PSYCHO-SOCIAL PREDICTORS OF MENTAL HEALTH AMONG ORPHANS IN SOUTHWEST NIGERIA: EFFICACY OF PSYCHO-EDUCATION INTERVENTION

BY

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BEING A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHOLOGY, SCHOOL OF HUMAN RESOURCE DEVELOPMENT, COLLEGE OF DEVELOPMENT STUDIES, COVENANT UNIVERSITY, OTA, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY IN PSYCHOLOGY.

CERTIFICATION

This is to certify that this research was carried out by ELEGBELEYE, Ayotunde Oluwadamilola and has been read and approved as meeting the requirements of the Department of Psychology, Covenant University, Canaan-land, Ota.

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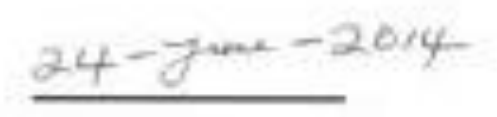

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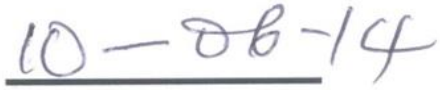

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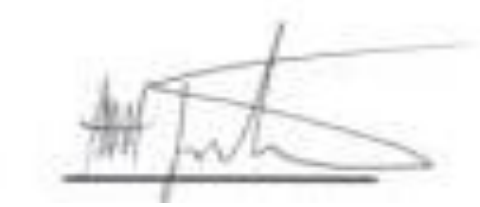
DECLARATION

It is hereby declared that this research was undertaken by ELEGBELEYE, Ayotunde Oluwadamilola. The thesis is based on her original study in the Department of Psychology, College of Development Studies, Covenant University, Ota, under the supervision of Prof. S. E. Idemudia and Prof. A. A. Alao. Ideas and views of this research work are products of the original research undertaken by Elegbeleye Ayotunde Oluwadamilola and the views of other researchers have been duly expressed and acknowledged.



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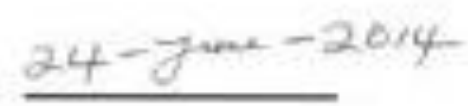

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DEDICATION

I dedicate this thesis to my Heavenly Father, God Almighty, who was there at the very beginning, and has brought it to a glorious completion. He alone deserves my adoration. Also to the memory of my late father, Pastor F. B. Elegbeleye, who was my first mentor in academia.

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ELEGBELEYE Ayotunde Oluwadamilola
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1. United Nations Programme on HIV/AIDS (UNAIDS)
2. United Nations Children's Fund (UNICEF)
3. Human Immunodeficiency Virus (HIV)
4. Acquired immunodeficiency Syndrome (AIDS)
5. Centre for Economic and Leadership Development (CELD)
6. Orphans and Vulnerable Children (OVC)
7. World Health Organization (WHO)
8. Orphans and Vulnerable Children – Comprehensive Action Research (OVC-CARE)
9. AVERTing AIDS & HIV (AVERT)
10. American Academy of Child and Adolescent Psychiatry (AACAP)
11. Subjective Well-Being (SWB)
12. Cognitive Behavioural Therapy (CBT)
13. Centre for Disease Control and Prevention (CDC)
14. Department for Children and Families (DCF)
15. Post Traumatic Stress Disorder (PTSD)
16. University of North Carolina (UNC)
17. Interpersonal Social Support (ISS)

ABSTRACT

Orphanhood is a global phenomenon. Over the years, due to the HIV/AIDS pandemic and the upsurge of killings, terrorism, accidents, and other disasters, there has been a steady increase in the orphan population across the globe, particularly in Africa. These crises have negatively impacted the lives of many orphans as they are faced with multifaceted challenges that leave them helpless, distraught, and distressed. This study was done in two phases: Phase I and Phase II. Phase I of the study set out to examine the psychosocial variables that predict the mental health of orphans in Southwest, Nigeria. The variables examined are self-concept, self-esteem, social support, life satisfaction, age, gender, and child abuse. Phase II of the study examined the efficacy of a psycho-educational programme in improving the mental health of orphans. A cross-sectional survey design was adopted to collect data in phase I. A sample of two hundred orphans, between ages 13 and 18 years, was selected from orphanages in Ogun, Lagos, and Oyo States respectively and another sample of two hundred non-orphans within the same age range was selected as a control group. The participants completed measures of the General Health Questionnaire (GHQ-28), Self-Concept Subscale of the Adolescent Personal Data Inventory, Rosenberg Self-Esteem Scale, Duke-UNC Functional Social Support Questionnaire, Quality of Life Enjoyment and Satisfaction Questionnaire, and Childhood Abuse Questionnaire. Pre-posttest control group design was utilized for Phase II with a sample of twenty-two orphans randomly assigned to experimental and control groups respectively. The experimental group was exposed to a psycho-educational programme (Covenant Coping Skills Intervention Programme). Six research hypotheses were tested at p=0.05 level of significance. Independent-samples t-test was used to test hypotheses one, two, four and five; Multiple regression was used to test hypothesis three; and One-way ANCOVA was used to test hypothesis six. The results revealed that there was a significant difference in the mental health of orphans and non-orphans ($t=2.898$, $df=398$, $p<.05$). Orphans differed significantly from non-orphans on self-concept, self-esteem, social support, life satisfaction, and child abuse ($t= -3.733$, $df=398$, $p<.05$; $t= -2.084$, $df=398$, $p<.05$; $t= -4.926$, $df=398$, $p<.05$; $t= -6.219$, $df=398$, $p<.05$; $t=3.158$, $df=398$, $p<.05$). Age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse significantly predicted orphans' mental health ($R=.628$, $R^2=.395$, $F_{(7, 192)} = 17.898$, $P<.05$). There was no significant age difference in the mental health of orphans ($t=.540$, $df=198$, $p>.05$). There was no significant gender difference in the mental health of orphans ($t= -.810$, $df=198$, $p>.05$). There was a significant difference in the mental health of orphans exposed to psycho-educational programme and orphans not exposed to same programme ($F_{(1,19)}=19.655$, $P<.05$). The results underscore the need to shield orphans from vulnerable situations that could result in abuse and development of poor self-concept. It is also important to develop intervention programmes that are specifically tailored to improve the mental health of orphans.

Key Words: Orphans, Mental Health, Self-concept, Self-esteem, Social Support, Life Satisfaction, Child Abuse, Psycho-educational Programme, Southwest Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The phenomenon of orphans is as old as the creation of the world. Globally, as the years roll by, the situation and circumstances of children who are made orphans by all causes are on the plummet for the worse (Odeku, 2008). In the African context, there is a rapid increase in the population of orphans as the HIV/AIDS pandemic increasingly hits the sub-Saharan African regions (United Nations Children's Fund [UNICEF], 2006). Nigeria as a nation is not left out of the orphan crisis. The upsurge of killings and terrorism, as well as increased disasters of varying sorts, has yielded an increase in the orphan population. According to Odeku (2008), the orphan crisis is an economic, educational, psychological and social struggle for orphaned children. Children are orphaned due to several causes and this exposes them to multiple challenges, which include child abuse, child labour, trafficking, malnutrition, HIV transmission, declining school enrolments/lack of educational opportunities, and diseases, among others (Odeku, 2008).

Studies have shown that there is abundance of orphans globally. According to World Orphans (2012), there are an estimated 153 million orphans worldwide. Also, according to statistics obtained by Cates (2011), Asia has the highest number of orphans in the world with 28.4 million maternal orphans; 57.7 million paternal orphans; and 6.1 million double orphans. In Latin America and the Caribbean, there are 3.3 million maternal orphans; 9.1 million paternal orphans; and 500,000 double orphans. In sub-Saharan Africa, there are 27.6 million maternal orphans; 32 million paternal orphans; and 9.6 million double orphans. In Nigeria, the number of orphans due to all causes is estimated at 10.8 million (UNICEF/Childinfo, 2013).

The 'term' orphan is defined in different ways and this definition is varied from one country to another. The main variables of consideration in the definition of an orphan are age – a child who is 18 years or below; and parental loss – either father, or mother, or both parents deceased (Smart, 2003). As commonly used, an orphan has no parent

to cater for him or her. The term also means a child whose parents are both dead (Wordnet, 2007). However, the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV and AIDS (UNAIDS), and other organizations describe an orphan as any child, who is 18 years or below, and whose father or mother is dead or whose parents are dead. This means that a child who has lost his or her mother is a maternal orphan; a child who has lost his or her father is a paternal orphan; and a child who has lost both parents is a double orphan (United Nations Programme on HIV/AIDS [UNAIDS] Global Report, 2008). This broader definition of orphan was adopted by UNICEF and numerous international organizations in the mid-1990s as AIDS became widespread and led to the death of a large percentage of parents all over the world, making a large proportion children grow up without one or both parents (UNICEF, 2008). Apart from this categorization, Dillion (2008) added another category of orphans he referred to as social orphans. According to him, social orphans are children living without parents because of abandonment or because their parents gave them up as a result of poverty, alcoholism, imprisonment, and others (Dillion, 2008).

Other causes of parental death include poverty, crime and violence, wars, natural disasters, accidents, drug abuse, and illnesses of various types among others. In Nigeria, it has been noted that the main reasons for children being orphaned include AIDS, ethno-religious conflicts, high maternal mortality rate, and road accidents, and several children become vulnerable due to unfavourable cultural practices, poverty, conflict, and gender inequality (Centre for Economic and Leadership Development [CELD], 2012; Obinna, 2012). The increasing number of orphans in Nigeria is also caused by the high level of sectarian or inter-community conflicts and inter-group crises that are rampant in some parts of the country. Hence, there is a large pool of children orphaned by conflict in some states in Nigeria, such as Plateau, Benue and Taraba (Nigeria OVC National Plan of Action, 2011).

At very tender ages, orphans experience a very drastic turnaround in life as they are suddenly left to fend for themselves. They are rid of the protective care and support of parents and are left to either roam the streets, find shelter under the care of relatives/foster parents who may already have too many responsibilities and could not be bothered by the “extra luggage” or stay in orphanages. Orphaned children become

desperately in need of clothes, shelter, food, medical care, and education. Children who lose their parents are faced with unique vulnerabilities such as fear, instability, insecurity and other negative effects. This change in life event may influence a variety of other psychological changes and experiences in an orphan and may negatively affect mental health and overall well-being.

Mental health is described as a state of well-being where individuals become aware of their own ability, and are able to function productively and make useful contributions at work and in the community (World Health Organization [WHO], 2007). Mental health status of orphans demands attention because they severely experience negative emotions, behavioural problems, and higher levels of psychological difficulties due to reasons of being cared for by someone who is not their biological parent, deficient care, stigma, child abuse, and discrimination (Swaran & Shikha, 2013). It is important to examine how orphans' mental health is at risk and ways of developing prevention and intervention programmes to improve their mental health.

Several studies have been done on the mental health and well-being of orphans. For instance, among others, Swaran and Shikha (2013) studied the mental health of HIV/AIDS orphans; Whetten et al. (2009) compared the well-being of orphans and abandoned children in institutional and community care based settings in five poor nations; Makame, Ani, and Grantham-McGregor (2002) studied the psychological well-being of orphans in Dar El Salaam, Tanzania; Cluver and Gardner (2006) studied the psychological well-being of AIDS orphans in Cape Town, South Africa, and others. However, it appears that very few studies have been carried out as regards the mental health and well-being of orphans in Nigeria. Information from OVC-CARE Project (2009) suggested that in relation to the population of orphans, Nigeria ranked 3rd highest country in the world, hence, the growing concern about the research gap existing on the mental health and well-being of orphans in Nigeria.

The state of orphanhood impacts children negatively. Due to lack of basic caregivers and economical support, they are at higher risk of illness, faulty development, psychological problems, involvement in risky behaviours, and all forms of exploitation (Swaran & Shikha, 2013). There is the need for relentless research to provide helpful information to programmes and policy makers for the purpose of

designing evidence based interventions that will improve the general well-being of orphans.

Due to the sudden loss of their primary caregivers, orphans in most cases, lack the adequate care and resources that should have been provided by these caregivers. This lack in turn predisposes orphaned children to become exposed to experiences that could affect their mental health and well-being. Some of the problems that may be encountered by orphaned children include taking on adult responsibilities, child labour, growing up in impoverished conditions, poor nutrition and healthcare, psychological stress, negative impact on education, physical and sexual abuse. The psychological and emotional well-being of orphaned children is threatened by myriad of stressors and traumatic life experiences. The children with no parents are most helpless because they do not have the emotional and physical maturity to address the psychological trauma associated with parental loss. Double orphans also seem the most helpless or negatively impacted due to being repeatedly exposed to traumatic experiences. Most studies revealed that orphans suffer higher level of psychosocial problems than their non-orphan peers (Afework, 2013). Furthermore, Subbarao, Maltimore, and Plangemann (2001) as cited in Afework (2013) noted that orphaned children are being discriminated against based solely on their status as orphans. Due to discrimination emanating from their non-orphaned peers or from their immediate environment, orphaned children may see themselves as different from other children and they may consequently develop negative self-identity (self-concept) and low self-esteem.

Also, orphans are faced with striving to integrate previous roles of being young and carefree to having to deal with the emotional demands of loss with no support from parents. This may worsen the grieving process as they re-organize their sense of self and also deal with the possibility of a future with no parents, or abandonment by those in whose care they are placed, or an overwhelming fear of suffering and rejection. This may in turn jeopardize their state of mental health and sense of well-being. Healthy development depends on safe and supportive environments that provide opportunities for young ones to build strong and meaningful connections with their schools, families and communities (Boeree, 2006). Being orphaned does not always provide an ideal environment and may lead to mental health problems such as

depression. Cluver and Gardner (2006) also reported that AIDS orphans exhibit post-traumatic stress disorder and psychosomatic ailments. Furthermore, parents' role in development of self-esteem of a child is very vital in early childhood. A child brought up in a family has a highly developed emotional attitude towards him/herself. This emotional attitude in most cases is positive. Such a child accepts and loves him/herself independently of others' opinion. Institutionalized children on the other hand primarily evaluate themselves and they most times do not have emotional attitude towards themselves. If they do, it is negative and if not, they just maintain indifference.

Losing a loved one or loved ones has been shown to have psychological effects on an individual. When a parent or both parents die, an orphaned child is traumatized with trying to cope with his or her life and the loss he or she is suffering. Some of the psychosocial problems which orphans and vulnerable children may experience include worry about the future, feeling different from other children, losing educational opportunities, pain of losing parents, changing homes, inadequate adult love, lack of guidance, lack of protection, neglect and abuse isolation, or gossip. These situations can lead to shame, withdrawal, fear and anxiety, depression, grief and sadness, misbehavior due to being often misunderstood. Furthermore orphans go through stress, discrimination and avoidance. They sometimes experience behavioural disturbances and stigmatization. Most often, they show symptoms of low self-esteem and lack of self-confidence (Hajane, n.d.). The deprivation that follows the loss of a parent is hard to manage for children, and most times, the effects are not seen until many months or years afterwards (Atwine, Cantor-Graae, & Bajunirwe, 2005 as cited in Kaggwa & Hindin, 2010). Also, when orphans are put in poorer families, anxiety about what the future holds, especially the tendency to not finish school may result in other mental health issues. Orphans also do not receive the valuable life-skill knowledge that a parent would typically pass on. AVERTing AIDS & HIV [AVERT] (2007) says that without these knowledge and skills gained through school education and parental guidance, children may be more likely to face economic, health, or social problems as they grow up.

Furthermore, orphans seem to suffer some sort of lack of opportunities or misfortunes due to the death of their parents and this leads to deprivation. Oftentimes, they are

forced to live in environments that do not possess enough stimulation which engenders the full development of an individual's potentials. Being orphaned early in life may later bring about negative consequences in terms of socialization and personality development. Orphaned children may become distrustful individuals and their social and personality development may be impeded. The loss of a parent results in social, economic and emotional deprivation. The orphaned child may have no role model(s) or an authority figure to take counsel from. As a result of this deprivation, an orphan's self-esteem may be affected negatively, because deprivation often affects self-esteem. Deprivation of parental care affects the self-esteem of a child. When parents inform their children about what they expect of them, the children always feel confident and secure. This means that children without parents may have no one who would have expectations of them and this, in turn, affects their self-esteem adversely. Moreover, stigma and discrimination is still very rampant in schools and when orphans are treated differently by other children, this may affect their self-concept and self-esteem, which may further result into various negative behavioural and psychological consequences.

Children exposed to early deprivation and neglect are significantly at increased risk of a myriad of emotional and behavioural disorders (Widom, DuMon, & Czaja, 2007 as cited in Bos, Zeanah, Fox, Drury, McLaughlin, & Nelson, 2011). Orphans who are raised in institutions, which is categorized as an extreme case of social deprivation, represent a group of children through which one can understand the impact of neglect on a child's health and development. Institutional care is still common practice worldwide, and it remains a risk factor for a series of negative outcomes across cognitive, emotional, behavioural and social areas. Despite the differences among institutions, the common factors that characterize institutional life include unfavorable child/caregiver ratio, isolation, lack of psychological investment by caregivers, regimentation, and limited stimulation (Bos et al., 2011).

Parents play a vital role in the development of a child's self-concept and self-esteem. As a consequence, orphans are at risk of developing poor self-concept and low self-esteem (Weidner, 2013). Orphaned children with no one to assume the role of parents may develop a poor self-concept and low self-esteem. Ferrer and Fugate (2012) noted that a healthy self-concept is the basis for the positive development and overall well-

being of a child. According to them, the healthier a child's self-concept, the more he or she perceives himself or herself as being loved and valuable. In addition, a child who has a healthy self-concept has better chances of being able to reach his or her full potential and does better in school. A healthy self-concept enables a child to set goals for himself or herself and make decisions; he is open to learning new things and trying out new activities; he enjoys better relationships with family members and friends; and he has control of his behaviour and possesses good interpersonal skills (Ferrer & Fugate, 2012). Low self-esteem can be damaging for any child. While a healthy self-esteem boosts a child's performance in school, enables him or her establish healthy relationships and excel in life; low self-esteem in children may lead to discipline problems, learning disabilities, and depression (Weidner, 2013). Donnellan, Trzesniewski, Robin, Moffitt and Capsi (2005) found an association between low self-esteem and aggression, delinquency, as well as antisocial behaviour. In another study, Trzesniewski et al. (2006) also found a relationship between low self-esteem during adolescence and an increased probability of manifesting problems in adulthood, including depression, anxiety, greater employment difficulties, poor physical health, increased tobacco use, and increased criminal behaviour.

Social support has been linked to many physical and mental health benefits. Social support enables people reduce psychological distress e.g., anxiety or depression during periods of stress (Taylor, 2011). People who have low social support record higher rates of major mental disorders than those who enjoy high social support. These include post-traumatic stress disorder, panic disorder, social phobia, major depressive disorder, and eating disorders (Huang, Yen, & Lung, 2010; Lakey & Cronin, 2008). In addition, people with low support have more suicidal ideation (Casey, Dunn, Kelly, Birkbeck, Dalgard, Lehtinen, 2006). Similar results have been found among children (Chu, Saucier, & Hafner, 2010).

As a consequence of their unfortunate circumstance, orphans encounter such problems as taking on adult responsibilities, child labour, growing up in impoverished conditions, poor nutrition and healthcare, poor education, neglect, and abuse, among others, resulting in poor quality of life. Without having an immediate solution to these challenges and seeing other children of same age in better positions, orphans feel

different and may tend towards not being satisfied with their lives, thereby reporting reduced life satisfaction, which in turn could militate against their mental health.

Children without proper adult care are more vulnerable to physical and emotional abuse, as well as sexual exploitation. Orphaned children are at greater risk of experiencing abuse and exploitation due to poverty, living with a non-biological caregiver, stigma, and alcohol abuse (Morantz et al., 2013). Abuse has also been associated with mental health in various dimensions. American Academy of Child and Adolescent Psychiatry [AACAP] (2011) stated that generally, abused children may display certain characteristics such as poor self image; sexual promiscuity, and lack of trust or love for others. They also show traits of aggression and sometimes engage in illegal behaviour. Abused children also have anger or rage problems; they may engage in self destructive behaviour; they struggle with suicide ideation; and they are sometimes withdrawn, passive, or possessive. They manifest fear of getting into new activities or relationships; they exhibit anxiety and fears, poor academic performance, sleep problems, feelings of sadness or other symptoms of depression; and they also engage in substance abuse (AACAP, 2011).

In response to the varying needs of orphans, it is expedient for the government and other organizations within the society to fund the development of intervention programmes to support and care for orphans. According to Schenk (2009), an evaluation of community interventions for orphans and vulnerable children in African settings with high HIV-prevalence showed that interventions bring about tangible improvement in child and family well-being.

1.2 Statement of the Problem

Information from studies suggests that the state of orphanhood may have definite impact on the mental health and overall well-being of orphans (Afework, 2013; Cluver, Gardner & Operario, 2007 as cited in Afework, 2013; Kedija, 2006 as cited in Afework, 2013; Swaran & Shikha, 2013). It has been observed that most of the studies carried out on orphans have been done in other African nations and other parts of the world. However, many studies have not been carried out regarding mental health of orphans in Nigeria. In Nigeria, the number of children orphaned due to all

causes is estimated at 10.8 million. Out of this population, 2.2 million are orphaned by HIV/AIDS while 8.6 million are orphaned by other causes (UNICEF/Childinfo, 2013). This is an issue of concern considering that statistics place Nigeria as one of the top African countries with the highest population of orphans (Uneze, 2010). Moreover, most of the studies that have been done regarding orphans have been focused on HIV/AIDS orphans and not enough studies have been carried out on children orphaned by other causes, yet, according to statistics, the population of children orphaned by other causes is far greater than the population of children orphaned by HIV/AIDS. Apart from HIV/AIDS, children become orphans due to poverty, conflicts, road accidents, disease, among others (Bakare, 2013).

As elucidated earlier, more studies have been done to capture the mental health and overall well-being of HIV/AIDS orphans, as well as the predictors of their mental health but very few studies have been conducted in this area for non-AIDS orphans. Children orphaned by other causes also go through similar difficult experiences that HIV/AIDS orphans go through and their mental health is also of the utmost importance. In view of this, more studies need to be carried out to address this other group of orphans.

Most researches done on orphans have been restricted to studying at most a combination of two or three psychosocial variables. There is hardly any study that combines all the psychosocial variables of age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse as it has been done in this study. All of these psychosocial variables potentially have individual and collective impact on the mental health of orphans. Since orphans are faced with a myriad of psychosocial stressors, empirical study of a combination of the psychosocial variables impacting the mental health of orphans is crucial and will provide a robust addition to already existing literature on mental health of orphans.

Also, researchers from Duke Global Health Institute (2011) suggest that early mental healthcare and community-wide interventions could avert further traumatic events for orphans. They also pointed to the need for teaching coping skills to orphans. Again, as elucidated earlier, there are not many records of studies on interventions and their effectiveness in improving the mental health of orphans in Nigeria. Studies on intervention programmes will provide empirical based information on factors that are

effective in combating the effect of the negative psychosocial experiences orphans go through. Such studies will also throw light on the coping skills relevant to the adjustment of orphans and the improvement of their mental health and overall well-being.

Based on the various gaps in literature, this study seeks to investigate the psycho-social predictors of mental health of orphans in South-west, Nigeria and to demonstrate the effectiveness of a psycho-educational intervention programme.

1.3 Objectives of the Study

1.3.1 General Objectives:

The main objectives of this study are to:

1. Identify the psychosocial factors that predict the mental health of orphans as baseline data for intervention.
2. Empirically determine the effectiveness of a psycho-educational coping programme.

1.3.2 Specific Objectives:

Other specific objectives of this study include:

1. Investigate whether orphans significantly differ in mental health from non-orphans.
2. Investigate whether orphans differ significantly from non-orphans on the psychosocial variables of self-concept, self-esteem, social support, life satisfaction, and child abuse.
3. Examine whether age factor has a significant effect on mental health of orphans.

