

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

A COMPARATIVE STUDY OF THE
PSYCHOLOGICAL AND SOCIAL ADJUSTMENT
OF NON-INSTITUTIONALIZED AND
INSTITUTIONALIZED HIV/AIDS ORPHANS IN
ADDIS ABABA

BY

BEFIKADU EJETA



JUNE 2005

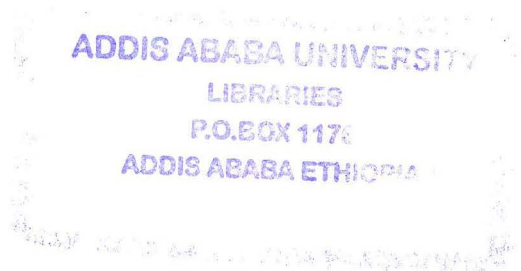
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A COMPARATIVE STUDY OF THE PSYCHOLOGICAL
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HIV/AIDS ORPHANS IN ADDIS ABABA

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THE DEGREE OF MASTER OF ARTS IN
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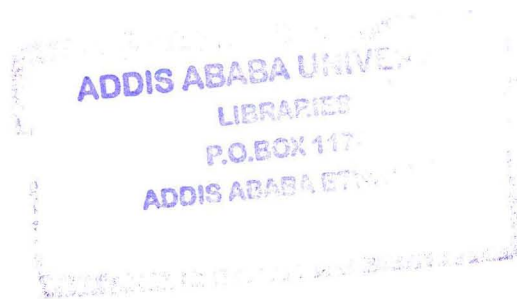


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Acronyms

| | |
|--------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| BDI | Beck Depression Inventory |
| HIV | Human Immunodeficiency Virus |
| MOLSA | Ministry of Labor and Social Affairs |
| OSSA | Organization for Social Services for AIDS |
| RCBS | The Revised Cheek and Buss Shyness Scale |
| RCMAS | The Revised Children's Manifest Anxiety Scale |
| SAD | Social Avoidance and Distress Scale |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNICEF | United Nations Children's Fund |

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Abstract

The main purpose of this study was to compare the psychological and social adjustment of non-institutionalized and institutionalized HIV/AIDS orphans in Addis Ababa.

94 HIV/AIDS orphans were selected from Organization for Social Services for AIDS (OSSA), Tesfa Berhan Ethiopia AIDS Orphans Association, Selam Children's Village and Kechene Children's Home using stratified random sampling.

Analysis of the data was made using quantitative methods. Independent t-test was run and mean comparison was made. Results of the study revealed that there was significant difference in both psychological and social adjustment between non-institutionalized and institutionalized HIV/AIDS orphans. In accordance with the findings and conclusions, recommendations were forwarded.

CHAPTER ONE

INTRODUCTION

1.1. Background of the Problem

The rate of HIV/AIDS infection is growing globally; however, Africa has the highest incidence of HIV infection in the world. That is, out of the total 40 million people living with HIV, 95% are said to be living in the developing world and among these, 71% (28.5 million) are found in sub-Saharan Africa. The rate at which the pandemic is spreading is also much higher in this region. In sub-Saharan Africa, Ethiopia is among the top most countries that are highly affected by the pandemic (UNAIDS, 2002).

One of the devastating consequences of the HIV/AIDS pandemic is the vast number of children it leaves orphaned. According to MOLSA (2004) about one million children have become orphans by losing the mother or both of their parents in Ethiopia up to the year 2003. HIV/AIDS starts to affect a child early in a parent's illness, and its impact continues through the course of the illness and throughout the child's development after the parent's death. Children who are deprived of the guidance and protection of their primary caregivers are therefore more vulnerable to health risks, violence, exploitation, discrimination and psychosocial adjustment problems (Children on the Brink, UNAIDS and UNICEF, 2004).

For the healthy development of children a caring environment that is characterized by love, care, support and protection is a must. Whereas the reality at orphanages is at such variance that the inmates, children experience worry, sadness, fear, depression, and hopelessness. This state of affair of the children starts during their parent's AIDS affliction period and gets accentuated at the orphanage where they end up after the death of both parents.

The immeasurable losses, the accompanying personal and social problems and the multiple responsibilities they undertake expose AIDS orphans to various social and psychological problems that are reflected in their adjustment levels. In fact, psychosocial problems start to surface on AIDS orphan children long before mothers' death. A study carried out in Zambia, for example, revealed that 82% of those caring for children noted changes in their behavior during parental illness. Parents noted that children become worried and sad, and they tried to help more in the home and stopped playing so as to stay near by. According to this study, children in households affected by AIDS were more likely to become solitary; to appear miserable or distressed, and to be fearful of new situations than were children in households not affected by the epidemic (Max E., et al., 2002).

Another case study on 193 children conducted in Raki District of Uganda by Sengendo & Nambi (1997) revealed that many children lost hope when their parents fell sick; some become desperate, worried or scared of the looming death of their parents.

The losses of the parents continue to afflict the children's developmental stages. For example, a study conducted in Zambia by Family Health International (2003) on 788 orphans concerning their emotional well-being revealed that orphans often had scary dreams or nightmares while others were sometimes unhappy. In addition, the study find out that some orphans were sometimes, or often, fighting with other children, desired to be alone and often were worried.

A study conducted in Ethiopia by Ministry of Labor and Social Affairs (2003) revealed that the mean score for emotional adjustment level of AIDS orphans was lower than that of the non-AIDS orphans. According to MOLSA, this lower level of emotional adjustment among AIDS orphans was reflected in the degree of unhappiness, worry, level of patience, fatigue, depression, and feeling of hopelessness and pessimism among AIDS orphans.

Another finding similar to emotional adjustment revealed that AIDS orphans have lower mean score on social adjustment level compared with the non-AIDS orphans group. Further analysis of the data indicated that AIDS orphan children manifested such behaviors as avoiding people, shyness, difficulty to talk to strangers, and distrusting other people.

Keeping in mind the above-mentioned problems HIV/AIDS orphans encounter, the current study attempts to compare the psychological and social adjustment of non-institutionalized and institutionalized HIV/AIDS orphans using a quantitative approach.

1.2. Statement of the Problem

This research is designed with an intention of finding answers to the following basic questions:

1. Is there significant difference in psychological adjustment between non-institutionalized and institutionalized HIV/AIDS orphans?
2. Is there significant difference in social adjustment between non-institutionalized and institutionalized HIV/AIDS orphans?
3. Is there sex difference in psychological adjustment between non-institutionalized HIV/AIDS orphans?

4. Is there sex difference in social adjustment between non-institutionalized HIV/AIDS orphans?
5. Is there sex difference in Psychological adjustment between institutionalized HIV/AIDS orphans?
6. Is there sex difference in social adjustment between institutionalized HIV/AIDS orphans?

1.3. Objective of the Research

General Objective

The general objective of the study is to see the psychological and social adjustment of the institutionalized AIDS orphans and the unique problems they encounter in comparison to non-institutionalized AIDS orphans.

Specific Objective

- to see whether there is or not significant difference in social and psychological adjustment between non-institutionalized and institutionalized HIV/AIDS orphans.
- to see whether there is or not sex difference in psychological and social adjustment between non-institutionalized HIV/AIDS orphans.
- to see whether there is or not sex difference in psychological and social adjustment between institutionalized HIV/AIDS orphans.

1.4. Significance of the Study

Some progress has recently been made in understanding the psychosocial impact of losing a parent to AIDS. Nevertheless, there is clearly a need for more rigorous and systematic quantitative research aimed at establishing whether AIDS orphans are in fact at risk for psychological and social adjustment difficulties. An understanding of the line of causality or

mediating processes for the psychological problems and the protective factors that might facilitate resilience and successful adjustment in children will help us to plan the strategies for suitable intervention programs.

