, when compared to their non-orphaned counterparts, were more vulnerable to psychological distresses as they evinced significantly higher levels of anxiety symptoms. Moreover, a considerably high number of the orphaned children (41%), relative to the non-orphans (at 40%), showed mild-to-severe depressive symptoms. These figures were fairly high and suggest that the depression is a common feature of the psychological state of both groups. Although the between-group differences in symptoms of depression did not reach significance, it is a concern that such a high number of children presented with what appears to be clinical depression – a factor that points to the heightened vulnerability to mental health problems. This suggests that interventions aimed at containing psychological distress should ideally include both orphans and non-orphaned children. For the orphaned group of children, the presence of depression and anxiety confirmed findings from previous studies that have reported that orphanhood and orphanage placement can have adverse effects and can lead to poor psychological well-being (e.g., Damnjanovic et al., 2011; Fawzy & Fouad, 2010; Hermenau et al., 2011; Hong et al., 2010; Wolff & Fesseha, 1999). We discuss each of these findings, and their implications for the psychological well-being of orphans and non-orphans.

The finding that both orphaned and non-orphaned children presented with mild-to-severe depression was in contrast to our prediction that depressive symptoms would be more common in the orphaned children and lesser in non-orphans, and is not in line with the literature that indicates that orphaned children are more vulnerable to psychological distress (depression) than the non-orphaned children (Damnjanovic et al., 2011; Fawzy & Fouad,

2010; Hermenau et al., 2011; Hortaçsu et al., 1993; Margoob et al., 2006; Thabet et al., 2007; Wolff & Fesseha, 1999). The finding that both groups reported high prevalence of depressive symptoms suggests that both the orphans and non-orphaned children were equally distressed irrespective of their parental status. The prevalence of depression in the two groups of children might have resulted from their individual vulnerabilities. Depression in orphaned children might have resulted from the adverse effects associated with losing a parent (such as grief, loss of care, separation from family members as well as social changes) and the adverse conditions in the orphanages, which include poor stimulating environment, poor care-giving, strict routines, the frequent absence of care-givers, stigma as well as administration restraints (Browne, 2009; Daunhuaer et al., 2005; Luecken, 2008; Maier & Lachman, 2000; Wolff & Fesseha, 1999; Zhao et al., 2007). All of these factors have been linked to poor psychological well-being in orphaned children.

Regarding school children, although studies have not been conducted specifically on the stressors of school children in the Ghanaian context, we draw from the findings of other studies to explain our results. Studies have highlighted that children who grow up in scarce-resource contexts (such as Ghana) are at risk for poor well-being due to the impact of poverty and material deprivation (Richter et al., 2010). A South-African study also found that school-going children experience lack of financial support from parents, minimal or no contact with their fathers and poor school performance; all of these factors affected the well-being of the children (Richter, Panday, Swart, & Norris, 2009). It is plausible that the school children showed high depressive symptoms as a result of material and emotional deprivation.

In addition to material and emotional deprivation, school-going children have been found to experience verbal, physical and sexual violence in the school environment (Brown, 2009) and in the community (Kaminer, Hardy, Heath, Mosdell, & Bawa, 2013). These forms of violence were associated with post-traumatic stress disorders in the children studied.

Against this background, it is possible that the Ghanaian non-orphaned sample could have experienced daily stressors that were challenging and detrimental to their psychological well-being. This might have resulted in depressive symptoms that were similar to the level shown by their orphaned counterparts. The reasons for high depressive symptoms in the sample, and specifically in the non-orphaned children thus warrants further research enquiry. The inclusion of indicators of socio-economic status in future studies of the psychological well-being of children in Accra, Ghana, would be essential.

In line with our hypothesis, the present findings showed that orphaned children evinced significantly higher anxiety symptoms than the controls. The present finding was consistent with previous studies that showed higher anxiety symptoms for orphaned children in orphanages than for their non-orphaned counterparts living in foster care (Damnjanovic et al., 2011; Hong et al., 2010). The presence of high anxiety symptoms in the orphaned children was not surprising, given that parental loss is regarded as the most significant stressor that predicts anxiety in children (Eppler, 2008). Given that parental figures often play a protective role in the lives of their children (Moore et al., 2011; Rosenberg & Wilcox, 2006), the loss of a parent is seen as resulting in the removal of such protection (Vasey & Dadds, 2001). There is also evidence that such a loss could elicit fear (Muris, 2007), and lead to the resurgence of childhood fears that such children might have learned to overcome (Adam & Chase-Lansdale, 2002; Vasey & Dadds, 2001).

In line with our hypothesis, anxiety emerged as a significant negative predictor of the orphaned children's overall quality of life. This finding was consistent with a previous study of orphanage children in Serbia that found anxiety to be negatively associated with overall quality of life (Damnjanovic et al., 2011). Anxiety is known to negatively predict overall quality of life because it leads individuals to feel worse about themselves and thus worsen their overall quality of life (Abbey & Andrews, 1986).

The present findings also confirmed our hypothesis: Support-social coping emerged as a significant positive predictor of quality of life for orphaned children. Although there is no notable empirical support for this relationship, it is worth noting that, in a Turkish study on adolescents placed in institutional care (Erol et al., 2010), associations were found between perceived social support and mental health. Given the documented evidence for diminished perceptions of social support for Ethiopian orphaned children placed in orphanages (Aboud et al., 1991), and particularly in Ghanaian orphanages (Adu, 2011; Kristiansen, 2009), it is plausible that the coping strategies characterised by seeking social support for the present sample stemmed from the perceptions of the lack of such support – a factor that is arguably central to the quality of the life that they lead as well as their psychological state of being at the orphanages – especially when considering the high levels of anxiety and depression. It is worth noting that programmes aimed at providing continuous psychosocial support in times of distress have been found to have incremental effect on the well-being of Zimbabwean orphaned children (Chitiyo, Changara, & Chitiyo, 2008). International literature has also shown social support to have a protective role against the adverse effects of stressful experiences and mental health (Cluver et al., 2009; House, 1986; Tyler, 2006). This is because such support lead people to believe that they are “...cared for and loved, that he is esteemed and valued, and that he belongs to a network of communication and mutual obligation” (Cobb, 1976, p. 300).

5.6.1. Conclusion and implications for intervention

The results of our study revealed that, irrespective of their parental status (that is, whether or not they had lost a parent), this sample of Ghanaian children showed heightened vulnerability to psychological distresses. Given the high prevalence of depressive symptoms in both groups of children, psychological interventions aimed at improving well-being should be made effective to both groups of children. For example, policy makers in Ghana could

consider adopting the Ugandan model of intervention for orphans and other vulnerable children (Hope Never Runs Dry, 2011). Included in this model is the psychosocial intervention that has two components. The first component is the provision of expert counselling services. The second component is the furnishing of life skills training such as stress management and coping skills, the formation and sustenance of healthy peer relationship, problem-solving and decision making skills, as well as conflict management skills. Life skills training on how to assist vulnerable children could also be made available to care-givers of orphaned children and parents of non-orphans. The implementation of the intervention outlined above would significantly improve the psychological well-being and overall quality of life of the Ghanaian children.

In line with the finding that support-seeking coping significantly predicted overall quality of life of the orphaned children in the present study, interventions that promote positive interpersonal relationship for the orphaned children would be beneficial. An intervention that has been tested in Zimbabwe showed positive effects for orphans and vulnerable children (Chitiyo et al., 2008). This intervention has four components. The first part is the emotional component that involved the provision of grief and bereavement counselling for coping and stress management. The second part is the social component that involved the ball games and buddy system for the promotion of social interactions and building trust. The third part is the physical component that involved the provision of school uniforms, fees and stationary to improve school attendance and participation. The fourth part is the spiritual component that involved the provision of scripture union lessons.

5.6.2. Limitations

The present study had two limitations. Firstly, the study followed a cross-sectional design – as a result, causal inference between parental loss, orphanage placement and psychological well-being could not be drawn. Orphanhood is an irrevocable, life-changing

experience that has far-reaching consequences for the surviving child whose life journey gets affected by the parental loss, and placement in an orphanage is a compounding factor in the experience of being an orphan. Given the cross-sectional nature of the study, we could not conclusively draw a causal association between orphanage placement and psychological distress exhibited by the orphaned children. For example, given that the non-orphaned children also presented with psychological distress not dissimilar to that of their orphaned counterparts, we were unable to discern if such distress was due to orphanage placement. Thus, longitudinal studies should be conducted to enable an appraisal of the extent to which the variables of depression, anxiety, coping and the overall quality of life manifest in different time-points, in order to draw inferences about how orphanage placement impacts on psychological well-being of orphans. Qualitative study could also be conducted in order to ascertain data that could explain the heightened emotional distress in both the orphaned- and non-orphaned children.

Secondly, the small sample size, could have limited the generalizability of the findings to the population of orphaned children in Ghana. Therefore, future studies should use larger samples of orphaned children that are drawn from orphanages and the communities across Ghana to help ascertain if, for instance, psychological distress and the overall experience of orphanhood are different for orphans placed in orphanages, when compared to orphans in the communities. Despite these limitations, the present study provided significant information on the psychological well-being of orphaned children relative to non-orphans, and forms groundwork and impetus for further research on the mental health of orphaned children in Ghana.

Chapter 6: Manuscript 3

Title: Problems, coping and efficacy: An exploration of subjective distress in orphans placed in Ghanaian orphanages

Authors: Joana Salifu Yendork & Nceba Z. Somhlaba

Brief Summary: In this empirical manuscript, we used both qualitative (content analysis) and quantitative (t-test, chi-square and One-way ANOVA) data analytic techniques to explore the nature of the statistical relationship between problems, coping and coping efficacy in the Ghanaian orphaned children placed in orphanages, in comparison to their non-orphaned controls. From the theoretical perspectives under consideration and prevailing research trends, we discuss the findings of the vulnerability of both the orphaned- and non-orphaned children to distress associated with problems with peers, caregivers and school, their coping with the distress, as well as how efficacious such coping were and the adverse effects of problem-saturated accounts of the relationship with peers on their psychological functioning. We also discuss the implications of the findings for intervention and future research.

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6.1. Abstract

We used the Kidcope scale to explore problems experienced by participants within the preceding month, coping and coping efficacy for 89 orphaned children sampled from orphanages and 100 non-orphans sampled from public schools in Accra, Ghana. Results reveal that orphaned children report significantly more relationship problems with peers than non-orphans, whereas for non-orphans problems cited are relationship difficulties with caregivers. With all children considered, resignation features predominantly as coping strategy to manage problems with caregivers than in managing problems with both school and peers. Moreover, adolescents use self-criticism and wishful thinking significantly more than children. Implications of the findings are discussed.

6.2. Introduction

In 2011, the number of orphans in Ghana was estimated to be about 970 000 (UNICEF, 2012a). Although Ghana does not have a disproportionately high prevalence rate of orphans, when compared to other sub-Saharan African countries (UNICEF, 2012b), the mere fact that the country has recorded a high number of orphans is still a concern. This is because, the majority of the Ghanaian population are young with 41 per cent being under the age of 15 years, whereas a mere 5 per cent were 65 years and above (Ghana Statistical Service, Ghana Health Service, & ICF Macro, 2009). The concern often raised about the well-being of orphans is that the elderly people, notably grandparents, are mostly the ones who traditionally care for orphans (Deters, 2008). Concerns about the long-term sustainability of orphan care by the elderly have been raised because of the emotional burden and consequences this ‘parental’ responsibility has on the elderly (in addition to having to deal with the loss of their offspring) and limited financial resources (Alden et al., 1991). Additionally, Ghanaian orphans are at risk for lacking care due to the low number of available elderly people to care for a large number of orphans (Deters, 2008). As a result, there is a

continued need for research enquiry on the psychological well-being of Ghanaian orphans in order to provide insights on ways in which meaningful intervention could be effected to improve well-being and quality of life.

Traditionally, the extended familial networks in Africa provide a ‘safety net’ and care for orphans following parental loss (Foster, 2000; Van der Brug, 2012). However, research has noted some extended families’ inability to always cater for orphans, due to the rising number of children within these families orphaned through HIV and AIDS, labour migration, urbanisation, demographic change, westernisation, and formal education (Foster, 2000). The weakening of the traditional safety-net has resulted in some orphans living on the streets, in child-headed households and in institutions of orphan care (Sengendo & Nambi, 1997).

Despite the limited capacity of some extended families to care for orphans notwithstanding, placement with extended families is still recognised as the ideal living condition for African orphans (UNICEF, UNAIDS, & USAID, 2004). However, it has been found that even when such avenues are available, there are associated problems that adversely affect the psychological well-being of orphans (Morantz et al., 2013; Van der Brug, 2012). For example, problems such as poverty, stigma, relationship problems with peers that include incidence of bullying and teasing (Cluver & Gardner, 2007), as well as neglect, child labour, exploitation and abuse (Morantz et al., 2013) have been reported in studies on orphans who live with extended families. While studies on problems experienced by orphans in the extended family settings have received considerably much attention in the African context, little is known about the stressors of orphans placed in African orphanages. In addition, studies that involve orphanage children have examined children’s stress through the use of standardized measures (e.g., Fawzy & Fouad, 2010; Hermenau et al., 2011). These studies exclude the examination of events that do not necessarily relate to parental loss or orphanage

placement but are appraised as problematic and influential on the well-being of orphanage children.

In Ghana, although there seemingly is no consensus regarding the best orphan care, Ansah-Koi (2006) has noted a surge in the institutionalisation of orphans in recent times, which has resulted from the rising number of orphans due to the HIV and AIDS epidemic. Noteworthy, Ghanaian orphanages do not only care for orphaned due to parental death, they also care for abandoned children, children from abusive families and children who have both parents alive but are unable to care for them due to poverty (Adu, 2011; Ministry of Manpower, Youth and Employment & Department of Social Welfare, 2008). Thus, the sampling of orphans in Ghanaian orphanages should take into consideration whether parents are deceased or alive but not caring for their children. While Ghanaian orphanages provide care for children (Ministry of Employment and Social Welfare & UNICEF, 2010), there has been documented evidence of incidents of corruption by orphanage administrators (Colburn, 2010), exploitation of visitors and the misuse of funds by the orphanage administrators (Pyper, 2010), as well as negative child-caregiver relationships (Kristiansen, 2009).

International research on common problems in children (that used the Kidcope) has highlighted that relationship problems with peers and family as well as problems with school are the commonly reported sources of distress for children (Pereda, Forns, Kirchner, & Munoz, 2009; Reinoso & Forns, 2010). However, health problems and loss of a loved one (Pereda et al., 2009), as well as minor-to-major accidents (Reinoso & Forns, 2010) have also been cited in other studies. Additionally, research that used Coping Response Inventory-Youth form has also highlighted relationship problems (with peers, boyfriend or girlfriend, and with family) as well as problems with school, illness and loss as sources of distress (Forns, Kirchner, Abad, & Amador, 2012). We, however, found no research that explored

problems experienced by orphans placed in orphanages, and hence argue for the need for research dedicated to this subject area.

Given the potential problems that orphanage children experience, it is essential that children placed in these homes are able to manage stressors associated with parental loss and orphanage placement. Effective coping can mediate the adverse effects of negative experiences and improve psychological adjustment (Compas et al., 2001; Pincus & Friedman, 2004). In this regard, research has highlighted that children utilise more than one coping strategy in response to stress. For example, children in general have been found to use wishful thinking, problem-solving and emotional regulation more frequently than they use blaming others, self-criticism, and resignation as forms of coping (Donaldson et al., 2000). However, the choice of strategies is dependent on temperament, developmental level as well as the nature and context of the stressors concerned (Holen et al., 2012).

Regarding the association between stressors and coping, Donaldson et al. (2000) found that resignation coping was used more often for family problems, blaming others and emotion regulation for sibling problems and cognitive restructuring for school problems. Moreover, Pereda et al. (2009) found that children used social withdrawal for problems that affected other people whereas blaming others and self-criticism strategies were used for interpersonal problems. Regarding the influence of age, Compas et al. (2001) have highlighted that during childhood, children make use of complex emotion regulation skills and cognitive strategies, such as cognitive reframing, self-talk, cognitive distractions, self-reassuring statements and rumination. However, by early adolescence, individuals are expected to match coping efforts to perceive objectives of the stress. A more varied and wider range of coping strategies becomes readily available to adolescents, and strategies such as problem-solving methods, humour, support-seeking as well as maladaptive coping are used (Compas, Banez, Malcarne, & Worsham, 1991; Donaldson et al., 2000).