4. Examine whether gender factor has a significant effect on mental health of orphans.

1.4 Research Hypotheses

The following research hypotheses stated in the alternate form were tested in this study:

Hypothesis one: There will be a significant difference in mental health of orphans and non-orphans.

Hypothesis two: There will be a significant difference between orphans and non-orphans on the psychosocial variables of self-concept, self-esteem, social support, life satisfaction, and child abuse.

Hypothesis three: Age, gender, self-concept, self-esteem, social support, life satisfaction and child abuse will significantly predict the mental health of orphans.

Hypothesis four: There will be a significant age difference in mental health of orphans.

Hypothesis five: There will be a significant gender difference in mental health of orphans.

Hypothesis six: Orphans in the experimental group will report less mental health issues than orphans in the control group.

1.5 Significance of the Study

The outcome of this study will be extremely beneficial to the government, NGOs, orphanages, caregivers, teachers, and every one who has the opportunity of coming in contact with or reaching out to orphans.

Findings from this study will educate the government on the state of the mental health of orphans in Nigeria. This will help in providing insight into policies that should be implemented to give adequate attention to the cause of orphans in Nigeria and to

improve their lot as citizens of the nation. Some of the policies that can be implemented include the provision of quality education, healthcare, social support, shelter, food, and a robust environment for orphans.

NGOs, orphanages, caregivers and teachers will have firsthand information, from the findings of this study, on the factors that are most crucial to the maintenance of the mental health of orphans. This information will foster the development and adoption of strategies that are concerned with a reappraisal of the quality of care orphans are exposed to.

Furthermore, clinicians, through the outcome of this study, will become more conversant with the psychosocial variables that best predict the mental health and well-being of orphans. In addition, the effectiveness of the psycho-educational programme in improving the mental health and well-being of institutionalized orphans will provide a tried, true, and efficient intervention strategy, which can be used by clinicians to help orphans who are facing challenges in the area of their mental health and overall well-being. It will also facilitate and aid the development of more intervention and treatment programmes that will target the areas of concern to help in ameliorating the mental health of orphans.

The theories used in this study provide information that will help clinicians, NGOs, caregivers, and others approach mental health issues of orphans from a scientific and psychological point of view.

This study will also serve as a valuable source of information to various individuals dealing with children at one level or the other. The adequate knowledge of the factors that are relevant to improved mental health and overall well-being of children can enrich adults' interaction with children in their care in a way that will foster their mental health and overall well-being.

1.6 Scope of the Study

The study covered orphans and non-orphans in the South-west region of Nigeria (Ogun, Lagos, and Oyo States). It examined the psychosocial variables of age, gender, self-concept, self-esteem, social support, life satisfaction and child abuse to find out if

these variables impact on orphans and non-orphans' mental health. The study was to also determine the degree to which exposure to psycho-educational programme can improve the negative effects these variables may have on orphans' mental health.

1.7 Operational Definition of Terms

The terms used in this study were operationally defined as follows:

Age: This is defined as ranging from 13-18 years.

Child Abuse: The physical, psychological/emotional, sexual maltreatment, as well as neglect of a child by a parent or caregiver.

Gender: This is defined as male or female.

Life Satisfaction: An individual's perception of his or present life and his or her future life.

Mental Health: This is operationally defined as a state of well-being.

Older Orphan: This is defined as a child between 16-18 years.

Orphan: A child between 13-18 years that has lost both parents.

Psycho-educational Programme: A behavioural coping skills programme developed from an amalgamation of some psychological concepts and core values.

Self-concept: This is defined as an individual's perception of himself.

Self-esteem: This is the value an individual assigns to himself or herself.

Social Support: This is the perception that one is being cared for; that one has assistance available from other people; and that one is part of a supportive social network.

Younger Orphan: This is defined as a child between 13-15 years.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A quality and reliable research work must of necessity be rooted in past efforts and findings of scholars in relevant areas. This chapter broadly examines the conceptual framework, which puts the concepts being studied in the right perspective; the theoretical framework, which serves as the framework for explaining the concepts being studied; and the empirical framework, which reviews other related studies in order to better situate the concepts being studied.

2.2 Conceptual Framework

This aspect of the study fully expatiates on the concepts being studied. The concepts are mental health, self-concept and self-esteem, social support, life satisfaction, child abuse, and psychological intervention.

2.2.1 Mental Health

Mental health is an essential aspect of health. The World Health Organization (2012) constitution describes health as a state of well-being and wholeness in the physical, mental, and social sense, and not just the absence of infirmity or disease. An important inference from this description is that mental health does not focus on mental disabilities or mental disorders only. Again, mental health is described as a state of well-being where an individual becomes aware of his or her own abilities, can effectively deal with the normal stresses of life, and is able to make productive contribution to his or her community. In this positive sense, mental health is the key to individual well-being and the foundation for the effective functioning of a community. According to Boyle (2011), mental health means a state of emotional,

behavioural, and social normalcy or maturity; the absence of a mental or behavioural disorder; a state of psychological well-being where one has been able to sufficiently integrate one's instinctive desires and interests in ways that are personally and socially acceptable; a proper balance of work, leisure, and love pursuits.

Mental health also refers to cognitive, and/or emotional well-being. Mental health has to do with how individuals think, feel and behave. An individual's daily life, physical health, and relationships can be affected by the state of his or her mental health. Mental health can also be described in terms of a person's ability to enjoy life by attaining a balance between daily life activities and endeavours to obtain psychological resilience (Nordqvist, 2009).

In simple terms, mental health refers to 'health of the mind' (Kozier, 2008). Holmes (2010) argues that although many people may not suffer from a mental disorder that is diagnosable, the truth still holds that some individuals exhibit better mental health than others. Storrie, Ahern and Tuckett (2010) note that facts from the World Health Organization suggest that almost half of the world's population struggle with mental illness that affect their self-esteem, relationship with others, and ability to function in everyday life. An individual's emotional health can also affect physical health and poor mental health can lead to problems such as substance abuse (Richards, Campania, & Muse-Burke, 2010). In order to live a long and healthy life, it is important to maintain good mental health. Good mental health can improve one's life, while poor mental health can hinder someone from living a normal life. According to Richards et al. (2010), there is increasing evidence that shows the association between emotional abilities and pro-social behaviours such as stress management and physical health. They also concluded in their research that being void of emotional expression leads to maladjusted behaviours in people. These behaviours are a direct reflection of the mental health of such individuals.

Some individuals engage in self-destructive behaviours to suppress emotions. Some of these acts include drug and alcohol abuse, physical fights or vandalism (Richards et al., 2010). Good mental health and well-being are associated with improved outcomes for individuals including longevity, physical health, social connectedness, educational achievement, maintaining a home, employment status and productivity. Mental health problems are characterized by the extent to which they disrupt an individual's ability

to function. As a matter of fact, many consider the inability to learn, work, or participate fully in life to be one of the hallmarks of having a mental illness. Mental health issues generally, including those not severe enough to be labeled by professionals as "illnesses," can still interfere with functioning across all areas of life – socially, emotionally, and physically. Poor mental health has been known to result in adjustment as well as interpersonal problems, diminished quality of life and deteriorating physical health. Poor mental health and well-being can have impact on every area of a person's life including physical health, education, employment, family, relationships, and the effects can last a lifetime.

The mental health of individuals, especially children is of utmost importance. The importance of healthy mental and physical development of children cannot be overemphasized. Many people recognize the importance of a healthy childhood, but few understand the critical part played by mental and emotional problems and how important and harmful they can be for children and youth throughout their growing years. Mental health covers a lifespan, from infancy to the elderly years, but it is in the earliest years, so often disregarded, that the interaction of inherent genetic potential, environmental nurturing and daily experience mold the nature of our personality and our vulnerability to damaging events. Childhood mental health is very important because a healthy start is crucial for mental health and well-being throughout life. The consequences of poor mental health in childhood and adolescence extend into adulthood, increasing the likelihood of low employment level and low income, criminality, adult mental illness, and marital difficulties (Richards & Abbott, 2009).

Broadly, well-being has been defined from two perspectives. The clinical perspective defines well-being as the absence of negative conditions and the psychological perspective defines well-being as the prevalence of positive attributes. Positive psychological definitions of well-being generally include some of six general characteristics. The six characteristics of well-being most prevalent in most definitions of well-being are: the active pursuit of well-being; a balance of attributes; positive affect or life satisfaction; pro-social behaviour; multiple dimensions; and personal optimization (Baiwais, 2011). Gough and McGregor (2007) as cited in Baiwais (2011) defined well-being as what people are notionally able to do and to be,

and what they have actually been able to do and to be. According to Angner (2008) as cited in Baiwais (2011), even the philosophical literature refers to the 'simple notion' of well-being (i.e. 'a life going well') in a variety of ways, including a person's good, benefit, advantage, interest, prudential value, welfare, happiness, flourishing, utility, quality of life, and thriving. According to Camfield, Streuli and Woodhead (2010) as cited in Baiwais (2011), well-being is more than the absence of illness or pathology with subjective (self-assessed) and objective (ascribed) dimensions. It can be measured at the level of individuals or society and it accounts for elements of life satisfaction that cannot be defined, explained or primarily influenced by economic growth. Subjective Well-Being (SWB) was defined by Deiner (2009) as the general evaluation of one's quality of life. It has been conceptualized as having three components: (1) a cognitive appraisal that one's life was good (life satisfaction); (2) experiencing positive levels of pleasant emotions; (3) experiencing relatively low levels of negative moods (Deiner, 2009).

2.2.2 Positive Psychology and Mental Health

Positive psychology is a new branch of psychology that presents psychology in light of positive human functioning. Positive psychology aims at strengthening positive growth in individuals, families, and communities by means of scientific knowledge and efficient interventions. Positive psychologists are not solely interested in treating mental disorders, they try to find and nourish extraordinary mental capacity and talent, and also to make normal life more satisfying (Compton, 2005). Positive psychology does not intend to be a substitute for traditional psychology but to complement it. Its purpose is not to deny the significance of acquiring knowledge on how things go wrong, but rather to stress the relevance of using the scientific method to ascertain how things go right. Diverse topics in psychology can be put together under the umbrella of positive psychology, which provides opportunity for new discoveries. These new discoveries do a lot to help people live their lives up to its maximum potential. Researchers in the area of positive psychology are concerned with concepts like values, skills, expertise, strengths, and how they can be promoted by social organizations. Positive psychologists are interested in four topics: Positive

experiences, Enduring psychological traits, Positive relationships and Positive institutions (Peterson, 2009).

Positive psychology has its roots in humanistic psychology, which highly concentrated on happiness and fulfillment. Positive psychology was first influenced by philosophical and religious views before taking its contemporary form in the late 19th century. Judaism promotes a Divine command theory of happiness: happiness and rewards result from observing the sacred commands (Compton, 2005). The ancient Greeks had many schools of thought. Socrates supported the notion of self-knowledge being the path to happiness. Plato's iconic representation of the cave persuaded western thinkers who believe that one can find happiness when he or she finds profound meaning. Aristotle believed that happiness is formed by engaging in logical activity that is in harmony with virtue over a complete life. The Epicureans agreed that happiness can be attained by enjoying things that gratify. The Stoics believed in the possibility of remaining happy by being unbiased and agreeable to reason. They also reported several "spiritual exercises" that are similar to the psychological exercises utilized in Cognitive Behavioural Therapy (CBT) and Positive Psychology (Compton, 2005; Robertson, 2010).

Christianity kept on with the Divine command theory of happiness. Theologians of the Middle Ages posited that it is not quite possible to find true happiness until life after death. The seven deadly sins are concerned with earthly self-indulgence and extreme self-love. On the other hand, the Four Cardinal Virtues and Three Theological Virtues were supposed to make one refrain from sinning (Compton, 2005). During the Renaissance and Age of Enlightenment, individualism became a thing of worth. At the same time, the people who were creative gained reputation because they were now regarded as skilled individuals. Utilitarian philosophers such as John Stuart Mill believed that virtuous actions are those actions that make it possible for most people to be happy. He suggested that a verifiable science of happiness should be used to ascertain which actions are virtuous and ethical (a science of morality). Thomas Jefferson and other advocates of democracy believed that life, liberty and the pursuit of happiness are rights that cannot be taken away (Compton, 2005). The Romantics placed value on individual emotional expression and searched for their emotional "true selves," which were not restrained by social prohibitions.

Also, love and intimacy became the main reasons for people to marry one another (Compton, 2005). Positive psychology can be demarcated into three overlapping areas of research:

1. Research into the **Pleasant Life**, or the "life of enjoyment", investigates how people best experience, estimate, and enjoy the positive sensations and emotions that are part of normal and healthy living (for instance, relationships, entertainment, interests, hobbies, and others). Martin Seligman opines that this most fleeting element of happiness may be the least important, in spite of the interest shown in it (Wallis, 2005).

2. The study of the **Good Life**, or the "life of engagement", examines the helpful impact of the engrossment and flow that individuals experience when they engaged with their primary activities to the best of their ability. Individuals reach these states when there is a positive agreement between a person's expertise and the duty he or she is performing, i.e. when an individual feels confident about accomplishing the task he or she is faced with.

3. Inquiry into the **Meaningful Life**, or "life of affiliation", queries how individuals obtain a positive sense of well-being, meaning, belonging, and purpose from being part of and giving back to something bigger and more enduring than themselves (namely, nature, social groups, organizations, movements, traditions or belief systems).

These categories do not appear to be widely resisted, neither are they embraced by researchers over the period of 12 years that this area of psychology has existed. Martin Seligman initially proposed these 3 categories, but has since recommended that the last category, "meaningful life", be regarded as 3 different categories. The acronym that is formed from this is PERMA – Positive Emotions; Engagement, Relationships, Meaning and Purpose; and Accomplishments (The World Question Centre, 2011). The broaden-and-build theory of positive emotions alludes that positive emotions (such as happiness, interest, anticipation) widen one's awareness and motivate new, varied, and exploratory thoughts and actions. Over time, this widened behavioural skills and resources. For example, inquisitiveness about a landscape becomes valuable navigational intelligence; pleasant interactions with a

stranger become a supportive friendship; and physical play with no intent or purpose becomes exercise and physical perfection. Positive emotions are differentiated from negative emotions, and this prompts behaviours that are focused on survival.

Positive Psychology is a science of positive aspects of human life, happiness, well-being, and flourishing. It is the scientific study of what improves life and helps people to attain their greatest potential. The aim of Positive Psychology is to shift focus from being preoccupied with providing remedy to the worst things in life to increasing the best attributes in life. It is about building positive experiences and positive traits, which leads to an improved quality of life for people. The school of Positive Psychology provides positive interventions for individuals and shows how social support, optimism, self-esteem, a sense of expertise, and active coping skills augment health and well-being.

2.2.3 Self-concept

The term self-concept refers to how an individual perceives himself or herself. Self-concept is one's perception or image of one's competence and uniqueness. At first, one's self-concept is very general and subject to change. As we grow older, these self-perceptions become much more organized, detailed, and specific (Pastorino & Doyle-Portillo, 2013). According to Weiten, Dunn and Hammer (2012), self-concept is a collection of beliefs about one's own natural unique qualities, and typical behaviour. It is one's mental picture of oneself. It is a collection of self-perceptions. Self-concept is how one thinks about and evaluates oneself. To be aware of oneself is to have a concept of oneself (McLeod, 2008). Self-concept has been divided into two frameworks by social psychologists: conceptual and operational. The conceptual definition of self-concept is further broken down into four self identities, which include: the material self, the inner self, the interpersonal self, and the societal self. The material self refers to the self that resides within the boundaries of the physical body. The inner self relates to the more individual, private and self-reflective identity. The interpersonal self is a reflection of an individual's "collection of roles" in the context of interactions with others. Finally, the societal self is related to the social identities of collective society or culture (Fiske, 2004 as cited in Diaz, 2011). The

operational definition of self-concept addresses the working definition of self-concept, which includes how it can be measured. The operational definition focuses on the ways in which self-concept affects people on the cognitive (self-concept), affective (self-esteem), and behavioural (self-presentation) levels. In this way, self-concept is deemed the cognitive representation of the self and is primarily focused on the knowledge people have of themselves. Self-esteem, which involves the self and emotion, focuses on the way people generally feel about themselves and the extent to which they view themselves as worthy or lovable. Self-presentation, a facet of behaviour, refers to the ways in which people attempt to convey a certain image to others.

People acquire self-knowledge and interpret that knowledge in various ways, primarily from four sources of self-knowledge, which include: self-perception, introspection, social comparison, and social feedback. Typically, people develop an isolated self-concept from self-perception and introspection, whereas they develop an interrelated self-concept from social comparison and social feedback. Self-perception theory, which was developed by Daryl Bem, claims that people will look at their own behaviour to determine their attitude when they are unsure of their attitude (Nier, 2007 as cited in Diaz, 2011). Therefore, one important source of self-knowledge is observing one's own behaviour. Observing oneself in this way, as an outsider might, can assist people in making more accurate judgments about how others perceive them. Introspection refers to how people develop a sense of who they are from their inner thoughts and feelings. Considering their own inner experience, rather than behaviour, can help people to identify attitudes that are incongruent with their actions. When it comes to self-concept, people generally tend to believe that their thoughts and feelings are the most revealing whereas outsiders view behaviour as more telling. Social comparison discusses the comparisons people make between themselves and others in order to ascertain progress. This enables them to obtain self-knowledge from looking at others. It is believed that when people have others around them, it helps them to determine a standard of measure, such as economic status, intelligence, emotional stability, among others (Myers, 2005 as cited in Diaz, 2011). People compare themselves to others in order to determine how they "measure up," both in the short- and long-term. Similar to social comparison, social feedback is also an important source of self-knowledge. It refers to judgments people make about

themselves in reaction to responses from others. A person's self-concept is affected by both actual and perceived appraisals; a person's self-concept is correlated with how he/she thinks he/she is viewed. The way people use their interpretation of others' appraisals to form perceptions about themselves is referred to as the "looking-glass self," a concept developed by Charles Cooley (Myers, 2005). Thus, people use reflections from others as a way to decide how they view themselves.

A child's self-concept begins to develop at birth. It begins with how adults respond to him/her. Parents and caregivers create a positive emotional bond with an infant through warm and caring interactions with a lot of eye contact and touch. This positive emotional bond with parents and caregivers promotes a child's healthy self-concept. It is the basis of a relationship in which the child feels the parents' and caregivers' love, acceptance, and respect. As the child grows into a toddler and preschooler, his/her ability to interact successfully with his environment promotes a healthy self-concept (Ferrer & Fugate, 2012). A child will continue to develop a healthy self- concept when he/she is given the opportunity to explore his environment, to ask questions without feeling like a nuisance, and to engage in make-believe play activities. During this time of exploration, the responsiveness and support of his parents and caregivers will enhance his self-concept. The child's own responsiveness and support of others will also enhance his self-concept. Through interactions with others he begins to think of himself/herself as being a good person and a valuable part of a group (Ferrer & Fugate, 2012). A healthy self-concept is the foundation for the positive development and overall well-being of a child. When a child has a healthy self-concept, he sees himself as being loved, loving, and valuable. A child with a healthy self-concept is also better able to reach his full potential. He does better in school. He is better able to set goals for himself and make decisions. He is more willing to learn new things and try new activities. With a healthy self-concept, a child has better relationships with family members and friends. He can control his behaviour and get along with others (Ferrer & Fugate, 2012).

2.2.4 Self-esteem

In psychology, the term self-esteem is used to describe a person's overall sense of self-worth or personal value. Self-esteem is how an individual values himself, how he perceives his value to the world, and how valuable he thinks he is to others. Self-esteem is also described as the amount of respect or self-worth that an individual has for himself. According to Amaechi (2008) as cited in Farooqi and Intezar (2009), self-esteem is the feeling of being happy with one's character and abilities. It is obvious in a wonderful feeling of inner balance, grounded on self- acceptance and a healthy, comforting self respect towards one. This is totally different from self confidence which is deeply rooted in what one believes one can attain. Mazhar (2004) as cited in Farooqi and Intezar (2009) described self-esteem as a sense of self, the value one puts on self and the worth one attaches to self. Self-esteem is the basic belief about self. It can thus be inferred that, if one has a positive belief system about oneself, one will have a positive self-esteem. On the other hand, if one views oneself as worthless, one will have a negative self-esteem.

People exhibit either high self-esteem, meaning they think very well of themselves and their abilities, or low self-esteem, meaning they doubt themselves and criticize their own abilities. Twenge (2009) as cited in Farooqi and Intezar (2009) stated that self-esteem is strongly related to happiness. He argued that people with high self-esteem report being more likeable and attractive; having better relationships and making better impressions on others than people with low self-esteem. Self-esteem is important because it is an essential human need that is vital for survival and normal, healthy development. Abraham Maslow opined that psychological health is not possible unless the essence of a person is fundamentally accepted, loved and respected by himself or herself and others. Self-esteem allows people to face life with more confidence, optimism and altruism, which enables them reach their goals easily and attain self-actualization ("Self-esteem," 2012).

2.2.5 Social Support

Social support is the perception that one is being cared for; that one has assistance available from other people; and that one is part of a supportive social network. These

supportive resources can be emotional (e.g., nurturance), tangible (e.g., financial assistance), informational (e.g., advice), or companionship (e.g., sense of belonging). Social support can be measured as the perception that one has assistance available, or that one actually receives assistance, or the degree to which an individual fit into a social network. Sources of support include family, friends, organizations, co-workers, and others ("Social Support," 2012). Social support is studied across a wide range of disciplines including psychology, and has been linked to many advantages for both physical and mental health. In stressful periods, social support helps people diminish psychological distress such as anxiety or depression (Taylor, 2011). Social support can be categorized and measured in several different ways. There are four common functions of social support:

Emotional support is showing empathy, concern, care, love, trust, acceptance, intimacy, affection, or encouragement. It is the provision of warmth, as well as physical and emotional care by sources of social support (Taylor, 2011). Providing emotional support gives an individual the impression that he or she is valued. Emotional support is also sometimes called or appraisal support or esteem support.

Tangible support is providing for an individual in terms of financial assistance, material goods, or services (Heaney & Israel, 2008). Also called instrumental support, this form of social support includes the tangible and direct ways people assist others.

Informational support is providing guidance, suggestions, advice, or useful information to someone. This type of information helps others in problem-solving.

Companionship support is the type of support that gives someone a sense of social belonging. This type of support is shown when an individual has companions to share social activities with.

Researchers usually make a distinction between perceived and received support (Taylor, 2011). Perceived support refers to an individual's subjective judgment that providers will offer (or have offered) effective help during times of need. Received support (also called enacted support) refers to specific supportive actions (such as advice or reassurance) an individual receives during times of need (Gurung, 2006). Furthermore, social support can be measured in terms of structural support or functional support. Structural support (also called social integration) refers to the

degree of an individual's connectedness within a social network, like the number of social ties or how integrated a person is within his or her social network. Family relationships, friends, and membership in clubs and organizations bring about social integration (Lakey, 2011). Functional support is concerned with the specific functions that members of social network can provide, such as the emotional, instrumental, informational, and companionship support as specified earlier.

2.2.6 Life Satisfaction

Life satisfaction describes how a person perceives his or her life presently and how he or she feels about the future. It is a measure of well-being, as well as a logical, global judgment. Life satisfaction means having a favourable attitude towards one's life in general. The criteria used to measure life satisfaction include economic standing, amount of education, experiences, and a person's residence and others ("Life Satisfaction," 2012). Life satisfaction mirrors experiences that have affected a person in a positive way. These experiences often motivate people to pursue and reach their goals ("Life Satisfaction," 2012). Two types of emotions, hope and optimism; affect how people perceive their lives. These two emotions consist of cognitive processes that are usually geared towards the perception of goals and attaining those goals. An individual's perception of his or her life satisfaction can be influenced by his or her mood and outlook to life (Bailey, Eng, Frisch, & Snyder, 2007).