For children, among the several causes leading to adjustment problems, parental loss is paramount. Therefore, our knowledge of the impact of parental death on children must be set. For this reason, it is hoped that this study will answer some of the questions and fill the gap in our knowledge of the forgotten, but the very important, group- children orphaned by HIV/AIDS.

In addition to pointing out areas of problems encountered by orphans, this study is also expected to indicate some factors that may specify the adverse out comes of losing a parent to HIV/AIDS. This body of research may be important for those involved in therapy and in counseling to know how to identify children who are at particular risk for psychosocial adjustment difficulties and to develop and improve prevention and intervention efforts for orphaned children.

Finally, it is hoped that the findings of this study and their implication may provide some important direction for conducting further researches in the areas of orphaned children due to HIV/AIDS.

1.5 Delimitation of the Study

The scope of this study is limited to the comparison of the psychological and social adjustment of 47 non-institutionalized AIDS orphans from OSSA and Tesfa Berhan

Ethiopia AIDS Orphans Association and 47 institutionalized HIV/AIDS orphans from Selam Children's Village and Kechene Children's Home aged 12–18 years in Addis Ababa.

1.6 Operational Definitions

Following is the definition of selected terms used in the study:

HIV/AIDS Orphans: - for the purpose of this study HIV/AIDS orphans are orphan children who lose both their mother and father to AIDS and are aged between 12 – 18 years.

Non-Institutionalized HIV/AIDS orphans: - are HIV/AIDS orphans who get care and support by different NGO's and government in the community (community based care and support) i.e. extended family, child-headed households or foster by non - relatives.

Institutionalized HIV/AIDS Orphans: - are HIV/AIDS orphans, who get care and support in institutions including children's home, children's village and orphanages.

Psychological Adjustment: Self-reported feelings, perceptions, or experience of children that reflect their feelings of sadness or hopelessness; stress and strain, anxiety and depression and satisfaction with personal life as measured by the Revised Children's Form of the Manifest Anxiety Scale, Beck Depression Inventory and Rosenberg's Self-esteem Scale.

Social adjustment: - self-reported perceptions of children as indicated by their social relationships at schools and in the community in relation to their social competence, shyness, loneliness and social anxiety and distress as measured by the Watson and Friend Social Avoidance and Distress Scale, the Revised Cheek and Buss Shyness Scale and Loneliness and Social Dissatisfaction Scale.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

The purpose of this chapter is to present a comprehensive review of research studies concerning the impact of parental death due to HIV/AIDS on children's psychological and social adjustments.

2.1 Stressors Facing AIDS Orphans

As indicated in *Children on the Brink* (2004), a joint report of USAID/UNICEF/UNAIDS, HIV/AIDS starts to affect a child early in a parent's illness, and its impact continues through the course of the illness and throughout the child's development after the parent's death.

The death of the parent leads to a crisis for any child, as it means losing the love, support, guidance, stability and security that parents ideally provide, as well as losing a link with the past and the possibility of a shared future (Dane, 1997; Fleming, 1994). Clinical reports suggest that the process of grieving may be difficult for AIDS orphans, because it is complicated by a set of material and psychological stressors which often accompany the parent's illness and death.

2.1.1. Economic Deprivation and Disrupted Schooling

Both in developing and developed countries HIV/AIDS have a disproportionate impact in the communities of poverty (Taylor et al., 1999). Most of the families have a hand to mouth existence in sub-Saharan Africa. Therefore, when a breadwinner in these communities falls

ill, their families face a loss of even the meager income they have as well as are pushed to meet expenses incurred in the care of the patient. If the illness is prolonged, the family is likely to become destitute by the time the parent eventually dies, and children may be left with out any inheritance what so ever (McKerrow, 1995).

Orphans who are subsequently taken in by relatives or community members are thus likely to place financial strain on the household, resulting in reduced access to resources. Others may end up in child-headed, impoverished households or on the streets. AIDS orphans are therefore likely to be at risk for having inadequate access to food, shelter, clothing and health care (Foster et al., 1997; Hunter, 1990; MOLSA, 2003). They may also be forced to leave school in order to go out to work, to stay at home to take care of the home, younger siblings, or ill person, or because their family can not afford school fees or uniforms (Sengendo and Nambi, 1997; Taylor et al., 1999). These factors in turn are likely to place orphans at risk for abuse, exploitation and engaging in dangerous lifestyles such as prostitution as they attempt to provide for themselves and their families (Cook, 1998).

2.1.2 Multiple Losses

Because HIV is sexually transmitted most of the time, children who lose one parent to AIDS are at considerable risk of losing their other parent as well. They may also lose young siblings who acquired HIV prenatally. Once parents die, children are likely to be moved from the family home, and may be relocated to another area and school, thus depriving them of friendship and neighborhood networks and predictable surroundings (Dane, 1997). They may also be separated from their siblings if their foster families do not have the resources to care for large number of children (Geballe and Gruendel, 1998). Some orphans

may subsequently undergo to experience the death of a second set of elderly or sickly foster parents, and be relocated to a third home (Hunter, 1990). Thus, AIDS orphans are at risk for experiencing multiple losses.

2.1.3 Disturbing and Uncertain Clinical Course of the Illness

AIDS is inevitably fatal; patients often experience a period of prolonged chronic illness before death occurs. The clinical course of this illness is uncertain and unpredictable, involving crises period interspersed with days and months of wellness (Fleming, 1994; UNAIDS, 1999). Children whose parents die of AIDS experienced disrupted routines, unscheduled absences of their parent from the home due to hospitalization, and periods of formal fostering by persons other than parents (Geballe and Gruendel, 1998). As the illness progresses, many children are also likely to have witnessed their parents undergoing profound and distressing physical, behavioral, cognitive and emotional aberrations, often including severe debilitation (Andiman, 1995).

2.1.4 Lack of Adequate Care and Control

Geballe et al., (1995) argue that parents struggling with their own disease/or with disease in their partners and children are likely to have great difficulty in providing their uninfected children with a "secure base". Denial, anxiety, depression and anger are common reactions in people diagnosed with a life-threatening disease, and are likely to be exacerbated by the social stigma attached to HIV/AIDS and the parent's feelings of guilt and anxiety about "abandoning" their children when they die.

Parents also have been found to alternate between overprotecting their children in an effort to compensate for their perceived failures, and distancing themselves from their children as a way of reducing the intensity of their feelings (Taylor et al., 1999). Moreover, as the disease progresses, parents are likely to become periodically incapacitated, hospitalized, and unable to care for their children. A study of adolescents in families with AIDS in New York (Hudis, 1995) found that parents reported decreasing influence over their adolescents' behavior as their illness progressed, in part because they become less able to supervise, and in part because they feared that disciplining would threaten their already fragile relationship with their adolescent children.

Other adults in families affected by AIDS may also find it difficult to provide uninfected children with consistent guidance and support, as the exigencies of the disease require them to focus more and more attention on the ill persons, and less on those who are not physically impaired (Andiman, 1995). Particularly when multiple family members are infected, illness and death can preoccupy the family over a period of several years (Karlenza, 1998). In some cases normal parent-child roles may be reversed, as older children and adolescents assume responsibilities such as taking care of the ill parent, home and younger siblings (Dane, 1997; Geballe & Gruendel, 1998). Some orphans may continue to live in child-headed households when their parent dies; others may be taken care of by elderly caregivers or extended families stressed by large numbers of orphans. These very old, young, and overburdened caretakers may struggle to provide orphans with adequate support and supervision, particularly if they also have to deal with their own grief (Dane, 1994; Hunter, 1990).