While a variety of coping strategies are available to children, it has been found that not all strategies are equally efficacious for varied problems. For example, Donaldson et al. (2000) found that distraction coping was less helpful for relationship problems with peers than for problems with school or family. Additionally, Pereda et al. (2009) found that support-seeking, emotional regulation and wishful thinking were the most efficacious strategies whereas blaming others and self-criticism were the least efficacious strategies.

Given the gap in research on this specific topic in orphans, the present study was designed to examine the following hypotheses. Firstly, given the differences in parental status (whether or not they had lost a parent) and living environment (whether placement in orphanage or residing with parents) of orphans and non-orphans, we hypothesised that there would be significant differences between orphans and non-orphans on reported problems. Secondly, there would be significant age differences in the coping strategies used by all participants combined. Thirdly, there would be significant associations between problems and coping strategies for all children combined. Fourthly, there would be significant associations between problems and coping efficacy for all children combined.

6.3. Method

6.3.1. Participants

We used purposive sampling technique to select orphans from four orphanages in Accra, Ghana: namely, Savers Foundation, Paradise Foster Home, God Saves Orphanage and Haven for Orphans Foundation (all names are pseudonyms). Orphans were included if they were aged between 7 and 17 years, had lost one or both parents through death or abandonment (the latter criterion – abandonment – was used to rule out the inclusion of children who, although also staying in orphanages, had indicated their parents were still alive, even when their whereabouts were unknown), resided in an orphanage and were willing to participate in the study. Orphans were identified through the assistance of the orphanage

administrators. The first author (who, as the native of Ghana, had the insider knowledge of the Ghanaian context) and a trained research assistant approached participants who met the inclusion criteria within the orphanages as invitation for possible participation in the study. Out of the 104 children who were approached, four were excluded from the data analyses on the basis that, although they also lived in the orphanages, their residence status was due to their parents being caregivers or administrators of the orphanages. A further 11 orphans who did not report a problem on the Kidcope scale, which is the main measure under consideration in the present study, were excluded from the final analyses. The orphaned sample was thus reduced to 89 participants.

The non-orphans were sampled from two public schools: namely, Dynamic Senior High School and Good Starters Basic School (all names are pseudonyms). Non-orphans were included if both of their parents were alive, if they were between the ages of 7 and 17 years, attended public schools in Accra, lived with their parents, and were willing to participate in the study. School children were identified through the assistance of the head teachers of the schools and were approached by the first author and a research assistant for possible participation in the study. All the 115 children who were approached agreed to participate in the study. Out of these, 15 children (13.05%) were excluded from the data analyses for various reasons: six were orphans and nine were older than the cut-off age of 17 years. After excluding the 15 children, 100 non-orphans were included in the study.

For the purpose of analyses, participants were divided into children (7-12 years) and adolescents (13-17 years), in order to ascertain if there were any differences between the two groups of children. The orphaned group was made up of 51 (57.3%) boys and 38 (42.7%) girls; and 37 (41.6%) children and 52 adolescents. The control group was made up of 60 (60%) boys and 40 (40%) girls; and 41 (41%) children and 59 (59%) adolescents. The age for all children ranged from 7 to 17 years ($M = 13.35$ years, $SD = 3.14$; For orphans: $M = 13.34$

years, $SD = 3.22$; For non-orphans: $M = 13.37$ years, $SD = 3.08$). There was no significant age difference between orphans and non-orphans, $t(187) = -.07, p > .05$. Regarding religious affiliations, 85 (95.5%) orphans and 95 (95%) non-orphans reported to be Christian while 3 (3.4%) orphans and 5 (5%) non-orphans reported to be Muslim. There was no significant differences between orphans and non-orphans on religious affiliations ($t(186) = -.54, p > .05$). Data were collected over a five-month period spanning from September 2012 to February 2013.

6.3.2. Measuring instruments

A *demographic questionnaire* was used to ascertain information pertaining to participants' age and sex.

The *Kidcope scale* (Spirito et al., 1991) measures subjective distress and coping strategies in children. For subjective distress, this measure has a single-item question – “Write down a problem that you have experienced during the prior month” – that requires children to report on any problem, irrespective of intensity. Subsequently, participants are required to read 15 statements pertaining to various ways of coping with the problem reported or identified, and then answer two sets of questions. The first question – ‘did you do this [did you make use of each of 15 listed coping strategies]?’ – assesses whether or not the coping strategies listed were used, and uses the ‘yes-no’ response-type question format. The second question –‘how much did it [coping strategy] help you?’ – assesses coping efficacy, and has three-response options that range from 0 (‘not at all’ – not efficacious) to 2 (‘a lot’ – highly efficacious). Sample items on the Kidcope include ‘I just tried to forget it’ and ‘I tried to fix the problem by thinking of answers’. For the younger childhood version, which was used in the present study, the coping strategies of distraction, social withdrawal, problem-solving, emotional regulation and wishful thinking have two items on the scale, whereas self-criticism, blaming others, cognitive restructuring, support-seeking and resignation are coping strategies

that each have a single item on the scale. Psychometric values ranging from .41 to .81 for test-retest reliability in the short time, .15 to .43 for a 10-week period, as well as moderate to high-concurrent validity ranging from .33 to .77, have been reported (Spirito et al., 1991; Spirito et al., 1988).

6.3.3. Procedure

The Kidcope scale was administered on orphans in their respective orphanages either after school hours or over the weekends. For non-orphans, the administration of the Kidcope took place during their short-break periods at the school premises. Participants were asked to write down a problem they had encountered during the prior month, after which they were asked to rate each of the coping strategies, by how often (frequency scale) they had used a particular coping strategy and how effective (efficacy scale) they believed the coping strategy was for them. Children who could respond to the questions on their own (usually older participants aged between 12 to 17 years) completed the questionnaire by themselves whereas those who could not respond to the questions on their own (usually younger participants aged between 7 to 11 years) were interviewed by the researcher and a research assistant on the questions in the questionnaire. As a gesture of gratitude for participating, participants were given a monetary value of GHC5 (Equivalent to US\$ 2.5).

6.3.4. Ethical considerations

The research ethics committee (REC, Humanities) at Stellenbosch University, South Africa, granted ethics clearance for the study to be conducted. Moreover, we obtained permission from the Ghana Education Service and the Department of Social Welfare in Accra, Ghana for the study to be conducted in schools and orphanages respectively. Additionally, parents (of non-orphans), legal guardians and administrators of orphanages designated to give parental consent for orphans gave consent. Lastly, all children who participated in the study gave assent. We also adhered to the ethical principles of

confidentiality, participant anonymity and voluntary participation. Although no participant required, or made use of, the counselling services made available, contingency plans were put in place in the eventuality of the need for referral of the children for psychological support.

6.3.5. Data analyses

Content analysis was used to analyse the problems reported by participants in order to ascertain categories of problems. Before data analyses, there were no predetermined sets of categories; these categories emerged from the data, and the analyses were done solely by the first author. The first author read through each quote and then assigned code names with a focus on the existence and frequency of the sources of problems. Subsequently, codes with similar emphasis were grouped into categories. After content analyses of the problems, statistical analyses were carried out using the Statistical Programme for Social Sciences (SPSS, version 20.0 for windows). The Chi-square test (χ^2) was used to compare differences in problems and coping strategies between orphans and non-orphans. One-way analysis of variance (ANOVA) was used to explore the association between coping strategies and problems as well as the association between coping efficacy and problems.

6.4. Results

6.4.1. Group differences on problems

The results of the content analyses revealed that relationship problems with peers were mostly cited and were reported by 59 (31.22%) participants, made up of 41 (46.1%) orphans and 18 (18%) non-orphans. Examples of excerpts for problems with peers are as follows:

“I had a fight with my friend at school” (Participant 13, 12-year-old male orphan)

“A friend of mine came for my video game and kept it for some time. When I was going for it, it became a problem and I became annoyed because he gave the game to someone else” (Participant 99, 17-year-old male non-orphan)

Problems with school were the second most cited problems and were reported by 32 (16.9%) participants, made up of 17 (19.1%) orphans and 15 (15%) non-orphans. School

problems were surrounding difficulty with school work, poor academic achievements, lateness to school, relationship problems with teachers and dislike for the school environment. Examples of excerpts for problems with school are as follows:

“I don’t understand what I am being taught at school” (Participant 30, 12-year-old male orphan)

“I don’t understand some of the subjects I am taught at school” (Participant 153, 11-year-old male non-orphan)

Relationship problems with caregivers were the third commonly cited problems and were reported by 31 (16.4%) children, made up of eight (8.9%) orphans and 23 (23%) non-orphans. For orphans, caregiver problems were surrounding relationship problems with house mothers whereas for non-orphans, they were surrounding the use of corporal punishment as a disciplinary measure and relationship problems with parents. Examples of excerpts for relationship problems with caregivers are as follows:

“I went home late and my father slapped” (Participant 160, 13-year-old female non-orphan)

“I took water to drink and an aunty in the orphanage slapped me and it affected my eyes” (Participant 5, 11-year-old female orphan)

Lastly, 67 (25.45%) children, made up of 23 (25.84) orphans and 44 (44%) non-orphans reported other problems surrounding relationship problems with siblings and boyfriend or girlfriend as well as problems with emotion, finance, health, loss of loved ones, home environments, misplacement of personal items and negative personal experiences. Relationship problems with peers and caregivers as well as problems with school were the three most cited problems and were used for further analyses.

The results of the chi-square (χ^2) analyses, presented in Table 6.1., revealed significant differences between orphans and non-orphans on problems with peers ($\chi^2[1, N = 59] = 15.99$, $p < .05$) and caregivers ($\chi^2[1, N = 31] = 5.76$, $p < .05$). The results suggested that orphans

experienced more relationship problems with peers than non-orphans whereas non-orphans experienced more problems with caregivers than orphans. There was no significant difference between orphans and non-orphans on problems with school ($\chi^2[1, N = 32] = .31, p > .05$). The results (illustrated in Table 6.1.) thus confirmed the research hypothesis:

- *There would be significant differences between orphans and non-orphans on reported problems.*

Table 6.1.

Frequencies of Problems Reported by Orphans and Non-orphans

Problems	Orphans (n = 89)		Non-orphans (n = 100)	
	n	(%)	n	(%)
Peers	41	(46.1)	18	(18)
School	17	(19.1)	15	(15)
Care-givers	8	(8.9)	23	(23)
Financial	7	(7.9)	5	(5)
Health	6	(6.7)	9	(9)
Others	2	(2.2)	9	(9)
Emotional	3	(3.4)	6	(6)
Siblings	0		3	(3)
Home	2	(2.2)	0	
Loss	1	(1.1)	2	(2)
Boyfriend/girlfriend	1	(1.1)	5	(5)
Misplacement	1	(1.1)	5	(5)

* $p < .05$. ** $p < .001$

6.4.2. Age differences in coping strategies

To ascertain the association between age and coping strategies, both the orphans and non-orphans were combined into a single group for analyses. This was done in accordance with the literature that explored problems, coping and coping efficacy in children (Forns et al., 2012; Pereda et al., 2009; Reinoso & Forns, 2010). The results of the chi-square analyses revealed significant age differences on self-criticism ($\chi^2[1, N = 189] = 4.65, p < .05$) and wishful thinking ($\chi^2[1, N = 189] = 4.19, p < .05$). The results suggested that adolescents used more self-criticism and wishful thinking than children. There were no significant age differences on social withdrawal ($\chi^2[1, N = 131] = .67, p > .05$), cognitive restructuring ($\chi^2[1, N = 144] = 2.92, p > .05$), distraction ($\chi^2[1, N = 164] = .01, p > .05$), blaming others ($\chi^2[1, N = 67] = .44, p > .05$), problem solving ($\chi^2[1, N = 162] = .33, p > .05$), emotional regulation ($\chi^2[1, N = 164] = .91, p > .05$), support-seeking ($\chi^2[1, N = 145] = 2.65, p > .05$) and resignation ($\chi^2[1, N = 73] = .52, p > .05$). The results confirmed the research hypothesis:

- *There would be significant age differences in the coping strategies used by all participants combined.*

6.4.3. Associations between problems, coping strategies and coping efficacy

The results of the one-way analyses of variance, presented in Table 6.2., revealed a significant association between resignation coping and reported problems ($F[2, 119] = 4.25, p < .05$) as well as blaming others coping and problems ($F[2, 119] = 3.17, p < .05$). Resignation coping was used more often in managing problems with caregivers ($M = .61, SD = .50$) than for relationship problems with peers ($M = .31, SD = .46$). Blaming others coping was used more often in managing relationship problems with peers ($M = .44, SD = .50$) than for problems with school ($M = .19, SD = .40$). There were no significant associations between other strategies and problems.

Also, the results of the one-way analyses of variance, presented in Table 6.2., revealed significant associations between problems and the efficacy of cognitive restructuring ($F[2, 119] = 3.52, p < .05$), blaming others ($F[2, 119] = 3.90, p < .05$) and resignation ($F[2, 119] = 5.77, p < .05$). Cognitive restructuring was more efficacious for relationship problems with peers ($M = 1.27, SD = .58$) than for caregiver problems ($M = 1, SD = .63$) and school problems ($M = .97, SD = .6$). Blaming others was more efficacious for caregiver problems ($M = 1.39, SD = .80$) than for peer problems ($M = 1.38, SD = .82$) and school problems ($M = 1.78, SD = .49$). Resignation coping was more efficacious for caregiver problems ($M = 1.06, SD = .85$) than for peer problems ($M = 1.59, SD = .67$) and school ($M = 1.53, SD = .67$). There were no significant associations between problems and self-criticism ($F[2, 119] = .5, p < .05$), social withdrawal ($F[2, 119] = 1.16, p < .05$), distraction ($F[2, 119] = .21, p < .05$), problem solving ($F[2, 119] = 2.45, p < .05$), emotion regulation ($F[2, 119] = 2.92, p < .05$), wishful thinking ($F[2, 119] = .92, p < .05$), and support seeking ($F[2, 119] = 1.39, p < .05$). The results (illustrated in Table 6.2.) confirmed the research hypotheses:

- *There would be significant associations between problems and coping strategies for all children combined.*
- *There would be significant associations between problems and coping efficacy for all children combined.*

Table 6.2.

Summary of Analyses of Variance Results of Coping Strategies on the Three Most Common Problems Reported by All Children Combined

Strategies	Stressors			<i>F</i>	<i>p</i>
	School	Peers	Caregivers		
	(n = 32)	(n = 59)	(n = 31)		
Strategies	M (SD)	M (SD)	M (SD)		
Self-criticism	.56 (.50)	.49 (.50)	.61 (.50)	0.63	.532
Social withdrawal	.66 (.48)	.71 (.46)	.84 (.37)	1.42	.247
Cognitive restructuring	.84 (.37)	.66 (.47)	.81 (.40)	2.26	.109
Distraction	.81 (.40)	.86 (.35)	.90 (.35)	0.54	.585
Blaming others	.19 (.40)	.44 (.50)	.42 (.50)	3.17	.046*
Problem solving	.94 (.25)	.85 (.36)	.77 (.43)	1.686	.190
Emotion regulation	.81 (.40)	.92 (.28)	.90 (.30)	1.14	.324
Wishful thinking	.81 (.40)	.85 (.36)	.87 (.34)	0.21	.815
Support-seeking	.69 (.47)	.76 (.43)	.68 (.48)	0.483	.618
Resignation	.38 (.49)	.31 (.46)	.61 (.50)	4.25	.016*

**p* < .05

6.5. Discussion

This study aimed to explore (1) the nature of problems for orphans and non-orphans, (2) the influence of age on coping strategies, and (3) the association between problems and coping as well as the association between problems and coping efficacy. While our data did not give an account of the pattern of problems and strategies of coping with problems over time, it was evident that orphanhood and placement in orphanages are life-altering experiences that variably evoke acute emotional upheavals that, if unattended to, could

adversely affect the well-being of orphans in the long term. Therefore, interventions aimed at ‘containing’ the wide range of emotional reactions arising out of this kind of loss should be given a priority if the psychological needs of orphans are to be addressed.