The family also influences life satisfaction. Family life satisfaction is an important topic because one way or another, everyone is influenced by his or her family in some way, and most people strive to have high levels of satisfaction in life as well as within their own families. A family can make all the difference in someone's life satisfaction. Studies have shown that an adolescent's life satisfaction is heavily influenced by his or her family's dynamic characteristics. Parental support, family bonding and family flexibility, are all immense factors that determine an adolescent's life satisfaction. The more bonding, flexibility, and support there is within a family the higher the adolescent's life satisfaction. It has been revealed, for instance, that adolescents living in a two-parent home had significantly higher life satisfaction than adolescents living in a single-parent family home ("Life Satisfaction," 2012).

2.2.7 Child Abuse

Child abuse is any emotional, sexual, or physical maltreatment, as well as neglect of a child (Medical News Today, 2012). In the United States, the Centre for Disease Control and Prevention (CDC) and the Department for Children and Families (DCF) describe child maltreatment as any act or series of acts committed or neglected by a parent or other caregiver that results in potential for harm, or threat of harm, or actual harm to a child (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). Child abuse can take place in a child's home, organizations, schools or communities the child interacts with. Child abuse is any recent act or failure to act on the part of a parent or caretaker towards a child, which results in death, or serious physical/emotional harm, or sexual abuse/exploitation. It is also an act or failure to act, which presents an impending risk of serious harm to a child (Herrenkohl, 2005).

The four main types of child abuse are physical, sexual, psychological, and neglect ("Child Abuse," 2010). Physical abuse involves physical aggression aimed at a child by an adult. Most nations with child-abuse laws consider the intentional infliction of serious injuries, or deliberate actions that place the child at obvious risk of serious injury or death, to be illegal. Child sexual abuse (CSA) is a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation (U. S. National Library of Medicine, 2008). Forms of CSA include asking a child or putting a child under pressure to engage in sexual activities (irrespective of the outcome), immodest exposure of the genitals to a child, showing pornographic materials to a child, actual sexual contact with a child, touching a child's genitals, looking at a child's genitalia without touching it, or making a child participate in child pornography (U. S. National Library of Medicine, 2008). Effects of child sexual abuse include insomnia, flashbacks, nightmares, fear of things associated with the abuse (including objects, smells, places, doctor's visits, among others), guilt and self-blame, self-esteem issues, chronic pain, addiction, sexual dysfunction, self-injury, somatic complaints, depression, suicidal ideation, anxiety, and post-traumatic stress disorder. Other mental health challenges include dissociative identity disorder, borderline personality disorder, among others.

Of all the other forms of abuse, the hardest to define is emotional abuse. It could include name-calling, ridicule, excessive criticism, degradation, withholding

communication, destruction of personal belongings, inappropriate or excessive demands, torture or killing of a pet, and routine labeling or humiliation (The National Centre for Victims of Crime, n.d.). Victims of emotional abuse may react by distancing themselves from the abuser, internalizing the abusive words, or fighting back by insulting the abuser. Emotional abuse may result in abnormal or disrupted attachment development, self blame, learned helplessness, and overly passive behaviour (The National Centre for Victims of Crime, n.d.). Neglect can be described as the failure to meet the basic needs of children including housing, clothing, food and access to medical care. With information from a database of cases substantiated by protective services agencies, some researchers discovered over 91,000 cases of neglect in one year – October 2005 to 30 September 2006 (Leeb et al., 2008). Neglect could also take the form of financial abuse where a parent or caretaker refuses to purchase necessary materials that will aid the survival of the child (People Helping People, 2009). Children who have a history of neglect or physical abuse are at risk of developing a disorganized attachment style or psychiatric problems ("Child Abuse," 2012). Disorganized attachment is associated with a number of developmental problems, including dissociative symptoms, as well as symptoms of anxiety, depression, and behavioural problems ("Child Abuse," 2012).

2.2.8 Psychological Intervention

In applied psychology, interventions are actions performed to bring about change. Psychological interventions are methods used to bring about change in an individual. Specifically they are activities used to change an individual or behaviour or group behaviour as well as an individual's emotional state or feelings ("Psychological Intervention," 2013). Psychological intervention can also be said to be a method of inciting changes in a person's behavior, thoughts, or feelings. Intervention takes place whenever psychologists resolutely try to produce change in the lives of others. Interventions can be used to promote good mental health in order to prevent mental disorders. These interventions are not adapted towards treating a mental condition but are designed to foster healthy emotions, attitudes and habits. Such interventions can enhance quality of life even when mental illness is not present (Feldman & Dreher, 2012). Depending on the needs, psychological interventions can

be diverse and can be tailored specifically to the individual or to the group that is being treated. This flexibility adds to the effectiveness of psychological interventions in addressing all kinds of situations (Domínguez et al., 2011).

There are various types of psychological intervention, one of which is psycho-education. Authier (1997) as cited in Griffiths (2006) described psycho-education as a therapeutic approach that does not focus on diagnosing abnormality or prescribing medication, or finding a cure, but focuses on setting goals, teaching skills, attaining satisfaction, and achieving goals. Psycho-education or psycho-educational interventions comprises a wide range of activities that combine education and other activities such as counseling and supportive interventions. Psycho-educational interventions may be administered individually or in groups and may be tailored or standardized. This type of intervention generally includes providing patients with information about treatments, symptoms, resources, and services; training to provide care and respond to disease-related problems; and problem-solving strategies for coping (Bruera et al., 2013).

2.3 Theoretical Framework

There are various theoretical foundations that will assist in providing an in-depth explanation of this study. Theories are scientific principles that explain phenomena. They are set of facts, propositions, or principles analyzed in their relation to one another and used, especially in science, to explain phenomena. In this study, theories that suitably explain each variable of study shall be examined and they include: attachment theory of mental health, locus of control theory of mental health, Carl Roger's theory of self-concept, social identity theory of self-concept/self-esteem, buffer theory of social support, social comparison theory of life satisfaction, Erikson's psychosocial theory, and Yalom's therapeutic factors of group therapy.

2.3.1 Attachment Theory of Mental Health

Attachment theory, propounded by John Bowlby, is one of the most universal and most rigorously tested of all psychological theories relating to mental health. Research

universally shows that individuals who experienced severely disturbed or disrupted attachments to care-givers over the development years also present with the most severe mental health problems (Seager, 2007). Immediately after World War II, homeless and orphaned children presented many difficulties, and psychiatrist/psychoanalyst, John Bowlby, was asked by the United Nations (UN) to write a pamphlet on the matter. He later went on to propound the attachment theory. Attachment theory describes the dynamics of long-term relationships between humans. Its most important tenet is that an infant needs to develop a relationship with at least one primary caregiver for social and emotional development to occur normally. Infants become attached to adults who are sensitive and responsive in social interactions with them, and who remain as consistent caregivers for some months during the period from about six months to two years of age. When an infant begins to crawl and walk they begin to use attachment figures (familiar people) as a secure base to explore from and return to. Parental responses lead to the development of patterns of attachment; these, in turn, lead to internal working models which will guide the individual's perceptions, emotions, thoughts and expectations in later relationships. Separation anxiety or grief following the loss of an attachment figure is considered to be a normal and adaptive response for an attached infant.

Within attachment theory, *attachment* means an affectionate bond or tie between an individual and an attachment figure (usually a caregiver). Such bonds may be reciprocal between two adults, but between a child and a caregiver these bonds are based on the child's need for safety, security and protection, paramount in infancy and childhood. Infants form attachments to any consistent caregiver who is sensitive and responsive in social interactions with them. The quality of the social engagement is more influential than the amount of time spent. The biological mother is the usual principal attachment figure, but the role can be taken by anyone who consistently behaves in a "mothering" way over a period of time. In attachment theory, this means a set of behaviours that involves engaging in lively social interaction with the infant and responding readily to signals and approaches. Nothing in the theory suggests that fathers are not equally likely to become principal attachment figures if they provide most of the childcare and related social interaction. Some infants direct attachment behaviour (proximity seeking) towards more than one attachment figure almost as soon as they start to show discrimination between caregivers; most come to do so

during their second year. These figures are arranged hierarchically, with the principal attachment figure at the top.

The set-goal of the attachment behavioural system is to maintain a bond with an accessible and available attachment figure. "Alarm" is the term used for activation of the attachment behavioural system caused by fear of danger. "Anxiety" is the anticipation or fear of being cut off from the attachment figure. If the figure is unavailable or unresponsive, separation distress occurs. In infants, physical separation can cause anxiety and anger, followed by sadness and despair. By age three or four, physical separation is no longer such a threat to the child's bond with the attachment figure. Threats to security in older children and adults arise from prolonged absence, breakdowns in communication, emotional unavailability or signs of rejection or abandonment. The attachment system is very robust and young humans form attachments easily, even in far less than ideal circumstances. In spite of this robustness, significant separation from a familiar caregiver, for example, the loss of a parent – or frequent changes of caregiver that prevent the development of attachment – may result in psychopathology at some point in later life. Barber, Ball and Armistead (2003) also contend that emotional closeness and healthy attachment between the parent and child results in positive psychological adjustment, whereas insecure attachment and less emotional closeness are associated with negative psychological outcomes.

The attachment theory is related to this study because most times, orphans are separated from their primary caregivers (parents) at a very tender age and as such are deprived of the necessary attachment they would have formed, which is essential to the facilitation of their social and emotional development. Some children who have formed attachment with their parents lose this bond when they are orphaned and because they are placed in environments where there may not be enough social support or the one-on-one care and attention that a parent will give to a child, they fail to form attachments with individuals who are presently in their lives. Failure to develop attachment with a caregiver or a significant other at that stage in life may result in mental health challenges for an orphan. Also, failure to form attachment may eventually affect the relationship of orphans with others around them. This makes them feel detached from the rest of the world and they may perceive themselves as

different from others or that others lead better lives than they do. This may gravely affect how satisfied they are with life and it may affect the development of their healthy self-concept and self-esteem.

2.3.2 Locus of Control Theory of Mental Health

A psychological theory that explains mental health is the locus of control theory. The locus of control theory, which originated from Julian Rotter, postulates that every human being has a "place"- the locus where he/she feels the control of his/her life rests; this place or locus of control can either be internal or external; and it is this position that creatively determines how much "in control" an individual feels about his/her life (Kabamba, 2009). Locus of control is defined as an individual's generalized expectancies regarding the forces that determine rewards and punishments. Individuals with an internal locus of control view events as resulting from their own actions. Persons with an external locus of control view events as being under the control of external factors such as luck (Wise, 2006 as cited in Bos et al., 2011). For instance, a person with an internal locus of control will attribute the failure to meet a desired goal to poor personal preparation, whereas, one with an external locus of control will attribute failure to circumstances beyond the individual's control. The way individuals interpret such events has a profound affect on their psychological well-being. If people feel they have no control over future outcomes, they are less likely to seek solutions to their problems. The far-reaching effects of such maladaptive behaviours can have serious consequences (Wise, 2006 as cited in Bos et al., 2011).

People who have internal locus of control are generally the happiest in life; even when surrounded by negativity, they still feel they are in control and that the ability to make a desirable change lies within them. Those with external locus of control easily give in to feelings of helplessness in difficult times and they are generally the most miserable in society. This agrees with the Law of Control, which posits that, an individual's state of happiness or unhappiness depends on how much the individual feels in control of his or her life (Kabamba, 2009). An individual's levels of

confidence will, therefore be, mainly determined by how much of control he has over his life and everything happening to him (Kabamba, 2009).

Locus of control theory is related to this study because orphans may have the tendency to attribute happenings in their lives to external situations and circumstances, believing that if they had better opportunities, their lives would have had better outcomes. This makes them exhibit external locus of control, which negatively influences their levels of confidence in themselves and overall satisfaction with life leading to poor psychological well-being and other forms of psychopathology like depression.

2.3.3 Carl Rogers' Theory of Self-concept

Carl Rogers' theory of self-concept relates to individuals' perception or image of themselves, which is based on life experience. If a child's first experiences are negative, it is most likely that in adulthood, the child will have poor self-concept. The theory includes the organismic self (or self-actualizing tendency) and the self-concept. The organismic self is present from birth and aims to mature and achieve self-actualization. According to this theory, self-concept is acquired in early childhood, and it is shaped by the unconditional positive regard of important others (usually parents). Self-concept usually comes into act due to secondary needs, positive regard from others, and positive self-regard.

Humanist psychologist Carl Rogers (1959) as cited in McLeod (2008) believed that there were three different parts of self-concept:

1. **Self-image**, or how an individual sees himself or herself. It is important to note that self-image does not necessarily agree with reality. People might have a bloated self-image and believe that they are better at things than they really are. In another vein, people are also predisposed to having negative self-images and they perceive or exaggerate flaws or weaknesses. For instance, a teenage boy might believe that he is clumsy and socially awkward when he is actually quite pleasant and likeable. A teenage girl might believe that she is obese, when she is really thin. Each individual's self-image is probably a blend

of different aspects including one's physical characteristics, personality traits, and social roles.

2. **Self-esteem,** or how much value an individual places on himself or herself. A series of different factors can affect self-esteem, including the comparisons an individual makes between himself/herself and others; and how others respond to him/her. When people respond positively to one's behaviour, it increases the likelihood of developing positive self-esteem. However, when an individual compares himself/herself to others and is lacking, it can negatively impact his/her self-esteem.

3. **Ideal self,** or how an individual wishes he/she could be. In many cases, the way an individual actually sees himself/herself and how he/she would like to see himself/herself do not quite match up.

As mentioned, an individual's self-concepts are not always perfectly aligned with reality. For instance, some students might believe that they are great at their studies, but their school transcripts might tell a different story. According to Carl Rogers (1959) as cited in McLeod (2008), the degree to which a person's self-concept matches up to reality is known as congruence or incongruence. While an individual tends to distort reality to a certain degree, congruence occurs when self-concept is fairly well aligned to reality. Incongruence happens when reality does not match up to one's self-concept.

Rogers believed that incongruence has its earliest roots in childhood. When parents place conditions on their affection for their children (only expressing love if children "earn it" through certain behaviours and living up to the parents' expectations), children begin to distort the memories of experiences that leave them feeling unworthy of their parents' love. Unconditional love, on the other hand, helps to foster congruence. Children who experience such love feel no need to continually distort their memories in order to believe that other people will love and accept them as they are.

Carl Rogers' theory of self-concept is related to this study in the following way: According to Rogers, the development of self-concept is fostered by life experiences and when a child's first life experiences are negative, it is theorized that such child

will mostly develop poor self-concept in adulthood. Orphans lose their parents so early in life and the traumatic experiences that follow such loss can negatively impact on their self-concept. Besides, parents play such important role in the development of a child's self-concept and when a child loses the parents, there is a void, especially if there is no one to play the role and such child might end up with a poor self-concept. Furthermore, a parent's unconditional love and positive regard might not be available for an orphan because if at all he is cared for by other caretakers, they may not express to him, the unconditional love or positive regard that is required for the development of good self-concept.

2.3.4 Social Identity Theory of Self-concept and Self-esteem

According to Tajfel and Turner's social identity theory, self-concept/self-esteem is composed of two key parts: personal identity and social identity. An individual's personal identity includes such things as personality traits and other characteristics that make each person unique. Social identity includes the groups people belong to including their community, religion, college, and other groups. Social identity is a person's sense of who he or she is based on his or her group membership(s). Henri Tajfel proposed that the groups (i.e. social class, family, and others) which people belonged to were an important source of pride and self-esteem. Groups give individuals a sense of social identity and a sense of belonging to the social world. In order to increase our self-image we enhance the status of the group to which they belong. People can also increase their self-image by discriminating and holding prejudiced views against the out group (McLeod, 2008).

Social identity theory lends credence to this study because orphans belong to a group that is exposed to discrimination and prejudice and this may affect their self-esteem negatively. Moreover, in a bid to fit in to a better social group or class, orphans may take measures, which may expose them to exploitation and abuse. Orphans between13 and 15 years may be more vulnerable in this regard because at this age, they tend to value being accepted and feeling at home in a place or group; they are easily upset, easily humiliated, and very concerned about social appraisal (Canadian Centre for Child Protection n.d.).

2.3.5 Buffer Theory of Social Support

This is one of the earliest theories of social support. According to the buffer theory, social support protects an individual and acts as buffer to environmental stresses like death and loss of loved ones. There are many effective coping techniques for stress and challenges in life, but one that surfaces time and time again is the one called social support networks commonly known as "friends". A good social support network of family and friends is a good coping technique to fall back on when life's turmoil comes, especially loss of loved ones. Having someone to soften the hurts and pains of life's challenges is apt in nursing individuals back to normal functioning and stability. Research shows that people who have solid social support network tend to weather the storms of stress better than those who have a poor social network, or who feel isolated (Ogunsakin, Shehu & Oniyangi, 2012).

People are often referred to as social animals, and no man can really exist as an island or live in isolation. The logic behind the buffer theory is that a strong support group tends to buffer or protect one from the harshest effects of stress and life challenges and soften the blow if/when individuals get knocked over. Support groups act as sounding boards, conversation partners, and people who simply show up because one needs a shoulder to cry on.

Buffer theory of social support relates well with this study. Most orphans, at the loss of their parents, become traumatized and vulnerable. The fact that they are children who do not know how to get by in life without the support of their parents makes the matter worse for them. This group of children will, therefore, be in dire need of one form of support or the other in other to cushion the effect of the loss they have suffered. If they do not have access to adequate social support, coping with the traumatic experiences that have suddenly become their harsh reality may become too overwhelming and thus have an adverse effect on their mental health and well-being, as well as other significant areas of their lives.

2.3.6 Social Comparison Theory of Life Satisfaction

In his theory of social comparison, Leon Festinger identified the drive in humans to evaluate their opinions and abilities. When there are no objective criteria, individuals make assessments by comparing their opinions and abilities to those of similar individuals. The social comparison theory presupposes that human beings are naturally driven to evaluate their opinions, abilities and overall self-worth. In order to assess themselves, individuals look towards other people they can identify with, and compare themselves with others (Seidel, 2009). By making comparisons between themselves and others who are worse off, people may create a lower reference point to assess their own situation, which can make them perceive their situation in a more positive way (Buunk, Oldersma, & De Dreu, 2001). These kinds of downward comparisons will make people feel more satisfied about their own circumstances (Buunk et al., 2001) and have been shown to predict life satisfaction more than factors such as present level of aspiration or comparison with one's previous situation. By making comparisons between themselves and others who are much better off (upward comparison), people enter into unfavourable competition that will make them feel more dissatisfied with their lives (Frieswijk & Buunk, 2004).

Social comparison theory relates to this study because just like any other child, orphans have certain life expectations and may tend to compare themselves with other children who seem to be doing well and better than they are doing (upward comparison). This will definitely impact negatively on their overall life satisfaction.

2.3.7 Erikson's Psychosocial Theory

Erik Erikson, a German-born American psychoanalyst, propounded an eight-stage theory of identity and psychosocial development. He explored three aspects of identity: the ego identity (self), personal identity (the personal idiosyncrasies that distinguish a person from another) and social/cultural identity (the collection of social roles a person might play).

Erikson's psychosocial theory of development considers the impact of external factors, parents and society on personality development from childhood to adulthood.

According to Erikson's theory, every person must pass through a series of eight interrelated stages over his or her entire life cycle. These eight stages, spanning from birth to death, are split in general age ranges.

1. Infancy: Birth-18 Months Old

Basic Trust vs. Mistrust – Hope

During the first or second year of life, the major emphasis is on the mother and father's nurturing ability and care for a child, especially in terms of visual contact and touch. The child will develop optimism, trust, confidence, and security if properly cared for and handled. If a child does not experience trust, he or she may develop insecurity, worthlessness, and general mistrust to the world.

2. Toddler / Early Childhood Years: 18 Months to 3 Years

Autonomy vs. Shame – Will

The second stage occurs between 18 months and 3 years. At this point, the child has an opportunity to build self-esteem and autonomy as he or she learns new skills and right from wrong. The well-cared-for child is sure of himself, carrying himself or herself with pride rather than shame. During this time of the "terrible twos", defiance, temper tantrums, and stubbornness can also appear. Children tend to be vulnerable during this stage, sometimes feeling shame and low self-esteem during an inability to learn certain skills.

3. Preschooler: 3 to 5 Years

Initiative vs. Guilt – Purpose

During this period children experience a desire to copy the adults around them and take initiative in creating play situations. They make up stories with play characters, toy phones and miniature cars, playing out roles in a trial universe, experimenting with the blueprint for what they believe it means to be an adult. They also begin to use that wonderful word for exploring the world—"WHY?" While Erikson was influenced by Freud, he downplays biological sexuality in favor of the psychosocial features of conflict between child and parents. Nevertheless, he said that at this stage children usually become involved in the classic "Oedipal struggle" and resolve this

struggle through "social role identification." If a child is frustrated over natural desires and goals, he may easily experience guilt. The most significant relationship is with the basic family.

4. School Age Child: 6 to 12 Years

Industry vs. Inferiority – Competence

During this stage, often called the Latency, children are capable of learning, creating and accomplishing numerous new skills and knowledge, thus developing a sense of industry. This is also a very social stage of development and if children experience unresolved feelings of inadequacy and inferiority among peers, they can have serious problems in terms of competence and self-esteem. As the world expands a bit, their most significant relationship is with the school and neighbourhood. Parents are no longer the complete authorities they once were, although they are still important.

5. Adolescent: 12 to 18 Years

Identity vs. Role Confusion – Fidelity

Up until this fifth stage, development depends on what is done to a person. At this point, development now depends primarily upon what a person does. An adolescent must struggle to discover and find his or her own identity, while negotiating and struggling with social interactions and "fitting in", and developing a sense of morality and right from wrong. Some attempt to delay entrance to adulthood and withdraw from responsibilities (moratorium). Those unsuccessful with this stage tend to experience role confusion and upheaval. Adolescents begin to develop a strong affiliation and devotion to ideals, causes, and friends.

Erikson's psychosocial theory is related to this study in the following way: The first five stages (birth to adolescence) describe how a child explores his immediate environment in relation to significant others – parents/caregivers. They describe how the nurturing, learning opportunity, experimenting, and creativity, which a child's environment provides influence his development of confidence, self-esteem, trust, self identity, sense of morality, etc. If any of these stages is tampered with, a child may have severe issues with his or her self-concept, self-esteem, and eventual satisfaction with life. Orphans, in most cases do not have the opportunity to have an interaction

with individuals or environments that foster the kind of development responsible for their overall well-being.

2.3.8 Yalom's Therapeutic Factors of Group Therapy

Group therapy refers to any form of psychotherapy conducted in group format. It also includes any helping process that takes place in groups, for instance, psycho-education groups. One of the proponents of group therapy, Irvin Yalom created some therapeutic factors (curative factors) which according to him, help promote change in individuals in group therapy settings. Yalom (2005) posited that therapeutic change is an intricate process that takes place through an interaction of human experiences which he labeled 'therapeutic factors.' In Yalom's view, the therapist is responsible for creating effective group interaction that will foster therapeutic change in group members through therapeutic factors. He argued that these therapeutic factors bring about change in group settings in ways that individual therapy cannot.

The first therapeutic factor is the instillation of hope. The facilitator helps the group members feel optimistic about the group therapy experience, assuring them that change is possible. Group members must be hopeful and have faith that the treatment can foster their healing. The therapist must first show to group members that he or she fervently believes in the therapeutic process. In a similar vein, when a group member witnesses other group members being transformed during the group therapy process, he or she becomes hopeful about the therapy. Another Therapeutic Factor is universality. This therapeutic factor helps clients understand that their psychological issues are not peculiar to them and being in a group therapy setting with individuals who have similar issues can be healing in itself. Yalom (2005) believes that there is no unique experience that is fully different from what others have experienced before. Many individuals tend to suffer in silence, feel alone, or afraid and shameful because they believe their psychological issue is peculiar to them. When group members are accepted by other members irrespective of their issues, feelings of shame and isolation begin to dissipate. Also, the understanding that human experience and emotion are universal can provide a sense of connection, and in turn, great healing.