2.1.5 Stigma, Secrecy and Social Isolation

AIDS is commonly viewed as a punishment for "immoral" life styles such as promiscuity, homosexuality and drug use. Additionally irrational fear of contagion prevails (Taylor et al., 1999). Persons with AIDS, their partners and children may be rejected by their extended family, friends and/or by society at large. For these reasons, they may cut themselves off from social support networks (Nagler et al., 1995).

Some children may be lied to, or not told about, the cause of their parent's illness and death. Others may be aware of the diagnosis, but be required-or choose to keep it as a secret (Dane, 1997). A New York study (Hudis, 1995) found that very few parents had chosen to reveal their HIV status outside the family. Although this "conspiracy of silence" is understandable given the stigma that still surrounds AIDS, it can leave AIDS orphans without anyone with whom to share their feelings and fears (Pivnick & Villegas, 2000), heighten their feelings of being "different" from other children and associate their loss with a sense of shame.

2.2. Psychosocial Impact of HIV/AIDS on Children

Affected and orphaned children are often traumatized and suffer a variety of psychological reactions to parental illness and death. In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatization as it is either assumed that they too are infected with HIV or that their family has been disgraced by the virus. Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health. Existing studies of

children's reactions suggest that they tend to show internalized rather than externalized symptoms in response to such impacts-depression, anxiety and withdrawal - as opposed to aggression and other forms of anti social behaviors (Sengendo & Nambi, 1997).

Research is depicting a reality of worry, sadness, fear, and hopelessness among children and adolescents during their parent's HIV/AIDS illness and death and, subsequently, in orphanage.

2.2.1 Children of Parents Living with HIV/AIDS

As mentioned above children whose parents are ill because of HIV/AIDS become worried, feel sad, and they try to help in the home and stop playing so as to stay near by the sick parent. In addition children whose parents are ill due to HIV/AIDS face stigma and discrimination as one 16-year-old South African put it:

"They treat you badly. You do not feel like walking in the street, they give you names. They whisper when you pass. They take it that when one person in the house is sick, all of you in that house are sick." (Save the children UK, 2001).

Children in households affected by HIV/AIDS were more likely to become solitary; to appear miserable or distressed, and to be fearful of new situations than were children in house-holds not affected by the epidemic (Sengendo & Nambi, 1997).

This implies that psychosocial problems start to surface on AIDS orphan children long before mothers' and fathers' death. A study carried out in New Orleans on children whose mothers were infected with HIV/AIDS revealed that the children demonstrated difficulties

in four areas of psychosocial adjustment: externalized problems such as aggression and disruptive behavior; internalizing problem behaviors like depression and anxiety, pro-social competence including peer relationship; and cognitive competence as demonstrated in their academic performance (Forehand, 2002).

Generally, as HIV infection progresses from initial infection to mild HIV-related illness to the life-threatening stage of the illnesses, children live with a long period of uncertainty and intermittent crises, as both parents slowly sicken and die. So in Sub-Saharan Africa, where effective remedy for pain or other symptoms is often unavailable children who live through their parent's pain and illness frequently suffer from depression, stress and anxiety.

2.2.2 Research on Psychological and Social Adjustment of HIV/AIDS Orphans after Parental Death

The impact of HIV/AIDS does not stop at parent's illness it continues after their death also. John Williamson (2000) says:

The common impacts of HIV/AIDS include deepening poverty, pressure to drop out of school, food insecurity, reduced access to health services, deteriorating housing, worsening material conditions, and loss of access to land and other productive assets. Psychosocial distress is another impact on children and families, and it includes anxiety, loss of parental love and nurture, depression, grief, and separation of siblings among relatives to spread the economic burden of their care.

The loss of parents and loved ones is associated with internalized psychological conditions including anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem (Tremblay & Israel, 1998).

Children react to stress in different ways. Many will find it difficult to talk about their worries. They internalized their feelings and stress, believing that they are abnormal in some way, and suffer from low self-esteem, depression or anxiety. In this line a study conducted in suburbs of Dares Salaam, Tanzania by Makame & Grantharm (2002) compared 41 orphans (mostly double orphans) with 41 matched non-orphans aged 10 to 14 years. Orphans scored higher than non-orphans on a semi-structured questionnaire that assessed internalized problems. Nearly three times as many orphans say they had contemplated suicide in the last year. Going to bed hungry and not going to school were independently related to internalizing problems and accounted for some but not all of the association with the orphan hood: orphans still had significantly higher internalizing problems. The authors noted that orphans who were living with a surviving parent or with adult relatives had the lowest scores, and girls tended to have the most internalized problems.

Separation from siblings is another source of trauma. Even older children are distressed by separation. Of a group of older orphans in Uganda separated from their siblings, 44 percent said that they felt sad about it and 17 per cent said it made them feel isolated (Gilborn, 2001).

One can observe lack of capacity for intimacy and responsibility to others, poor peer relations; lack of problem solving skills; failure to recognize adults who may assist in problem solving, risky behaviors, and emotions of anger, resentment, hopelessness and depression in HIV/AIDS orphans. In this line Poulter (1997) concluded children felt worried and sad when parents were not well. In addition his work revealed that children in affected homes were significantly more likely to worry about many things, be fearful of new things or situations, do things alone, and appear unhappy, tearful, and miserable, distressed.

All these studies imply that children understand the nature of loss but may not directly express their worries and anxieties. They may feel resentment and anger at the death of a parent or close family member. They may seem to be coping, but at the same time they can experience depression, hopelessness, and increased vulnerability. This can lead to a sense of alienation, desperation, risk-taking behavior and withdrawal.

Psychosocial trauma can continue even when orphans move to foster families. They may be treated as second-class members, discriminated against in the allocation of food, perhaps, or in the distribution of work. To this end in his psychological assessment Forehand (2001) found that about one quarter of HIV/AIDS orphans presented psychological troubles: approximately eight per cent of all orphans presented affective disorders (depression, anxiety, irritability, and hyper-aggressiveness), 11-15 percent presented adaptive disorder (leaving home or school, delinquent behaviors, and drug addiction), and 6 percent with symptoms of posttraumatic stress disorder. More double than single orphans were affected.

2.3 Cares for HIV/AIDS Orphans

Care for orphans can be classified in to two broad categories:

- a) Household - based care and
- b) Institutional care

2.3.1. Household - Based Care

Throughout Sub-Saharan Africa, fostering within family lines still remains the most common safety net for the care of orphans. For example in Rural Tanzania, 95% of the orphans were taken care of by relatives. A similar pattern was found in Uganda and Zambia (Deininger et al., 2002).

By staying with known relatives and other children, orphans may grow up in a more stable and secure environment favoring their psychological, intellectual and social development. However, they may be discriminated in basic needs allocation (e.g. food, education, and clothing) because foster parents may favor their biological children first, either because of the resource depletion effect (i.e. the decrease in per capita house hold resources following the entry of orphans in the household).

2.3.1.1 Living with the Surviving Parent

The surviving parent is usually the principal caregiver. However, single orphans do not always remain with their living parent. Often the death of one parent, especially the mother, is followed by dissolution of the family. This practice is quite common through out Sub-Saharan Africa and has been increasing significantly for maternal orphans during the last decade. For example in 2000, 73% of maternal orphans and 29% of paternal orphans were not living with their surviving parents in Malawi (Case et al., 2002).

2.3.1.2 Care Provided by the Extended Family

Single orphans who are not taken care of by their surviving parent and double orphans are usually absorbed by their extended families. With the rapid spread of HIV/AIDS epidemic some changes are taking place. Uncles / Aunts, the traditional first choice as substitute caregivers, are less available - either because they are themselves victims of AIDS or because they are now more reluctant to foster orphans-usually forcing grandparents and older orphans to take on this new role (Foster et al., 1996).