Our results showed that when both groups of children were considered, problems with peers, school and caregivers were predominantly cited as stressors. These findings were not surprising given that they constituted the usual childhood problems that have been reported in various other studies on stressors in children (e.g., Forns et al., 2012; Pereda et al., 2009; Reinoso & Forns, 2010). Therefore, interventions on child- and adolescent stress management should include a close monitoring of predominant stressors that can lead to psychological distress and skills for managing stressful encounters.

In line with our hypothesis, the present findings revealed significant differences between orphaned children and non-orphans on the source of their distress. While orphans reported significantly more problems with peers than non-orphans, non-orphans reported significantly more problems with caregivers than orphans. Although there is no notable empirical support for these results, the findings could have resulted from differences in parental status and living environment. Considering the high child-to-caregiver ratio often found in orphanages (Merz & McCall, 2010), and that orphans generally have limited contact with their families (Luecken, 2008), it is plausible that the present sample of Ghanaian orphans had minimal contact with caregivers in the orphanages. As a result, relationships with peers served as a major source of social network and interaction, and could have been a source of social concern for orphans.

Given the adverse effects of parental loss on children’s well-being, such as emotional distress (Taylor, Weems, Costa, & Carrión, 2009), poor physical and mental health (Luecken, 2008) and the adverse conditions in orphanages reported by previous research (Browne, 2009), we expected orphans to voluntarily report emotional problems, issues surrounding

parental loss and negative experiences regarding orphanage placement. However, only one orphaned child reported problems regarding parental loss and only a few (8.99% of them) reported problems related to orphanage placement. The results were partly consistent with previous research (Reinoso & Forns, 2010) and suggested that parental loss and orphanage placement could not have been issues of daily concern that were so prominent for the orphans. It was also possible that the orphaned children did not voluntarily report problems regarding their status as orphans placed in the orphanage in order to avoid jeopardising their placement at the orphanage. We were unable to account for such a low number of children voluntarily expressing problems regarding their status as orphans, and believed that this to be a subject that warrants further research exploration.

Consistent with previous research (Donaldson et al., 2000; Reinoso & Forns, 2010), we found that both orphans and non-orphans frequently used distraction, problem-solving, emotion regulation, wishful thinking and support-seeking coping more than coping strategies that included blaming others and self-criticism. In light of the research that indicates the maladaptiveness of wishful thinking (Morris & Rao, 2013) and distraction (Marsac, Donlon, Hildenbrand, Winston, & Kassam-Adams, 2014), the present finding points to the need for the psycho-education of children and adolescents regarding the best ways of coping with distress. This should include education on differences between maladaptive and adaptive styles of coping in order to augment coping efforts that are sustainable in the long term.

Consistent with our hypothesis, adolescents (aged 13-17 years) used self-criticism and wishful thinking more frequently than younger children (aged between 7 and 12 years). Although there was no empirical support for the present finding, research on children and adolescent coping has shown that coping follows a developmental course, and that by the adolescence stage, coping efforts are matched by the initial evaluation of the distress and the perceived competence in managing such a stressful encounter (Compas et al., 2001). As a

result, it is possible that the present sample of Ghanaian adolescents' use of self-criticism and wishful thinking represented a characteristic pattern of early adolescents' reaction to the world around them. Early adolescent developmental stage is characterized by such trends as egocentric thinking, personal fables, imaginary audience (seen as the equivalents of wishful thinking), and that the stage is typically centred around the on-going negotiation of the 'crisis' of the definition of their group identity and the formation of, and conformity to, socially defined group membership (Meyer, 2005), from which self-criticism is mainly derived.

Furthermore, both groups of children used resignation coping more frequently in response to caregiver problems than for peer-relationship problems. Although there was no empirical support for the present finding, resignation coping has been used in response to problems with family than for problems with school (Donaldson et al., 2010). The present finding was expected given that the Ghanaian culture promotes values that encourage children to respect and obey the elderly at all times without challenging their authority (Twum-Danso, 2009). Therefore, it is possible that when children encountered problems that involved an authority figure (such as a caregiver or a parent), 'resigning' to their fate could have been the only available and culturally appropriate way of dealing with the problem, as it would have been considered impolite to adopt a confrontational approach towards the adults. Moreover, given that these children rated resignation as less efficacious for managing problems with caregivers pointed to the internalised strategies of dealing with distress that could arguably be deemed as not helpful for well-being. Therefore, Ghanaian children would benefit from interventions that focus on teaching adaptive means of coping with problems that involve an authority figure while still balancing out on how to express their problems within the prevailing socio-cultural prescriptions and prohibitions relating to their behaviour in interpersonal-relationship contexts.

6.5.1. Conclusions and implications for interventions

Our study revealed that for the present Ghanaian sample of orphaned and non-orphaned children, problems with peers, school and caregivers were the major sources of their distress. Therefore, interventions aimed at teaching skills for managing stress should be effected to both groups of children. For example, clinicians and policy makers could consider adopting the Coping with Kids Programme (Henderson, Kelby, & Engerbreton, 1992), which is a cognitive-behavioural intervention programme that teaches children how to cope with stress, manage anger, develop healthy interpersonal relationships, and solve problems in relationships. Furthermore, given that the majority of the orphans and non-orphans collectively cited relationship problems with peers, interventions that mainly focus on teaching the skills for the formation and sustenance of healthy peer relationships should be effected to both groups. The other intervention that has positive effects is the School-based Social Skills Group Intervention (S.S.GRIN; DeRosier, 2004; DeRosier & Marcus, 2005).

6.5.2. Limitations

The study had four limitations. Firstly, given that orphanhood is an irrevocable, life-changing experience that has far-reaching consequences for the surviving children, and that placement in an orphanage is a compounding factor, the cross-sectional nature of our study limited our ability to draw causal inferences between parental loss, orphanage placement and psychological distress. For example, regarding the findings that both groups of children reported problems with peers, school and caregivers, we could not determine whether the problems reported were due to placement in an orphanage or familial experiences (for the non-orphans). Moreover, we could not ascertain whether orphans' reported problems were due to parental loss or placement in an orphanage. Therefore, future research should consider adopting longitudinal designs that would enable the appraisal of the extent to which problems

manifest over time, in order to draw inferences about how parental loss and orphanage placement differentially impact on the psychological well-being of orphans.

Secondly, given that the line of questioning on the Kidcope scale was more problem-saturated in nature, this raised the possibility of social desirability. Participants could have exclusively focus on problematic aspects of their lives, thus making the study miss data on neutral or positive aspects of their experiences. Therefore, future research could consider including measures that enable the quantification of the alternative (positive and neutral) experiences and how these relate to the negative experiences that the Kidcope focuses on, thereby addressing the issue of the exclusively problem-oriented focus that the study explored.

Thirdly, the use of purposive sampling technique and a non-probability sample could have led to selection bias and limited our ability to generalise our results to the population of orphanage-placed children in Accra, Ghana. Therefore, future research should use a probability sampling technique in order to sample orphans that are statistically representative of the population of orphans in Accra, Ghana.

Finally, the single-item coping strategies on the Kidcope scale rendered the inter-item reliability assessment impossible, and the present data were collected at a one-time point. We could not establish the replicability of the measure for the present sample of Ghanaian children. Future research could explore the possibility of gathering the data on coping strategies of orphaned children over time or use qualitative interviewing in order to address this limitation.

Chapter 7: Manuscript 4

Title: Do social support, self-efficacy and resilience influence the experience of stress in Ghanaian orphans? An exploratory study

Authors: Joana Salifu Yendork & Nceba Z. Somhlaba

Brief Summary: In this empirical manuscript, we explored the statistical relationship between stress (as indicated by the symptoms of both depression and anxiety), perceived social support, perceived self-efficacy and subjective evaluation of personal resilience in the Ghanaian orphaned children placed in orphanages, in comparison to the non-orphaned controls. Using the theory and literature on social support, self-efficacy and resilience, we discuss the findings of the orphaned children's perception of social support from friends, the protective role of perceived self-efficacy and social support on resilience in the orphaned children, and the implications of these for their overall psychological well-being. We also discuss the implications of the findings for research and intervention.

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Salifu Yendork, J., & Somhlaba, N.Z. (*in press-b*). Do social support, self-efficacy and resilience influence the experience of stress in Ghanaian orphans? An exploratory study. *Child Care in Practice*. Doi: 10.1080/13575279.2014.985286

7.1. Abstract

Much of the literature suggests that the availability of certain protective factors can help to buffer the adverse effects of negative life events such as parental loss (Cluver & Gardner, 2007; Haine et al., 2008) and the negative experiences surrounding placement in orphanages (El Koumi et al., 2012; Simsek et al., 2007). Following on this perspective, the present study explore the influence of perceived social support, self-efficacy and resilience on the stress experience (as measured by the symptoms of depression and anxiety) of 200 children in Accra, Ghana. The sample comprise 100 orphans placed in orphanages and 100 non-orphans – all aged between 7 and 17 years. The children completed the Children's Depression Inventory, the Revised Children's Manifest Anxiety Scale, the Multidimensional Scale of Perceived Social Support, the General Self-efficacy Scale and the 14-item Resilience Scale. The results reveal that orphans have significantly stronger perceptions of social support from friends than non-orphans whereas non-orphans have significantly stronger perceptions of support from families than orphans. However, both the orphans and non-orphans report high levels of self-efficacy and resilience. Regression analyses also reveal that self-efficacy emerge as a significant positive predictor of resilience for the orphaned children whereas self-efficacy and perceived social support emerge as significant positive predictors of resilience for the non-orphans. Implications of the findings are discussed.

7.2. Introduction

The well-being of orphans has increasingly been in the purview of academic research (Grant & Yeatman, 2012), due to the rising number of orphans resulting from HIV and AIDS related deaths (Abebe & Aase, 2007). While parental loss and subsequent placement in an orphanage can be stressful due to the life-changing status associated with these experiences (Daniel, 2005; Luecken, 2008), some studies have reported positive mental health in these children (Kodero, 2000; Zimmerman, 2005). Research has shown that certain protective

factors such as individual attributes (e.g., intelligence, resilience as qualities embedded in the individual child, self-efficacy) and perceived social support (from family, peers, and significant others) can promote children's abilities to cope and thrive in difficult circumstances (Bandura, 1986, 2002; Werner, 1993). The review of existing literature on the well-being of orphanage-placed children shows that the effect of social support has seemingly gained momentum (cf. Adu, 2011; Çaman, & Özcebe, 2011; Emond, 2009; Kodero, 2000; Kristiansen, 2009; Şimşek et al., 2007; Zimmerman, 2005), but little is known about the contributions of individual attributes such as self-efficacy and resilience.

In Ghana, the systemic failure of extended families in caring for orphaned children has seen an increase in the placement of orphaned children in orphanages (Ansah-Koi, 2006; cf. Salifu Yendork & Somhlaba, 2014). However, little is known about the psychological well-being of the orphaned children following placement in orphanages due to limited scholarly work on the subject in Ghana. Our literature search shows two studies that have focussed on the psychological well-being of Ghanaian orphans placed in orphanages (Adu, 2011; Kristiansen, 2009), and to date no study of note has explored the influence of stress-moderating variables on the experience of stress in orphanage-placed children. It was against this background that the present study aimed to examine the influence of perceived social support, self-efficacy and resilience on the experience of stress in Ghanaian orphaned children.

The structure of the paper is as follows. The literature review discusses the variables under study. The methodology section presents information on participants, measuring instruments, procedure, ethical considerations and the methods of data analyses. The results section outlines the findings of the present study. Finally, the findings of the study are discussed and the implications for interventions, limitations and conclusions drawn are presented.

7.3. Literature Review

Social support functions as a buffer against stressful experiences (Cluver et al., 2009; Tyler, 2006) through motivating individuals to perceive that they are loved, cared for, esteemed, valued and belong to a mutually reciprocal relationship (Cobb, 1976; Rigby, 2000). Cobb also indicates that social support indirectly promotes a sense of well-being by reducing the effects of stress and enhancing coping skills.

It is noteworthy that a review of literature on the appraisal of social support in orphanage-placed children has rendered inconsistent results. For example, while some studies have reported low levels of social support (Aboud et al., 1991) and adverse relationships (Adu, 2011; Kristiansen, 2009), other studies have highlighted the availability of positive and adequate social support for orphans (Adamson & Roby, 2011; Emond 2009; Kodero, 2000). Despite the inconsistency in the literature, research (Çaman, & Özcebe, 2011; Şimşek et al., 2007) has highlighted the proactive role of social support on the adverse effects of parental loss and orphanage placement and thus warrant exploration in the present study.

Another variable that has been linked to the well-being of orphaned children is self-efficacy (Kiyiapi, 2007). Bandura (1986, 2002) refers to self-efficacy as individual's belief in their capabilities to organise the motivation, the cognitive resources and personal agency to produce a desired outcome. Bandura emphasises that self-efficacy is the most essential of all the human forms of agency that helps people to persevere in the face of difficulty and enhance the quality of an individual's functioning and emotional well-being. Likewise, self-efficacy promotes resilience through fostering competence and self-worth during adversities (Hamill, 2003).

Despite the protective role of self-efficacy on well-being, there is scarce research on relation to children who are orphaned. Notably, Worden (1996) highlighted low levels of self-efficacy in orphans. In her research, Kiyiapi (2007) argues that high self-efficacy help

orphaned youth to develop internal resources to confidently cope with stressful events and appraised hassles as challenges rather than difficulties. Given the scarce research on the influence of self-efficacy on orphans' well-being, studies are warranted.

Moreover, resilience as a personality characteristic also relates to well-being in children. Resilience is viewed as qualities embedded in children that buffer against adverse effects of stress and promote positive adaptation in the face of adversities (Brooks, 2006; Wagnild & Young, 1993). These factors include easy temperament, self-mastery, self-efficacy, problem-solving and planning skills, personal competence and acceptance of self and life. Despite the protective role of resilience, research has highlighted that resilience as a characteristic of individual's personality is hardly measured (Wagnild & Young, 1993), and there is minimal information on the specific resilience characteristics present in orphans (Eppler, 2008). Notably, self-efficacy and self-care (Mohangin et al., 2011), as well as intelligence (Adu, 2011) have been highlighted as resilience characteristics that promote well-being in orphanage-placed children. Given the few existing studies on the influence of resilience on well-being in orphans, research is warranted.

In Africa and, particularly in Ghana, protective factors for orphans' well-being can be traced to child rearing practices that is carried out through the traditional inheritance system that serve as a medium through which extended families and community members provide social support to orphans (Ansah-Koi, 2006; Kuyini et al., 2009). Through the traditional inheritance system, elders of a clan select a member of the extended family, and depending on that member's ability to care for the orphaned children, to assume the parental role of looking after the offspring of the deceased – whether the deceased is a man or a woman (Ansah-Koi, 2006; Apt et al., 1998). This practice has also been noted in many other African countries, notably Zimbabwe (Foster, 2000) and Kenya (Nyambenda et al., 2003). Through this practice, orphans receive continued care, reinforced social bonds as well as reduced emotional and

psychological stress following parental loss. Research continues to show that support (social, material and emotional) from friends, extended families, significant others, community members and organisations is a protective factor on Ghanaian orphans' well-being (Adu, 2011). Moreover, Adu (2011) also notes that orphans' intelligence is a positive attribute that fosters self-worth, positive mood and promotes well-being. The review of the literature on the protective factors of Ghanaian orphans' well-being shows that studies on the role of social support is seemingly gaining grounds, however, research on the role of positive individual attributes are scarce and warrant research.

This study was part of a broader study that aimed to explore the psychological functioning and experiences of Ghanaian orphans placed in orphanages, in comparison to non-orphaned children who lived with their parents in Accra, Ghana. The present paper explored the role of perceived social support, self-efficacy and resilience on stress (as measured by the symptoms of depression and anxiety) in Ghanaian orphanage-placed children in comparison to non-orphans. Against this background, we explored the following hypotheses: (1) There would be significant differences between orphanage-placed children and non-orphaned children on self-efficacy, (2) There would be significant differences between orphanage-placed children and non-orphaned children on perceived social support, (3) There would be significant differences between orphanage-placed children and non-orphaned children on resilience, (4) Participants' perceived social support would emerge as significant negative predictor of their stress levels (depression and anxiety), (5) Participants' self-efficacy would emerge as significant negative predictor of their stress levels (depression and anxiety), (6) Participants' resilience would emerge as significant negative predictor of their stress levels (depression and anxiety), (7) Participants' perceived social support would emerge as significant positive predictor of their resilience levels, and (8) Participants' self-efficacy would emerge as significant positive predictor of their resilience levels.