The next therapeutic factor is imparting information, also known as psycho-education. Group therapists may give instructions, advice and/or suggestions to clients. A therapist can educate clients on their mental health challenges or ineffective thought patterns. This enables them carry out reality checks with the information provided. Also, the therapist can share information on how effective group therapy can be for the transformation of group members. Development of socializing techniques is another important factor that occurs in the group setting. Therapy groups help clients obtain refined social skills while learning to process emotions, be helpful, be more empathetic, and resolve conflicts with others. These skills are indirectly imparted through feedback from the group leader and other group members. Group cohesiveness allows members to experience the warmth and comfort of being a part of a group. Yalom described group cohesiveness as the primary curative factor in group therapy. Group cohesiveness gives group members a sense of belonging and they feel valued by others in the group. They also feel unconditional acceptance and support. This is believed to promote self-esteem, hope, and well-being.

This relates to this study because delivering psycho-educational intervention to orphans in group therapy settings promotes their mental health and overall well-being. When orphans participate in intervention programmes, among other things, they have the opportunity of learning new social skills and coping mechanisms; they bond with other members of the group, which gives them a sense of belonging, and they experience support from the group. They are able to open up and freely express emotions when they become aware that their situation is not peculiar to them and this helps them overcome discrimination or stigmatization.

2.4 Empirical Studies

Various studies have been done to capture the interactions of the variables under study in this research. These related studies will be reviewed to provide further insight for this study. Some of such related studies that will be reviewed in this study include the following:

2.4.1 Mental Health

Cluver and Gardner (2006) investigated the mental health results for urban children who live in impoverished settlements in Cape Town and found a high likelihood for orphans to perceive themselves as being without good friends, having conspicuous problems with concentrating, experiencing frequent somatic symptoms; but less likelihood of displaying anger because of loss of temper. They also found that orphans were more likely to have consistent nightmares, and 73% of orphans made scores that were above the cut-off for Post-Traumatic Stress Disorder. Olley (2008) conducted a study on the health and behavioural characteristics of AIDS orphans in Abuja by making comparisons between them and a matched non-orphan group. The result showed that AIDS orphans had higher likelihood of developing possible childhood mental disorder than non-orphans. Also, orphans had a higher tendency than non-orphans to complain of headaches, to bed wet, and to return from school with tears. AIDS orphans often exhibit behaviour-related problems such as constant fights, disobedience, and restlessness. Orphans were not much liked by other children; they worried about many things; they often appeared unhappy; they were unable to settle down to tasks; they often told lies; and they were more likely to become bullies (Olley, 2008). Kaggwa and Hindin (2010) explored the effects of orphanhood on the psychological well-being of orphans and reported an association between orphanhood and psychological ill health among male orphans, as their level of hopelessness was significantly higher than that of their non-orphaned counterparts.

Makame et al. (2002) researched the psychological well-being of orphans. They compared 41 orphans with 41 matched non-orphans and found out that orphans had increased internalized problems and suicidal ideation compared with non-orphans. Musisi, Kinyanda, Nakasujja and Nakigudde (2008) compared behavioural and emotional disorders among orphans in primary school and non-orphans in Uganda. The results showed that orphans presented with emotional, behavioural, as well as psychiatric disorders. They also found that more orphans reported to have had past suicidal wishes. A study conducted by Irudayasamy (2006) showed that orphans are more prone psychological disorders because they lose their parents at the age when they need much support from their parents and siblings to cope with physical and emotional development. Manuel (2002) compared 76 orphaned and 74 non-orphaned

children on their psychological well-being. He discovered that orphans have higher symptoms of depression, experience bullying, and are less likely to have close friends than non-orphans. Findings from the study conducted by Wild, Flisher, Lass and Robertson (2006) revealed that orphaned children showed higher depression and anxiety symptoms than non-orphaned children.

A national survey in Zimbabwe by Nyamukapa et al. (2010) applied factor analysis to compare orphans and non-orphaned children aged 12-17 (n = 5321). A 16-item unstandardized scale, with items from the Child Behaviour Checklist, Rand Mental Health and Beck Depression Inventories were used to measure psychosocial disorders. Findings showed more psychosocial disorders among orphans than non-orphans. Delva et al. (2009) conducted a cross sectional survey to evaluate the psychological well-being and socioeconomic hardship of orphans and non-orphans in Conakry, Guinea. The study included 133 orphans and 140 non-orphans. The result showed that the psychological well-being score was significantly higher among non-orphans than orphans.

2.4.2 Self-concept/Self-esteem and Mental Health

Crocker (2006) as cited in Kernis (2006) asserts that people with low self-esteem have been shown to experience more negative mood, less life satisfaction, more anxiety, more hopelessness, and more depressive symptoms than those with high self-esteem. O'Brien, Bartletti and Leitzel (2006) as cited in Kernis (2006) affirm that low self-esteem has been linked to a number of psychopathologies including schizophrenia, personality disorders, anxiety disorders, mood disorders, learning disorders, eating disorders, conduct disorders and substance abuse. Farooqi and Intezar (2009) investigated differences in self-esteem of orphaned children and children living with both parents in their homes. The children in orphanages reported lower degree of self-esteem than children living with their parents. Further findings, however, suggested no significant gender difference in the self-esteem of orphaned children and children living with both parents.

Mwebaza (2010) investigated self-esteem and academic performance of orphaned and non-orphaned children and found that self-esteem of orphaned children is significantly lower than that of non-orphaned children. Low self-esteem can be particularly injurious during adolescence. Donnellan et al. (2005) found an association between low self-esteem and aggression, antisocial behaviour, and delinquency. In another study, Trzesniewski et al. (2006) also found that low self-esteem during adolescence was related to a high likelihood of future problems in adulthood, including depression, anxiety, poor physical health, increased tobacco use, increased criminal behaviour, and increased employment difficulties.

Juffer, Marinus and Ijzendoorna (2007) as cited in Farooqi and Intezer (2009) argued that adopted children show lower self-esteem than their non-adopted peers. Adopted children are believed to be at risk of low self-esteem. The research findings of Mohanty and Newhill (2006) as cited in Farooqi and Intezar (2009) suggest that adolescent adoptees have lower self-esteem and are at higher risk for developing severe mental health problems and social maladjustment than children of the same age living with their biological families in the general population. Wild et al. (2006) also found in their study that orphaned children have lower self-esteem than non-orphaned children. Findings from Musisi et al. (2008) showed that orphans, compared to non-orphans were described as needy and sensitive, having low confidence and self-esteem, and often lacking love, protection, identity, security, food and shelter.

2.4.3 Social Support and Mental Health

Low social support has been linked to several disorders. Agrawal and Moak (2010) tested the relationship between perceived interpersonal social support (ISS) and aspects of mental and physical health. They reported that low perceived ISS correlated with increased prevalence of several physical health problems, major depressive disorder, generalized anxiety, and social phobia. Puffer et al. (2012) examined orphan status, mental health, social support, and HIV risk among adolescents in rural Kenya. According to their findings, orphans reported less social support, fewer material resources and poorer mental health. Cluver, Fincham and Seedat (2009) examined the hypothesis that social support may reduce the association

between trauma exposure and posttraumatic stress for AIDS-orphaned children. When compared to participants with low perceived social support, participants with high perceived social support displayed significantly lower levels of posttraumatic stress disorder (PTSD) symptoms after both low and high levels of exposure to traumatic situations. This suggests that strong perception of social support from caretakers, school staff, and friends may lessen harmful effects of exposure to trauma, and could be a focus of intervention efforts to improve psychological outcomes for AIDS-orphaned children. Gilborn et al. (2006) reported that non-orphans scored higher on the social support scale than orphans, suggesting that orphans have less social support. They also reported that orphans' lack of social support was linked to psychosocial distress.

2.4.4 Life Satisfaction and Mental Health

Further studies have established a relationship between life satisfaction and mental health. In a study, Zullig, Valois, Huebner and Drane (2005) explored the relationship between perceived satisfaction with life and health-related quality of life in a sample of 13-18-year-old adolescents (n = 4914). The findings revealed that self-rated health, poor physical days (past 30 days), poor mental health days (past 30 days), and activity limitation days (past 30 days) were significantly related ($p < 0.05$) to reduced life satisfaction, irrespective of race or gender. In another research, Zhao et al. (2009) compared perceived life improvement and life satisfaction among double orphans in three main care arrangements (group home, AIDS orphanage, kinship care) in two rural Chinese counties. Participants were 176 children from four orphanages, 30 children from eight group homes, and 90 children from kinship households. Results indicated that children living in government-supported group homes were more likely to report greater life improvement and positive attitudes toward their current lives than children in orphanages and kinship care.

Bjarnason et al. (2012) examined differences in life satisfaction among children in different family structures in 36 western, developed countries (n = 184 496). Children living with a single parent or a step-parent reported lower levels of life satisfaction than children living with both biological parents. From their study, Musisi et al.

(2008) found that more orphans claimed that life was unfair and difficult. He and Ji (2007) indicated that orphans in China are less satisfied with their lives and show symptoms of depression and lower self-esteem.

2.4.5 Child Abuse and Mental Health

Research has also shown that severe mental health problems are consistently linked to histories of abuse (physical, sexual, emotional), trauma, neglect, abandonment, and lack of attachment (Seager, 2007). Leeb, Lewis and Zolotor (2011) noted that child mistreatment is linked to a variety of negative physical and mental health outcomes that negatively impact the individual all through his or her life and place a vast burden on victims as well as the whole population. Hermenau et al. (2011) carried out a study on childhood misfortune, mental ill-health and aggressive behaviour in an African orphanage and found that violence experienced in the orphanage correlated more strongly with all indicators of mental ill-health and also had a positive correlation with the aggressive behaviour of the children. Baguma, Kyomugisha and Kimeze (2005) explored the psychosocial needs of AIDS orphans in Uganda. The result showed that the prevalence and seriousness of psychosocial problems were lower among the control group than among orphans. Furthermore, qualitative results identified the presence of physical, sexual, and emotional abuse, as well as behavioural problems among the orphans.

Musisi et al. (2008), in their study, found that more orphans reported past forced sex than non-orphans. Heath and Kaminer (2004) concluded that exposure to domestic violence consistently predicted internalized problems in children including post-traumatic stress symptoms. Literature on children in general found that child mistreatment is associated with intensified levels of emotional difficulties such as dissociation, withdrawal, anxiety, and depression (Carey, Walker, Rossouw, Seedat, & Stein, 2008; Chen, Dunne, & Han, 2006).

2.4.6 Psychological Intervention and Mental Health

In a cluster randomized control trial of a school-based peer-group support intervention with 326 AIDS orphans (aged 10-15) in Uganda, Kumakech, Canto-Graae, Maling and Bajunirwe (2009) found that peer-group interventions led by teachers and complemented by healthcare check-ups significantly decreased anxiety, depression and anger among the intervention group. 42.6% of the children in the study were double orphans. The intervention featured peer-group support meetings twice a week and was conducted by a trained teacher over a period of ten weeks. The sessions were supplemented with monthly healthcare examinations and treatment. The support meetings presented topics of concern to orphans through plays, stories, poems, and games; requested the orphans to point out the problems encapsulated in the activities; inquired if the orphans had gone through similar issues; examined the causes of the problems and their effects on families; and brainstormed solutions. Although, prior to the intervention, the children in the intervention group had lower self-concept scores and higher indications of depression than the control group; they had lower scores of anxiety, depression, and anger afterwards.

A 2006 follow-up survey of an 18-month intervention with 593 youth household heads (equal number of males and females) in Rwanda reported that mentorship program may decrease grief among youth. According to Brown et al. (2009), youths who have mentors showed a decrease in marginalization, increase in perceptions of adult support and stability in grief levels. They also reported a slight, though significant decrease in depressive symptoms.

Nyangara, Thurman, Hutchinson and Obiero (2009) reported that in Kenya and Tanzania, a 2006-2007 post-test study of 6,127 children ages 8-14 in four OVC programmes found that kids' clubs had mixed results in improving children's psycho-social outcomes. One kids' club with standardized curriculum and a well trained staff, hold meetings once a month. The children in this club were associated with higher perceptions of having adult support, fewer emotional problems and improved pro-social behavior.

Figure 1: CONCEPTUAL MODEL (PHASE I)

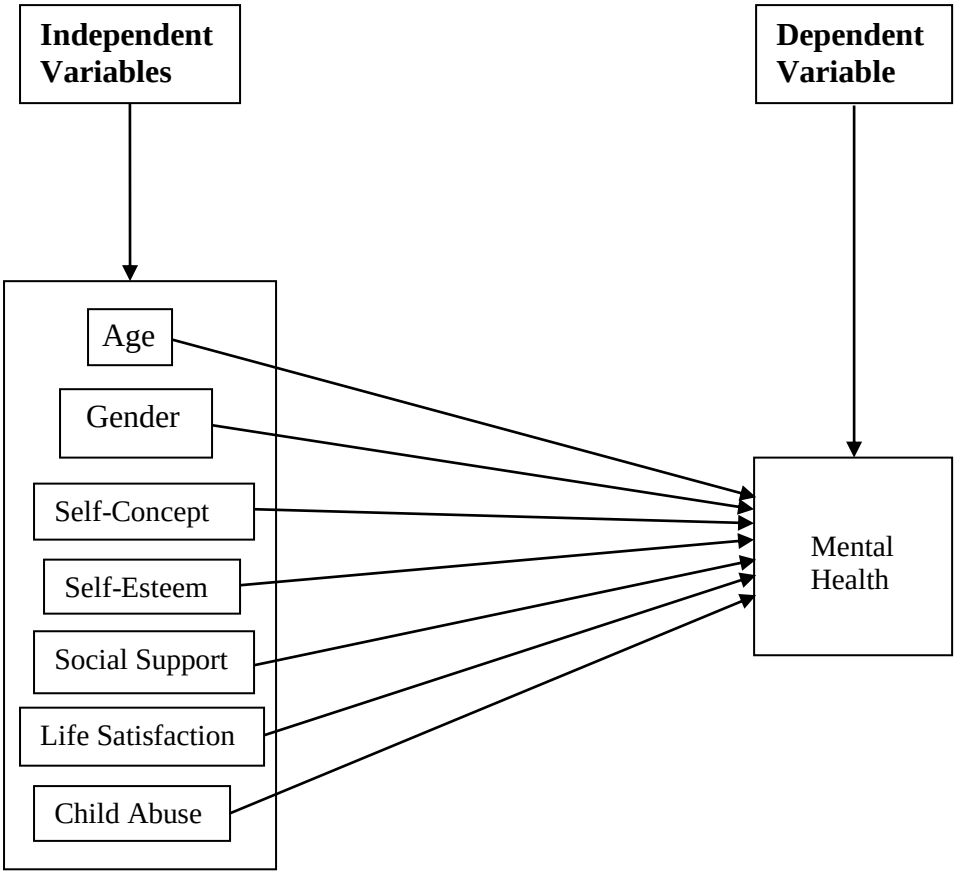

Figure 1 above shows the conceptual model, which describes the variables in phase I (assessment phase) of this study. The variables include the independent variables, age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse; and the dependent variable, mental health.

Figure 2: CONCEPTUAL MODEL (PHASE II)

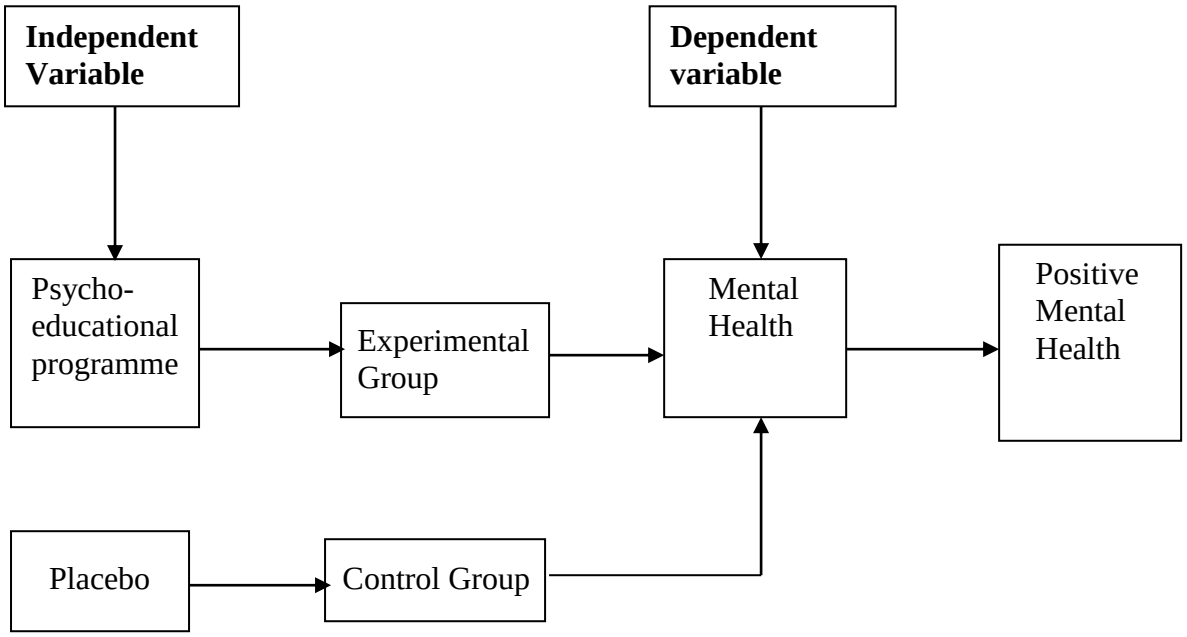

Figure 2 above shows the conceptual model, which describes the variables in phase II (intervention phase) of this study. The independent variable is psycho-educational programme administered on the experimental group, while the placebo is administered to the control group. The dependent variable is mental health and the expected effect of the independent variable on the dependent variable is the emergence of positive mental health.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter is concerned with the methods and procedures employed to carry out this study. They are: research design, population, sample and sampling procedure, instrumentation, procedure for the administration of questionnaires, and methods of data analysis.

3.2 Design

The study was carried out in two phases – Phase I (Assessment) and Phase II (Intervention). The cross-sectional survey design was utilized for Phase I of the study. Cross-sectional survey design draws from the population at one point in time and the sample is regarded as a cross-section of the population, thereby making it possible to explore the relationship between related variables (Fife-Schaw, 2000) and make inferences about the population of interest at that point in time. Surveys allow the collection of a large amount of data in a relatively short period of time and are used to assess information on a wide range of things such as people's personal facts, thoughts, opinions, feelings, and attitudes. Phase II of the study utilized the pre-posttest control group experimental design. Pre-posttest control group experimental design compares participant groups and measures the degree of change occurring as a result of treatments or interventions.

3.3 Variables in the Study

The variables in phase I of this study include the independent variables, consisting self-concept, self-esteem, social support, life satisfaction, child abuse, age and gender. The dependent variable is mental health. The variables in phase II of this

study include the independent variable, which is psycho-educational programme and the dependent variable, which is mental health.

3.4 Population

For phase I, the population for this study included orphans between the ages of 13 and 18 years cared for by Ijamido Motherless Babies' Home, Ogun State; Little Saints Orphanage, Lagos State; Living Words Mission, Oyo State; and His Heritage Home, Oyo State, respectively. It also included non-orphans in the same age range, selected from secondary schools in the respective states (Anglican Grammar School, Ogun State; Hansebol College, Lagos state; and Seed of Life College, Oyo State). For phase II, the population consisted orphans between the ages of 13 and 18 years cared for by Ijamido Motherless Babies' Home, Ogun State. The orphanages for phase I were selected because they had orphans within the age range being studied. The orphanage for phase II was selected based on proximity to enhance easy access to participants in the intervention phase.

Table 3.4.1 Tabular Description of Population

Phase	Name of Orphanage	Location	
Phase I	Ijamido Motherless Babies' Home Little Saints Orphanage Living Words Mission His Heritage Home	Ota, Ogun State Lagos, Lagos State Ibadan, Oyo State Ibadan, Oyo State	The orphanages for phase I were selected because they had orphans within the age range being studied.
Phase II	Ijamido Motherless Babies' Home	Ota, Ogun State	The orphanage for phase II was selected based on proximity to enhance easy access to participants in the intervention phase.

3.5 Sample and Sampling Procedures

The sample for phase I of this study included 200 orphans between the ages of 13 and18 years, who had lost both parents, and 200 non-orphans in the same age range, with no history of parental loss. The sample was drawn by means of purposive sampling. In purposive sampling, subjects are selected because of some characteristics (Patton, 1990). Purposive sampling is used in the study of clearly defined and relatively very limited group. The sample for phase I was purposively selected because participants were double orphans and their age range was between 13 and 18 years. The sample for phase II of this study included 22 orphans between the ages of 13 and18, with higher scores in General Health Questionnaire (GHQ28) [Pretest]. A double-blind approach was used to assign sample to the experimental and control groups by means of odd-even random sampling. In double-blind approach, the experimenter and the participants are not privy to who is assigned to the experimental group or control group.

3.6 Instruments

Six instruments were used for data collection in this study. They are:

i. General Health Questionnaire (GHQ28)

ii. Adolescent Personal Data Inventory (APDI) [Self-concept Subscale]

iii. Rosenberg Self-Esteem Scale (RSES)

iv. Duke-UNC Functional Social Support Questionnaire (FSSQ)

v. Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

vi. Childhood Abuse Questionnaire (CAQ)

3.6.1 General Health Questionnaire (GHQ 28)

General Health Questionnaire (GHQ28) was developed by Goldberg (1978). It is designed to screen those likely to have or be at risk of developing psychiatric disorders. It measures somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. It contains twenty-eight (28) items, which are measured on a 4-point Likert scale: Better than usual (0); Same as usual (1); Worse than usual (2); and Much worse than usual (3). Jackson (2007) reported that reliability coefficients for this instrument have ranged from 0.78 to 0.95 in various studies. Lopez-Castedo & Dominguez (2010) reported internal consistency and test re-test reliability of 0.93 and 0.94 respectively. Higher scores indicate the presence of psychiatric disorder and lower scores suggest the absence of psychiatric disorder. Content validity was ascertained by expert judgment.

3.6.2 Adolescent Personal Data Inventory (APDI) [Self-Concept Subscale]

This instrument was developed by Akinboye (1977). The self-concept subscale is designed to measure adolescents' self-concept. It contains thirty (30) items, which are measured on a scale of 1 to 5, 1 being "Least like me" and 5 being "Most like me." For this instrument, Gesinde (2011) reported internal consistency and test-retest reliability of 0.87 and 0.93 respectively. Higher scores indicate good self-concept and lower scores indicate poor self-concept. Content validity was ascertained by expert judgment.

3.6.3 Rosenberg Self-Esteem Scale (RSES)

This self-esteem scale was originally developed by Rosenberg (1965). It is designed to measure an individual's self-esteem. It contains ten (10) items, which are measured on a 4-point Likert scale: Strongly Agree (3); Agree (2); Disagree (1); and Strongly Disagree (0). Swenson (2003) reported an alpha coefficient of 0.86 for RSES in his study. Higher scores indicate high self-esteem and lower scores indicate low self-esteem. Content validity was ascertained by expert judgment.

3.6.4 Duke-UNC Functional Social Support Questionnaire (FSSQ)

FSSQ was developed by Broadhead, Gehlbach, DeGruy & Kaplan (1988). It is designed to measure the strength of an individual's social support network. It contains eight (8) items, which are measured on a 5-point Likert scale: As much as I would like (5); Almost as much as I would like (4); Some, but would like more (3); Less than I would like (2); and Much less than I would like (1). Ayala et al. (2012) reported for this instrument, a Cronbach's alpha coefficient of 0.94. Higher scores indicate a high level of social support and lower scores indicate a low level of social support. Content validity was ascertained by expert judgment.

3.6.5 Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

This questionnaire is copyrighted by Jean Endicott (1993). It is designed to measure the level of an individual's satisfaction with his/her total life. It contains sixteen (16) items, which are measured on a 5-point Likert scale: Very Poor (1); Poor (2); Fair (3); Good (4); and Very Good (5). Mick, Faraone, Spencer, Zhang, & Biederman (2008) reported internal consistency of 0.88 for this instrument in their study. In another study, Stevanovic (2011) reported internal consistency and test-retest coefficient of 0.9 and 0.93 respectively. Higher scores indicate a high level of satisfaction with life and lower scores indicate a low level of life satisfaction. Content validity was ascertained by expert judgment.