In many settings, grandparents appear to be the most common caregivers. In Northern Uganda, 22% of the orphans were taken care of by their grand parents, while in rural Tanzania; the proportion was 43% (Ntozi et al., 1999). Although grandparents may provide a securing and loving environment that helps children to socialize, they may have difficulties responding to children's psychological, legal, economic, and basic needs.

A non-negligible proportion of orphaned children are also taken care of by older orphans. This is the situation with 7% of the cases in rural Tanzania, and almost 20% in Northern Uganda (Ntozi et al., 1999). Although, this later figure is quite high and does not represent the general situation elsewhere, one must recognize that child-headed families are becoming more & more visible. A survey conducted on 43 orphan heads in Manicaland, Zimbabwe (Foster et al., 1997) helps understanding the reasons attached to the establishment of such households. The most frequent reasons expressed were (1) there were no known relative in the family able to take care of the children, (2) the relatives did not want to take care of the orphan children and, (3) the children did not want to move to the homes of the relative's. By

avoiding being split-up between various relatives, and being able to stay in their home in familiar surroundings, children may face less emotional and psychological trauma.

2.3.2. Institutional Care

World wide, institutional care is quite limited: according to MacLeod (2001), only 1 to 3% of the orphans are cared for in institutional settings (can reach 5% in some specific zones). With sharp increase in orphans in Africa, in the process of de-institutionalization, new and innovative forms of institutional or semi-institutional care have emerged, such as children's homes and children's villages.

2.3.2.1. Children's Home

This type of care consists of having a paid and usually trained foster mother living with a group of orphans (generally 4 to 6 children) in an ordinary home (rather than an institutional building) within the community. Children with a family-like setting and a trained mother get basic needs, safety, and psychological needs may be met (Kalanidhi, 2003).

2.3.2.2 Children's Village

Different concepts of "children's villages" have emerged in the recent past. One developed by "SOS children's village" consists of the gathering of about 10 to 20 houses, which form a community and provide a family - like setting for vulnerable children. Children grow up in conditions comparable to that of "normal families" in the sense that biological siblings are not split up, children of different ages and gender are becoming brothers and sisters, all are enrolled in public schools and are strongly encouraged to maintain contacts with the community (Kalanidhi, 2003).

Children's village seems to meet most of orphan's basic & economic needs; uncertainties remain on whether or not psychological and safety needs are met.

2.3.2.3. Orphanages

In this setting, orphans are taken care of by social workers, and are provided with basic needs such as shelter, food, clothes and education. Interaction with the community is not very common, especially when children are sent to the orphanages school rather than to the public school (Kalanidhi, 2003).

2.4. Research on the Psychological Effects of Orphanage Care

Children in residential care often lose their connections to their families, clans and friends. This alienation, coupled with inadequate and inconsistent attention to developmental needs, especially of small children, leads to stunting of social and intellectual development.

As residential care facilities are usually established in urban centers or isolated rural locations, they typically prevent connection between children and their clans. The stigma associated with residence in such a facility, and the separation of the child from the community, also hinders reintegration of children when they leave. In this respect Altshuler & Poertner (2002) studied 63 adolescents living in-group homes (institutions) in Illinois and concluded youths living in group home or institutions take more risks, have more threats to achievement and have poorer peer influences.

Colton (1992) compared 12 children from orphanage to 12 children from specialized foster homes aged 12 years and above and concluded that residential caregivers were found to

make far greater use of inappropriate and ineffective techniques of control than special foster parents. In addition his work revealed that the orphanages were generally found to be markedly less child-oriented than the special foster homes.

Such findings appear to confirm that the role of residential caregivers involves a heavy emphasis on control and supervision; they further suggest that a greater degree of familiarity, reciprocity and social closeness characterized relations between special foster parents and foster children than existed between residential caregivers and the youngsters they looked after.

Tizard & Hodges (1978) compared 65 institutionalized and non - institutionalized children. Their study revealed that significant differences were found between institutionalized children and their non-institutionalized counterparts on total problem behaviors and anti-social scores. Deviations included restless behavior, poor peer relations, disciplinary problems and disruptive attention seeking behavior among children who had been institutionalized.

So one can say that despite great improvements, these institutions have so far been unable to provide children with long-term stable, affectionate relationship that are essential to later social relations. To this point Youngleson (1973) compared 24 institutionalized children and a matched control group aged 15 & 17 years. The data gleaned from the social adjustment inventory confirmed that institutionalized children are less well adjusted and that they manifest less self-esteem compared with a control group. Available literature also

suggests that institutionalization have impact on the psychological functioning of children after they leave the institution and also on their adult life (later life).

CHAPTER THREE

METHODOLOGY AND DESIGN OF THE STUDY

The procedures for selecting subjects, developing measurement instruments, data collection and analysis are described in this chapter.

3.1. Procedure of Selecting Subjects of Study

The population for this study consists of HIV/AIDS orphans from two groups: non-institutionalized and institutionalized HIV/AIDS orphans. The populations for non-institutionalized HIV/AIDS orphans are orphans who get care and support from Organization for Social Services for AIDS (OSSA) and Tesfa Berhan Ethiopia HIV/AIDS Orphans Association.

The Organization for Social Services for AIDS (OSSA) Addis Ababa Main Branch give community based care and support for 720 HIV/AIDS orphans and Tesfa Berhan Ethiopia for 690 HIV/AIDS orphans. For the purpose of this study these HIV/AIDS orphans were stratified based on their age and the period of their parental death.

Accordingly children aged 12-18 years and only those whose parents died 2-6 years ago were taken for this study. To get the period of parental death of HIV/AIDS orphans a screening questionnaire which asks when their parents died were distributed to double orphans aged 12 -18 years based on their personal data available at both organizations.

As a whole the screening questionnaire revealed that among the 250 HIV/AIDS orphans aged 12-18 who are double orphans from OSSA and 230 from Tesfa Berhan Ethiopia HIV/AIDS Orphans Association 115 and 86 said that their parents died 2-6 years ago

respectively. Once the tasks of screening procedure had been accomplished, applying simple random sampling techniques made the final choice of subjects in both these organizations. As a whole, a total of 47 HIV/AIDS orphans were selected by taking 26 and 21 HIV/AIDS orphans from OSSA and Tesfa Berhan Ethiopia HIV/AIDS Orphan Association respectively for non - institutionalized HIV/AIDS orphans.

The populations for institutionalized HIV/AIDS orphans are orphans living in Selam Children's Village and Kechene Children's Home. There are 90 HIV/AIDS orphans living with other orphans in Selam Children's Village and 10 female HIV/AIDS orphans in Kechene Children's Home. For the purpose of this study 42 HIV/AIDS orphans based on age and period of their parents death were taken by screening their personal data found in the village from Selam Children's Village and 5 female HIV/AIDS orphans from Kechene Children's Home using purposive sampling.

Table 1 below shows the number of participants with mean and standard deviations of their age

| Subjects | Sex | No | Age | |
|---|-----|----|-------|------|
| | | | Mean | SD |
| Non-Institutionalized HIV/AIDS orphans | M | 24 | 14.83 | 1.60 |
| | F | 23 | | |
| Institutionalized HIV/AIDS orphans | M | 23 | 14.62 | 1.52 |
| | F | 24 | | |

3.2 Instruments Used for Data Collection

The instruments used to collect data from subjects have two major parts.