7.4. Methodology

7.4.1. Participants

Data were collected over a five-month period spanning from September 2012 to February 2013. We used purposive sampling technique with predetermined criteria to select the orphanage-placed children from four orphanages in Accra, Ghana; namely, Savers Foundation, Paradise Foster Home, God Saves Orphanage and Haven for Orphans Foundation (all names are pseudonyms). The orphans were included; if they were between the ages of 7 and 17 years, had lost one or both parents through death or abandonment (the latter criterion – abandonment – was used to rule out the inclusion of children who, although also staying in orphanages, had indicated their parents were still alive, even when their whereabouts were unknown), resided in an orphanage and were willing to participate in the study. One hundred and four children were originally sampled and following the inclusion criteria outlined above, we excluded four children (3.8%) from the data analyses on the basis that both of their parents were alive, although they were residing in an orphanage. After excluding four children, 100 orphans (96.2% response rate) were included in the study, as the experimental group, of which 43 (22%) were taken from Savers Foundation, 26 (13%) were from God Saves Orphanage, 20 (10%) were from Haven for Orphans Foundation and 11 (6%) were from Paradise Foster Home.

We used purposive sampling technique with predetermined criteria to select the non-orphans (control group) from two public schools in Accra, Ghana; namely, Dynamic Senior High School and Good Starters Basic School (all names are pseudonyms). The non-orphaned children were included; if children were between the ages of 7 and 17 years, attended public schools in Accra, lived with their parents and were willing to participate in the study. The original sample comprised 115 children and following the inclusion criteria outlined above, 15 children (13.05%) were excluded from the data for various reasons: 6 were orphans and

the remaining nine were also excluded because they were above the cut-off age of 17 years. After excluding the 15 children, the non-orphaned sample was reduced to 100 participants (86.95% response rate), of which 45 (23%) were taken from Dynamic Senior High School and 55 (28%) were from Good Starters Basic School.

7.4.2. Measuring instruments

The *Revised Children's Manifest Anxiety Scale* (RCMAS; Reynolds & Richmond, 1978) was used to screen for participants' anxiety symptoms. This measure has 37 items that assess three domains of anxiety symptoms; namely, physiological behaviours, worry and concentration. The 37 items on the scale are made up of 28 anxiety items that measure the three domains of anxiety and nine lie detectors that serve to reduce social desirability. RCMAS is recommended for children aged between 6 and 19 years (Reynolds & Paget, 1983; Reynolds & Richmond, 1978). The RCMAS is a 'yes-no' response-type of scale and scores range from 0 to 28, with a score of 19 and above suggesting clinical level of anxiety (Stallard et al., 2001). Cronbach's alphas ranging from .79 to .85, test-retest reliability of .98 as well as good concurrent and discriminant validity for the RCMAS have been reported (Reynolds & Paget, 1983; Reynolds, & Richmond, 1978). The internal consistency based on Cronbach's alpha of RCMAS for the present Ghanaian sample was .82.

The *Children's Depression Inventory* (CDI; Kovacs, 1992) was used to screen for participants' depressive symptoms. This measure has 27 items that assess five domains of depressive symptoms; namely, negative mood, interpersonal problems, ineffectiveness, anhedonia (the decreased ability to experience pleasure from activities that were previously enjoyable) and negative self-esteem (Kovacs, 1992), and it is recommended for children aged between 7 and 17 years (Kovacs, 1992). The items have three response options ranging from 0 (absence of symptoms) to 2 (severe symptoms) and the total scores range from 0 to 54. Scores are categorised into non-depressive symptoms (10 or less), mild depression (11–18),

and severe depression (19 and above; Kaslow et al., 1984; Smucker et al., 1986). Good psychometric properties including Cronbach alphas ranging from .83 to .89, split-half reliability of .77 to .81, test-retest reliability of .54 to .87, and concurrent validity of .71 to .84 have been established (Kovacs, 1992; Smucker et al., 1986). The internal consistency based on Cronbach's alpha of the CDI for the present Ghanaian sample was .77.

The *14-item Resilience Scale* (RS-14; Wagnild, 2009b) was used to measure participants' levels of individual resilience. This 14-item, self-report is a shorter scale of the 25-item resilience scale, and assesses personal competence and acceptance of self and life, both which are positive personality characteristics that enhance individual adaptation (Wagnild, 2009b). The RS-14 is a 7-point Likert scale with scores ranging from 1 (strongly disagree) to 7 (strongly agree). Its total scores are categorised into low (14–64), medium (65–81), and high (82–98) resilience (Wagnild, 2009b). Strong psychometric properties that include Cronbach alphas ranging from .72 to .91, test-retest reliability of .84, and good content and concurrent validity have been reported (Abiola & Udofoia, 2011; Wagnild, 2009a). In addition to its child-friendly language, and its wide use for all age groups (Windle et al., 2011), this measure seems appropriate for the study. The internal consistency based on Cronbach's alpha of RS-14 for the present Ghanaian sample was .79.

The *General Self-efficacy Scale* (GSS; Schwarzer & Jerusalem, 1995) was used to assess participants' general self-efficacy. This 10-item self-report measure assesses the general sense of self-efficacy of coping with daily hassles and adapting after the experience of stressors. The GSS has responses ranging from 1 (not at all true) to 4 (exactly true). Internal consistency values ranging from .79 to .91, test-retest ranging from .55 to .75, as well as good criterion, discriminant and concurrent validity have been established across a wide population including children and orphans (Jerusalem, 1990; Kiyapi, 2007; Schwarzer et al., 1997;

Schwarzer & Jerusalem, 1995). The internal consistency based on Cronbach's alpha of GSS for the present Ghanaian sample was .79.

The *Multidimensional Scale of Perceived Social Support* (MSPSS; Zimet et al., 1988) was used to screen for participants' perceived adequacy of social support. This 12-item measure assesses perceived social support (PSS) from three sources (family, friend and significant others). The MSPSS is a 7-point Likert scale, with scores ranging from 1 (strongly disagree) to 7 (strongly agree), with a higher score reflecting a greater perceived social support. Good psychometric properties for the MSPSS have been reported, including internal consistency values ranging between .69 and .90 for the subscales, and .79 and .89 for the entire scale (Cluver et al., 2008; Getachew et al., 2011). The internal consistency based on Cronbach's alpha of MSPSS for the present Ghanaian sample was .87.

7.4.3. Procedure

After obtaining permission from the administrators and head teachers of orphanages and schools respectively, we administered the measures outlined above on orphans during their free periods (usually after school hours or during the weekends) in their respective orphanages and on non-orphaned children during their short-break periods at their respective school premises. Participants who could complete the measures by themselves were given the questionnaires to complete independently (these were older participants who were aged between 13 and 17 years). Those children who required assistance were interviewed on questions in the questionnaires by the first author and a research assistant (these were younger participants aged between 7 and 12 years). Participants were given a monetary value of GHC 5 (Ghanaian currency that is equivalent to US\$ 2) as a gesture of gratitude for participating.

7.4.4. Ethical considerations

The research ethics committee (REC, Humanities) at Stellenbosch University, South Africa, granted ethics clearance for the study to be conducted. Moreover, the Ghana

Education Service and the Department of Social Welfare in Accra, Ghana, gave permission for the study to be conducted in schools and orphanages respectively. Additionally, we obtained written consent from the parents (of non-orphaned children), legal guardians (of orphaned children), and administrators of orphanages for orphans who did not have a legal representative. Lastly, all children who participated in the study gave assent. To adhere to the ethical principle of confidentiality, questionnaires were securely stored away from the reach of unauthorised individuals, and to ensure participant anonymity, codes were used to identify participants. Contingency plans were put in place in the eventuality of the need for referral of the children for psychological support. Despite these plans, however, no participant expressed nor even implicitly displayed (at any time during the course of data gathering) the need for the counselling services that were made available. The Graduate School of the Arts and Social Sciences at Stellenbosch University funded the present study as part of the scholarship of the first author's doctoral research.

7.4.5. Data analyses

Statistical analyses were carried out using the Statistical Programme for Social Sciences (SPSS, version 20.0 for windows). One-way analysis of variance (ANOVA) was used to compare differences between orphans and non-orphans on depression, anxiety, perceived social support, self-efficacy and resilience. The Pearson correlation coefficients were used to determine association between variables and Regression analyses were carried out to explore variables that emerged as predictors of depression, anxiety and resilience.

7.5. Results

7.5.1. Descriptive statistics

Descriptive analyses were carried out to explore age and sex patterns of the participants in the study. The age for all children considered ranged from 7 to 17 years ($M = 13.34$ years, $SD = 3.10$; for orphans: $M = 13.31$ years, $SD = 3.14$; for the control group: $M = 13.34$ years, $SD = 3.10$).

13.37 years, $SD = 3.08$). There was no significant age difference between the two groups, $t(198) = -0.14, p > .05$. The age for all boys ranged from 7 to 17 years ($M = 13.01$ years, $SD = 3.29$; for orphans: $M = 13.03$ years, $SD = 3.29$; for the control group: $M = 12.98$ years, $SD = 3.32$). There was no significant age difference between the two groups, $t(118) = 0.08, p > .05$. The age for all girls ranged from 7 to 17 years ($M = 13.84$ years, $SD = 2.74$; for orphans: $M = 13.72$ years, $SD = 2.88$; for the control group: $M = 13.95$ years, $SD = 2.62$). There was also no significant age difference between the two groups, $t(78) = -0.37, p > .05$.

7.5.2. Orphans and non-orphans on anxiety, depression, resilience, self-efficacy and perceived social support

One-way analyses of variance (ANOVA) were carried out to explore the differences between the orphans and non-orphans on overall scores of depressive and anxiety symptoms (as also reported in Salifu Yendork & Somhlaba, 2014), perceived social support, self-efficacy and resilience. As presented in Table 7.1., 75 (75%) of the orphans and 89 (89%) of the non-orphans had scores of anxiety that fell below 19, which is the threshold score indicating clinical anxiety symptom level. Moreover, 25 (25%) of the orphans and 11 (11%) of the non-orphans had scores that ranged between 19 and 28 (thus indicating clinical anxiety symptoms).

Additionally, 59 (59%) orphans and 60 (60%) non-orphans had scores of depression that fell below 10, which is the scores indicating non-depressive symptoms. Also, 32 (32%) orphans and 31 (31%) non-orphans had scores of depression that ranged from 11 to 18 (that indicated mild depression). Lastly, nine (9%) orphans and nine (9%) non-orphans had scores of 19 and above (that indicated severe depression). In all, 41 (41%) orphans and 40 (40%) non-orphans were mildly-to-severely depressed.

The frequency results for depression and anxiety for the orphaned children pointed to the heightened emotional vulnerability, which has been highlighted in previous research (notably, Fawzy & Fouad, 1999; Wolff & Fesseha, 1999).

Concerning resilience, 34 orphans (34%) and 42 (42%) non-orphans scored in the low range, 40 (40%) orphans and 39 (39%) non-orphans were moderately resilient and 26 (26%) orphans and 19 (19%) non-orphans were highly resilient. In all, 66 (66%) orphans and 58 (58%) non-orphans were moderately-to-highly resilient.

The participants' scores for self-efficacy (which has a maximum score of 40) ranged from 10 to 40 for orphans and 15 to 40 for non-orphans. For the orphaned sample, 54 participants (54%) had scores of self-efficacy that ranged from 30 to 40, which to us suggested high levels of self-efficacy beliefs. In comparison, 42 participants (42%) of the non-orphaned group had scores that ranged from 30 to 40, which also suggested high levels of self-efficacy beliefs.

Regarding perceived social support, the overall scores ranged from 12 to 84 for orphans. For the three subscales, orphaned children's scores ranged from 4 to 28, with scores ranging from 25 to 28 being in the high range. For this group in the 'Significant Others' subscale, 30 participants (30%) had scores ranging from 25 to 28. For the 'Family' subscale, 22 participants (22%) had scores ranging from 25 to 28. For the 'Friends' subscale, 35 participants (35%) had scores that ranged from 25 to 28. Taken together, it was noteworthy that more than a third of the sample of orphaned children had perceptions of social support received from friends, compared to the number of children who perceived social support from significant others and those who perceived support from family. For the non-orphans, overall scores for the scale ranged from 20 to 84. For the three subscales, non-orphaned children's scores ranged from 4 to 28, with scores ranging from 25 to 28 being in the high range. For this group in the 'Significant Others' subscale, 31 participants (31%) had scores ranging from

25 to 28. For the ‘Family’ subscale, 41 participants (41%) had scores ranging from 25 to 28. For the ‘Friends’ subscale, 12 participants (12%) had scores ranging from 25 to 28. Taken together, it was noteworthy that more than 40% of the sample of non-orphaned children had perceptions of social support received from family, compared to the number of those children who perceived social support from significant others and those who perceived support from friends.

The ANOVA results revealed significant differences between orphans and non-orphans on anxiety [$F(1, 145) = 4.29, p < .05$]; and two subscales of the perceived social support measure; family [$F(1, 198) = 5.56, p < .05$] and friends [$F(1, 197) = 8.16, p < .01$]. Orphans ($M = 13.55, SD = 6.44$) showed more anxiety symptoms than non-orphans ($M = 11.93, SD = 4.31$) and had stronger perceptions of support from friends ($M = 20.31, SD = 6.21$) than non-orphans ($M = 17.84, SD = 5.99$), but non-orphans ($M = 21.05, SD = 6.25$) had stronger perceptions of support from family than orphans ($M = 18.81, SD = 7.15$).

Table 7.1.

Summary of Analyses of Variance Results for Scores on the Measures for Orphans and Non-orphans

Measures	Orphans		Non-orphans		<i>F</i>	<i>p</i>
	M	(SD)	M	(SD)		
RCMAS	13.55	(6.44)	11.93	(4.31)	4.29	.040*
CDI	9.72	(5.69)	9.98	(6.41)	0.09	.76
RS-14	69.59	(15.61)	66.50	(15.02)	1.99	.16
GSS	28.70	(7.12)	28.20	(5.60)	0.3	.59
MSPSS: Total	59.89	(15.62)	59.01	(15.18)	0.16	.69
Family	18.81	(7.15)	21.05	(6.25)	5.56	.019*
Friends	20.31	(6.21)	17.84	(5.99)	8.16	.005**
Significant others	20.77	(5.68)	20.01	(6.22)	0.81	.37

Note. RCMAS = Revised Children's Manifest Anxiety Scale; CDI = Children's Depression Inventory; MSPSS = Multidimensional Scale of Perceived Social Support; GSS = General Self-efficacy Scale; RS-14 = 14-item Resilience Scale.

p* < .05, *p* < .01

7.5.3. Correlation analyses

The Pearson correlation coefficients were used to explore the association between depression, anxiety, perceived social support, self-efficacy and resilience. For the orphaned children, a strong significant positive correlation emerged between depression and anxiety ($r = .63, p < .001$) and *vice versa*. In addition, a strong significant positive correlation emerged between self-efficacy and resilience ($r = .66, p < .001$). For the non-orphaned children, a moderate significant positive correlations emerged between depression and anxiety ($r = .42, p$

< .001). The results suggested that the more anxious the participants were, the more they evinced depressive symptoms and *vice versa*. Furthermore, a strong significant positive correlation emerged between self-efficacy and resilience ($r = .59, p < .001$). This suggests that the higher participants' self-efficacy, the higher their own level of resilience.

For the non-orphaned children, a weak significant negative correlations were found between anxiety and self-efficacy ($r = -.27, p < .001$); depression and social support ($r = -.39, p < .001$); depression and self-efficacy ($r = -.40, p < .001$); depression and resilience ($r = -.39, p < .001$). These results suggested that the lower the levels of the non-orphans' self-efficacy, perceived social support and resilience, the more anxious and depressed they were. In addition, a moderate significant positive correlation was found between perceived social support and self-efficacy ($r = .51, p < .001$), thus suggesting that the stronger the non-orphaned children's perceptions of social support, the higher were their self-efficacy levels. Lastly, a moderate significant positive correlation was found between perceived social support and resilience ($r = .5, p < .001$), thus suggesting that the stronger the non-orphans' perceptions of social support, the higher were their resilience levels. The results are presented in Table 7.2.

Table 7.2.