3.6.6 Childhood Abuse Questionnaire (CAQ)

The Childhood Abuse Questionnaire (CAQ) was developed by Gesinde (2008). It is designed as a self-report inventory to measure childhood or adolescent abuse or neglect. It contains twenty-four (24) items, which are measured on a 3-point Likert scale: Never (0); Sometimes (1); and Often (2). For this instrument, Gesinde (2008) reported a Pearson Correlation coefficient of 0.71. Higher scores indicate the presence of abuse and lower scores suggest no abuse. Content validity was ascertained by expert judgment.

3.7 Procedure for Data Collection

The study was carried out in two phases:

- Phase I: Assessment Phase
- Phase II: Intervention Phase

3.7.1 Assessment Phase

Institutional consent and formal permission were obtained from the Directors of Ijamido Motherless Babies' Home, Ogun State; Little Saints Orphanage, Lagos State; Living Words Mission, Oyo State; and His Heritage Home, Oyo State, respectively. Formal permission was also obtained from Principals of the secondary schools where the non-orphans were drawn.

The researcher visited the research settings and before the administration of the instruments, the participants were briefed about the nature and purpose of the study. In order to elicit their true responses, rapport was established with the respondents and they were assured of the confidentiality of their personal information. Research assistants helped with the administration of instruments to the respondents and they were given time to complete the questionnaires. Where they had little difficulty in interpreting the items on the questionnaire, the researcher and research assistants were available to put them through.

3.7.2 Intervention Phase

Pretest data were obtained from participants in the experimental and control groups, after which the experimental group was exposed to a psycho-educational programme named "Covenant Coping Skills Intervention Programme" for a period of six (6) weeks and duration of one hour per week, while the control group received placebo within those same weeks. The content of this programme was derived from an amalgamation of some psychological concepts and Covenant University core values. This is beneficial because the Covenant University core values hinge on basic life

tenets and principles that promote the emergence of a 'total man'. The psycho-educational programme was delivered in form of class discussions and interactions in a group format (Group therapy). Group therapy promotes healing in varying dimensions. It helps members gain a boost to their self concept; they receive tremendous understanding, support, and encouragement from others facing similar situations; they gain different perspectives, ideas, and viewpoints; they benefit from education or advice provided by the therapist; they experience an environment that fosters adaptive and effective communication; and they experience promoted feelings of trust, belonging, and togetherness. After the experimental group had full exposure to the programme, posttest data were obtained from both experimental and control groups.

3.7.2.1 Session by Session Account of the Intervention Phase

The research setting for the intervention phase was visited by the researcher. The sole aim of the visit was to interact with the participants, assign them to the experimental and control groups, respectively, and obtain pretest data on General Health Questionnaire (GHQ 28) from both groups. Self introduction was done by both researcher and participants. Afterwards, the participants in the experimental group were informed that the programme was divided into six (6) sessions, scheduled to last for six (6) weeks of one interactive hour a week. They were also informed that the sessions involved class discussions on various topics, group interactions (therapy), as well as feedback from both participants and researcher. Furthermore, the participants were assured of the confidentiality of information provided by them during the intervention programme, and were implored by the researcher to cooperate maximally, be honest about information given, be committed to the programme. They were advised against avoidance behaviour and informed about its ability to make the intervention programme non-effective. Pretest data was obtained from both experimental and control groups and the participants were given note books and pens as incentives. The participants were encouraged to be present at the first session and to bring their note books and pens along.

Session One: Mental Health

The session started as soon as all participants were comfortably seated. There was another round of self-introductions by both researcher and participants. The researcher announced the topic of discussion for the session and encouraged participants to listen, as well as take some notes while the researcher delivered a short lecture. They were also encouraged to freely ask questions and participate in the interactive session. In the lecture, the researcher provided adequate definitions of mental health to enable the participants have an adequate understanding of the meaning of mental health. The researcher also gave an extensive explanation on the importance of mental health. The participants were informed why their mental health should be of paramount importance. The researcher went further to expound on the characteristics of an individual with positive mental health. Participants were urged to use the given characteristics as yardsticks for checking their state of mental health at any given time. Lastly, the researcher taught the participants about promoting good mental health through the instrumentation of resilience, and demonstrated various steps toward building resilience.

When the lecture was over, participants were allowed to ask questions in areas where they needed clarification and the researcher responded accordingly. During the interactive session, the researcher and participants discussed areas of individual challenges, especially with respect to building resilience, and suggested additional ways of building resilience and how they are applicable to participants' everyday lives.

Assignment: As discussed with participants, one of the ways of building resilience is to "Do something new and fulfilling." For their assignment, the participants were required to think on something new and fulfilling they would like to embark on and map out strategies of achieving such.

The researcher ended the session with words of appreciation and encouraged the participants to attend the next session.

Session Two: Self-Concept and Self-Esteem

After the participants were fully seated and relaxed, the researcher welcomed them to the second session. The researcher reviewed last discussion and discussed the assignment with participants. The topic for the second session was announced and the researcher encouraged participants to listen to the short lecture and take some notes. The objective of this topic was to help participants understand the effect of self appraisal or self evaluation. In the lecture, the researcher provided the participants adequate definitions of self-concept and self-esteem, and made a distinction between both concepts. The participants were told of the importance of self-concept and self-esteem, and that the direction of their lives largely depended on their self-concept and self-esteem. Self-concept and self-esteem shape individual's behaviour, decision making, view of the world, and ability to cope with life's ups and downs. Furthermore, participants were told that good self-concept and self-esteem are important for the avoidance of psychological problems or disorders. The researcher went further to explain the characteristics of low and high self-esteem, as well as how participants could attempt to change or enhance their self-concept and self-esteem.

When the lecture was over, participants were allowed to ask questions in areas where they needed clarification and the researcher responded accordingly. During the interactive session, the researcher and participants discussed areas of challenge bordering on self-concept and self-esteem. The researcher gave room for participants to express what they thought or believed of themselves, and afterwards discussed how participants should challenge negative ideas and beliefs about self.

Assignment: Participants were required to engage in self-appraisal by expressing what they thought and believed of themselves in writing. If there was any negative idea or belief, they were required to also express this in written form, how they would challenge such negativity.

The researcher ended the session with words of appreciation and encouraged the participants to attend the next session.

Session Three: Child Abuse

After the participants were fully seated and relaxed, the researcher welcomed them to the third session. The researcher reviewed last discussion and discussed the assignment with participants. The topic for the third session was announced and the researcher encouraged participants to listen to the short lecture and take some notes. The objective of this topic was to enlighten participants about child abuse and its negative effect. The researcher defined child abuse and mentioned the different types of child abuse as neglect, physical abuse, psychological/emotional abuse, and sexual abuse. The researcher also highlighted the warnings signs of the different types of child abuse, the consequences of child abuse, and how to overcome child abuse.

After the lecture, participants were allowed to ask questions in areas where they needed clarification and the researcher responded accordingly. During the interactive session, the researcher and participants discussed ways of preventing child abuse.

Assignment: Participants were required to imagine they were social workers or law enforcement agents, and write out the steps they would take in helping a victim of abuse.

The researcher ended the session with words of appreciation and encouraged the participants to attend the next session.

Session Four: Traumatic Stress, Coping Mechanism and Strategies

The researcher welcomed participants to the fourth session after they were all comfortably seated. The researcher reviewed last discussion and discussed the assignment with participants. The topic for the fourth session was announced and the researcher encouraged participants to listen to the short lecture and take some notes. The objective of this topic was to make participants understand traumatic stress and learn ways of effectively coping with it. The researcher defined trauma and the possible reactions that follow a traumatic event, including the normal physical and emotional reactions to traumatic events. The researcher also helped participants understand that coping mechanisms and strategies are important tools that help individuals to effectively cope with traumatic situations. Coping mechanisms and

strategies also help maintain good physical health as well as mental health and overall well-being. The participants were further taught the various types of coping mechanisms and strategies.

After the lecture, participants were allowed to ask questions in areas where they needed clarification and the researcher responded accordingly. During the interactive session, the researcher allowed participants to identify possible stressful situations they have gone through or are presently going through, and discussed effective coping strategies for such situations.

Assignment: Participants were required to outline as many stressful situations that different individuals may go through and suggest effective coping mechanisms and strategies for such.

The researcher ended the session with words of appreciation and encouraged the participants to attend the next session.

Session Five: Spirituality and Integrity

The researcher welcomed participants to the fifth session after they were all comfortably seated. The researcher reviewed last discussion and discussed the assignment with participants. The topic for the fifth session was announced and the researcher encouraged participants to listen to the short lecture and take some notes. Studies have shown that spirituality is beneficial to individuals' sound health and overall well-being, therefore the objective of this topic was to help participants understand the need for spirituality. Furthermore, following one's moral compass in doing what is known to be right brings a sense of completeness to an individual, hence the participants' need to have an understanding of the importance of integrity, which is also linked with spirituality. The researcher explained the link between spirituality and mental health. The participants were also taught that qualities of spirituality like faith, hope, forgiveness, love and social support, and prayer have been noted to have noticeable effect on health and healing. The researcher defined integrity and explained the benefits of integrity. The researcher also taught participants how to develop personal integrity.

After the lecture, participants were allowed to ask questions in areas where they needed clarification and the researcher responded accordingly. During the interactive session, the researcher and participants discussed more on the importance and benefits of spirituality and how it could be applied in participants' everyday lives. The group also discussed areas where participants are finding it difficult to maintain integrity and ways to combat such.

Assignment: Participants were required to make a list of tasks in which they would become more trustworthy.

The researcher ended the session with words of appreciation and encouraged the participants to attend the next session.

Session Six: Possibility Mentality and Capacity Development

After the participants were fully seated and relaxed, the researcher welcomed them to the sixth and final session. The researcher reviewed last discussion and discussed the assignment with participants. The topic for the sixth session was announced and the researcher encouraged participants to listen to the short lecture and take some notes. Possibility mentality enhances positive thinking, which further enhances positive living. Possibility mentality also boosts capacity development, which enhances confidence, self-concept, and self-esteem. The objective of this topic was to help participants understand the need for possibility thinking and capacity building. The researcher explained the need for possibility mentality because the journey to actualization in life is full of bumps and only individuals with possibility mentality can go through the rough ride and come out successfully. Participants were taught the benefits of possibility mentality and how to develop possibility mentality. They were also exposed to the importance and benefits of capacity development and how to develop their capacity.

After the lecture, participants were allowed to ask questions in areas where they needed clarification and the researcher responded accordingly. During the interactive session, the researcher and participants discussed areas where participants exhibit "I can't" mentality and how to challenge such mentality with possibility thought

patterns. They also discussed areas of participants' abilities, as well as skills or knowledge that can be acquired to develop and strengthen such areas.

Assignment: Participants were required to identify the things they had abilities for, but which they previously thought they could not do. Thereafter, they were required to write "I CAN" in front of the things they had identified and also write out the possible skills or knowledge they would need to acquire to develop their areas of capabilities.

At the end of the session, the researcher thanked the participants for their time and co-operation. The participants were encouraged to keep revisiting the information they had acquired in the course of the programme for it to become a habitual part of them.

Finally, the researcher obtained posttest data on General Health Questionnaire (GHQ 28) from participants in both experimental and control groups.

3.8 Ethical Consideration

Ethical approval and Institutional consent was obtained before the study was carried out. The researcher spent some time interacting and familiarizing with the orphans before the administration of instruments for the study and during the administration of the psycho-educational programme. This helped cushion the effect of any psychological strain the study might otherwise have on them. The researcher made sure the respondents participated of their free will and they were assured of the confidentiality of their responses. Furthermore, the researcher collected only relevant information pertaining to the study in order to avoid unnecessary invasion of privacy.

3.9 Data Analysis

The data obtained from this study were analyzed with both descriptive and inferential statistical methods. Descriptive statistics include frequency counts, percentage, measures of central tendency, and measures of dispersion. The inferential statistics used in this study are multiple regression analysis, independent-samples t-test, paired-samples t-test, and one-way analysis of covariance (one-way ANCOVA).

Independent-samples t-test was used to test hypotheses one (1), two (2), four (4), and five (5) to find if there were significant differences in the mean scores of orphans and non-orphans; male and female orphans; as well as older and younger orphans, on the variables of study. Multiple regression was used to test hypothesis three (3) to find out if the independent variables in this study predicted the dependent variable. One-way ANCOVA was used to test hypothesis six (6) to find if the change in mean score for the experimental group significantly differed from the change in mean score of control group.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter focuses on the results. It starts with the description of the participants' demographic information. The descriptive analysis of the variables used in the research work is presented first, followed by the presentation of tested hypotheses. This informs the order of arrangement of the tables presented in this chapter. Each hypothesis is followed by a summary of the main findings, while findings from demographic data collected are used to inform and contrast the findings.

4.2 Demographic Data

This section presents the description of the participants of this study in frequency counts and percentages.

4.2.1 Demographic Data for Phase I

Table 4.2.1.1: Demographic Characteristics of Participants

Variable	Orphan		Non-orphan	
	Frequency	**%**	**Frequency**	**%**
Gender				
Male	97	48.5	79	39.5
Female	103	51.5	121	60.5
Total	200	100	200	100
Age (M=15.51)				
13-15	98	49.0	90	45.0
16-18	102	51.0	110	55.0
Total	200	100	200	100

Table 4.2.1.1 reveals the demographic characteristics of the participants. For the orphan population 97 participants (48.5%) were males, while 103 participants (51.5%) were females. This indicates a significant number of females in the distribution compared to males. Also, 98 participants (49%) were between 13 and15 years, while 102 participants (51%) were between 16 and18 years. This indicates a larger percentage of older orphans than younger orphans, according to age distribution.

For the non-orphan population, 79 participants (39.5%) were males, while 121 participants (60.5%) were females. This also shows a significant number of females in the distribution compared to males. Also, 90 participants (45%) were between ages 13 and 15, while 110 participants (55%) were between ages 16 and18. This also shows a larger percentage of older non-orphans than younger non-orphans, according to age distribution.

Table 4.2.1.2: Psychosocial Characteristics of Participants

Variable	Orphan		Non-orphan	
	Frequency	**%**	**Frequency**	**%**
MHS				
Good	112	56.0	155	77.5
Poor	88	44.0	45	22.5
Total	200	100	200	100
Self-concept				
Poor	39	19.5	6	3.0
Average	12	6.0	1	0.5
Good	149	74.5	193	96.5
Total	200	100	200	100
Self-esteem				
Low	20	10.0	9	4.5
High	180	90.0	191	95.5
Total	200	100	200	100
Social Support				
Low	6	3.0	1	0.5
Moderate	96	48.0	41	20.5
High	98	49.0	158	79.0
Total	200	100	200	100

Life Satisfaction				
Low	0	0	0	0
Moderate	122	61.0	74	37.0
High	78	39.0	126	63.0
Total	200	100	200	100
Child Abuse				
No Abuse	138	69.0	178	89.0
Abuse	68	31.0	22	11.0
Total	200	100	200	100

MHS – Mental Health Status

Table 4.2.1.2 reveals the psychosocial characteristics of the participants. For the orphan population, 112 participants (56%) had good mental health status, while 88 participants (44%) had poor mental health status. This indicates that orphans with good mental health status in this study are more than orphans with poor mental health status. For the non-orphan population, 155 participants (77.5%) had good mental health status, while 45 participants (22.5%) had poor mental health status. This indicates that non-orphans with good mental health status in this study are more than non-orphans with poor mental health status. The table further reveals that orphans exhibit poor mental health status than non-orphans.

For the orphan population, 39 participants (19.5%) had poor self-concept, 12 participants (6%) had average self-concept, and 149 participants (74.5%) had good self-concept. This shows more orphans in this study with good self-concept than average and poor self-concept. For the non-orphan population, 6 participants (3%) had poor self-concept, 1 participant (0.5%) had average self-concept, and 193 participants (96.5%) had good self-concept. This shows that the non-orphans in this study have good self-concept more than average and poor self-concept. The table further reveals that orphans exhibit poor self-concept than non-orphans.

For the orphan population, 20 participants (10%) had low self-esteem, 180 participants (90%) had high self-esteem. This shows that most orphans in this study have high self-esteem. For the non-orphan population, 9 participants (4.5%) had low self-esteem, 191 participants (95.5%) had high self-esteem. This also shows that most

non-orphans in this study have high self-esteem. The table further reveals that orphans exhibit low self-esteem than non-orphans.

For the orphan population, 6 participants (3%) reported low social support, 96 participants (48%) reported moderate social support, and 98 participants (49%) reported high social support. This shows that orphans in this study with high social support are less compared to those with both moderate and low social supports combined. For the non-orphan population, 1 participant (0.5%) reported low social support, 41 participants (20.5%) reported moderate social support, and 158 participants (79%) reported high social support. This shows that the non-orphans in this study with high social support are more than those with both moderate and low social supports combined. The table further reveals that non-orphans experience high social support than orphans.

For the orphan population, no participant (0%) reported low life satisfaction, 122 participants (61%) reported moderate life satisfaction, and 78 participants (39%) reported high life satisfaction. This shows that most orphans in this study are moderately satisfied with life. For the non-orphan population, no participant (0%) reported low life satisfaction, 74 participants (37%) reported moderate life satisfaction, and 126 participants (63%) reported high life satisfaction. This shows that most non-orphans in this study are highly satisfied with life. The table further reveals that non-orphans are more satisfied with life than orphans.

For the orphan population, 138 participants (69%) reported no abuse, 62 participants (31%) reported abuse. This shows that orphans in this study that have not experienced abuse are more than those that have experienced abuse. For the non-orphan population, 178 participants (89%) reported no abuse, 22 participants (11%) reported abuse. This shows that non-orphans in this study that have not experienced abuse are more than those that have experienced abuse. The table further reveals that orphans experience abuse more than non-orphans.

Table 4.2.1.3: Cross Tabulation of Participants' Demographic Characteristics and Mental Health

Mental Health Status	Orphan		Non-orphan	
	Good	**Poor**	**Good**	**Poor**
Gender				
Male	56 (57.7%)	41 (42.3%)	62 (78.5%)	17 (21.5%)
Female	56 (54.4%)	47 (45.6%)	93 (76.9%)	28 (23.15%)
Age				
13-15	55 (56.1%)	43 (43.9%)	73 (81.1%)	17 (18.9%)
16-18	57 (55.9%)	45 (44.1%)	82 (74.5%)	28 (25.5%)

For the orphan population, table 4.2.1.3 reveals that male participants with good mental health status (56) constituting 57.7% of the participants were same in number with female participants with good mental health status (56) constituting 54.4% of the participants. Female participants with poor mental health status (47) constituting 45.6% of the participants were more than male participants with poor mental health status (41) constituting 42.3% of the participants. For the non-orphan population, female participants with good mental health status (93) constituting 76.9% of the participants were more than male participants with good mental health status (62) constituting 78.5% of the participants. Female participants with poor mental health status (28) constituting 23.1% of the participants were more than male participants with poor mental health status (17) constituting 21.5% of the participants. This further suggests that female participants exhibit poorer mental health than male participants.

Furthermore, for the orphan population, the table reveals that older participants with good mental health status (57) constituting 55.9% of the participants were more than younger participants with good mental health status (55) constituting 56.1% of the participants. Older participants with poor mental health status (45) constituting 44.1% of the participants were more than younger participants with poor mental health status (43) constituting 43.9% of the participants. For the non-orphan population, older participants with good mental health status (82) constituting 74.5% of the participants were more than younger participants with good mental health status (73) constituting 81.1% of the participants. Older participants with poor mental health status (28) constituting 25.5% of the participants were more than younger participants with poor

mental health status (17) constituting 18.9% of the participants. The percentage of older orphans with poor mental health status is higher than that of younger orphans and the percentage of older orphans with good mental health status is less than that of younger orphans. This suggests that older orphans exhibit poorer mental health than younger orphans.

Table 4.2.1.4: Cross Tabulation of Participants' Demographic Characteristics and Self-concept

Self-concept	Orphan			Non-orphan		
	Poor	**Average**	**Good**	**Poor**	**Average**	**Good**
Gender						
Male	17 (17.5%)	4 (4.1%)	76 (78.4%)	3 (3.8%)	1 (1.3%)	75 (94.9%)
Female	22 (21.4%)	8 (7.8%)	73 (70.8%)	3 (2.5%)	0 (0%)	118 (97.5%)
Age						
13-15	23 (23.5%)	2 (2.0%)	73 (74.5%)	3 (3.3%)	0 (0%)	87 (96.7%)
16-18	16 (15.7%)	10 (9.8%)	76 (74.5%)	3 (2.7%)	1 (0.9%)	106 (96.4%)

For the orphan population, Table 4.2.1.4 reveals that female participants with poor self-concept (22) constituting 21.4% of the participants were more than male participants with poor self-concept (17) constituting 17.5% of the participants. Female participants with average self-concept (8) constituting 7.8% of the participants were more than male participants with average self-concept (4) constituting 4.1%. Male participants with good self-concept (76) constituting 78.4% of the participants were more than female participants with good self-concept (73) constituting 70.8% of the participants. For the non-orphan population, male participants with poor self-concept (3) constituting 3.8% were same number with female participants with poor self-concept (3) constituting 2.5% of the participants. Only one male participant had average self-concept (1) constituting 1.3%. Female participants with good self-concept (118) constituting 97.5% of the participants were more than male participants with good self-concept (75) constituting 94.9% of the participants. This further suggests that female orphans exhibit poorer self-concept than male orphans.

Also, for the orphan population, the table reveals that younger participants with poor self-concept (23) constituting 23.5% of the participants were more than older participants with poor self-concept (16) constituting 15.7% of the participants. Older participants with average self-concept (10) constituting 9.8% of the participants were more than younger participants with average self-concept (2) constituting 2%. Older participants with good self-concept (76) constituting 74.5% of the participants were more than younger participants with good self-concept (73) constituting 74.5% of the participants. For the non-orphan population, younger participants with poor self-concept (3) constituting 3.3% of the participants were same number with older participants with poor self-concept (3) constituting 2.7% of the participants. Only one older participant had average self-concept (1) constituting 0.9%. Older participants with good self-concept (106) constituting 96.4% of the participants were more than younger participants with good self-concept (87) constituting 96.7% of the participants. This further suggests that younger orphans exhibit poorer self-concept than older orphans.

Table 4.2.1.5: Cross Tabulation of Participants' Demographic Characteristics and Self-esteem

Self-esteem	Orphan		Non-orphan	
	Low	**High**	**Low**	**High**
Gender				
Male	11 (11.3%)	86 (88.7%)	3 (3.8%)	76 (96.2%)
Female	9 (8.7%)	94 (91.3%)	6 (5.0%)	115 (95.0%)
Age				
13-15	6 (6.1%)	92 (93.9%)	2 (2.2%)	88 (97.8%)
16-18	14 (13.7%)	88 (86.3%)	7 (6.4%)	103 (93.6%)

For the orphan population, Table 4.2.1.5 reveals that male participants with low self-esteem (11) constituting 11.3% of the participants were more than female participants with low self-esteem (9) constituting 8.7% of the participants. Female participants with high self-esteem (94) constituting 91.3% of the participants were more than male participants with high self-esteem (86) constituting 88.7% of the participants. For the

non-orphan population, the table reveals that female participants with low self-esteem (6) constituting 5% of the participants were more than male participants with low self-esteem (3) constituting 3.8% of the participants. Female participants with high self-esteem (115) constituting 95% of the participants were more than male participants with high self-esteem (76) constituting 96.2% of the participants. This further suggests that female orphans in this study exhibit higher self-esteem than their male counterparts.

Also, for the orphan population, the table reveals that older participants with low self-esteem (14) constituting 13.7% of the participants were more than younger participants with low self-esteem (6) constituting 6.1% of the participants. Younger participants with high self-esteem (92) constituting 93.9% of the participants were more than older participants with high self-esteem (88) constituting 86.3% of the participants. For the non-orphan population, older participants with low self-esteem (7) constituting 6.4% of the participants were more than younger participants with low self-esteem (2) constituting 2.2% of the participants. Older participants with high self-esteem (103) constituting 93.6% of the participants were more than younger participants with high self-esteem (88) constituting 97.8% of the participants. This further suggests that younger orphans in this study exhibit higher self-esteem than older orphans.