3.2.1 Demographic Questionnaire

In this part of the instrument items were prepared in such a way that they would cover some areas the study aimed to assess in addition to the scales adopted and mentioned below. As part of the study the demographic questionnaire includes age, sex and background information of the subject's parents. In addition there are certain questions that assess the problems HIV/AIDS orphans face to supplement the psychological and social adjustment measure scales adopted.

3.2.2. Psychological and Social Adjustment Measures

Psychological and social adjustment are dependent variables where as residence and sex are independent variables.

3.2.2.1. Psychological Adjustment Measures

The first indicator of adjustment status of HIV/AIDS orphans used in this study is psychological adjustment, which covers the components of measures of psychological distress, namely, self-esteem, depression, and anxiety. Self - esteem was measured by Rosenberg's self-esteem scale (10 items) that asks respondents to indicate their perceptions of themselves in positive or negative ways.

Depression was measured by Beck Depression Inventory (BDI) (20 items) taken from Tabachinck et al., (1983) which center on the feeling of dissatisfaction with one self and ones ability to achieve desired outcomes. Finally psychological distress and anxiety were

measured by the Revised Children's Manifest Anxiety Scale (RCMAS) that consists of 15 items that center on behavioral expressions of internal anxiety or emotionality such as nervousness, tension, and worry.

Therefore, measure of psychological distress scale, which we labeled psychological adjustment, is a summed scale of these three measures that provide a pool of 45 items. Items were statements to which HIV/AIDS orphans responded on a 5- point scale ranging from 1 (strongly disagree) to 5 (strongly agree).

3.2.2.2. Social Adjustment Measures

The other indicator of HIV/AIDS orphans well-being, which we labeled social adjustment, is made by aggregating various subscales that assess orphan's self-perceptions regarding their social experiences.

Accordingly, the components covered by the items were that deal with subjects' perceptions of their social peer relations, with regard to sociability, perceptions of their social competence, intimacy of friendship, shyness, and feeling of dissatisfaction with peer relationships. So the measures were: (a) The Watson and Friend Social Avoidance and Distress Scale (SAD) contains 10 items taken from Jones et al., (1986) which center on the anxiety, tension, and distress provoked by social encounters and on a desire to escape from or avoid such situations; b) Shyness and Sociability (14 items) by the Revised Cheek and Buss Shyness Scale (RCBS) developed by Cheek and Buss and that assess the construct of shyness broadly and orphans' perceptions of their social competence; and (c) Loneliness and Social Dissatisfaction Scale (11 items) taken from Asher et al., (1984) that describes

loneliness in terms of a subjectively felt discrepancy between the kinds of relationships that individual perceives himself as having and what he would like to have.

As a whole, these three scales provide a pool of 35 items. These items were statements to which orphans responded to each item on a 5-point scale, indicating the degree to which each statement is a true description of themselves which range from 1 (not at all true about me) to 5 (always true about me).

Finally the scales were translated into Amharic and back to English and given to three experts to know about its applicability to local population.

3.3 Pilot Testing

Pilot testing was made on 20 subjects for the purpose of determining the reliability of the scales. Accordingly the selected 80 items (translated into Amharic) were tried on 10 non-institutionalized and 10 institutionalized HIV/AIDS orphans. No time limit was made for the completion of the questionnaire. Finally the responses of the subjects were scored for both scales and their reliability were assessed by computing Cronbach Alpha. The two measures proved to be reliable with $\alpha = 0.872$ and $\alpha = 0.816$ for psychological adjustment and social adjustment, respectively.

Finally orphans' responses to psychological adjustment measure items were summed to yield total scale score that could range from 45 (higher psychological adjustment problem) to 225 (lower psychological adjustment problem). And 35 items for social adjustment measures range from 35 (indicating greater difficulty in social Adjustment) and 175 (lower difficulty in social adjustment).

3.4 Data Collection Procedure and Analysis

Data Collection

After identifying our target subjects, data was collected by the researcher and four other assistants who were counselors and caregivers of HIV/AIDS orphans. The participants were assured that information obtained will remain confidential and not be used for other unintended purposes. Targeted HIV/AIDS orphans were followed to their respective service giving organizations and the researcher and research assistants administered the questionnaire by reading instructions, answering questions, and finally collecting the completed forms. Orphans were not allowed to write their names on the questionnaire.

Scoring of the responses of the two adjustment measures received the same weight, and total score for each measure were obtained by adding up the numerical value of the responses. Then, each respondent's total score for each test was used in subsequent analyses.

Data Analysis

The data collected to measure the psychological, social adjustment of HIV/AIDS orphans was organized in line with the objective of the study, and SPSS 10.0 for windows was applied.

As explained earlier, the subjects investigated in this study constitute HIV/AIDS orphans from two groups. The research questions were concerned with the comparison of non-institutionalized and institutionalized HIV/AIDS orphans, sex, and the two adjustment variables, so t-test was run and mean comparison was taken.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1. Results

This chapter presents the results of the main study in terms of the basic questions, which the study has set out to test. The findings are presented in two main sections. The first part deals with the demographic information. The second part of the chapter deals with the relationship between, residence, sex, and the two adjustment variables.

4.1.1. Demographic/ Background Information

Table 2. Age and Gender of HIV /AIDS Orphans

| Demographic Variables | | Non -Institutionalized HIV/AIDS orphans | | Institutionalized HIV/AIDS orphans | | Total | |
|-----------------------|-------------|---|-------|------------------------------------|-------|-------|-------|
| | | N | % | N | % | N | % |
| Sex | Male | 24 | 51.06 | 23 | 48.94 | 47 | 100 |
| | Female | 23 | 48.94 | 24 | 51.06 | 47 | 100 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| Age | 12-14 years | 28 | 59.57 | 26 | 55.32 | 54 | 57.45 |
| | 15-18 years | 19 | 40.43 | 21 | 44.68 | 40 | 42.55 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| | Mean Age | 14.83 | - | 14.62 | - | - | - |

A total of 94 non-institutionalized and institutionalized HIV/AIDS orphans were surveyed of which 50% were female and 50 % male. Concerning their age 59.57% non-institutionalized and 55.32% institutionalized HIV/AIDS orphans were 12-14 years old and 40.43% non-institutionalized and 44.68% institutionalized HIV /AIDS orphans were 15-18

years old. The mean age for non-institutionalized HIV/AIDS orphans was 14.83 and 14.62 for institutionalized HIV/AIDS orphans.

Table 3. Child -Guardian Relationship

| Demographic Variables | | Non-Institutionalized HIV/AIDS orphans | | Institutionalized HIV/AIDS Orphans | | Total | |
|---|--------------|--|-------|------------------------------------|-------|-------|-------|
| | | N | % | N | % | N | % |
| What is the relationship to your guardian? | Aunt | 5 | 10.64 | - | - | 5 | 10.64 |
| | Uncle | 6 | 12.77 | - | - | 6 | 12.77 |
| | Grandmother | 15 | 31.91 | - | - | 15 | 31.91 |
| | Grand father | 8 | 17.02 | - | - | 8 | 17.02 |
| | Sister | 6 | 12.77 | - | - | 6 | 12.77 |
| | Brother | 2 | 4.26 | - | - | 2 | 4.26 |
| | Neighbor | 2 | 4.26 | - | - | 2 | 4.26 |
| | Cousin | 3 | 6.38 | - | - | 3 | 6.38 |
| | Institution | - | - | 47 | 100 | 47 | 100 |
| Total | 47 | 100 | 47 | 100 | 94 | 100 | |
| How do you get along with your guardian (care giver)? | Very well | 16 | 34.04 | 17 | 36.17 | 33 | 35.10 |
| | Well | 20 | 42.55 | 19 | 40.43 | 39 | 41.50 |
| | Poorly | 9 | 19.15 | 8 | 17.02 | 17 | 18.10 |
| | Very poorly | 2 | 4.26 | 3 | 6.38 | 5 | 5.30 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| How do you feel about being separated from your brothers/sisters or other children? | Sad | 20 | 42.55 | 25 | 53.19 | 45 | 47.85 |
| | Worried | 6 | 12.77 | 9 | 19.15 | 15 | 16.00 |
| | Angry | 2 | 4.26 | 3 | 6.38 | 5 | 5.30 |
| | Scared | 7 | 14.89 | 6 | 12.77 | 13 | 13.85 |
| | Isolated | 4 | 8.51 | 4 | 8.51 | 8 | 8.50 |
| | Happy | - | - | - | - | - | - |
| | Total | 39 | 82.98 | 47 | 100 | 86 | 91.50 |