Summary of Intercorrelations for Scores on RCMAS, CDI, MSPSS, GSS and RS-14 for Orphans and Non-orphans

		Measures									
1. RCMAS		2. CDI		3. MSPSS		4. GSS		5. RS-14			
Orphans	Non-orphans	Orphans	Non-orphans	Orphans	Non-orphans	Orphans	Non-orphans	Orphans	Non-orphans	Orphans	Non-orphans
1	-	-	.63***	.42***	-.05	-.15	.11	-.27**	.03	-.18	
2					-.16	-.39***	-.02	-.4***	-.13	-.39***	
3							-.07	.51***	.06	.5***	
4									.66***	.59***	
5									-	-	

Note. RCMAS = Revised Children's Manifest Anxiety Scale; CDI = Children's Depression Inventory; MSPSS = Multidimensional Scale of Perceived Social Support; GSS = General Self-efficacy Scale; RS-14 = 14-item Resilience Scale.

** $p < .01$. *** $p < .001$

7.5.4. Regression analyses

The stepwise regression analyses (backward stepwise procedure) were carried out to explore the variable(s) that would emerge as significant predictor(s) of depression and anxiety in the participants. Perceived social support, self-efficacy and resilience were considered as independent variables whereas depression and anxiety were considered as dependent variables in both groups. For orphans, the initial results indicated that the independent variables explained 1% of the variance in anxiety ($R^2=.01, F(3, 87) = .30, p > .05$) and 4% of the variance in depression ($R^2=.04, F(3, 90) = 1.24, p > .05$). None of the independent variables emerged as a significant predictor of anxiety (perceived social support: $\beta = -.07, p > .05$; self-efficacy: $\beta = .07, p > .05$; resilience: $\beta = -.01, p > .05$) and depression (perceived social support: $\beta = -.16, p > .05$; self-efficacy: $\beta = .02, p > .05$; resilience: $\beta = -.11, p > .05$).

For non-orphans, the initial results revealed that the independent variables explained 7% of the variance in anxiety ($R^2=.07, F(1, 95) = 7.26, p < .05$). Through the backward

elimination procedure, self-efficacy emerged as a significant negative predictor of anxiety ($\beta = -.27, p < .05$). The result suggested that the higher their self-efficacy, the less anxious they were. Regarding depression, the initial results revealed that the independent variables explained 22% of the variance in depression ($R^2 = 0.22, F(3, 93) = 8.92, p < .05$), with perceived social support ($\beta = -.25, p < .05$) and self-efficacy ($\beta = -.27, p < .05$) emerging as significant negative predictors of depression. The results suggested that the higher their self-efficacy and perceived social support, the less depressed they were. The results confirmed the research hypotheses for the non-orphaned group:

- *Participants' self-efficacy would emerge as significant negative predictor of their stress levels (depression and anxiety).*
- *Participants' perceived social support would emerge as significant negative predictor of their stress levels (depression and anxiety).*

Further regression analyses were carried to explore whether perceived social support and self-efficacy (independent variables) would emerge as significant predictors of resilience in the participants. The results, presented in Table 7.3., revealed that for orphans, the independent variables explained 45% of the variance in resilience ($R^2 = .45, F(2, 91) = 36.76, p < .001$), with self-efficacy ($\beta = .67, p < .001$) emerging as a significant positive predictor of resilience. The result suggested that the higher the orphans' self-efficacy levels, the more resilience they were.

For the non-orphans, the result revealed that the independent variables explained 41% of the variance in resilience ($R^2 = .41, F(2, 95) = 33.26, p < .001$). Both perceived social support ($\beta = .26, p < .01$) and self-efficacy ($\beta = .47, p < .001$) emerged as significant positive predictors of resilience, thus, suggesting that the higher the levels of their perceived social support and self-efficacy, the more resilient they were. The results (illustrated in Table 7.3.) confirmed the research hypothesis:

- Participants' self-efficacy would emerge as significant positive predictor of their resilience levels.

Table 7.3.

Predictors of Resilience for Orphans and Non-orphans

Variables	Orphans		Non-orphans	
	β	p	β	p
MPSS	.11	.16	.26	.006**
GSS	.67	.0001***	.47	.0001***

Note. GSS = General Self-efficacy Scale; MSPSS = Multidimensional Scale of Perceived Social Support.

p < .01. *p < .001

7.6. Discussion

This study explored (1) the differences between orphans and non-orphans on perceived social support, self-efficacy and resilience, (2) the influence of perceived social support, self-efficacy and resilience on stress (as measured by the symptoms of depression and anxiety), and (3) the influence of perceived social support and self-efficacy on resilience. Our results showed support from friends and family as salient aspects of the subjective appraisals of social networks of orphans and non-orphans. Moreover, although parental loss and placement in orphanages are life-changing experiences that potentially induce emotional distress in orphans, self-efficacy as a positive individual attribute was central to enhancing individual resilience.

Our data did not provide empirical support for the hypothesis that there would be significant differences between orphans and non-orphans on the overall scores for perceived social support. However, we found that perceptions of support from friends were significantly stronger for orphans when compared to their non-orphaned counterparts. In addition,

perceptions of social support from family emerged as significantly weaker for the orphaned children, in comparison to the non-orphans. We discuss each of these findings next.

The finding of stronger perceptions of perceived social support from friends for orphans was in line with findings from studies conducted in Kenya (Kodero, 2000) and Indonesia (Wanat et al., 2010), which showed stronger perceptions of support from friends in orphans relative to their non-orphaned counterparts. Also noteworthy, empirical support for high perceptions of support from friends among orphanage-placed children has been found in Ghana (Adu, 2011) and Cambodia (Emond, 2009). Considering the high child-to-caregiver ratio often found in orphanages, which limits social interaction and -support from care-givers (The St. Petersburg-USA Orphanage Research Team, 2008), as well as diminished contact with their families (Luecken, 2008), the present finding was not surprising. It is plausible that relationships with friends served as a major source of social network and interaction for the present sample of Ghanaian orphans. Moreover, given that peer support serves as a protective factor against the adverse effects of parental loss and orphanage placement (Adamson & Roby, 2011; Adu, 2011; Emond, 2009; Gilborn et al., 2006), the stronger perceptions of support from friends need to be understood from the vantage point of peers being the readily available source of support and interaction. Therefore, interventions should be aimed at psycho-educating orphans on the identification of important relationships, and strengthening those social ties and relationships that serve to promote well-being.

The finding of weaker perceptions of social support from family for orphaned children was partly consistent with research that indicates orphans' attenuated perceptions of social support from their families (Gilborn et al., 2006; Matshalaga, & Powell, 2002). Given that orphanhood is associated with the loss of alternative avenues for support and social interaction, especially from surviving parents and members of the extended family – that include aunts, uncles and other relatives (Foster, 2000; Seeley et al., 1993), the present

finding was not surprising. It is plausible that compared to the non-orphans who lived with both parents, the present sample of Ghanaian orphans' weaker perception of familial social support resulted from diminished contacts and interaction with their families following parental loss and placement in an orphanage. Given that supportive relationship with a family buffers the negative effects of adverse experiences (Duncan & Arnston, 2003), interventions should aim at the exploration of alternative avenues outside the orphanages for soliciting social support (e.g., from existing extended families, foster/adoptive families [or god-families]) and ways in which these avenues could be strengthened in order to increase the perceptions of orphans' social support.

Moreover, our findings did not support our prediction that there would be significant differences between orphanage-placed children and non-orphans on the measures of self-efficacy and resilience. However, it was noteworthy that both groups evinced high levels of self-efficacy and resilience on measures of these variables. For orphans, the findings were particularly significant considering their status as orphanage-placed children and their heightened emotional distress (as shown by their high levels of anxiety and depressive symptoms). Orphanhood is a life-changing experience that has negative consequences for the surviving children; placement in an orphanage is also a compounding factor and coupled with weaker perceptions of social support from families, it was surprising that they evinced high levels of self-efficacy and resilience. The results suggested that despite the adversities, the present sample of Ghanaian orphans possessed positive attributes that when nurtured could improve their well-being. These results were partly consistent with the literature that indicates positive attributes such as hope (Adamson & Roby, 2011), self-efficacy and self-care (Mohanjin et al., 2011), and intelligence (Adu, 2011) in orphanage-placed children. Research has emphasised the impact of positive peer relationships in the development of self-efficacy and resilience. Bandura (1986, 2002) emphasises that peers serve as models for the

development of efficacy behaviours and as reference point against which children compare the appraisal of their capabilities. Research has also emphasised that healthy peer relationships foster orphans' agency and increase their resilience (Evans, 2012). Against this background, it is plausible that the present sample of Ghanaian orphans' perception of strong support from friends fostered their self-efficacy and resilience. Interventions should focus on nurturing these positive attributes in order to improve the well-being of Ghanaian orphans.

Finally, consistent with our hypothesis, self-efficacy emerged as a significantly positive predictor of resilience in both groups of children. Although we found no empirical support for the present finding, it was noteworthy that self-efficacy is highlighted as a characteristic of individual resilience and is inversely related to stress (Brooks, 2006). Evidence also shows that efficacy beliefs enhance positive self-thoughts (Ozer & Bandura, 1990), and foster resilience as well as promote overall well-being (Bandura, 1986, 2002). Against this background, it is possible that the high levels of self-efficacy in the present sample of Ghanaian children fostered their resilient attributes in the context of both parental loss and placement in an orphanage. For example, self-beliefs about the ability to cope in emotionally-trying circumstances in these children could be closely associated with heightened self-perceptions of the ability to thrive against the challenges they experienced, whether these were related to parental loss or orphanage placement. Of interest to note pertaining to the relationship between self-efficacy and resilience, research highlighting the multifaceted nature of resilience has linked resilient attributes to aspects of personal competences (Wagnild & Young, 1993) as well as self-concept and self-regulation (Zolkoski & Bullock, 2012). Therefore, interventions aimed at promoting the well-being of orphaned and non-orphaned Ghanaian children should focus on fostering self-beliefs about competence in gaining and retaining some semblance of control over aspects of their lives that they experience as insurmountable. An approach streamlined towards developing positive self-

beliefs would serve to facilitate the children's overall outlook in life that promotes their awareness of their abilities to thrive in the face of adverse effects of parental loss and placement in an orphanage.

7.6.1. Implications for intervention

Given that both the orphans and non-orphaned children reported high levels of resilience and self-efficacy, interventions should be aimed at nurturing these positive personal attributes. Psycho-education should focus on the solidification of these attributes in the management of distress and the skills for strengthening healthy peer relationships. For example, mental health practitioners involved in orphan care (notably, psychologists, social workers, and trained counsellors) and policy makers could consider adopting intervention programmes aimed at enhancing emotional resilience and reducing mental health problems associated with orphanhood. Mental health practitioners, who work with orphans in other African countries, and in communities beyond the African continent where orphanhood directly translates to heightened emotional vulnerabilities, could also adopt intervention programmes aimed at nurturing positive personal attributes in order to improve the well-being of orphaned children. For example, the FRIENDS intervention programme (Action for Children, 2007; Barrett, Farrell, Ollendick, & Dadds, 2006; Stallard et al., 2005), which is based on principles of the cognitive behaviour therapy (CBT), is centred on promoting self-esteem, problem-solving, psychological resilience, self-expression, and building positive relationships with peers and adults.

7.6.2. Limitations

Despite the relative contribution of the present study in advancing the understanding of the psychological functioning of orphans placed in orphanages in Ghana (an under-researched terrain), there were five limitations that merit consideration. Firstly, we used a cross-sectional design that limited our ability to conclusively draw a causal association

between the stress-moderating variables (perceived social support, self-efficacy and resilience) and stress associated with parental loss and orphanage placement. For example, given that we found significant relationships between stress and the stress-moderating variables for non-orphaned children, we could not ascertain why these relationships did not emerge for orphaned children. Moreover, we could not determine whether the orphans' heightened emotional distress resulted from the loss of a parent or was due to placement in an orphanage. Future research could use longitudinal designs to enable the exploration of stress and the influence of perceived social support, self-efficacy and resilience on the experience of stress over time.

Secondly, the use of purposive sampling technique and a non-probability sample could have led to selection bias and limited our ability to generalise our results to the population of orphanage-placed children in Ghana. Therefore, future research could use a probability sampling technique in order to sample orphans that are statistically representative of the population of orphans in Ghana.

Thirdly, despite the present sample being large (considering the sample sizes of bereaved populations), we could not generalize our findings to the population of orphans in Ghana. Specifically, we could not ascertain if the observed patterns of the influence of perceived social support, self-efficacy and resilience on stress resulted from placement in an orphanage or were a general trend for Ghanaian orphans regardless of placement status. Therefore, future studies could sample orphans from orphanages and communities across Ghana to help ascertain if any significant differences emerged between these two groups.

Fourthly, no participant expressed the need for, nor elicited behavioural and emotional reactions to being interviewed that we could interpret as an indication of requiring counselling services during the course of data gathering. Owing to this, we remained unaware of the participants' well-being after the data collection periods. Therefore, future studies could

benefit from the inclusion of a follow-up enquiry into the well-being of orphaned children who participate in a study in which being interviewed has the potential to arouse emotional distress.

Fifthly, we did not explore the potential influence of ethnicity and culture on the psychological well-being of the present sample of Ghanaian children. In communities characterised by culturally-sanctioned and -oriented child-rearing practices, and where societal values and norms of relations and parentage directly influence virtually every aspect of that child's life, any disruption to the family equilibrium could have adverse effects on that child's internalisation of the important aspects of their culture. For example, disruptions resulting from death, displacement, abandonment or even placement in an environment with which the child is unfamiliar reduce the child's continued contact with his or her extended family network. For the orphaned children particularly, such a limited contact with the family networks could have implications for their perceptions of social support, their self-beliefs about coping with challenges and their self-perceptions of the ability to thrive in the face of adverse circumstances. Future research could consider the inclusion of ethnicity and aspects of culture in studying the psychological well-being of orphaned children.

7.6.3. Conclusion

On the question of whether social support, self-efficacy and resilience influenced stress in the present sample of Ghanaian orphans, our results showed that these variables were neither associated to, nor predicted stress. Future studies should consider exploring other stress-moderating variables to ascertain their influence on the experience of stress in Ghanaian orphans. However, our results revealed that, despite the status of orphanhood and heightened emotional distress for these children, protective factors including high levels of self-efficacy and resilience as well as strong perceptions of social support from friends were salient.

Chapter 8: Manuscript 5

Title: '*Blessed or cursed? At home or in exile?*' Exploring Ghanaian orphan narratives of orphanage placement

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Brief Summary: In this empirical manuscript, we used the qualitative data obtained from follow-up interviews with selected orphaned participants to delve into the subjective experiences of Ghanaian orphaned children, in order to draw on their experiences on their orphanhood status and overall psychological functioning following placement in orphanages. Deriving the themes identified from the thematic analyses of data (and using the prevailing socio-cultural context from which the subjective meanings of the placement in Ghanaian orphanages take place), we discuss orphans' experiences and overall sentiments about placement in an orphanage and how religion and spirituality enhanced the well-being of the Ghanaian orphaned children. We also discuss the implications of the findings for their overall psychological well-being, intervention and future research.

Status: As of 27 November 2014, the manuscript was still under review.

8.1. Abstract

There has been a surge in institutionalisation of Ghanaian orphans in recent times. However, little is known about orphans' experiences following placement. Drawing on data from follow-up interviews with 20 orphans, aged between 8 and 17 years, the present study explores orphans' experiences subsequent to placement in an orphanage. Through thematic analyses, we found that orphanages provide structure, nurturance, and the avenues for positive peer relationships that engender a sense of belonging and emotional well-being. They also evoke peer- and caregiver-relationship problems and financial constraints. Additionally, the Christian-religious orientation seemingly fosters orphans' well-being. Implications of the findings are discussed.

8.2. Introduction

Documented evidence on the Ghanaian culture shows a long history of support for, and adherence to, the traditional means of caring for children following parental loss. This includes the traditional inheritance system (clan members select a family member who act as a successor and inherit the obligations of the deceased parent) and fosterage where orphans are placed with uncles, aunts, or distant cousins to be cared for (Ansah-Koi, 2006; Kuyini et al., 2009). These practices create avenues for orphans to be raised as members of the 'adoptive' family. However, research has highlighted that with rural-urban migration trends, financial constraints on families and increased in the rate of orphanhood due to HIV infection, there has been a steady decline in the Ghanaian traditional means of orphan care (Ansah-Koi, 2006; Apt et al., 1998; Deter, 2008; Voyk, 2011). This has resulted in alternative care arrangements for orphans, which include adoption, foster care and institutionalisation (Department of Social Welfare, 2014).