Table 4.2.1.6: Cross Tabulation of Participants' Demographic Characteristics and Social Support

Social Support	Orphan			Non-orphan		
	Low	**Moderate**	**High**	**Low**	**Moderate**	**High**
Gender						
Male	4 (4.1%)	46 (47.4%)	47 (48.5%)	0 (0%)	18 (22.8%)	61 (77.2%)
Female	2 (2.0%)	50 (48.5%)	51 (49.5%)	1 (0.8%)	23 (19.0%)	97 (80.2%)
Age						
13-15	4 (4.0%)	52 (53.1%)	42 (42.9%)	1 (1.1%)	21 (23.3%)	68 (75.6%)
16-18	2 (2.0%)	44 (43.1%)	56 (54.9%)	0 (0%)	20 (18.2%)	90 (81.8%)

For the orphan population, according to Table 4.2.1.6, male participants who reported low social support (4) constituting 4.1% of the participants were more than female participants who reported low social support (2) constituting 2% of the participants. Female participants who reported moderate social support (50) constituting 48.5% of the participants were more than male participants who reported moderate social support (46) constituting 47.4% of the participants. Female participants who reported high social support (51) constituting 49.5% of the participants were more than male participants who reported high social support (47) constituting 48.5% of the participants. For the non-orphan population, only one (1) female participant reported low social support constituting 0.8% of the participant. Female participants who reported moderate social support (23) constituting 19% of the participants were more than male participants who reported moderate social support (18) constituting 22.8% of the participants. Female participants who reported high social support (97) constituting 80.2% of the participants were more than male participants who reported high social support (61) constituting 77.2% of the participants. This further suggests that females in this study experience a higher level of social support than their male counterparts.

For the orphan population, younger participants who reported low social support (4) constituting 4% of the participants were more than older participants who reported low social support (2) constituting 2% of the participants. Younger participants who reported moderate social support (52) constituting 53.1% of the participants were more than older participants who reported moderate social support (44) constituting 43.1% of the participants. Older participants who reported high social support (56) constituting 54.9% of the participants were more than younger participants who reported high social support (42) constituting 42.9% of the participants. For the non-orphan population, only one (1) younger participant reported low social support constituting 1.1% of the participants. Younger participants who reported moderate social support (21) constituting 23.3% of the participants were more than older participants who reported moderate social support (20) constituting 18.2% of the participants. Older participants who reported high social support (90) constituting 81.8% of the participants were more than younger participants who reported high social support (68) constituting 75.6% of the participants. This result further suggests

that older participants in this study experience a higher level of social support than the younger participants.

Table 4.2.1.7: Cross Tabulation of Participants' Demographic Characteristics and Life Satisfaction

Life Satisfaction	Orphan			Non-orphan		
	Low	**Moderate**	**High**	**Low**	**Moderate**	**High**
Gender						
Male	0 (0%)	57 (58.8%)	40 (41.2%)	0 (0%)	25 (31.6%)	54 (68.4%)
Female	0 (0%)	65 (63.1%)	38 (36.9%)	0 (0%)	49 (40.5%)	72 (59.5%)
Age						
13-15	0 (0%)	74 (75.5%)	24 (24.5%)	0 (0%)	30 (33.3%)	60 (66.7%)
16-18	0 (0%)	48 (47.1%)	54 (52.9%)	0 (0%)	44 (40.0%)	66 (60.0%)

For the orphan population, according to Table 4.2.1.7, no participant reported low life satisfaction (0%). Female participants who reported moderate life satisfaction (65) constituting 63.1% of the participants were more than male participants who reported moderate life satisfaction (57) constituting 58.8% of the participants. Male participants who reported high life satisfaction (40) constituting 41.2% of the participants were more than female participants who reported high life satisfaction (38) constituting 36.9% of the participants. For the non-orphan population, no participant reported low life satisfaction (0%). Female participants who reported moderate life satisfaction (49) constituting 40.5% of the participants were more than male participants who reported moderate life satisfaction (25) constituting 31.6% of the participants. Female participants who reported high life satisfaction (72) constituting 59.5% of the participants were more than male participants who reported high life satisfaction (54) constituting 68.4% of the participants. This further suggests that female orphans in this study are less satisfied with life than their male counterparts.

Also, for the orphan population, no participant reported low life satisfaction. Younger participants who reported moderate life satisfaction (74) constituting 75.5% of the

participants were more than older participants who reported moderate life satisfaction (48) constituting 47.1% of the participants. Older participants who reported high life satisfaction (54) constituting 52.9% of the participants were more than younger participants who reported high life satisfaction (24) constituting 24.5% of the participants. For the non-orphan population, no participant reported low life satisfaction. Older participants who reported moderate life satisfaction (44) constituting 40% of the participants were more than younger participants who reported moderate life satisfaction (30) constituting 33.3% of the participants. Older participants who reported high life satisfaction (66) constituting 60% of the participants were more than younger participants who reported high life satisfaction (60) constituting 66.7% of the participants. This further suggests that younger participants in this study are less satisfied with life than the older participants.

Table 4.2.1.8: Cross Tabulation of Participants' Demographic Characteristics and Child Abuse

Child Abuse	Orphan		Non-orphan	
	No Abuse	**Abuse**	**No Abuse**	**Abuse**
Gender				
Male	71 (73.2%)	26 (26.85%)	71 (89.9%)	8 (10.1%)
Female	67 (65.0%)	36 (35.0%)	107 (88.4%)	14 (11.6%)
Age				
13-15	60 (61.2%)	38 (38.8%)	81 (90.0%)	9 (10.0%)
16-18	78 (76.5%)	24 (23.5%)	97 (88.2%)	13 (11.8%)

For the orphan population, Table 4.2.1.8 reveals that male participants who reported no abuse (71) constituting 73.2% of the participants were more than female participants who reported no abuse (67) constituting 65% of the participants. Female participants who reported abuse (36) constituting 35% of the participants were more than male participants who reported abuse (26) constituting 26.8% of the participants. For the non-orphan population, female participants who reported no abuse (107) constituting 88.4% were more than male participants who reported no abuse (71) constituting 89.9% of the participants. Female participants who reported abuse (14)

constituting 11.6% of the participants were more than male participants who reported abuse (8) constituting 10.1% of the participants. This further suggests that female orphans and non-orphans tend to experience abuse more than their male counterparts.

Furthermore, for the orphan population, the table reveals that older participants who reported no abuse (78) constituting 76.5% of the participants were more than younger participants who reported no abuse (60) constituting 61.2% of the participants. Younger participants who reported abuse (38) constituting 38.8% of the participants were more than older participants who reported abuse (24) constituting 23.5% of the participants. For the non-orphan population, older participants who reported no abuse (97) constituting 88.2% were more than younger participants who reported no abuse (81) constituting 90% of the participants. Older participants who reported abuse (13) constituting 11.8% of the participants were more than younger participants who reported abuse (9) constituting 10% of the participants. This further suggests that the younger orphans tend to experience abuse more than older orphans.

4.2.2 Demographic Data for Phase II

Table 4.2.2.1: Demographic Characteristics of Participants

Variable	Experimental		Control	
	Frequency	**%**	**Frequency**	**%**
Gender				
Male	4	36.4	4	36.4
Female	7	63.6	7	63.6
Total	11	100	11	100
Age (M=15.14)				
13-15	7	63.6	8	74.7
16-18	4	36.4	3	27.3
Total	11	100	11	100

For the experimental group, Table 4.2.2.1 reveals that 4 participants (36.4%) were males, while 7 participants (63.6%) were females. This indicates a significant number of females in the distribution compared to males. For the control group, 4 participants

(36.4%) were males, while 7 participants (63.6%) were females. This indicates a significant number of females in the distribution compared to males.

Furthermore, for the experimental group, the table reveals that 7 participants (63.6%) were between 13 and 15 years, while 4 participants (36.4%) were between 16 and 18 years. This indicates a larger percentage of younger participants than older participants, according to age distribution. For the control group, 8 participants (72.7%) were between ages 13 and 15, while 3 participants (27.3%) were between ages 16 and 18. This also shows a larger percentage of younger participants than older participants, according to age distribution.

4.3 Hypotheses Testing

This section presents the result of tested hypotheses and interpretation of analyzed data.

Hypothesis One:

There will be a significant difference in mental health of orphans and non-orphans.

Table 4.3.1: Means, Standard Deviations, and t-value of Participants' Mental Health

Groups	No. of Cases	Mean	Std Dev.	df	t-value	Sig.
Orphan	200	18.22	10.875	398	2.898	.004
Non-orphan	200	15.30	9.693			

Table 4.3.1 reveals a higher mean for orphans than non-orphans. This indicates that orphans displayed poorer mental health than non-orphans. The table further reveals that there is a significant difference in mental health of orphans and non-orphans ($t = 2.898$, $df = 398$, $p<.05$, two tailed). The hypothesis was therefore sustained.

Hypothesis Two:

There will be a significant difference between orphans and non-orphans on the psychosocial variables of self-concept, self-esteem, social support, life satisfaction, and child abuse.

Table 4.3.2: Means, Standard Deviations, and t-value of Participants' Self-Concept

Groups	No of Cases	Mean	Std Dev.	Df	t-value	Sig.
Orphan	200	106.70	17.639	398	-3.733	.000
Non-orphan	200	112.22	11.195			

Table 4.3.2 reveals a higher mean score for non-orphans than orphans. This indicates that non-orphans had better self-concept than orphans. The table further reveals a significant difference in self-concept of orphans and non-orphans ($t = -3.733$, $df = 398$, $p<.05$, two tailed). The hypothesis was therefore sustained.

Table 4.3.3: Means, Standard Deviations, and t-value of Participants' Self-Esteem

Groups	No of Cases	Mean	Std Dev.	Df	t-value	Sig.
Orphan	200	20.05	4.120	398	-2.084	.038
Non-orphan	200	20.86	3.639			

Table 4.3.3 reveals a higher mean score for non-orphans than orphans. This indicates that non-orphans exhibited higher self-esteem than orphans. The table further reveals a significant difference in self-esteem of orphans and non-orphans ($t = -2.084$, $df = 398$, $p<.05$, two tailed). The hypothesis was therefore sustained.

Table 4.3.4: Means, Standard Deviations, and t-value of Participants' Social Support

Groups	No of Cases	Mean	Std Dev.	Df	t-value	Sig.
Orphan	200	31.31	6.073	398	-4.926	.000
Non-orphan	200	34.15	5.462			

Table 4.3.4 reveals a higher mean score for non-orphans than orphans. This indicates that non-orphans experienced more social support than orphans. The table further reveals a significant difference in social support of orphans and non-orphans ($t = -4.926$, $df = 398$, $p<.05$, two tailed). The hypothesis was therefore sustained.

Table 4.3.5: Means, Standard Deviations, and t-value of Participants' Life Satisfaction

Groups	No of Cases	Mean	Std Dev.	Df	t-value	Sig.
Orphan	200	51.54	8.467	398	-6.219	.000
Non-orphan	200	56.33	6.852			

Table 4.3.5 reveals a higher mean score for non-orphans than orphans. This indicates that non-orphans were more satisfied with life than orphans. The table further reveals a significant difference in life satisfaction of orphans and non-orphans ($t = -6.219$, $df = 398$, $p<.05$, two tailed). The hypothesis was therefore sustained.

Table 4.3.6: Means, Standard Deviations, and t-value of Participants' Child Abuse

Groups	No of Cases	Mean	Std Dev.	Df	t-value	Sig.
Orphan	200	6.74	6.932	398	3.158	.002
Non-orphan	200	4.90	4.455			

Table 4.3.6 reveals a higher mean score for orphans than non-orphans. This indicates that orphans experienced more abuse than non-orphans. The table further reveals a significant difference in child abuse of orphans and non-orphans ($t = 3.158$, $df = 398$, $p<.05$, two tailed). The hypothesis was therefore sustained.

Hypothesis Three:

Age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse will significantly predict the mental health of orphans.

Table 4.3.7: Summary of Regression Analysis on Predictors of Mental Health

Regression Analysis		**Analysis of Variance**					
R	.628[a]	**Sources**	**SS**	**Df**	**MS**	**F**	**Sig.**
R^2	.395	Regression	8570.038	7	1229.291	17.898	.000[a]
Adjusted R^2	.373	Residual	13133.717	192	68.405		
Std. Error	8.271	Total	21703.755	199			

Predictors: (Constant), age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse

Dependent Variable: Mental Health

Table 4.3.8: Relative Contribution of Independent Variables to the Prediction of Mental Health

Coefficients[a]

		Unstandardized Coefficients		Standardized Coefficients		
Model	**Predictor Variables**	**B**	**Std. Error**	**Beta**	**T**	**Sig.**
1	(Constant)	31.193	8.152		3.827	.000
	Child Abuse	.642	.112	.426	5.714	.000
	Self-concept	-.131	.045	-.221	-2.909	.004
	Life Satisfaction	-.153	.102	-.124	-1.501	.135
	Social Support	.074	.129	.043	.569	.570
	Age	.141	.372	.023	.379	.705
	Gender	.069	1.207	.003	.057	.955
	Self-esteem	-.001	.188	-.001	-.007	.994

a. **Dependent Variable:** Mental Health

Standard Multiple Regression was used to assess the ability of the independent variables (age, gender, self-concept, self-esteem, social support, life satisfaction and child abuse) to predict mental health. Table 4.3.7 reveals that the independent variables significantly predicted the mental health of orphans ($F_{(7, 192)}$ = 17.898, P<.05). The hypothesis was therefore sustained.

Table 4.3.7 also reveals that the independent variables jointly accounted for only 39.5% of the variance in mental health (R^2 = .395). Table 4.3.8 shows the relative contribution of independent variables to the prediction of mental health. This table

reveals that child abuse is the strongest or best predictor of orphans' mental health ($\beta = .426$, $p<.05$), followed by self-concept ($\beta = -.221$, $p<.05$).

Hypothesis Four:

There will be a significant age difference in mental health of orphans.

Table 4.3.9: Means, Standard Deviations, and t-value of Participants' Mental Health based on Age

Groups (Orphan)	No. of Cases	Mean	Std Dev.	Df	t-value	Sig.
13-15	98	18.62	10.362	198	.540	.590
16-18	102	17.82	10.557			

Table 4.3.9 reveals that there is no significant age difference in orphans' mental health ($t = .540$, $df = 198$, $p>.05$, two tailed) This indicates that older orphans do not necessarily display better mental health than younger orphans and vice versa. The hypothesis was therefore rejected.

Hypothesis Five:

There will be a significant gender difference in mental health of orphans.

Table 4.3.10: Means, Standard Deviations, and t-value of Participants' Mental Health based on Gender

Groups (Orphan)	No. of Cases	Mean	Std Dev.	Df	t-value	Sig.
Male	97	17.60	10.525	198	-.810	.419
Female	103	18.80	10.383			

Table 4.3.10 reveals that there is no significant gender difference in orphans' mental health (t = -.810, df = 198, p>.05, two tailed) This indicates that male orphans do not necessarily display better mental health than female orphans and vice versa. The hypothesis was therefore rejected.

Hypothesis Six:

Orphans in the experimental group will report less mental health issues than orphans in the control group.

Table 4.3.11: Pretest and Posttest of Experimental and Control Groups

Group	Pretest		Posttest	
	Mean	**Std Dev.**	**Mean**	**Std Dev.**
Experimental	14.09	8.642	8.82	4.622
Control	11.18	16.167	11.82	15.741

Table 4.3.12: Tests of Between-Subjects Effects (One-Way ANCOVA)

Dependent Variable: Posttest

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	2580.707[a]	2	1290.354	153.167	.000
Intercept	4.526	1	4.526	.537	.473
Pretest	2531.207	1	2531.207	300.458	.000
Group	165.582	1	165.582	19.655	.000
Error	160.065	19	8.424		
Total	5083.000	22			
Corrected Total	2740.773	21			

Table 4.3.11 shows the pretest and posttest values for the experimental and control groups. Table 4.3.12 reveals a significant difference between experimental group and control group ($F_{(1, 19)} = 19.655$, $P<.05$). This indicates a significant difference in mental health of orphans exposed to psycho-educational programme and orphans not exposed to psycho-educational programme. The hypothesis was therefore sustained.

4.4 Summary of Findings

Phase I of the study focused on examining the psychosocial variables that predict the mental health of orphans. It further examined whether orphans differ from non-orphans in mental health, as well as other psychosocial variables. Phase II of the study examined the effect of intervention in the form of psycho-educational programme on the mental health of orphans. The findings drawn from the results suggest that:

1. Orphans in this study exhibited poor mental health than non-orphans; female orphans exhibited poor mental health than male orphans; and older orphans exhibited poor mental health than younger orphans.

2. Orphans in this study exhibited poor self-concept than non-orphans; female orphans exhibited poor self-concept than male orphans; and younger orphans exhibited poor self-concept than older orphans.

3. Orphans in this study exhibited low self-esteem than non-orphans; female orphans exhibited high self-esteem than male orphans; and younger orphans exhibited high self-esteem than older orphans.

4. Orphans in this study reported low social support than non-orphans; female orphans reported high social support than male orphans; and younger orphans reported low social support than older orphans.

5. Most orphans in this study reported moderate life satisfaction and were less satisfied with life than non-orphans; female orphans were less satisfied with life than male orphans; and younger orphans were less satisfied with life than older orphans.

6. Orphans in this study reported more abuse than non-orphans; female orphans reported more abuse than male orphans; and younger orphans reported more abuse than older orphans.

7. Orphans in this study significantly differed from non-orphans in mental health, self-concept, self-esteem, social support, life satisfaction, and child abuse.

8. The independent variables of age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse significantly predicted orphans' mental health. Child abuse is the best predictor of orphans' mental health, followed by self-concept.

9. There was no significant age difference in the mental health of orphans.

10. There was no significant gender difference in the mental health of orphans.

11. Orphans in the experimental group reported less mental health issues than orphans in the control group.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The main goal of this study was to examine the psychosocial variables that predict the mental health of orphans and examine the efficacy of intervention in form of psycho-educational programme. Six research hypotheses were formulated and tested by means of multiple regression, independent-samples t-test, and one-way ANCOVA statistic. All hypotheses were tested at the 0.05 level of significance.

This chapter presents the discussion of the findings, the implication of the findings, and the limitation encountered in the study. Conclusions, as well as recommendations and suggestions for further studies are also made.

5.2 Discussion of Findings

Orphans are known to face a wide range of challenges compared to non-orphans, as parental loss can have negative consequences for orphans. An overview of participants' psychosocial characteristics revealed that orphans reported poor mental health, poor self-concept, low self-esteem, low social support, low life satisfaction and high child abuse than non-orphans. This confirms the conclusion made by Baguma et al. (2005) that prevalence and seriousness of psychosocial problems are higher among orphans.

Age and gender differences in mental health, self-concept, self-esteem, social support, life satisfaction, and child abuse were also observed in this study. This is consistent with the findings and conclusions of some researchers. Omotosho (2010) reported gender differences in the expressed problems and adjustment needs of in-school orphans; Zhao, Li, Fang, Zhao and Stanton (2010) recorded age differences in measures of depression among orphans; Zhao et al. (2010) reported significant age difference in measures of orphans' social support; Hong, Li, Stanton, Fang, Lin, &

Wang (2008) stated that gender and age are significant covariates of perceived social support; and Farooqi & Intezar (2009) reported significant gender difference in the self-esteem of orphaned children and children living with both parents. Puffer et al. (2012) noted that orphans may not enjoy enough support from caretakers as non-orphans do, and Baguma, et al. (2005) stated that orphans experience cases of abuse.

Hypothesis One

The first hypothesis, which stated that there will be a significant difference in mental health of orphans and non-orphans, was sustained. The result from the tested hypothesis showed that orphans (mean = 18.22) recorded higher scores on measures of psychological distress than non-orphans (mean = 15.30) and also showed a significant difference from non-orphans in their mental health ($t = 2.898$, $df = 398$, $p<.05$). This result corroborates findings from many studies that have been done in this area. Musisi et al. (2008) compared behavioural and emotional disorders among primary school-going orphans and non-orphans in Uganda. The results showed that emotional, behavioural, as well as psychiatric disorders occurred in the orphan children. They also found that more orphans reported having past suicidal wishes. Makame et al. (2002) researched the psychological well-being of orphans. They compared 41 orphans with 41 matched non-orphans and found out that orphans had increased internalized problems and suicidal ideation compared with non-orphans.

Olley (2008) conducted a study on the health and behavioural characteristics of children orphaned by AIDS in Abuja by comparing them with a matched non-orphan group. The result indicated that AIDS orphans were more likely to have probable childhood mental disorder than non-orphans. Orphans were more likely than non-orphans to complain of headaches, bedwetting, and more likely to arrive from school with tears. AIDS orphans more frequently exhibited behaviour problems such as frequent fighting, restlessness, disobedience, were not much liked by other children, worried about many things, often appeared unhappy, were unable to settle down to tasks, often told lies, and more likely to bully other children. Kaggwa & Hindin (2010) explored the effects of orphanhood on psychological well-being of orphans and reported that orphanhood was associated with psychological ill health among the

males, as they had a significantly higher level of hopelessness than their non-orphaned counterparts.

Manuel (2002) compared 76 orphaned and 74 non-orphaned children on their psychological well-being. He found that orphans have higher depression symptoms, were easily bullied, and less likely to have trusted friends than non-orphans. Findings from the study conducted by Wild et al. (2006) revealed that orphaned children exhibited higher depression and anxiety symptoms than non-orphaned children. Delva et al. (2009) conducted a cross sectional survey to assess the psychological well-being and socio-economic hardship of 133 orphan and 140 non- orphan children in Conakry, Guinea. The result shows that the psychological well-being score was significantly lower among orphan children than non- orphan children. Nyamukapa et al. (2010) applied factor analysis to compare orphans and non-orphaned children aged 12-17 (n = 5321). Psychosocial disorders were measured using a 16-item unstandardized scale, with items from the Child Behaviour Checklist, Rand Mental Health and Beck Depression Inventories. Findings showed more psychosocial disorders amongst orphans than non-orphans.

Hypothesis Two

The second hypothesis, which stated that there will be a significant difference between orphans and non-orphans on the psychosocial variables of self-concept, self-esteem, social support, life satisfaction, and child abuse, was sustained. The result from the tested hypothesis showed that orphans (mean = 31.31) recorded lower scores on social support than non-orphans (mean = 34.15) and also showed a significant difference from non-orphans in social support ($t = -4.296$, $df = 398$, $p<.05$). The result also showed that orphans (mean = 106.70) recorded lower scores on self-concept than non-orphans (mean = 112.22) and also showed a significant difference from non-orphans in their self-concept ($t = -3.733$, $df = 398$, $p<.05$). Furthermore, orphans (mean = 20.05) scored lower on self-esteem than non-orphans (mean = 20.86) and this difference was statistically significant ($t = -2.084$, $df = 398$, $p<.05$). Orphans (mean = 51.54) scored lower on life satisfaction than non-orphans (mean = 56.33), indicating a significant difference between orphans and non-orphans ($t = -6.219$, $df = 398$, $p<.05$).

The result also showed that orphans (mean = 6.74) recorded higher scores on child abuse than non-orphans (mean = 4.90) and also showed a significant difference from non-orphans in child abuse ($t = 3.158$, $df = 398$, $p<.05$).

Findings from other studies support the findings in this study. Gilborn et al. (2006) reported that orphans scored lower on the social support scale than non-orphans, suggesting that orphans have less social support, and psychosocial distress was associated with lack of social support. Puffer et al. (2012) examined orphan status, mental health, social support, and HIV risk among adolescents in rural Kenya. According to their findings, orphans reported poorer mental health, less social support, and fewer material resources.