When non-institutionalized HIV/AIDS orphans were asked how they were related to their guardian, 10.64% of the children stated that their guardian was their aunt 12.77% said that it was their uncle, 31.91% said it was their grandmother, 17.02% stated it was their grand

father 12.77% said it was their sister, 4.26% stated it was their brother, 4.26% said it was their neighbor and 6.38% their cousin.

When asked how they feel being separated from their brothers/sisters 42.55% and 53.19% non – institutionalized and institutionalized HIV/AIDS orphans said they were sad, 16.00% worried, 5.30% angry, 13.85% scared and 8.50% isolated. 35.10% HIV/AIDS orphans got along very well with their guardian, 41.50% got along well with their guardian, 18.10% poorly, while 5.30% got along very poorly with their guardian.

Table 4. Emotional Well – being of HIV/AIDS orphans

| Demographic variables | | Non-institutionalized HIV/AIDS orphans | | Institutionalized HIV/AIDS orphans | | Total | |
|--|-----------|--|-------|------------------------------------|-------|-------|-------|
| | | N | % | N | % | N | % |
| How often would you say that you have scary dreams? | Often | 11 | 23.40 | 15 | 31.92 | 26 | 27.70 |
| | Sometimes | 20 | 42.56 | 21 | 44.68 | 41 | 43.53 |
| | Never | 16 | 34.04 | 11 | 23.40 | 27 | 28.77 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| How often would you say that you ever feel unhappy? | Often | 10 | 21.28 | 13 | 27.66 | 23 | 24.47 |
| | Sometimes | 21 | 44.68 | 22 | 46.80 | 43 | 45.70 |
| | Never | 16 | 34.04 | 12 | 25.54 | 28 | 29.83 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| How often would you say that you prefer to be alone, instead of playing with others? | Often | 10 | 21.28 | 13 | 27.66 | 23 | 24.47 |
| | Sometimes | 21 | 44.68 | 22 | 46.80 | 43 | 45.70 |
| | Never | 16 | 34.04 | 12 | 25.54 | 28 | 29.83 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| How often would you say that you ever feel worried? | Often | 13 | 27.66 | 11 | 23.40 | 24 | 25.54 |
| | Sometimes | 24 | 51.06 | 21 | 44.68 | 45 | 47.83 |
| | Never | 10 | 21.28 | 15 | 31.92 | 25 | 26.63 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| How often do you feel happy? | Often | 8 | 17.02 | 6 | 12.77 | 14 | 14.90 |
| | Sometimes | 18 | 38.30 | 18 | 38.30 | 36 | 38.40 |
| | Never | 21 | 44.68 | 23 | 48.94 | 44 | 46.70 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |
| How often do you feel hopeful? | Often | 9 | 19.15 | 12 | 25.54 | 21 | 22.34 |
| | Sometimes | 25 | 53.19 | 23 | 48.93 | 48 | 51.06 |
| | Never | 13 | 27.66 | 12 | 25.54 | 25 | 26.60 |
| | Total | 47 | 100 | 47 | 100 | 94 | 100 |

Some questions aimed at supplementing to the two measures of adjustment variables were asked. Each of the questions was set up to measure a range of possible experiences from "Never" to "often."

Accordingly 23.40% non-institutionalized and 31.92% institutionalized AIDS orphans often had scary dreams, 42.56% non-institutionalized and 44.68% institutionalized AIDS orphans sometimes had scary dreams or nightmares. 21.28 percent non-institutionalized and 27.66 percent of the institutionalized HIV/AIDS orphans were often unhappy. While 44.68% non-institutionalized and 46.80% institutionalized AIDS orphans sometimes unhappy.

When asked how often they prefer to be alone, instead of playing with other children 21.28% of non-institutionalized HIV/AIDS orphans and 27.66% of institutionalized HIV/AIDS orphans often prefer to be alone. 44.68% non-institutionalized and 46.80% institutionalized AIDS orphans sometimes prefer to be alone.

27.66 percent of non-institutionalized and 23.40 percent of institutionalized HIV/AIDS orphans responded they were often worried. 51.06% non-institutionalized and 44.68% institutionalized AIDS orphans were sometimes worried. Finally when they asked how often they feel hopeful, 72.34% non-institutionalized and 74.47% of institutionalized HIV/AIDS orphans some times or often hopeful. Close to 27.66% of non-institutionalized and 25.54% of institutionalized HIV/AIDS orphans were never hopeful respectively.

4.1.2. Residential Difference in Social and Psychological Adjustment

One of the purposes of this study was to investigate whether or not there is significant difference in social and psychological adjustment between non-institutionalized and institutionalized HIV/AIDS orphans. The results obtained were presented as follows.

Table 5. Means and Standard Deviations for Psychological and Social Adjustment by Residence

| Residence | | Psychological Adjustment | Social Adjustment |
|---|----------------|--------------------------|-------------------|
| Institutionalized HIV/AIDS orphans | Std. deviation | 36.36 | 20.20 |
| | Mean | 128.62 | 105.74 |
| | N | 47 | 47 |
| Non- Institutionalized HIV/AIDS orphans | Std. deviation | 16.12 | 12.02 |
| | Mean | 153.11 | 116.87 |
| | N | 47 | 47 |
| Total | Std. deviation | 30.56 | 17.45 |
| | Mean | 140.86 | 111.31 |
| | N | 94 | 94 |

As indicated in table 5 above the mean score of institutionalized HIV/AIDS orphans on psychological adjustment measure (128.62) as well as social adjustment measures (105.74) is lower than non-institutionalized HIV/AIDS orphans (153.11 and 116.87) respectively, implying institutionalized orphans have higher psychological adjustment problem and greater difficulty in social adjustment.

Table 6. Psychological Adjustment Difference between non-institutionalized and institutionalized HIV/AIDS orphans

| Residence | N | Mean | Std. deviation | t | df | Sig(2-tailed) |
|--|----|--------|----------------|-------|----|---------------|
| Non-institutionalized HIV/AIDS orphans | 47 | 153.11 | 36.36 | 4.22* | 92 | .000 |
| Institutionalized HIV/AIDS orphans | 47 | 128.62 | 16.12 | | | |

* *t*-value is significant at the 0.05 level (2-tailed)

In order to determine residential difference in psychological adjustment independent t-test analysis is used. Thus table 6 above shows, statistically significant residential difference in psychological adjustment ($t(92) = 4.22, p < 0.05$). In other words, institutionalized HIV/AIDS orphans showed more psychological adjustment problems than non-institutionalized HIV/AIDS orphans.

Table 7. Social adjustment difference between non-institutionalized and institutionalized HIV/AIDS orphans.

| Residence | N | Mean | Std. Deviation | t | df | Sig(2-tailed) |
|--|----|--------|----------------|-------|----|---------------|
| Non-institutionalized HIV/AIDS orphans | 47 | 116.87 | 12.02 | 3.25* | 92 | .002 |
| Institutionalized HIV/AIDS orphans | 47 | 105.74 | 20.02 | | | |

* *t*-value is significant at the 0.05 level (2-tailed).