To monitor the well-being of vulnerable children in alternative care systems, the Ghana Department of Social Welfare (DSW), UNICEF and Orphan Aid Africa have

developed the Care Reform Initiative (CRI) to ensure adequate training and resources for alternative care arrangements. This is aimed at ensuring that institutional care is used as a last resort after attempts to integrate vulnerable children into family settings have failed and to monitor the functioning of orphanages (DSW, 2014; MMYE & DSW, 2008). Despite measures of integrating orphans into the family setting (adoption and foster care), and to reduce the use of institutional care for orphans in Ghana, there has been an increase in providing orphanages for orphans and vulnerable children (Ansah-Koi, 2006; Simons & Koranteng, 2012). Attributed to this increase, has been the failure of the extended family system to cater for orphans and vulnerable children without family care (Kristiansen, 2009; MMYE & DSW, 2008). Although orphanages have cared for numerous vulnerable children in Ghana, very few studies have explored the experiences of the orphanage-placed orphans.

The literature has highlighted that Ghanaian orphanages provide structure, nurturance and a home environment that fosters a sense of belonging (Adu, 2011; Kristiansen, 2009). The bulk of other existing scholarly work, however, has found that many orphanages are operating illegally (DSW, 2008), and have limited accommodation, toilet, recreational and academic capacities (Simons & Koranteng, 2012), lack qualified staff, have inadequate medical care and have a high caregiver-to-child ratio (MMYE & DSW, 2008).

Other structural and operational problems include corrupt orphanage administrators (Colburn, 2010; Pyper, 2010) and malnutrition (Ribeira et al., 2009; Sadik, 2010). Moreover, problems that orphans cite as bothersome regarding their placement in orphanages ranged from generally negative caregiver attitudes (Adu, 2011; Kristiansen, 2009), limited quality food (Kristiansen, 2009) to community- and peer stigmatisation (Voyk, 2011). Given these systemic problems, coupled with limited research on the psychological functioning and experiences of orphans following placement in Ghanaian orphanages, the need for scholarly inquiry into these experiences is warranted.

Therefore, the present study aimed to explore the subjective experiences of orphans about their placement in four orphanages in Accra, Ghana. Such research would provide relevant information to mental health professionals and policy makers on appropriate ways of promoting orphan care and the overall psychological well-being of Ghanaian orphans.

8.3. Methodology

8.3.1. Research settings and participants

Twenty orphans (10 males and 10 females) were sampled from four orphanages in Accra, Ghana; namely, Savers Foundation, Paradise Foster Home, God Saves Orphanage and Haven for Orphans Foundation (all these are pseudonyms). All 20 participants were sampled for the follow-up interviews drawn from the quantitative data collected from 200 participants, the scope of the latter falls outside this paper. Participants were included in the study if they were aged between 7 and 17 years, had lost one or both parents (single- and double-orphaned, respectively) through death or abandonment, resided in an orphanage and were willing to participate. The selection of participants for the follow-up interviews was based on their age, gender, time since parental loss, duration of stay in the orphanages and the scores on the measures. The selection along these variables was done in order to include both younger and older participants, both male and female, those who had recently lost their caregivers and those whose loss had taken place in the distant past, those both recently and ‘temporal distantly’ placed in orphanages, those who scored high and those whose scores were low on the measures. All participants reported to be Christian, consistent with the self-described Christian orientation of the orphans.

8.3.2. Procedure

Semi-structured interviews were used to explore how they managed their distress and related experiences pertaining to orphanage placement. All the interviews took place in the participants’ respective orphanages, either after school hours or over the weekends. Being a

native of Ghana, and having the insider knowledge of the communities in which the four orphanages were situated in the Accra region, the first author conducted all the 20 individual interviews, which lasted for 15 to 20 minutes each. For their time and personal experiences shared with the interviewer, we gave each participant GHC 5 (the Ghanaian currency that is equivalent to US\$ 2.5).

8.3.3. Ethical considerations

The humanities research ethics committee (REC) at Stellenbosch University in South Africa gave clearance for the study. Additionally, the Department of Social Welfare and the individual orphanages in Accra, Ghana, granted permission to conduct the study in orphanages. We obtained consent from legal guardians and administrators designated to give ‘parental’ consent. Lastly, we sought informed assent from all orphans and also emphasized that their participation was voluntary, that they had a right to decline invitation to partake in the study (even if we had obtained consent from administrators and legal guardians), and that they reserved the right to withdraw from the study without consequences to them. We also assured participants of the confidentiality of their responses and that their identity would remain anonymous. We also made counselling services available should participants need referrals for psychological support. However, no child required or made use of the counselling services.

8.3.4. Data analyses

We analysed the data obtained from the interviews using the 7th version of Atlas.ti, which is the computer-assisted qualitative data analyses software (Muhr, 1991). Thematic analyses aimed to identify and report patterns within the data as well as interpret the various aspects of the research questions (Boyatzis, 1998) were used. Braun and Clarke’s (2006) recommended phases of thematic analyses, which included data familiarisation, initial code generation, searching for themes that are based on initial codes, review of themes, definition

and naming of themes, and report writing were also adopted. To understand orphans' experiences about placement in an orphanage, the first author, who was responsible for data analyses, immersed herself in the data by personally transcribing the interviews, reading through the transcripts and wrote memos, reflecting on the information presented after which initial codes were formed both from the data and from the literature (Miles & Huberman, 1994). After the generation of codes, codes were described in detail and classified. Texts that had similar codes were compared across interviews after which meanings were formulated in order to produce potential cluster of themes. Identified themes were then defined and labelled in accordance with the essence of the themes and their relation to the research questions. After the generation of themes, we interpreted the findings in light of the research questions and literature.

8.3.5. Trustworthiness of the results

In line with the literature on good practice in qualitative research, the validity of the results was ensured through several measures, which were consistent with Maxwell's (1992; 1996) conceptualisation of validity in qualitative research. These measures included: the provision of accurate and complete representation of participants' accounts of their experiences about placement in an orphanage; the interpretation made from the data was based on participants' perspectives that emerged from the interviews; alternative perspectives of experiences that emerged from the data were also presented. Consistent with literature on qualitative research (Creswell, 2007; Green & Thorogood, 2009), reliability was ensured by the acquisition of detailed data through the use of quality tape recorder, memos and comprehensive transcription of interviewed data.

8.4. Findings

The ages of participants ranged from 8 to 17 years. Of the 20 participants, nine (45%) had lost a father (paternal orphans), one (5%) had lost a mother, five (25%) had lost both

parents (double orphans) and five (25%) did not know the where-about of their parents (abandoned children). Two participants (10%) were in the senior high school (SHS), while eight (40%) were in the junior high school (JHS) and ten (50 %) were primary school learners.

Following the analyses of the data, we believed that the themes that emerged provided an adequate explanation of the data gathered which were presented by means of excerpts from the interviews. Although we will present each theme separately, all the themes were interconnected and as they reflected participants' experiences following placement in an orphanage. To ensure anonymity, the identities of the participants were protected through the use of identifiers (that included assigned interview number, age, sex, status of parenthood and grade level) to label participants' expressions.

In general, we found that ten (50%) out of the 20 participants felt happy about being placed in the orphanage while ten (50%) reported feeling happy and sad sometimes. Anxiety following placement was not reported in 19 (95%) children's accounts, with only one child (5%) reporting feeling anxious in the orphanage. Participants reported both positive and negative experiences that influenced their well-being. Themes that emerged, which are discussed in sections below, included early life experiences and overall sentiments about placement, and religion as pathway for well-being.

8.4.1. Early life experiences and overall sentiments about placement

From the participants' personal accounts, structural problems in the functioning of the extended family networks and -relationships following parental loss were reported to have resulted in them being placed in an orphanage. Also noteworthy was the participants' underlying ambivalence stemming from the subjective experience of placement as a given circumstance. Several participants felt powerless about their preferred living arrangements given that the decision about where to live after parental loss was taken for them by adults in

their lives. The following account from a child who had been living in the orphanage for over six years, after the death of both her parents, was a case in point:

"I came to live here... because my [maternal] aunt [whom I stayed with after my parents' death], is mentally ill... she always beat my sister and [me] and... [often kicked] us out of the house. But my other aunt in [United States of America] decided to bring us to this place [the orphanage... after she learned about my aunt's condition]... and [out of concern about] how she treat[ed] us..." (Participant 15, 12-year-old female double orphan in JHS)

Also extractable from the above expression is the extent to which the disempowering hierarchical power relations within the familial networks (particularly insofar as the decision-making powers being delegated to the parental figures – the aunts, uncles, and caregivers), like placement, could leave participants feeling ‘trapped’, and unable to define their life choices following parental loss. As the following account from a child who had lived in the orphanage for two years suggests, parental death that resulted in the orphanage placement served as a medium for which decisions were made for them, as a well-meaning gesture :

[After] my mother and father died, Maame Regina [administrator] came [and took] me and my brother to care for us (Participant 77, 17-year-old double orphan in JHS)

At times, participants seemed reluctant to renounce the value and curative effects that orphanage placement accrued, with self-definition and personal identity seen as embedded in the orphanage. Thus, the appreciation of the sanctuary that the orphanage provided, based on the information some participants reported to have sourced from their caregivers was implicit in the account of a child who had lived in the orphanage all his life, having been brought in after he was found abandoned soon after birth:

“I don’t know where I come from but I know how I got here... someone I don’t know brought me here... [after] he [found] me at the back of a building” (Participant 31, 13-year-old male child abandoned at birth, and currently attending primary school)

When specifically asked – ‘How do you feel about being here [in the orphanage]?’ – it was interesting to note participants’ varied responses, with some participants highlighting positive experiences whereas others highlighted negative experiences. For some, the emphasis on positive experiences that included the positive peer relationships, social support and overall emotional well-being revealed an intense need to belong, as illustrated in the following participants’ accounts:

“I feel happy to be here... because when a child... loses one or both parents and gets to the orphanage, he will have... like... brothers to play with, he will not feel lonely... when I am trying to do something [and I ask for help]... they [peers] help me... I do not feel alone.” (Participant 73, 15-year-old male paternal orphan in JSS, having lived in an orphanage for over six years)

“I feel happy being placed here... because of being with families, friends and people who love me” (Participant 2, 17-year-old female abandoned child in JHS, having lived in an orphanage all her life)

The centrality of the positive peer relationships to psychological well-being, and particularly the notion that these relationships engender a sense of belonging became evident in the expressed lamentation over the experience of occasional moments of peer-relationship problems. The following account from an orphan who had lived in an orphanage for ten years was a case in point:

“ ... sometimes the house [orphanage] is boring [because] people do not feel like talking to each other... it makes me feel sad.” (Participant 51, 17-year-old paternal female orphan in JHS)

Unsurprisingly, participants’ accounts revealed that orphanages signified a replication of the lost filial relationships predating the parental death, and participants’ experience of these ‘new homes’ was that they assumed parental role by providing the needed structure, nurturance, and a safe home environment. Simultaneously, the salience of orphanage life experienced as the ‘re-enactment’ of the stable family environments could be seen as symbolic representations of the yearning for the lost nurturance and comfort closely associated with the presence of the parents. The following expressions illustrate the point:

“I feel happy here because they [caregivers] take care of me, they give me food, they send me to school (Participant 50, 10-year-old paternal male orphan, attending primary school, and having lived in an orphanage for less than a year)

“I am happy to be living here... [because] they [caregivers] teach us everything our mothers [would have] taught us. In here, it feels like home because the mothers [caregivers] play the same role as our [biological] mothers.” (Participant 38, 16-year-old male paternal orphan in JHS, who had lived in an orphanage for five years)

The expressed experience of orphanages as virtual homes, and specifically the perceived *loco parentis* role of caregivers, could be seen as implicit affirmation of the orphanage placement as serving as the medium through which the provision of emotional and material needs of orphans got enacted, as well illustrated in:

“They [caregivers] make me happy [because] ... they play with me, they teach me my homework [and] talk to me nicely” (Participant 35, 12-year-old male double orphan attending primary school, who had lived in an orphanage for five years)

The positive experiences of orphanage placement notwithstanding, it would seem that, for some participants, such placement evoked negative experiences that ranged from financial constraints to peer relationship problems. With the status of being an ‘orphan from the orphanage’, was the expressed difficulty in transcending the perceived social stigma of burdening to those around them, and particularly challenges of ridding themselves of the guilt that inconveniencing others entailed. This is aptly illustrated in the expression of an orphan who had lived in the orphanage for five years:

“Sometimes they [orphanage administrators] wouldn’t pay [school fees] for us; and when I go to school, the teachers insult me and say that ‘the orphanage homes... don’t pay [tuition] fees’. When we come home and report this, [the administrators will often] say that we should stay home until they get the money... Somebody [a sponsor] was paying our fees when we were in the private school, when th[at] person stopped, all of us were taken to a public [school]” (Participant 35, 12-year-old male double orphans attending primary school)

The financial troubles with the public schooling (representing the loss of privileges of private schooling, with its constant donor funding) reported in the excerpt above seemed to point to the participants’ implicit resentment about the perceived unpredictability of the public schooling in Ghana.

Also prominent in some participants’ accounts of their orphanage-placement experiences were caregiver- and peer-relationship problems. Some participants, even for those who know no other life but that of an orphanage, lamented about their experience of orphanage life, despite all its good intentions, being an isolating reality. Some participants’ accounts of being bullied and having conflicted relationships with peers and caregivers were experiences that, to them, serve to militate against a sense of belonging that is the basic premise of orphanages as home for the homeless. Orphanage placement was thus fraught with

contradictions, given that participants sometimes felt a sense of belonging, however, the negative attitude of caregivers often negate this sense of belonging. The following accounts highlight the inherent paradoxes of orphanage placement:

“A girl [in the orphanage] told me that when people follow me they will die... a mother [caregiver] was [present] but she did nothing... because every day, she always curses me that it won’t be well with me, that my little sister is having AIDS and that my older brother is a mad boy who is roaming about” (Participant 15, 12-year-old female double orphan in JHS, and who had lived in the orphanage for over six years)

I don’t feel happy in this place because I don’t feel like I am being [considered] as a daughter. I want to be with my own parents. I want someone to take care of me [and consider] me as a daughter (Participant 2, 17-year-old female abandoned child in JHS, and who had lived in the orphanage all her life)

Considering the background of the orphans in Ghanaian orphanages, it would seem that these children had negative experiences prior to placement, which could have left some with traumatic memories that negatively impacted on their well-being. Despite the ambivalence towards placement and the negative experiences invoked by placement, it appeared that the orphanages were able to provide a home environment that offered parental care, love, security and fostered a sense of belonging in the present sample of Ghanaian orphans. This finding is in line with the literature that indicates that orphanages function as a virtual home for orphans and vulnerable children who lacked care (Licursi et al., 2013).

8.4.2. Religion as pathway for well-being

As already indicated, all the participants reported to be Christian. It was therefore not surprising that the influence of religion and spirituality on the well-being of the orphans were prevalent in their accounts. The positive influence of religion and spirituality on well-being

seemingly has empirical support (Blazer, 2009; Brown, Carney, Parrish, & Klem, 2013; Hadzic, 2011). Religion and spirituality are deemed to promote an individual's well-being through the provision of personal meaning and purpose in the wake of difficulties (Koenig, 2010), as a resource for comfort and a sense of direction in life (Angell, Dennis, & Dumain, 1998), and generate positive emotions (Koenig, 2010; Seybold & Hill, 2001). Adherence to religious beliefs has also been linked to the provision of social support networks (Salsman, Brown, Brechting, & Carlson, 2005), coping resources (Mohangi et al., 2011; Wanat et al., 2010) and positive self-perception and healthy beliefs (Joshi, Kumari, & Jain, 2008). Given this background, the religious orientation of the present sample of Ghanaian orphans was expected to be a prominent feature in their personal accounts of their livelihoods in the orphanages. Themes that emerged regarding the role of religion and spirituality on the participants' well-being are thus discussed next.