Findings from Musisi et al. (2008) showed that orphans, compared to non-orphans were described as needy, sensitive, isolative with low confidence and self-esteem and who often lacked love, protection, identity, security, play, food and shelter. Wild et al. (2006) also found in their study that orphaned children have lower self-esteem than non-orphaned children. Mwebaza (2010) investigated the self-esteem and academic performance of orphaned and non-orphaned children and found that non-orphaned children have a significantly higher level of self-esteem than orphaned children. Low self-esteem can be particularly damaging during adolescence. Juffer et al. (2007) as cited in Farooqi and Intezar (2009) stated that adopted children show lower self-esteem than their non-adopted peers. Adopted children are hypothesized to be at risk of low self-esteem. They may endure from the consequences of neglect, abuse and underfeeding in institutions before adoption. In their research findings, Mohanty & Newhill (2006) as cited in Farooqi and Intezar (2009) suggest that international adolescent adoptees have lower self-esteem and are at higher risk for developing severe mental health problems and social maladjustment than children of the same age living with their biological families in the general population.

Musisi et al. (2008) found that more orphans reported finding life unfair and difficult. Bjarnason et al. (2012) examined differences in life satisfaction among children in different family structures in 36 western, industrialized countries ($n = 184\,496$). Children living with both biological parents reported higher levels of life satisfaction than children living with a single parent or parent–step-parent. He & Ji (2007)

indicated that orphans in China are less satisfied with their lives and show symptoms of depression and lower self-esteem.

Literature on children in general has shown that child maltreatment is associated with heightened levels of emotional difficulties such as depression, withdrawal, anxiety, and dissociation (Carey et al., 2008; Chen et al., 2006). Musisi et al. (2008), in their study, found that more orphans reported past forced sex or abuse than non-orphans. Heath and Kaminer (2004) concluded that exposure to domestic violence was consistently found to predict internalized problems in children including post-traumatic stress symptoms. Baguma et al. (2005) explored the psychosocial needs of AIDS orphans in Uganda. The result showed that the prevalence and seriousness of psychosocial problems was higher among orphans than among the control group. Furthermore, qualitative results identified the presence of physical, sexual, and emotional abuse, as well as behavioural problems among the orphans.

Hypothesis Three

The third hypothesis, which stated that age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse will significantly predict the mental health of orphans, was sustained. The result of the tested hypothesis showed that the independent variables significantly predicted orphans' mental health ($F_{(7,\ 192)}$ = 17.898, P<.05). This result also revealed that the independent variables jointly accounted for only 39.5% of the variance in mental health (R^2 = .395), and that child abuse is the strongest or best predictor of orphans' mental health (β = .426, p<.05), followed by self-concept (β = -.221, p<.05).

Several studies lend credence to the finding in this study. Donnellan et al. (2005) reported an association between low self-esteem and delinquency, antisocial behaviour, as well as aggression. Weidner (2013) opined that low self-esteem in children may lead to discipline problems, depression, and learning difficulties. Again, Trzesniewski et al. (2006) observed a relationship between low self-esteem during adolescence and a high probability of manifesting psychological problems in adulthood.

Huang et al. (2010) argued that people who do have low social support record higher rates of major mental disorders than those who enjoy high social support; such people also have more suicidal ideation (Casey et al., 2006). Similarly, Agrawal and Moak (2010) reported a correlation between low perceived interpersonal social support and increased prevalence of physical health problems, generalized anxiety, and depressive disorder. Zullig et al. (2005) reported a significant relationship between poor mental health days and reduced life satisfaction.

The finding on child abuse as the best predictor of orphans' mental health supports Heath and Kaminer (2004), who concluded that exposure to domestic violence was consistently found to predict internalized problems in children including post-traumatic stress symptoms. Similarly, Cluver (2013) reported that abuse predicts mental health risks. Hermenau et al. (2011) carried out a study on childhood adversity, mental ill-health and aggressive behaviour in an African orphanage and found that violence experienced in the orphanage correlated more strongly with all indicators of mental ill-health and also had a positive relationship with the aggressive behaviour of the children. This is, however, contrary to the findings made by Getachew, Ambaw, Abebe and Kasahun (2011). In their study, they reported that self-esteem and perceived social support explained the largest percent of variation orphans' level of depression and anxiety. However, their result also showed that age and gender did not predict orphans' level of depression and anxiety.

Most studies on orphans have focused on self-esteem, a major component of self-concept, and have explained orphans' mental health in light of self-esteem than self-concept. However, self-concept predicting mental health can be explained in light of the relevance of self-concept to mental health and overall well-being. Self-concept is the perception or image of one's abilities and uniqueness. Weiten et al. (2012) describe self-concept as a collection of beliefs about one's own natural unique qualities, and typical behaviour. It is one's mental picture of oneself. It is a collection of self-perceptions. Self-concept is how we think about and evaluate ourselves. To be aware of oneself is to have a concept of oneself (McLeod, 2008). Ferrer and Fugate (2012) assert that a healthy self-concept is the foundation for the positive development and overall well-being of a child. When a child has a healthy self-concept, he or she sees himself or herself as being loved, loving, and valuable. A child

with a healthy self-concept is also better able to reach his or her full potential. He or she does better in school. He or she is better able to set goals for himself or herself and make decisions. He or she is more willing to learn new things and try new activities. With a healthy self-concept, a child has better relationships with family members and friends. He or she can control his behaviour and get along with others. Invariably, a healthy self-concept is implicated in the development of positive mental health and overall well-being and as such can adequately predict mental health.

Hypothesis Four

The fourth hypothesis, which stated that there will be a significant age difference in mental health of orphans, was rejected. The result from the tested hypothesis showed that older orphans (mean = 17.82) recorded lower scores on measures of psychological distress than younger orphans (mean = 18.62). There was, however, no significant difference in their scores ($t = .540$, $df = 198$, $p>.05$), suggesting no significant age difference in orphans' mental health. However, this finding and other findings in this area seem to contradict one another. Doku (2009) recorded that psychological problems in orphans appeared to increase with age. Nyamukapa et al. (2010) found that younger children reported significantly high psychological distress. Zhao et al. (2010) recorded that older orphans reported significantly higher scores in depression than younger orphans. The contradiction in these findings can be attributed to various reasons. For some orphans, especially those who live in child-headed homes, the adult responsibilities they are forced to take on might increase with age, that is, the older they become, the higher the adult responsibility. Bearing such heavy burden at such tender age could result in low life satisfaction, which negatively impacts their mental health. On the other hand, early and sudden separation from an attachment figure might cause anxiety and other psychological distresses in younger orphans.

Hypothesis Five

The fifth hypothesis, which stated that there will be a significant gender difference in mental health of orphans, was rejected. The result from the tested hypothesis showed that male orphans (mean = 17.60) recorded lower scores on measures of psychological distress than female orphans (mean = 18.80). There was, however, no significant difference in their scores (t = -.810, df = 198, p>.05), suggesting no significant sex difference in orphans' mental health. This finding contradicts Nyamukapa et al. (2010) who found in their study that girls reported significantly high psychological distress. Although the result did not show significant gender difference, the mean scores indicated that male orphans expressed less psychological distress than female orphans. This corroborates Omotosho (2010), who reported that female in-school orphans expressed having greater problems and adjustment needs than their male counterparts.

Hypothesis Six

The sixth hypothesis, which stated that orphans in the experimental group will report less mental health issues than orphans in the control group, was sustained. The result from the tested hypothesis showed a significant difference between orphans exposed to psycho-educational programme and orphans not exposed to psycho-educational programme ($F_{(1, 19)} = 19.655$, $P<.05$). This result corroborates findings from studies that have been done in this area. In a cluster randomized control trial of a school-based peer-group support intervention with 326 AIDS orphans (aged 10-15) in Uganda, Kumakech et al. (2009) found that peer-group interventions when led by teachers and complemented by healthcare check-ups significantly decreased anxiety, depression and anger among the intervention group. Although the children in the intervention group had started out having lower self-concept scores and higher indications of depression than the control group, the intervention group had lower scores of anxiety, depression, and anger at baseline.

According to Brown et al. (2009), mentorship programme may decrease grief among youth. Their study reported a significant decrease in depressive symptoms. According to findings from their study, Nyangara et al. (2009) reported that group therapy for

children was associated with higher perceptions of having adult support, improved pro-social behavior and fewer emotional problems.

5.3 Implications of the Study

The issue of orphanhood is a growing global concern as factors causing deaths are on the increase, and children are losing their parents everyday. As much as these deaths may be beyond control, helping orphans cushion the effect of parental loss is something that is very much within control. The society needs to provide ample opportunity for orphans to develop and live life like every normal child would.

Orphans are vulnerable and this exposes them to psychosocial stressors that impact their mental health negatively, as shown by findings from this study. It is important for the government to be mindful of the plight of orphans and make special provision for them in the national budget. Policies that are orphan-friendly, such as access to food, shelter, education, health care, support, and others, should be put in place, supervised, and implemented. Most residential institutions that take these orphans in to care for them are in a very bad shape because there are few or no facilities to aid in the quest to better the lot of orphans. Some orphans, who are not living in institutions, are probably living with poor relatives that lack the wherewithal to cater adequately for them. All these caretakers need financial aid and the government should provide this for them. Part of what to be done is to keep a database of orphans in the country - those who are living in institutions and without, so that proper monitoring and care of this group of individuals can be engendered.

An orphan needs maximum love and care like every other child. However, caring for orphans is a delicate responsibility because of their special state of vulnerability compared to other children. Caregivers should therefore be well informed on how to go about delivering this special care to orphans. They need to be aware of the vulnerable state of orphans and they need to be taught skills that are tailored towards taking care of them. Training, workshops and seminars, sponsored by the government and other NGOs should be mounted periodically for the sole purpose of training orphans' caregivers. Every child needs a good role model and caregivers should be such role models for orphans.

It is established from this study that orphans will benefit from intervention. Therefore, clinicians need to develop intervention programmes that can help in combating the effect of some of the negative psychosocial experiences orphans go through, and all psychosocial variables that militate against orphans' mental health should be factored into such programmes. With the aid of intervention programmes, orphans will be able to live well integrated, wholesome, healthy, and normal lives.

The responsibility of helping orphans integrate well into the society is not the sole responsibility of the government or their primary caregivers. Everyone who comes in contact with orphans one way or the other has a responsibility towards them. Orphans should not be neglected, exploited, taken advantage of, denied of their right, bullied or victimized, stigmatized or discriminated against. They should be treated like normal citizens who have the right to a good life.

5.4 Limitations of the Study

There are some limitations in the study. First, this study focused on children not orphaned by AIDS, however, most of the existing literatures focused on AIDS orphans. There were few works that centred on children orphaned by other causes, and some inferences had to be drawn from available literature on AIDS orphans.

Second, all the data were based on self-report, and might be subject to self-reporting bias. Furthermore, questionnaires were the only tools used to gather information from the respondents. A combination with structured interview might have yielded varied and deeper findings in this study.

Third, data were obtained from a limited sample. Most orphanages within the scope of study have more of younger orphans and the age range of participants in this study limited the number of orphans that was sampled from the orphanages. Furthermore, the study was limited to the south-western region of Nigeria, whereas, orphans abound all over the country. Data on orphans from other parts of the country could have yielded more robust findings.

Fourth, information on other demographical factors that could have interactions with the variables of study (for example, length of stay at orphanage, cause of parents'

death) was not available for analysis. Future study that captures such information will provide greater insight into the study of orphans.

5.5 Conclusion

This study investigated the psychosocial variables that predict the mental health of orphans. Orphans in this study exhibited poor mental health than non-orphans. They also reported poor self-concept, low self-esteem, low social support, low life satisfaction and high child abuse than non-orphans. It was also noted, from this study, that age, gender, self-concept, self-esteem, social support, life satisfaction and child abuse significantly predicted the mental health of orphans. Again, this study revealed child abuse as the strongest predictor of orphans' mental health, followed by self-concept.

Due to the death of their parents, orphans suffer lack of opportunities or misfortunes, which lead to deprivation. Children exposed to early deprivation and neglect are significantly at increased risk of various emotional and behavioural disorders (Widom, et al., 2007 as cited in Bos et al.,2011). Implementation of orphan-friendly policies by the government will reduce orphans' exposure to negative experiences that militate against their mental health. Furthermore, the development of intervention programmes targeted at the orphan population will help improve their mental health.

5.6 Recommendations

Based on the findings of this study, the following recommendations are put forward:

1. Orphans in this study displayed poor mental health than non-orphans. The Nigerian government should become more concerned with the issues affecting orphans, include them in national planning, and implement policies that will promote their mental health and overall well-being as well as enhance their existence.

2. From this study, child abuse was discovered to be the strongest predictor of orphans' mental health. Orphans should be shielded from abuse at every cost

and the government should implement policies that protect this group from all forms of child abuse and also impose strong penalty on child offenders.

3. Self-concept was also revealed as a strong predictor of orphans' mental health. It is known that parental care, love, and positive regard for a child is implicated in the development of good self-concept, and a healthy self-concept plays an important role in positive mental health. Caregivers should play the roles of caring and loving parents to orphans for the development of healthy self-concept. Doing this will produce children who have confidence in themselves and in their abilities. Such children will go on to attain self-actualization and become responsible citizens of the nation.

4. Findings from this study also showed that self-esteem, social support and life satisfaction predict orphan's mental health. All these are fostered in an environment with a favourable ambiance. Government should give financial aids to existing residential institutions and individuals that take up the responsibility of caring for orphans. Adequate facilities that will enhance the growth and development of orphans should be made available in these institutions and individuals taking care of them should be empowered with financial resources to do so. There is also need for adequate monitoring of these institutions.

5. Age and gender also predicted the mental health of orphans in this study. Age and gender differences should be noted by caregivers to be able to tailor their specific needs and meet such needs accordingly and adequately.

6. Findings from this study revealed that orphans will benefit from intervention programmes. Clinicians should develop programmes specifically aimed at assessing, diagnosing, treating, and possibly preventing problem areas for orphans. These intervention programmes should be supported and funded by the government, NGOs, and other private individuals who may have interest in the plight of orphans.

7. Government should fund basic and applied researches that are aimed at understanding the plight of orphans and proffering solutions to them. This will

serve as a means of having proper database of orphans in the country and also a means of reaching out to orphans and meeting their needs.

8. More hands should be employed in the care of orphans so that caregivers to orphans ratio will be at a reasonable range. A situation where a caregiver is responsible for caring for a large number of orphaned children is not too appropriate as such caregiver may not be able to give the best care to the children.

9. Government, in conjunction with NGOs, should organize trainings, workshops, and seminars for caregivers. This will serve as a platform for disseminating new information gleaned from research findings about the state and care of orphans.

10. Schools should have seasoned counselors who will further address the needs of orphans outside the home environment.

11. Government is not solely responsible for the welfare of orphans. Faith-based institutions and individuals in the private sector should also be committed to the care of orphans. Scholarships, financial and material donations, to meet orphans' basic need for food, shelter, health care, education, and others, should be a part of this commitment. Furthermore, regular social visits to orphans and interactions with them will enhance their social support.

5.7 Contribution to Knowledge

This study has contributed to the body of existing knowledge in the following ways:

It examined the combination of several factors (age, gender, self-concept, self-esteem, social support, life satisfaction, and child abuse) in the prediction of orphans' mental health. Most studies that have been done in this area have not had a combination of all these factors in a single study.

It revealed child abuse as the strongest predictor of orphans' mental health, followed by self-concept. However, most studies carried out on orphans in times past have not really taken a critical look at the role self-concept plays in orphans' mental health.

Rather, much focus had been placed on self-esteem, one of the components of self-concept. This finding can open up further researches into orphans' self-concept and its important role in their mental health.

There are not many researches carried out on orphans in Nigeria. Orphans, have however, been widely researched in some other parts of Africa. This study has added to the pool of literature on orphans in Nigeria. Furthermore, most researches on orphans, even in other African countries, have mainly concentrated on AIDS orphans. However, this study has provided more information on children orphaned by other causes.

This study also introduced a newly developed psycho-educational programme (Covenant Coping Skills Intervention Programme) that orphans in the study benefited from.

5.8 Suggestions for Further Studies

This study has made some novel findings about the mental health of orphans and further investigations should be conducted to confirm these findings.

This study focused on double orphans. Further studies should incorporate other types of orphans (maternal orphans and paternal orphans) for a robust research outcome. Differences between the different types of orphans in relation to their mental health should be explored.

The age range of participants in further studies should be stretched to accommodate much younger orphans. This will provide more information about the age differences in the mental health of orphans. This has implication for caregivers as they will gain more insight into age-specific psychosocial needs of orphans.

It is important to replicate this study for a larger population. Similar studies should include other geopolitical zones in Nigeria and more residential institutions should be covered. Also, orphans who live in settings other than residential institutions (for example, with extended family members), should be researched on as well and compared with orphans living in residential institutions.

Other demographical variables that were not assessed in this study should be factored into future similar studies. Furthermore, the self-concept of orphans should be studied extensively by other researchers who desire to carry out similar studies.

Generally, more studies should be carried out on orphans' mental health. However, AIDS orphans should not be extensively studied at the expense of other orphans. Children orphaned by other causes should also be given some priority in further studies.

More longitudinal studies on the mental health of orphans should be carried out. Orphans should be studied over a period of time to determine how variations in psychosocial factors affect or predict their mental health. This will further establish previous findings on orphans' mental health.

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APPENDIX I (QUESTIONNAIRES)

GENERAL HEALTH QUESTIONNAIRE (GHQ – 28)

Instruction:

Please read this carefully.

I would like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please it is important that you try to answer ALL the questions simply by <u>UNDERLINING</u> the answer which you think most nearly applies to you. Remember that I want to know about present and recent complaints, not those that you had in the past.

Have you recently

S/N	ITEMS				
1	Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
2	Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
4	Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
5	Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual

7	Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
8	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
9	Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
13	Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
14	Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
15	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
16	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
17	Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
18	Been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
19	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
20	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
21	Been able to enjoy your normal	More so	Same as	Less so	Much less

	day-to-day activities?	than usual	usual	than usual	than usual
22	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
23	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
24	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
25	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Has definitely crossed my mind
26	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
27	Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
28	Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Has definitely crossed my mind

ADOLESCENT PERSONAL DATA INVENTORY (APDI) [Self-concept subscale]

Instruction:

Please use the 5-point scale below to rate yourself on each of the following items. Rate the items most descriptive of yourself at the high end (5); those least descriptive of you at the low end (1), and those about you which you are not sure of or undecided about at the middle (3). For each item, record the number which represents your response on the blank space on the right side of the items.

Scale "Least like me" 1 2 3 4 5 "Most like me"

Example:

I am a happy boy ……4……..

Four (4) is put in the blank space on the right side of the item because this statement is somehow "most like me"

1. I have warm social attraction for others ……
2. I am a responsible person ……
3. My life has great value for me ……
4. I am afraid of enemies ……
5. I am a submissive person ……
6. I am active ……
7. I am confident about what other people think about me ……
8. I am concerned about what other people think about me ……
9. I constantly feel insecure ……

10. I express my feelings freely ……

11. I am an optimistic person ……

12. I usually like people ……

13. I like to work hard ……

14. I can face any difficulty in life ……

15. I am ambitious over attaining mastery of things ……

16. I am unreliable ……

17. I may lie in certain situations ……

18. I fear I would fail on anything I plan to do ……

19. I am self-centred ……

20. I always agree with my mate on all issues ……

21. I am dependably reliable ……

22. I often feel lonely ……

23. I am original in all ways ……

24. I am lazy ……

25. I am shy ……

26. I am always methodical ……

27. I like to generate new ideas all the time ……

28. I am always thirsty for knowledge ……

29. Life is meaningless ……

30. I like to be myself always ……

ROSENBERG SELF-ESTEEM SCALE (RSES)

Instruction:

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

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

DUKE–UNC FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (FSSQ)

Instruction:

Here is a list of some things that other people do for us or give us that may be helpful or supportive. Please read each statement carefully and place an 'X' in the column that is closest to your situation. Give only 1 answer per row.

S/N	Items	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
1	I have people who care about what happens to me					
2	I get love and affection					
3	I get chances to talk to someone about problems with my schoolwork					
4	I get chances to talk to someone I trust about my personal problem					
5	I get chances to talk about money matters					
6	I get invitations to go out and socialize with other people					
7	I get useful advice about important things in my life					
8	I get help when I am sick in bed					

QUALITY OF LIFE ENJOYMENT AND SATISFACTION QUESTIONNAIRE – SHORT FORM

(Q-LES-Q-SF)

Instruction:

Please read the items carefully and tick the appropriate response that best applies to you.

Taking everything into consideration, during the past week how satisfied have you been with your……

S/N	Items	Very poor	Poor	Fair	Good	Very good
1	Physical health?					
2	Mood?					
3	Work?					
4	Household activities?					
5	Social relationships?					
6	Family relationships?					
7	Leisure time activities?					
8	Ability to function in daily life?					
9	Sexual drive, interest, and/or performance?					
10	Economic status?					
11	Living/Housing situation?					
12	Ability to get around physically without feeling dizzy or unsteady or falling?					
13	Your vision in terms of ability					

	to do work or hobbies?					
14	Overall sense of well-being?					
15	Medication? (If not taking any, check/mark here ---------- and leave item blank)					
16	How would you rate your overall life satisfaction and contentment during the past week?					

CHILD ABUSE QUESTIONNAIRE (CAQ)

Instruction:

Please read the following items and tick the option that best describes your experience.

S/N	Items	Never	Sometimes	Often
1	When my caretakers are angry/frustrated, they throw objects at me with the intention of harming me			
2	My caretakers beat me even when I have not committed an offence			
3	My caretakers have beaten me to the point of getting injured/deformed			
4	My caretakers have applied pepper on my body in an attempt to force me to tell the truth			
5	My caretakers give me work that is too hard for my age			
6	My caretakers use corporal punishment (inflict pain) to correct my misbehaviour			
7	My caretakers rain curses and abuses on me at the slightest mistake			
8	When I misbehave, my caretakers confine me in a dark closet or tie my legs to a chair/table for a period of time			
9	I have been unjustly humiliated by caretakers in the presence of others			
10	My caretakers blame me for offence I did not commit			
11	My caretakers do not see anything good in whatever I do			
12	I have my caretakers engaging in physical combat			

13	When ill, my caretakers do not take me to the hospital for treatment on time			
14	My caretakers do not supervise me or bother about what I do at home or school			
15	I lack enough to eat or wear because my caretakers do not provide for me			
16	I am free to do anything at home or school			
17	My caretakers delay the provision of basic educational materials (e.g. uniform, textbooks, school fees) for me			
18	My caretakers have not been showing love towards me			
19	My caretaker is fond of touching my private part			
20	My caretaker persuades me to expose my private part			
21	My caretaker tells me stories of people engaging in sexual acts			
22	My caretaker allows me to watch/read pornographic materials			
23	I have been raped by my caretaker			
24	My caretaker encourages me to have sexual relationship with others in order to get money			

APPENDIX II (PSYCHO-EDUCATIONAL PROGRAMME)

COVENANT COPING SKILLS INTERVENTION PROGRAMME

Mental Health

Introduction

Define mental health as:

- ✓ A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.
- ✓ A level of psychological well-being, or an absence of a mental disorder.
- ✓ An individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience.
- ✓ An expression of emotions, and as signifying a successful adaptation to a range of demands.
- ✓ The way we think and feel about ourselves and others, our confidence, and our ability to control things in our life.

Why is mental health important?

- ✓ Good mental health is crucial to living a long healthy life.
- ✓ Good mental health can enhance one's life, while poor mental health can prevent someone from living an enriching life.
- ✓ Mental Health Improves the Quality of life. When we are free of depression, anxiety, excessive stress and worry, addictions, and other psychological problems, we are more able to live our lives to the fullest.

- ✓ Mental health strengthens and supports our ability to have healthy relationships; make good life choices; maintain physical health and well-being; handle the natural ups and downs of life; discover and grow toward our potential.
- ✓ Mental Health Treatment Reduces Medical Costs**.** Many research studies have shown that when people receive appropriate mental health care, their use of medical services declines. For example, excessive anxiety and stress can contribute to physical problems such as heart disease, ulcers, etc. Anxiety and stress can also reduce the strength of the immune system, making people more vulnerable to conditions ranging from the common cold to cancer. Psychological problems also increase the likelihood that people will make poor behavioral choices which can contribute to medical problems.