Table 7 shows statistically significant residential difference in social adjustment ($t(92) = 3.245, p < 0.05$). It means similar to psychological adjustment institutionalized HIV/AIDS orphans showed greater difficulty in social adjustment than non-institutionalized HIV/AIDS orphans.

4.1.3. Sex Difference in Psychological and social Adjustment

The other objective of the study was to see whether or not there is sex difference in psychological and social adjustment. Thus in order to determine sex difference in psychological and social adjustment independent t- test analysis is used and presented as follows.

Table 8. Sex Difference in Psychological Adjustment between Non-institutionalized AIDS Orphans

| Sex | N | Mean | Std. Deviation | t | df | Sig(2-tailed) |
|--------|----|--------|----------------|------|----|---------------|
| Male | 24 | 152.75 | 15.29 | .153 | 45 | .879 |
| Female | 23 | 153.49 | 17.27 | | | |

There was no significant difference between male and female non-institutionalized HIV/AIDS orphans in psychological adjustment ($t(45) = .153, p > .05$). In other words male and female HIV/AIDS orphans have similar psychological adjustment problems.

Table 9. Sex Difference in Social Adjustment between Non-institutionalized AIDS Orphans

| Sex | N | Mean | Std. deviation | t | df | Sig(2-tailed) |
|--------|----|--------|----------------|------|----|---------------|
| Male | 24 | 117.54 | 12.29 | .387 | 45 | .553 |
| Female | 23 | 116.17 | 11.96 | | | |

Table 9 Shows there was no significant difference between male and female non-institutionalized HIV/AIDS orphans in social adjustment ($t(45) = .387, p > .05$) similar to psychological adjustment.

Table 10. Sex Difference in Psychological Adjustment between Institutionalized AIDS Orphans

| Sex | N | Mean | Std. deviation | t | df | Sig(2-tailed) |
|--------|----|--------|----------------|------|----|---------------|
| Male | 23 | 133.13 | 37.92 | .829 | 45 | .412 |
| Female | 24 | 124.29 | 35.04 | | | |

There was no significant difference between male and female institutionalized HIV/AIDS orphans in psychological adjustment ($t(45) = .829, p > .05$).

Table 11. Sex Difference in Social Adjustment between institutionalized AIDS Orphans

| Sex | N | Mean | Std. deviation | t | df | Sig(2-tailed) |
|--------|----|--------|----------------|------|----|---------------|
| Male | 23 | 107.00 | 12.29 | .412 | 45 | .682 |
| Female | 24 | 104.54 | 11.96 | | | |

Similar to psychological adjustment table 11 shows there was no significant difference between male and female institutionalized HIV/AIDS orphans in social adjustment ($t(45) = .412, p > .05$).

4.2. Discussion

The findings provide consistent evidence that the death of the parent is a crisis for any orphan, as it means losing the love, support, guidance, stability and security that parents provide. The survey brought some significant evidence that both group of HIV/AIDS orphans felt worried, less hopeful, felt alone, had nightmares and not happy most of the time. These findings are consistent with previous studies (Poulter, 1997), which revealed that children who had lost one or both parents were significantly more likely to be unhappy and worry about many things than those living with both parents, even if the parents are unwell.

Children in affected homes were significantly more likely to worry about many things, be fearful of new things or situations, do things alone, and appear unhappy, and distressed.

When separated from their siblings, HIV/AIDS orphans feel sad, worried, scared and isolated. This is due to the multiple losses HIV/AIDS orphans face. Once a parent dies, children are likely to be moved from the family home, and may be relocated to another area and school, thus depriving them from their siblings, friends and neighborhood networks and predictable surroundings (Dane, 1997).

Concerning the psychological adjustment problem as well as difficulties in social adjustment, studies suggest various ways in which AIDS orphans might feel and behave in

response to the stresses they experience, although there is no standard response. However, common reactions of children to the terminal illness or death of parents include depression, hopelessness and suicidal ideation, loneliness, anger, confusion, helplessness, anxiety and a fear of being alone (Aronson, 1995; Foster et al., 1997).

Looking in to the psychological adjustment of HIV/AIDS orphans in the present study we find that the mean score for psychological adjustment of institutionalized HIV/AIDS orphans were lower than the mean score of non-institutionalized HIV/AIDS orphans. Further analysis indicated that the difference between psychological adjustment of institutionalized and non-institutionalized HIV/AIDS orphans was statistically significant implying that institutionalized HIV/AIDS orphans have more problems with psychological adjustment. This problem is reflected in the degree depression and anxiety they show and lower self-esteem.

Even though there are no studies, which compare the adjustment of, institutionalized and non-institutionalized HIV/AIDS orphans there are studies on the adjustment problem of HIV/AIDS orphans. To this end a study conducted in Ethiopia by MOLSA (2003) suggests that HIV/AIDS orphans have problems with emotional adjustment reflected in the degree unhappiness and worry they show, their level of patience, the degree of fatigue and depression, feeling of hopelessness and pessimism.

Similar to psychological adjustment, the present study shows that institutionalized HIV/AIDS orphans have lower mean score on social adjustment than non-institutionalized HIV/AIDS orphans. The independent t-test analysis revealed that the difference of mean

score on social adjustment between non-institutionalized and institutionalized HIV/AIDS orphans were significant, that is, institutionalized HIV/AIDS orphans have greater difficulty in social adjustment than non -institutionalized HIV/AIDS orphans.

This difficulty is manifested in such behaviors as poor social peer relations, feeling of dissatisfaction with peer relationships, shyness, and difficulty to talk with strangers, perceptions of their social competence and distrusting other peoples.

Tsagaye (2001) pointed out the following problems with regard to institutions: lack of psychosocial services, shortage of trained personnel as well as lack of long -term strategic planning and lack of adult guidance. As a result of these and other problems, the children in the orphanages often elicit the following behaviors: feelings of loneliness and hopelessness, low self -esteem and feeling of inferiority, depression and anxiety.

In addition many authors suggest that residential care is the least desirable options for orphans care. Further they suggest residential care is an option of last resort when there is no better placement option is found (Anthony, 2001).

Even though, the researcher does not come across with studies that compare institutionalized and non-institutionalized HIV/AIDS orphans, there are studies, which show the psychological effects of orphanage care. For example, Altshuler and Poertner (2002) concluded youths living in institutions take more risks, have more threats to achievement and have poorer peer influences. Another comparative study by Youngleson (1973) revealed that institutionalized children are less well adjusted and that they manifest less self-esteem compared with control group.

Based on the above information we can say by staying with known relatives and other children, orphans may grow up in a more stable and secure environment favoring their psychological, intellectual and social development.

In general it is true that institutionalized as well as non-institutionalized HIV/AIDS orphans face problem in psychological adjustment and difficulty in social adjustment after their parents death, but when we compare the degree of the problem the present study revealed that there were significant differences in both adjustment variables between non-institutionalized and institutionalized HIV/AIDS orphans. This is due to the above-mentioned problems related to residential care as compared to other types of foster homes.

With regard to sex, the present study shows that there is no significant difference in psychological and social adjustment between male and female non-institutionalized and institutionalized AIDS orphans. This is consistent with a study conducted in Ethiopia by MLOSA (2003); there is no statistically significant difference between male and female AIDS orphans in both their emotional and social adjustment levels.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1. Summary

The major objective of the present study was to examine the psychosocial characteristics of the institutionalized AIDS orphans and the unique problems they encounter in comparison to non-institutionalized AIDS orphans through assessing their psychological and social adjustment.