In line with the African religious beliefs about life in general (Kombo, 2009; Mbiti, 1975), and particularly in the Ghanaian context (Evans, 1950), religion and spirituality appeared as definitive characteristics of the participants' subjective worldview. Accordingly, the daily experiences and hassles were generally understood within the prevailing framework of the omnipresent supernatural force that underpinned the participants' existence, as illustrated in the young orphan's description of her religious orientation:

“God created the earth, and the heaven, and the plant, and the animals” (Participant 45, 8-year-old female abandoned child, attending primary school)

It also appeared that, even in subjective accounts of overall well-being, participants used religion and spirituality to take ownership of their feelings, which included positive affect derived from an opportunity for shared religious activities. This was illustrated in the account of a child who had lived in an orphanage for 2 years:

"I have been happy because of the church. When we are [attending] church services on Fridays and Sundays, it makes me feel happy... I like singing" (Participant 77, 17-year-old female double orphan in JHS)

In line with the theory of hope (Snyder, 1989; 2002), it appeared that religion was viewed as a pathway to goal achievement. When orphans gave accounts of their self-beliefs about handling distress and their perceived abilities to withstand challenges, religion still featured as a salient theme in the subjective appraisal of hope and optimism, as illustrated in the following account of an orphan who had lived in the orphanage for ten years:

"With God all things are possible, so I always tell God my aim... But I am learning hard so that I can go to the university or polytechnic because they say that education is the key to success. I know that with education and also with God it will be possible for me to make it to the university. When you have God and you study, God will help you. And when you study and you also have God, you can achieve your aims. So when I [study], I add [faith in] God, and when I pray, I also study [hard]" (Participant 51, 17-year-old female paternal orphan in JHS)

The inference that could be drawn from the excerpt is that, for participants, religion was seen as enhancing the potential for drawing on the inner strengths and identifying perceived capacities for achieving the set goals. This could be interpreted as indicative of personal resilience and overall psychological adjustment, despite the documented literature evidence of stress associated with orphanhood and placement in orphanage.

Also evident from participants' accounts was the centrality of religious faith as a resource for coping in times of distress. In this regard, religion and spirituality functioned as an interim relief from discomfort and despondency borne out of frustrated goals, as illustrated in the following expression of a child who had lived in the orphanage for ten years:

“Sometimes I just sit down and say, ‘why is this girl not talking to me?’. I [would] be thinking about it, ‘what have I done to her? What have I done?’ I [would then] ask her, or talk to her. But when she doesn’t respond, all that I [would] say is that, ‘God, You know why she is angry with me but I don’t know, so You will be the Person to let her talk to me’, then I will leave it... I normally forced [things through], but when [that] doesn’t work, I just leave it [to] God ...” (Participant 51, 17-year-old female paternal orphan in JHS).

From the above excerpt, it was interesting to note the inconsistency in which ownership of a personal experience (unresolved peer relationship problem) was simultaneously embedded in the deferral of responsibility (in this case, resolution of the problem) to a supernatural being. The varied, and at-times repeated, reference to the Deity – ‘God’, ‘You’, ‘Person’ – in the expression could be seen as a muted protest against, and ambivalence towards, the much-sought-after divine intervention that is seemingly not always yielding a desired outcome, despite relentless appeals.

In conclusion, we hold the view that the analyses of the present data have made substantial contributions to the understanding of the orphans’ subjective experiences following placement in an orphanage, within the Ghanaian context. The data also provided a meaningful insight into the psychological functioning of orphans placed in Ghanaian orphanages.

8.5. Discussion

Although we could not conclusively ascertain whether the experiences that Ghanaian orphans in the four orphanages shared predated their respective placement in the orphanages, the findings demonstrated that orphanage placement evoked varied experiences. Our findings showed that, although orphanages were able to provide care, problems that included peer- and

caregiver-relationship problems and financial constraints, if left unattended, could adversely affect the well-being of orphans.

From the participants' accounts, orphanages seemingly assumed parental responsibilities by providing structure, nurturance, a home environment, and avenues for positive peer relationships that engendered a sense of belonging. Consistent with this is evidence that orphanages provide material resources and education (Adu, 2011; Emond, 2009; Freidus, 2010; Zimmerman, 2005), a home environment (Kristiansen, 2009), the avenue for peer positive relationships that enhance social support (Adu, 2011; Emond, 2009; Kristiansen, 2009; Zimmerman, 2005), and foster a sense of belonging in children (Kristiansen, 2009). Thus, it would seem that, for some participants, the orphanages were able to fulfil the purposes for which they existed (Licursi et al., 2013), especially when considering the experiences of the children that necessitated placement. The positive experiences associated with orphanage placement could promote psychological well-being of Ghanaian orphans, given that they could provide orphans with the protection they need to thrive.

Some participants, however, reported that orphanage placement was associated with financial constraints. Consistent with this is the previous Ghanaian- (MMYE & DSW, 2008) and Chinese research (Shang & Wu, 2003) indicating financial constraints as limiting the operations of institutions of orphans care.

Orphans also reported peer- and caregiver-relationship problems that often induced feelings of isolation. Empirical support exists for orphanages being associated with relationship problems with peers (Kristiansen, 2009; Wolff & Fesseha, 1998) and caregivers (Kristiansen, 2009), with the lack of biological relations between caregivers and orphans being the factor (Freidus, 2010). Poor caregiver-orphan relationships could adversely impact on the psychological well-being of Ghanaian orphans placed in orphanages, given that caregivers are expected to act *in loco parentis* for the orphans (cf. Bynum & Kotchick, 2006;

Veneziano, 2000). Similarly, given the benefits of positive peer relationships among orphanage children, which include broadened social networks and enhanced social support and safety (Kristiansen, 2009), it is expected that peer-relationship problems might have detrimental effects on orphans' well-being.

On the issue of whether placement in an orphanage is a blessing or a curse, from the accounts of the orphans in the present study, it seemed that orphanage placement was both a blessing and a curse given that such placement evoked both positive and negative experiences. Moreover, on the issue of whether orphanage placement evoked feelings of being at home or in exile, given the results of our findings, it could be argued that some of the children in the present study felt at home in the orphanage whereas others felt they were in exile. Given the diverse experiences that emerged from the analyses, appropriate steps need to be taken in order to improve the quality of care for children in Ghanaian orphanages. Therefore, psychosocial interventions should focus on the containment of negative emotions surrounding negative experiences about orphanage placement, the psycho-education of orphans on skills for strengthening positive peer relationships, and caregiver psycho-education dedicated to appropriate ways for caring for orphaned children.

Chapter 9: Summaries and Conclusions

In this chapter, the main findings and conclusions drawn in the various manuscripts, the overall conclusion based on all the findings of the present study as well as the overall implications of the findings are discussed.

9.1. Introduction

Globally and in the African context, placement of orphans in institutions of orphan care is common, although there is continuing debate on the impact of such placement on the well-being of children. The literature on the psychological well-being of orphans placed in orphanages has yielded inconsistent results, with some studies highlighting positive mental health whereas others have highlighted poor well-being in the children concerned. Particularly in the Ghanaian context, few studies have been conducted on the psychological well-being of children placed in an orphanage and the results of these studies have not yielded in-depth results. It was against this background that the present study sought to explore the psychological functioning and experiences of orphaned children placed in orphanages in comparison with non-orphaned children who lived with their parents in Accra. In contrast to other studies in Ghana (Adu, 2011; Kristiansen, 2009), the present study was able to explore broader aspects of psychological well-being in a large sample of orphans compared with a control group of non-orphans through a mixed-method design that incorporated aspects of both qualitative and quantitative approaches.

The present study began with a review of literature on the well-being of orphaned children in Africa. Following the review was an exploration of the statistical relationship between stress (as measured by the symptoms of both depression and anxiety), coping and the overall quality of life of orphaned children in comparison with their non-orphaned counterparts. Additionally, using both qualitative (content analysis) and quantitative (chi-square test and one-way ANOVA) data analysis techniques, the present study explored the

nature of the statistical relationship between reported problems, coping and coping efficacy in orphans in comparison with the non-orphaned children. Furthermore, the study explored the statistical relationship between stress and stress-moderating factors (notably, perceived social support, perceived self-efficacy and resilience) in orphans in comparison with non-orphaned members of the control group. Moreover, the present study explored the subjective experiences of Ghanaian orphaned children and their overall psychological functioning following placement in an orphanage through semi-structured interviews. In the current chapter, the main findings are reported and the conclusions drawn in the various manuscripts as well as the association of the findings in the manuscripts to the objectives of the present study are discussed.

9.2. Literature Review on Orphanhood in Africa

The present study began with an inquiry into the subject of orphanhood and the well-being of orphans in the African context. The review, which was presented in Chapter 4 (Manuscript 1), was centred on the effects of parental loss on children's well-being, sociocultural factors in Africa that impact on the well-being of orphans, the merits and demerits of foster care and the institutionalisation of orphans, and the contribution that psychology can make towards the crisis concerning orphanhood in Africa.

Following the review, the major issue that was brought to light was the paucity of research on the subject. However, the few existing literature sources revealed that, besides the general negative impact of parental loss on children's well-being, orphans in Africa were uniquely affected by the impact of certain sociocultural practices, the breakdown of the traditional means of orphan care, poverty, disease (particularly the HIV/AIDS pandemic) and little governmental involvement in orphan care. These factors could negatively impact on the well-being of African orphans. Another concern that arose was that little attention was paid to

the psychological well-being of orphans and that little was known about the various care arrangements and their impact on the well-being of orphans in Africa.

Given the above findings, it was concluded that there was a need for psychological research on the subjective experiences and psychological functioning of orphans in Africa. It was also argued that the findings of the psychological research would bring to light the risks and protective factors associated with orphanhood in the African context. These findings can inform intervention approaches and guide policymakers about best strategies for prevention of mental health problems in orphans and could inform interventions for the improvement of orphans' well-being. It was against this background that the present study with the associated objectives was formulated.

9.3. Stress, Coping and Overall Quality of Life

Additionally, the present study aimed to determine the overall quality of life of the population of orphans in Accra orphanages in comparison to non-orphaned children, explore the levels of stress of orphans placed in orphanages in Accra in comparison to non-orphaned children, inquire into the differences between orphans and non-orphans on coping strategies, and find out whether participants' stress levels and coping strategies predict their overall quality of life. As presented in Chapter 5 (Manuscript 2), it was found that orphaned children were more anxious than non-orphaned children but there was no significant difference between orphans and non-orphans in depression. However, the results showed that a considerably high number of orphaned children (41%) relative to non-orphans (at 40%) showed mild-to-severe depressive symptoms. The results also showed that there was no significant difference between orphaned- and non-orphaned children in their overall perception of their quality of life. Additionally, the association between stress and quality of life revealed that for orphaned children, anxiety emerged as a significant negative predictor of quality of life whereas depression emerged as a significant negative predictor of quality of life

for non-orphaned children. It was also found that support-seeking coping positively predicted the quality of life of orphaned children.

Based on these findings, it was concluded that irrespective of the parental status of the orphans and non-orphans (that is, whether or not they had lost a parent), these two groups of Ghanaian children were equally vulnerable to psychological distress. However, for the orphaned children, support-seeking coping was a protective factor that was associated with the quality of their life. This brought to the fore that interventions aimed at improving psychological well-being should be aimed at both groups of children.

9.4. Common Problems, Coping and Coping Efficacy

Furthermore, the present study aimed to explore, the subjective distress in orphans in comparison to non-orphans, the kind of coping strategies that participants used to manage the distress and the efficacy of the strategies that they used. The results that were presented in Chapter 6 (Manuscript 3) revealed that for both groups of children, peer- and caregiver relationship problems and school-related problems were the sources of their distress. However, for orphaned children, relationship problems with peers were the major source of their distress, whereas for non-orphans, relationship difficulties with caregivers were the major source of their distress. Regarding coping, it was found that both orphans and non-orphans frequently used distraction, problem solving, emotion regulation, wishful thinking and support-seeking coping more often than coping strategies that included blaming others and self-criticism. When all children were considered, resignation featured more prominently in managing problems with caregivers than in managing problems with both school and peers. Moreover, adolescents used self-criticism and wishful thinking significantly more than children. Furthermore, it was found that blaming others was reported to be more efficacious in coping with school problems than relationship problems with peers. Resignation coping was

reported to be more efficacious in coping with problems with peers and with school than with caregivers.

Based on the above results, it was concluded that both orphans and non-orphans were vulnerable to psychological distress associated with peer and caregiver relationship problems and school-related problems. It was also concluded that relationships with peers were important to orphans and were a source of concern, especially considering that peers formed the major part of the social network of orphaned children. Additionally, it was concluded that the present sample of Ghanaian children possessed varied coping strategies, some of which were maladaptive. As a result, it was argued that there is the need for the psycho-education of both groups of children on the maladaptiveness of coping strategies that could result in poor well-being to improve their general coping strategies.

9.5. Stress, Social Support, Self-efficacy and Resilience

Moreover, the present study aimed to determine the differences between orphans and non-orphans on the stress moderating variables (perceived social support, perceived self-efficacy and resilience), find out whether participants' perceived social support, perceived self-efficacy and resilience predict their stress levels, and examine whether perceived social support and perceived self-efficacy predict resilience in the participants. The results, presented in Chapter 7 (Manuscript 4), showed that there were no significant differences between the two groups in the composite scores on perceived social support, self-efficacy and resilience, but there were significant differences between the two groups on the family and friends subscales of the perceived social support scale, with orphaned children perceiving stronger support from friends than non-orphans and non-orphans perceiving stronger support from family than orphaned children. It was also found that for orphaned children, perceived social support, self-efficacy and resilience did not predict stress (symptoms of depression and anxiety), but for non-orphaned children, self-efficacy predicted anxiety whereas perceived

social support and self-efficacy predicted depression. It was also found that self-efficacy emerged as a significant positive predictor of resilience for orphaned children whereas self-efficacy and perceived social support emerged as significant positive predictors of resilience for non-orphans.

Given the above results, it was concluded that, despite the status of orphanhood, placement in an orphanage and the heightened emotional distress in the present sample of Ghanaian orphans, they possessed positive personal attributes that could be protective against the adverse effects of stress. These included high levels of perceived self-efficacy and high levels of resilience. This finding confirms the argument by previous researchers that orphans are resilient (Abebe & Aase, 2007; Adamson & Roby, 2011; Case et al., 2006; Kiyapi, 2007; Nyamukapa et al., 2010; Wild et al., 2011). Additionally, available support from their friends was also a protective resource. It was also concluded that perhaps for orphaned children, there could be other factors that were influential in the stress experiences, given that none of the stress-moderating variables explored in the present study predicted their stress levels. It was therefore proposed that the exploration of other stress-moderating variables, besides those assessed in the present study, could be a subject for future research exploration.

9.6. Subjective Experiences about Orphanage Placement

Finally, the present study aimed to delve into the subjective experiences of placement in the orphanages in order to draw on the ‘lived’ narratives of the Accra orphans about placement and their overall psychological functioning following placement in orphanages, from their vantage point. This aim was achieved through follow-up interviews of 20 orphaned children who had participated in the survey (the quantitative phase of data collection). The findings of the analyses of the follow-up interview were presented in Chapter 8 (Manuscript 5) of the dissertation. Deriving from the themes identified through thematic analyses of orphans’ accounts, the overarching themes that emerged were that orphanage placement was

associated with both positive and negative experiences. From the participants' accounts, it seemed that orphanages assumed a parental role by providing structure, nurturance, a safe home environment and avenues for positive peer relationships. These positive experiences engendered a sense of belonging and overall emotional well-being. Furthermore, the Christian-religious orientation of the orphaned children appeared to foster their well-being through the promotion of positive affect, the provision of coping recourses and the fostering of positive self-beliefs. Despite these positive experiences, orphanage placement also evoked negative experiences that included financial constraints and relationship problems with peers and caregivers that induced a sense of isolation in the orphaned children.

Based on the above findings, it was concluded that, despite the ambivalence towards placement, orphanages functioned to provide a sanctuary and nurturance to the present sample of Ghanaian orphans. It was also concluded that due to the negative experiences that placement evoked in the present sample of Ghanaian orphans, there was a need for psychological interventions for the containment of the emotions associated with negative experiences about orphanage placement, the psycho-education of orphaned children about healthy peer relationships and the psycho-education of caregivers about the appropriate ways of caring for orphans, in order to improve the well-being of orphaned children placed in the orphanages.