Characteristics of persons with good mental health

- ✓ A sense of contentment with their lives.
- ✓ A zest for living, laughing, and having fun.
- ✓ Ability to deal with tress and to bounce back from adversity.
- ✓ Flexibility to learn new things and adaptability to deal with change.
- ✓ Ability to build and maintain healthy relationships.
- ✓ Self confidence and high self-esteem.
- ✓ Good balance between work and play.
- ✓ A sense of meaning and purpose in life, including activities and relationships.

Promoting good mental health

Good mental health doesn't mean that people never go through hard times or suffer through some painful situations. Surely, disappointments, loss, and change are all a

part of life, and they do cause stress, sadness, and anxiety in the healthiest individuals. However, individuals who have good mental health are able to bounce back from the adversity of a lost job, relationship, illness, sadness, or other setback. This is what is referred to as RESILIENCE. To experience better mental health, one must build resilience.

Steps towards building resilience:

- ✓ Accept that change is a part of living. All of life involves change. Accepting that fact, you will be better served by focusing on things that you can change and putting a plan together to do so.
- ✓ Make connections. Good relationships are important: family, friends, co-workers, and others. Accept help if you need it, and don't be afraid to ask for it.
- ✓ Avoid seeing crises as insurmountable problems. You can't change what's happened, but you can look toward the solution and act accordingly.
- ✓ Take decisive actions. Acting decisively, even during stressful or adverse situations, helps build self-confidence and resilience.
- ✓ Move toward your goals. Create realistic goals and take steps to achieve them. Even small steps are a sign of progress. Keep moving forward.
- ✓ Look for opportunities for self-discovery. You can often learn something good from any situation, even tragedies and hardship.
- ✓ Nurture a positive view of yourself. Develop your confidence and problem-solving ability helps to build resilience.
- ✓ Maintain a hopeful outlook. Try visualizing what you want, instead of worrying about how you'll attain it.
- ✓ Take care of yourself. Pay attention to the physical and mental aspects of personal caretaking. This keeps mind and body primed and ready to deal with situations requiring resilience.

- ✓ Keep things in perspective. Try to look at the broader, long-term view and avoid blowing things out of proportion.
- ✓ Find additional ways of strengthening resilience. Do something new and fulfilling.

Interactive session

- ✓ Discuss areas of challenges with participants, especially with respect to building resilience. Discuss additional ways of strengthening resilience and how participants can apply these in their day-to-day activities.

COVENANT COPING SKILLS INTERVENTION PROGRAMME

Self-concept and Self-esteem

Introduction

Define self-concept as:

- ✓ What you understand about yourself. It includes your social character or abilities; your physical appearance and body image; and your thinking.
- ✓ Your understanding of unchanging characteristics you have: Social (e.g. are you sociable?); Physical (e.g. are you tall?); Psychological (e.g. are you optimistic?)
- ✓ The idea you have of who you are and what makes you different from everyone else, in other words, the idea of what makes you "you".
- ✓ The way a person thinks about their abilities in a variety of facets of life, including academics, athletics and social interactions.
- ✓ A general term used to refer to how someone thinks about or perceives themselves.

Self-concept is related to self-esteem. An individual's self-concept of himself/herself affects the self-esteem.

Define self-esteem as:

- ✓ A term in psychology to reflect a person's overall evaluation or appraisal of his or her own worth.
- ✓ The extents to which we like accept or approve of ourselves or how much we value ourselves.
- ✓ The regard or respect that a person has for oneself.
- ✓ Your general attitude toward yourself, whether positive or negative.

While self-concept is what we think about the self; self-esteem, the positive or negative evaluation of the self, is how we feel about it. Self-concept is the informational side of things, where one knows facts or holds beliefs about what one is like; self-esteem is how one feels about those things he knows.

Self-concept is constructed and developed by the individual through interaction with the environment and reflecting on that interaction. Sources of self-concept include: others' images of you, social comparisons, cultural teachings, and your own interpretations and evaluations.

Having people inaccurately say bad things about you and your character, or make comparisons between you and people who are better than you at objective measures can hurt your self-esteem.

Importance of self-concept and self-esteem

- ✓ The direction of your life largely depends on your self-concept and self-esteem.
- ✓ It is the key to either success or failure. Successful people have healthy self-esteem and respect themselves, while those that struggle with life have low self-esteem and a negative view of themselves.
- ✓ Self-concept and self-esteem ultimately shape your behaviour, including the way you interact with others, decision making, your view of the world and your ability to cope with life's up's and down's.
- ✓ Most psychological problems/disorders can generally be traced back to low or poor self-concept/self-esteem. High or good self-concept and self-esteem is important for the avoidance of psychological problems/disorders.

Depending on an individual's evaluation/appraisal of himself/herself, self-esteem can either be high or low. If a person approves (or likes) of himself and his attributes, then he will have high self-esteem, and if he disapproves (or dislikes) of himself and the attributes he believes he possesses, and then he in return will have low self-esteem.

Characteristics of low self-esteem

Some characteristics of low self-esteem include:

- ✓ Feelings of unhappiness.
- ✓ Feelings of anxiety.
- ✓ Feelings of inferiority or superiority.
- ✓ Impatience or irritation with self or others.
- ✓ External oriented goals. Goals and direction in life are based upon what others might want or need, not necessarily on what you need.
- ✓ Negativity, e.g. negative inner self-talk; Pessimism.
- ✓ Lack of confidence.
- ✓ Always worrying what others might think.

Characteristics of high self-esteem

Some characteristics of low self-esteem include:

- ✓ Responsibility.
- ✓ Goal commitment.
- ✓ Genuineness.
- ✓ Tolerance; Forgiveness.
- ✓ Internal values – chosen values rather than values due to the demands or expectations of others.
- ✓ Positivity; Optimism.
- ✓ Self improvement.

- ✓ Confidence.
- ✓ Self acceptance.

You can change and enhance your self-concept and self-esteem by changing:

- ✓ Your attitudes.
- ✓ Your moods.
- ✓ Your values.
- ✓ Your beliefs.

If you can accept that you can change your beliefs, values, moods and attitudes then you accept that you can change how you feel about you and the idea of who you are together with your self appraisal will change also.

Interactive session

- ✓ Discuss areas of challenge bothering on self-concept and self-esteem with participants. Allow each participant to say what they think and believe of themselves and discuss measures of challenging negative ideas and beliefs about the self.

COVENANT COPING SKILLS INTERVENTION PROGRAMME

Child Abuse

Introduction

Define child abuse as:

- ✓ The physical or psychological/emotional mistreatment of children.
- ✓ Any act or series of acts of commission or omission by a parent or other caregiver that result in harm, potential for harm, or threat of harm to a child.

Child abuse is more than bruises or broken bones. While physical abuse is shocking due to the scars it leaves, not all child abuse is as obvious. Ignoring children's needs, putting them in unsupervised, dangerous situations, or making a child feel worthless or stupid are also child abuse. Regardless of the type of child abuse, the result is serious emotional harm.

Most child abuse occurs in a child's home, with a smaller amount occurring in the organizations, schools or communities the child interacts with. There are four major categories of child abuse: neglect, physical abuse, psychological/emotional abuse, and sexual abuse.

Neglect

Define neglect as:

- ✓ A passive form of abuse in which a perpetrator is responsible to provide care for a victim who is unable to care for himself or herself, but fails to provide adequate care.
- ✓ Child neglect – a very common type of child abuse – is a pattern of failing to provide for a child's basic needs, whether it be adequate food, clothing, hygiene, or supervision.

Warning signs of neglect in children

- ✓ Clothes are ill-fitting, filthy, or inappropriate for the weather.
- ✓ Hygiene is consistently bad (unwashed body and hair, noticeable body odour).
- ✓ Untreated illnesses and physical injuries.
- ✓ Child is frequently unsupervised or left alone or allowed to play in unsafe situations and environments.
- ✓ Child is frequently late or missing from school.

Physical abuse

Define physical abuse as:

- ✓ An act of another party involving contact intended to cause feelings of physical pain, injury, or other physical suffering or bodily harm.

Physical abuse involves physical harm or injury to the child. It may be the result of a deliberate attempt to hurt the child, but not always. It can also result from severe discipline, such as using a belt on a child, or physical punishment that is inappropriate to the child's age or physical condition.

Warning signs of physical abuse of children

- ✓ Frequent injuries or unexplained bruises, cuts, welts, etc.
- ✓ Child is always watchful and on 'alert' as if expecting something bad to happen.
- ✓ Injuries appear to have a pattern such as marks from a hand or belt.
- ✓ Child shies away from touch, flinches at sudden movements, or is afraid to go home.

- ✓ Child wears inappropriate clothing to cover up injuries, e.g. long-sleeved shirts in hot weather.

Psychological/emotional abuse

Define psychological/emotional abuse as:

- ✓ A form of abuse characterized by a person subjecting or exposing another to behavior that may result in psychological trauma, including anxiety, chronic depression, or post-traumatic stress disorder.

Psychological/emotional abuse can severely damage a child's mental health or social development, leaving lifelong psychological scars. Examples of psychological/emotional child abuse include:

- ✓ Constant belittling, shaming, and humiliating a child.
- ✓ Calling names and making negative comparisons to others.
- ✓ Telling a child he or she is "no good," "worthless," "bad," or "a mistake."
- ✓ Frequent yelling, threatening, or bullying.
- ✓ Ignoring or rejecting a child as punishment, giving him or her silent treatment.
- ✓ Limited physical contact with the child—no hugs or other signs of affection.
- ✓ Exposing the child to violence or the abuse of others, whether the abuse of a parent, a sibling, or even a pet.

Warning signs of psychological/emotional abuse in children

- ✓ Excessively withdrawn, fearful, or anxious about doing something wrong.
- ✓ Shows extremes in behavior (extremely compliant or extremely demanding; extremely passive or extremely aggressive).
- ✓ Doesn't seem to be attached to the parent or caregiver.

- ✓ Acts either inappropriately adult (taking care of other children) or inappropriately infantile (rocking, thumb-sucking, throwing tantrums).

Sexual abuse

Define child sexual abuse as:

- ✓ Child sexual abuse is a form of child abuse in which an adult or older adolescent abuses a child for sexual stimulation. Forms of CSA include asking or pressuring a child to engage in sexual activities (regardless of the outcome), indecent exposure of the genitals to a child, displaying pornography to a child, actual sexual contact against a child, physical contact with the child's genitals, viewing of the child's genitalia without physical contact, or using a child to produce child pornography.

Warning signs of sexual abuse in children

- ✓ Trouble walking or sitting.
- ✓ Child displays knowledge or interest in sexual acts inappropriate to his or her age, or even seductive behavior.
- ✓ Child makes strong efforts to avoid a specific person, without an obvious reason.
- ✓ Child doesn’t want to change clothes in front of others or participate in physical activities.
- ✓ An STD or pregnancy, especially under the age of 14.
- ✓ Child sexual abuse is also associated with very strong shame and guilt.

Consequences of child abuse

Some consequences of child abuse include:

- ✓ Attachment problems.
- ✓ Physical health problems.
- ✓ Trauma and psychological problems.
- ✓ Learning and developmental problems.
- ✓ Behavioural problems.
- ✓ Mental health problems.
- ✓ Eating disorders.
- ✓ Aggression and violence.
- ✓ Teenage pregnancy.

Overcoming child abuse

- ✓ Face the abuse.
- ✓ Forgive and release.
- ✓ Seek shelter.
- ✓ Move on.
- ✓ Find a good therapist.
- ✓ Seek a support group of others who share same trauma.
- ✓ Engage in journal exercises where you let out your feelings/emotions privately.
- ✓ Focus on your healing.

Interactive session

- ✓ Discuss ways of preventing child abuse.

COVENANT COPING SKILLS INTERVENTION PROGRAMME

Traumatic Stress

Introduction

Define trauma as:

- ✓ An emotional response to a terrible event.
- ✓ Emotional and Psychological trauma the result of extraordinarily stressful events that shatter your sense of security, making you feel helpless and vulnerable in a dangerous world.

Disasters are often unexpected, sudden and overwhelming. In some cases, there are no outwardly visible signs of physical injury, but there is nonetheless a serious emotional toll. It is common for people who have experienced traumatic situations to have very strong emotional reactions. Understanding normal responses to these abnormal events can aid an individual in coping effectively with feelings, thoughts and behaviors, and also help along the path to recovery.

What happens after a disaster or traumatic event?

Shock and denial are typical responses to traumatic events and disasters, especially shortly after the event. Both shock and denial are normal protective reactions.

- ✓ Shock is a sudden and often intense disturbance of your emotional state that may leave you feeling stunned or dazed.
- ✓ Denial involves not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event. You may temporarily feel numb or disconnected from life.

However, as the initial shock subsides, reactions vary from one person to another. Normal responses to traumatic events include:

- ✓ Feelings become intense and sometimes are unpredictable.

- ✓ Thoughts and behavior patterns are affected by the trauma.
- ✓ Recurring emotional reactions are common.
- ✓ Interpersonal relationships often become strained.
- ✓ Physical symptoms may accompany the extreme stress. E.g., headaches, nausea, chest pain, etc.

Normal emotional reactions also include:

- ✓ Shock and disbelief; fear; helplessness; guilt; anger; shame; relief.

Normal physical reactions include:

- ✓ Trembling or shaking; pounding heart; rapid breathing; lump in throat, feeling choked up; stomach tightening or churning; feeling dizzy or faint; cold sweats; racing thoughts.

Factors that may affect the length of time required for recovery

- ✓ The degree of intensity and loss.
- ✓ A person's general ability to cope with emotionally challenging situations.
- ✓ Other stressful events preceding the traumatic experience.

Steps to take to help restore well-being and a sense of control following a traumatic experience include:

- ✓ Give yourself time to adjust.
- ✓ Avoid obsessively thinking about the disastrous event.

- ✓ Ask for support from people who care about you and who will listen and empathize with your situation.
- ✓ Communicate your experience.
- ✓ Engage in healthy behaviors to enhance your ability to cope with excessive stress.
- ✓ Find groups led by appropriately trained and experienced professionals.
- ✓ Engage in relaxing activities.

Coping Mechanisms and Strategies

Introduction

Define coping as:

- ✓ Using conscious effort to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stress or conflict**.**
- ✓ An activity we do to seek and apply solutions to stressful situations or problems that emerge because of our stressors.

Define coping mechanism as:

- ✓ The sum total of ways in which we deal with minor to major stress and trauma.
- ✓ Ways, to which external or internal stress is managed, adapted to or acted upon.

Why coping mechanisms and strategies are important

Since people are faced with stressful and sometimes traumatic situations at one time or the other, it is important to develop strategies or mechanisms that will aid effective

coping with such situations. This will enable the maintenance of good physical and mental health.

Types of coping strategies

- ✓ **Appraisal-focused,** when the person modifies the way they think. For example, employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation.
- ✓ **Problem-focused**, when the individual tries to deal with the cause of their problem by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress.
- ✓ **Emotion-focused**, which involves releasing pent-up emotions, distracting oneself, managing hostile feelings, meditating or using systematic relaxation procedures. Emotion-focused coping is oriented toward managing the emotions that accompany the perception of stress.

General classification of coping mechanisms

- ✓ **Defense** – the unconscious ways of coping with stress.
- ✓ **Adaptive** – tolerates the stress.
- ✓ **Avoidance** – keeps self away from the stress.
- ✓ **Attack** – diverts one's consciousness to a person or group of individuals other than the stressor or the stressful situation.
- ✓ **Behavioral** – modifies the way we act in order to minimize or eradicate the stress.
- ✓ **Cognitive** - alters the way we think so that stress is reduced or removed.

- ✓ **Self-harm** – intends to harm self as a response to stress.
- ✓ **Conversion** – changes one thought, behaviour or emotion into another.

Interactive session

- ✓ Discuss the stressful situations participants have gone through or are going through and the effective coping mechanisms for such situations.

COVENANT COPING SKILLS INTERVENTION PROGRAMME

Spirituality

Introduction

Define spirituality as:

- ✓ Absolute faith in God.
- ✓ Cultivating a personal relationship with God.

Spirituality and Health

Many studies have shown that spirituality is beneficial to individuals' sound health and well-being. Spiritual practices tend to:

- ✓ Improve coping skill and social support.
- ✓ Foster feelings of optimism and hope.
- ✓ Promote health behaviour.
- ✓ Reduce feelings of depression and anxiety.
- ✓ Encourage a sense of relaxation.

By alleviating stressful feelings and promoting healing ones, spirituality can positively influence immune, cardiovascular (heart and blood vessels), hormonal, and nervous systems. Many researchers believe that certain beliefs, attitudes, and practices associated with being a spiritual person influence health. In a recent study of people with acquired immune deficiency syndrome (AIDS), those who had faith in God, compassion toward others, a sense of inner peace, and were religious had a better chance of surviving for a long time than those who did not live with such belief systems. Qualities like faith, hope, and forgiveness, and the use of social support and prayer seem to have a noticeable effect on health and healing.

- ✓ **Faith:** The beliefs, which are most deeply held by an individual, strongly influence his or her health. Some researchers agree that faith increases the body's ability to resist stress.

- ✓ **Hope:** Without hope (a positive attitude that an individual displays in difficult times) a lot of people become depressed and predisposed to illness.

- ✓ **Forgiveness:** Forgiveness is letting go of hostility and resentment from past hurts. Studies show that the ability to forgive oneself, and others, and the feeling that one is also forgiven by God, have favourable health effects. Some researchers indicate that emotions like anger and indignation cause stress hormones to accumulate in the blood, and that forgiveness decreases this build up.

- ✓ **Love and Social Support:** It has been found that having access to family and friends who give help and emotional support, protects against many diseases. Researchers believe that individuals who experience love and support tend to resist unhealthy behaviors and feel less stressed.

- ✓ **Prayer:** Many have come in contact with healing via the act staying in the presence of God or conversing with God. It is believed that prayer is an important part of daily life. In a poll, one half of doctors reported that they believe prayer helps patients, and 67% reported praying for a patient. Researches also opine that intercessory prayer (asking God to intervene on behalf of someone else, either known or unknown to the person praying) has advantages. Patients, who were prayed for, in comparison to those who were not prayed for, showed general improvements in the course of their illness. Less complications and lower death rates were also recorded (Ehrlich, 2011).

Quotes

- ✓ "God made the world for the delight of human beings----if we could see His goodness everywhere, His concern for us, and His awareness of our needs: the phone call we've waited for, the ride we are offered, the letter in the mail, just the little things He does for us throughout the day. As we remember and notice

His love for us, we just begin to fall in love with Him because He is so busy with us----you just can't resist Him. I believe there's no such thing as luck in life, it's God's love, and it's His." – Mother Teresa

Integrity

Introduction

Define integrity as:

- ✓ A concept of consistency of actions, values, methods, measures, principles, expectations, and outcomes.
- ✓ The honesty and truthfulness or accuracy of one's actions.
- ✓ Possession of firm principles: the quality of possessing and steadfastly adhering to high moral principles or professional standards.
- ✓ When a person says what they mean, means what they say, and does what they say they will do.
- ✓ Moral soundness; honesty; freedom from corrupting influence or motive.
- ✓ Firm adherence to a code of moral values, or the quality or state of being complete or undivided.

Integrity requires three steps:

- ✓ Discerning what is right and what is wrong.
- ✓ Acting on what you have discerned, even at personal cost.
- ✓ Saying openly that you are acting on your understanding of right from wrong.

Benefits of integrity

Integrity is beneficial because:

- ✓ When you follow your own moral compass and do what you know is right, you achieve a sense of completeness. If you disobey your own value system, you become divided, unbalanced, and uneasy.
- ✓ Integrity makes you trustworthy and enhances your relationship with others.
- ✓ People with integrity are well liked and they benefit from social support and other positive outcomes associated with enjoying close relationships with others.

Developing personal integrity

Personal integrity is the quality of being honest with yourself and others, and living a life that is aligned with your moral principles. Developing personal integrity requires examining your beliefs and value system, and taking conscious steps to behave in ways that are consistent with your personal moral code. You can develop personal integrity by:

- ✓ Identify aspects of your behaviour that require change.
- ✓ Face the obstacles that cause you to lie or violate your moral code.
- ✓ Practice truthfulness. Start by refraining from telling small, white lies.
- ✓ Make a list of tasks in which you will become more trustworthy.
- ✓ Listen to and respect the opinions and decisions of others.

Quotes

- ✓ "Integrity has no need of rules." – Albert Camus
- ✓ "Integrity is what we say, what we do, and what we say we do." – Don Galer

- ✓ “Lead your life so you wouldn’t be ashamed to sell the family parrot to the town gossip.” – Will Rogers
- ✓ “You’re a master of the words you don’t say and a slave to the ones you do.” – Unknown

Interactive session

- ✓ Discuss more on the importance and benefits of spirituality and how it can be applied in participants’ day-to-day lives.
- ✓ Discuss areas where participants are finding it difficult to maintain integrity and ways to improve on that.

COVENANT COPING SKILLS INTERVENTION PROGRAMME

Possibility Mentality

Introduction

Define possibility mentality as:

- ✓ A firm belief that nothing is impossible.
- ✓ Thinking creatively.
- ✓ Seeing a possibility in every idea.

The need for possibility mentality

Possibility mentality is necessary because:

- ✓ Whatever your mind can conceive, if you believe it's possible, you can achieve it.
- ✓ The journey to actualization in life is full of bumps and only individuals with possibility mentality can go through the rough ride and come out successfully.
- ✓ Possibility mentality births new, creative/innovative ideas. Almost everything we enjoy today was deemed impossible yesterday until someone with possibility mentality stepped into the picture.
- ✓ Possibility mentality enhances positive thinking, which enhances positive living.

Benefits of possibility mentality:

- ✓ Possibility mentality makes you a highly effective individual.
- ✓ You are able to overcome life's rejection with possibility mentality.

- ✓ Possibility mentality makes it possible for you to overcome intimidating and discouraging set backs.
- ✓ Possibility mentality enhances well-being because you are free from fear, anxiety, and worries about seemingly impossible situations.

How to develop possibility mentality

There are possibilities within your reach. Every day contains within it countless opportunities, all dictated by the choices you make. To develop possibility mentality, you need to:

- ✓ Challenge your beliefs about what you can and can't do.
- ✓ Challenge your ideas about how things should work.
- ✓ Replace negative thoughts with positive ones.
- ✓ Learn a new skill.
- ✓ Say yes to something you always talk yourself out of.
- ✓ Start something you always assumed it was too late to do.
- ✓ Look for opportunities in a tough situation.

Quotes

- ✓ "To get something you never had, you have to do something you've never done." – Unknown
- ✓ "The future is simply infinite possibility waiting to happen. What it waits on is human imagination to crystallize its possibility." – Leland Kaiser
- ✓ "The impossible is often the untried." – Jim Goodwin

Capacity Development

Introduction

Define capacity to mean:

- ✓ The ability to receive, hold, absorb.
- ✓ Ability to perform or produce; capability – the natural/practical ability necessary for doing something.
- ✓ The power to learn or retain knowledge; mental ability.
- ✓ Innate potential for growth, development, or accomplishment.

Define development as:

- ✓ The process of changing and becoming larger, stronger, more advanced, successful.
- ✓ A specified state of growth or advancement.

Define capacity development simply as:

- ✓ Advancing/growing/strengthening one's ability/capability.

Why capacity development is important and beneficial

Among others, capacity development:

- ✓ Makes you outstanding in a competitive environment.
- ✓ Gives you an edge over your contemporaries.
- ✓ Makes you competent and this enhances your confidence and self-concept and self-esteem.
- ✓ Makes you mentally active and sound.
- ✓ Creates an opportunity for you to positively affect your environment, which stirs in you positive feelings of fulfillment.
- ✓ Makes you relevant and useful.

How to develop one's capacity

- ✓ Identify your abilities/capabilities.
- ✓ Take steps towards personal development in the areas of your abilities/capabilities. Acquire skills and knowledge.

Interactive Session

- ✓ Discuss areas where participants have exhibited the "I can't" mentality and challenge such with possibility thought patterns.
- ✓ Discuss different areas of ability/capability of participants and skills/knowledge that can be acquired to develop/strengthen such areas.