9.7. Overall Conclusion and Contributions of the Present Study

Considering the findings from the quantitative data reported in Manuscripts 2, 3, and 4, it can be concluded that both the orphaned- and non-orphaned children were vulnerable to psychological distress, as shown by their scores on the depression and anxiety scales as well as the high prevalence of problems with peers, school and caregivers. From these findings, it could be argued that the level of vulnerability of the present sample of Ghanaian orphaned children to psychological distress was similar to their non-orphaned counterparts.

Furthermore, orphaned children, despite their status of orphanhood, placement in an orphanage and heightened emotional distress possessed a range of coping strategies, available support from friends, high levels of positive personal attributes (which include self-efficacy and resilience) and a connection with religion and spirituality that could be protective against the adverse effects of orphanhood and placement in an orphanage. Moreover, it was worth noting, based on the qualitative data reported in Manuscript 5, that orphanages in Accra were able to provide a sanctuary and nurturance to orphans that fostered well-being. Based on these findings, it could be concluded that the psychological functioning of the present sample of Ghanaian orphans par with that of the non-orphaned children.

The findings of the present study challenge the notion advanced by some researchers (Johnson et al., 2006; MacLean, 2003; The St. Petersburg–USA Orphanage Research Team, 2005; Zeanah et al., 2009) that orphanage placement is universally negative and adversely impact on the well-well-being of children and that family setting is better than institutional setting. While the researcher is not advancing the notion that orphanage placement is the preferred living environment for orphans, the author is of the opinion that family-based setting is not without problems and cannot be guaranteed as the better place for orphans to live. Instead, the focus should be on the nature and quality of care provided to children within a setting given that the difference in well-being depend on the quality of care within a setting (Whetten et al., 2014). Against this background, and given the positive findings, the research is of the opinion that orphanage placement could be considered as a viable option of orphan care for orphans who lack support in Ghana. However, substantial improvements, pertaining to financial support to the orphanages and psychological interventions for both orphans and caregivers are needed in order for orphanages to be able to provide quality and adequate care to orphans. In light of this, all stakeholders of orphanage services, including international bodies (e.g. UNICEF and UNAIDS), NGOs, policymakers in Ghana and mental health

workers, need to participate in improving the services of orphanage care in order to improve the well-being of children who live in orphanages.

Overall, the results of present study discussed in Manuscripts 2, 3, 4, and 5 brought to light the nature of the psychological functioning of the present sample of Ghanaian orphans in comparison to their non-orphaned counterparts. Moreover, the present study makes a substantial contribution to the body of scientific knowledge on the psychological well-being of orphans placed in orphanages and to the current debate on the psychological effect of orphanage placement on the well-being of orphans through providing information on the subject in the Ghanaian context.

9.8. Implications for Theory, Clinical Interventions, Policy Making and Future Research

The heightened emotional distress found in the orphaned children has implications for the two main theories (i.e. the attachment theory and the transactional model of stress and coping) that were employed in the study. Based on the attachment theory, it was hypothesised that parental loss would be associated with poor psychological well-being in children because it disrupted (and possibly terminated) the affectionate bond between a child and primary caregiver. The findings of the study showed heightened emotional distress in the orphanage children as present by high prevalence of depression and anxiety as well as high prevalence of school-related problems, peer- and caregiver relationship problems. In line with the attachment theory (Bowlby, 1969) the findings of the study highlighted that the loss of primary caregiver can lead to poor psychological well-being in children.

Following the transactional model of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984), it was hypothesised that parental loss would be appraised by children as a stressful experience that is beyond their coping capabilities and thus be associated with poor psychological well-being. It was also hypothesised that problems associated with orphanages would lead to poor psychological well-being in children. The findings of heightened

emotional distress thus point to the fact that parental loss can be stressful and that stressors in orphanages can lead to poor psychological well-being in children.

The study showed that Ghanaian orphaned and non-orphaned children were equally vulnerable to psychological distress; therefore, interventions aimed at improving the well-being of children should be aimed at both groups of children. Moreover, despite their heightened emotional distress, orphanage-placed children possessed positive personal attributes (notably, perceived self-efficacy and resilience) that when improved upon could be protective against the adverse effects of parental loss and orphanage placement. Thus, intervention should focus on strengthening these positive attributes in order to enhance the psychological well-being of Ghanaian orphans. Furthermore, besides positive personal attributes, factors such as support-seeking coping, perceived social support from peers as well as religion and spirituality also provided protection against the adverse effects of parental loss and orphanage placement. Based on these findings, psychological interventions should focus on augmenting the functioning of these factors in order to enhance their protective roles in the well-being of orphans.

Policymakers and clinicians in Ghana could consider adopting a range of interventions indicated in Manuscript 2, 3 and 4 of the present dissertation. These interventions include, the Ugandan model of intervention for orphans and other vulnerable children (Hope Never Runs Dry, 2011) to improve the psychological well-being of Ghanaian children; a psycho-social intervention programme designed by Chitiyo et al. (2008) to promote positive interpersonal relationships for orphaned children; the Coping with Kids Programme (Henderson et al., 1992) for teaching skills in stress management; the School-based Social Skills Group Intervention (S.S.GRIN; DeRosier, 2004; DeRosier & Marcus, 2005) for the formation and sustenance of healthy peer relationships; and the FRIENDS intervention programme (Action

for Children, 2007; Barrett et al., 2006; Stallard et al., 2005) for teaching skills for improving positive personal attributes and the formation of healthy peer relationships.

The suggested interventions should be carried out by trained mental health practitioners such as clinical psychologists, counsellors and social workers who are involved in the treatment and care of vulnerable children. Moreover, the Department of Social Welfare in Ghana can collaborate with mental health practitioners to train orphanage caregivers, parents and school teachers in order to enable the incorporation of some components of the interventions into the routines of the orphanages and school curriculums. Furthermore, international bodies (e.g., UNICEF and UNAIDS) and non-governmental organisations (NGOs) in Ghana could also be included in the interventions in order to determine the nature of their assistance (for example, providing the needed financial resources) for the implementation of the interventions.

The present study laid the foundation for research into the psychological well-being of Ghanaian orphanage-placed children and highlighted areas for future research inquiry. Future research would benefit from the use of a longitudinal design that would enable the assessment of the well-being of orphanage-placed children over time. Additionally, the inclusion of a diverse sample of orphans drawn from orphanages and communities across Ghana would also be beneficial. This would provide information on the well-being of orphans living in other care arrangements in Ghana and could serve as the basis for policy decision making regarding the best choice of orphan care in Ghana. Furthermore, future studies would benefit from the use of larger sample that is statistically representative of the orphaned children in Ghana. This would aid in the generalisation of the findings of research to the population of orphans in Ghana. Moreover, the inclusion of ethnicity and culture in future studies on orphanage-placed children would be beneficial so as to map out how cultural practices and norms influence the well-being of Ghanaian orphans.

9.9. Reflections on the Overall Study

As a researcher who explored the psychological well-being of orphans placed in orphanages for the first time, I believe that a reflection on my experiences throughout the research process is important. Reflexivity refers to the self-reflective process on a researcher's actions and values during the research (Parker, 2005; Seale, 1998). Engaging in reflexivity helps the researcher reflect upon her or his role and the assumptions taking into the research. This process also has implication for the methodology of a research as it impact on the selection of participants, triangulation of data collection methods and report writing (Savahl, 2010). In the subsequent paragraphs, I reflect on my experiences with respect to the operationalization of orphanhood, the power-relation between orphanage-placed children and adults (including the orphanage administrators, social workers and myself) and issues surrounding accessing sensitive information from orphans.

The first issue I reflect on is the challenge I had regarding the operationalization of orphanhood in the study. I felt that the accepted definition of orphanhood that is based on parental loss through death was inadequate for defining orphanhood. This concern arose out of my own personal experience of seeing and growing up with children dealing with parental abandonment. I grew up with a girl who was betrothed to an elderly man when she was 8 years old. The man, who already had a wife, was expected to raise her and then marry her when she was older. The girl had no contact with her parents and other family members. Family problems and abuse (both physical and sexual) resulted in her being placed under the protection of Social Welfare and in an institution. Growing up with the girl, I learned that a child can be orphaned through parental neglect even when both parents are alive. With this in mind, I felt the need to include children who did not know the whereabouts of their parents and lived in an orphanage. I must also admit that besides my personal experience, including abandoned children as part of my sample helped me to achieve the needed sample size for my

study because it was difficult to obtain 100 children who met the inclusion criteria from four orphanages. As already highlighted in this dissertation, orphanages in Accra do not shelter only “true orphans” (children aged below 18 years who have lost their parents through death). They also shelter abandoned children, children from abusive families, children who were lost and found by well-meaning strangers who could not locate the children’s families and sometimes, children of the orphanage caregivers. In addition, some orphanage-placed children are generally older than 18 years and, because of their age, are not officially considered as orphans (UNICEF, 1999; UNICEF/UANAIDS, 2006).

As a researcher, the challenge was surrounding the scholarly justification for including children who were not “true orphans”. To deal with this challenge, I did a literature search to find possible justifications to include abandoned children in my study. It was during this search that I came across the term “social orphans” (when loss is due to parental neglect and - abandonment; Dillon, 2009; Foster, 2000; McCall et al., 2010; Meintjes & Giese, 2006; cf. MESW & UNICEF, 2010; Skinner et al., 2006). This discovery enabled me to operationalise orphanhood to include children who were orphaned through death or abandonment and also to attain the sample of 100 orphanage-placed children.

The second experience that is worth reflecting on is regarding the power relations between the orphanage-placed children and adults, mainly the researcher, the orphanage administrators and social workers. Before going into the field, I critically reflected on my position as an adult researcher because I sensed that the status of the children in orphanages placed them in a powerless position for several reasons. Firstly, the Ghanaian culture promotes values that encourage children to respect and obey the elderly at all times without challenging their authority (Twum-Danso, 2009). In line with these values, children might feel obliged to participate in the study against their will when selected by the adults in the orphanages (administrators and social workers). I knew of the possibility of orphans in the

government-run orphanage being selected by the administrator and social workers due to the reported experiences of previous researchers in Accra orphanages (Adu, 2011; Kristiansen, 2009). Moreover, being an adult researcher also placed me at a higher position (of power and authority) over the children interviewees, and hence might have inadvertently coerced them to partaking in the interviews. Secondly, and related to the first point, the status of being placed in orphanages might have indirectly influenced orphans to participate out of the eagerness to please their caregivers, and for fear (albeit this was not expressed) of losing their residential privileges.

Having these issues in mind as a Ghanaian researcher, I tried as much as possible not to ‘take advantage’ of my position during the data gathering processes. Before each interview, I explained to the children that their participation was voluntary, and that even when they had been chosen by the orphanage administrators they reserved the right to decline the invitation to participate, could withdraw from the study and could choose to not answer some questions, without any consequences to them. Despite these reassurances, there were times that I thought that some children still felt a sense of obligation to participate in the study – hence the constantly reminding them of their rights as participants. It is noteworthy that others were happy about the chance they had to share their experiences.

The third challenge relating to conducting research on vulnerable children pertained to accessing sensitive information about their experiences with parental loss and placement in orphanages. Getting orphanage-placed children to discuss issues regarding their stress levels and their experiences as orphans living in an orphanage was sensitive and had to be handled with care. Before data gathering, I reflected upon this issue and thought about how to effectively handle this matter. My concern was confirmed during the data gathering process and particularly during the interviewing sessions, as some orphaned children kept looking over their shoulders when they were asked certain questions (about life in the orphanage and

their relationships with caregivers) and these children gave fewer details about their experiences. When I probed further, I found that they were concerned about the orphanage personnel getting access to the information they shared with me, despite having been assured of the confidentiality of the information they shared with me as a researcher. Some children felt that if their responses were communicated to the orphanage administrators and personnel, it would jeopardise their stay in the orphanage.

As a researcher, I carefully handled this sensitive issue with ethical principles during the data gathering. Firstly, the principle of confidentiality was helpful. I made certain that I conducted the interviews alone with the participants at a place that was away from the hearing of both the participants' peers and the orphanage personnel. Moreover, questionnaires were securely stored out of reach of unauthorised individuals. Secondly, the principle of voluntary participation became important as I pointed out to the participants at the beginning of data gathering when I explained their right to them and also during the process of data gathering when children expressed discomfort about answering some questions. Thirdly, adherence to the principle of anonymity was made by informing participants that any information that could be used to identify participants would be eliminated from the study. Instead, pseudonyms would be used in place of the real names of the orphans and generic identifiers (that included assigned interview number, age, sex, status of parenthood and grade level) would instead be used to report on participants' shared experiences. Finally, I pointed out to the children that I was interested in learning about their personalised experiences and that they were at liberty to share how they feel about the questions in their own words.

9.10. Limitations of the Overall Study

Despite the relative contribution of the present study in advancing the understanding of the psychological functioning of orphans placed in orphanages in Accra, Ghana, there were five limitations that merit consideration. Firstly, the study used a cross-sectional design, as a

result, causal inference between parental loss, orphanage placement and psychological well-being could not be drawn. Orphanhood is an irrevocable, life-changing experience that has far-reaching consequences for the surviving child whose life journey gets affected by the parental loss, and placement in an orphanage is a compounding factor in the experience of being an orphan. Given the cross-sectional nature of the study, a causal association between orphanage placement and psychological distress exhibited by the orphaned children could not be drawn. For example, given that the non-orphaned children also presented with psychological distress that was similar to that of their orphaned counterparts, the researcher was unable to discern if such distress was due to orphanage placement, parental loss or other factors. Thus, longitudinal studies should be conducted to enable an appraisal of the extent to which the influence of parental loss and orphanage placement on the psychological well-being of children manifests in different time-points, in order to draw inferences about how orphanage placement impacts on psychological well-being of orphans.

Secondly, although a modest monetary incentive was used as a token of appreciation for participants' time and responses, it might have unduly influenced children's decision to accept the invitation of participating in the study and this itself could have resulted in participants giving socially desirable responses. It was possible that children who were invited to participate in the study agreed due to the monetary incentives that they would receive after participation. It was also possible that the monetary incentives, given the background of material deprivation, influenced participants' choice of responses. For example, because of the monetary incentives, participants might have aimed to elicit the responses that they thought were desired by the researcher. This might have led to instances of participants possibly under reporting or exaggerating their distress and experiences following their placement in orphanage. Future studies on orphaned children would benefit from the

exclusion of monetary incentives or the use of non-monetary incentives to avoid the potential for social desirability.

The third limitation was surrounding the selection of participants (both orphans and non-orphans) from the study settings. All the orphaned children at Savers Foundation were selected by the orphanage administrator and social workers. Moreover, some of the learners at Good Starters Basic School were also selected by the teacher appointed by the school principal. Although the researcher made efforts to avoid this situation, it was not possible to “over-rule” this decision as it was the only way the orphanage administrator and head teacher would grant access to children in these institutions. The selection of the orphans in Savers Foundation might have been biased as the orphanage administrator and social workers might have chosen children that were likely to portray a positive image of the orphanage. Thus, it was possible that participants under-reported potential distress they might be experiencing. This problem has been encountered by other researchers (Adu, 2011; Kristiansen, 2009) who studied the well-being of orphanage-placed children in Accra, Ghana. It was also possible that the teacher who assisted in the recruitment of learners at Good Starters Basic School might have chosen leaners that were fluent in the English language and were likely to portray a good image of the school. The children chosen from these settings may also have been the ones that were fairly well adjusted and extrovert, as opposed to children that were more introverted, negative and aggressive. As a result, alternative views and experiences might have been lost. Future studies should consider recruiting children from orphanages and schools in a manner that would allow researchers to determine the participant-recruitment process, rather than relying on the selection that the orphanages and schools determine.

Fourthly, the use of purposive sampling technique and a non-probability sample could have led to selection bias and limited the generalization of findings of the study to the population of orphanage-placed children in Accra, Ghana. Therefore, future research should

use a probability sampling technique in order to sample orphans that are statistically representative of the population of orphans in Accra, Ghana.

Fifthly, despite the present sample being large (considering the sample sizes of bereaved populations), generalisation of the findings to the population of orphans in Ghana could not be made. Specifically, it was not possible to ascertain if the observed patterns of the influence psychological functioning and experiences resulted from placement in an orphanage or were a general trend for Ghanaian orphans regardless of placement status. Therefore, future studies could sample orphans from orphanages and communities across Ghana to help ascertain if any significant differences emerged between these two groups.

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