Accordingly, 47 non-institutionalized and 47 institutionalized HIV/AIDS orphan children were surveyed. In an attempt to investigate the effects of parental death as a result of AIDS on orphan's adjustment problems, measures were adopted from two broad areas- psychological and social adjustment measures. Comparison was made based on HIV/AIDS orphans adjustment scores.

To determine HIV/AIDS orphans' levels of adjustment, independent t-test was run for the two adjustment variables with residence and sex of HIV/AIDS orphans serving as independent variables.

There fore, from the outcomes of the present study and the foregoing analyses, one may arrive at the following conclusions.

5.2. Conclusions

1. More AIDS orphans manifest sadness, worry, loneliness, and also scared when they are separated from their siblings.

2. Most AIDS orphans have scary dreams, feel unhappy, prefer to be alone than playing with others, feel worried and less hopeful.
3. There is a significant difference in psychological adjustment between non-institutionalized and institutionalized HIV/AIDS orphans. It appears that HIV/AIDS orphans who get care and support in institutional setting were significantly worse off than those who get care and support in community based with respect to psychological adjustment. Therefore, it may be concluded that residential care may produce undesirable deviation in orphans' psychological development.
4. There is also a significant difference in social adjustment between non-institutionalized and institutionalized HIV/AIDS orphans. Similar to psychological adjustment institutionalized AIDS orphan children have been found to fall back significantly behind the non-institutionalized HIV/AIDS orphans children in their social adjustment level.
5. There is no significant difference in psychological and social adjustment between male and female non-institutionalized HIV/AIDS orphans.
6. There is no significant difference in psychological and social adjustment between male and female institutionalized AIDS orphans.

So from the present study it is possible to conclude that male and female HIV/AIDS orphans are equally affected by the pandemic.

In general, the present research findings are not new. The psychological and social adjustment problems of HIV/AIDS orphans as well as stressors of their life can be observed in the research literature. However, the comparison of institutionalized and non-

institutionalized HIV/AIDS orphans and a significant difference in the psychological and social adjustment are relatively a new perspective.

But the present study has some limitations. One of the foremost limitations of the study was its small sample size as a result of the refusal of the administrators of some residential care due to the confidentiality of the matter. The second limitation of the study was that there is limited literature on the psychological and social adjustment of HIV/AIDS orphans. Clearly, a representative large sample size would have added substantial weight to the conclusions drawn and recommendations made from the results.

4.3 Recommendations

Based on the findings and the conclusion drawn, the following recommendations are made:

1. As large-and rapidly growing-numbers of children are orphaned by the AIDS pandemic, providing them with care and protection is an increasing national and global concern. So further research should be made to identify children who are at particular risk for psychological and social adjustment difficulties, and intervention efforts for them.
2. Strengthening the protection and care of AIDS orphans children within their extended families and community by government as well as non-governmental organizations.
 - Service giving organizations should look for better solution, which involve enabling all siblings to remain together in the care of relatives or a family they already know.
 - For some orphans, who at least temporarily, do not have an acceptable possibility of family based care within their own community, efforts should be made to

expand fostering and adoption that more adequately meet children's needs than residential care.

3. Enhancing the capacity of families and communities to respond to the psychological and social needs of orphans.

- Effort should be made to train community and extended family to promote the psychological and social needs of AIDS orphans.
- Schools also play an important role in psychosocial support for AIDS orphans. Schooling itself helps normalize life and promote children's psychological and social adjustment. With training, teachers can identify signs of distress and provide appropriate emotional and psychosocial support. Students can support their peers, learn ways to advocate compassion and care within their communities, and reduce stigma.

4. Strengthening the economic capacities of families and communities.

Income is lost due to parental illness, and assets are used to pay medical costs. Households that take in orphans face additional expenses. Therefore, it is important to establish sustainable interventions within communities that respond to household economic needs by governmental and non-governmental organizations.

5. The psychological needs AIDS orphans are down played and the emphasis has so far been mostly on material provision. Service giving organizations as well as the community should recognize the importance of addressing the psychosocial issues children face. Caregivers and communities need to be trained on issues related to child development that include emotional and social development. Religious institutions have a large role to play in the

protection of children and in their psychological and social development. So training in psychosocial issues should include the religious institutions as well.

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APPENDIX

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Questionnaires and Scales used to Measure the Psychological and Social Adjustment Status of HIV/AIDS Orphans

Introduction: - My colleagues and I are gathering information on orphans for research purpose. The information obtained from the responses of the items will not be used for other purposes but for research. Therefore, there is no need of being secretive in your responses. Please, complete all the items according to the instruction given in each part. Since your frank and honest response for each item has practical and valuable significance for the success of this study, you are kindly requested to respond accordingly.

Thank you for your kind cooperation.

Section 1 Background Information

Instruction: Put a tick mark (✓) in front of the answer that represents your agreement.

| S. No. | Demographic Questions | Answer | |
|-------------|--|--------------|--|
| 1 | In what month and year were you born? | Month | |
| | | Year | |
| 2 | Sex | Male | |
| | | Female | |
| 3 | What is the relationship to your guardian? | Aunt | |
| | | Uncle | |
| | | Grand mother | |
| | | Grand father | |
| | | Sister | |
| | | Brother | |
| | | Neighbor | |
| | | Cousin | |
| Institution | | | |

| | | | |
|---|---|-------------|--|
| 4 | How do you get along with your guardian (care giver)? | Very well | |
| | | Well | |
| | | Poorly | |
| | | Very poorly | |
| 5 | How do you feel about being separated from your brothers/sisters or other children? | Sad | |
| | | Worried | |
| | | Angry | |
| | | Scared | |
| | | Isolated | |
| | | Happy | |

Emotional Well-being Measures

| Demographic variables | Answer | |
|---|-----------|--|
| 6. How often would you say that you have scary dreams? | Often | |
| | Sometimes | |
| | Never | |
| 7. How often would you say that you ever feel unhappy? | Often | |
| | Sometimes | |
| | Never | |
| 8. How often would you say that you prefer to be alone, instead of playing with others? | Often | |
| | Sometimes | |
| | Never | |
| 9. How often would you say that you ever feel worried? | Often | |
| | Sometimes | |
| | Never | |
| 10. How often do feel happy? | Often | |
| | Sometimes | |
| | Never | |
| 11. How often do you feel hopeful | Often | |
| | Sometimes | |
| | Never | |

Section 2. Psychological and Social Adjustment Measures

I. Psychological Adjustment Measures

Instruction: - The following statements refer to the experiences that people have in their daily life. You are to indicate, on a five-point scale, the extent of agreement between the feeling expressed in each statement and your own personal reactions. Please read each item carefully and decide to what extent it is characteristic of your feelings and behavior. Mark (✓) the point which best indicates your agreement or disagreement.

| Item No | Items | Response Categories | | | | |
|---------|---|---------------------|-------|-----------|----------|-------------------|
| | | Strongly Agree | Agree | Undecided | Disagree | Strongly Disagree |
| 1 | I feel that I have a number of good qualities | | | | | |
| 2 | I feel that I am a person of worth, at least on an equal plane with others. | | | | | |
| 3 | All in all, I am inclined to feel that I am a failure. | | | | | |
| 4 | I am able to do things as well as most other people. | | | | | |
| 5 | I feel I do not have much to be proud of | | | | | |
| 6 | I take a positive attitude toward my self | | | | | |

| | | | | | | |
|----|---|--|--|--|--|--|
| 7 | On the whole, I am satisfied with myself | | | | | |
| 8 | I wish I could have more respect for myself | | | | | |
| 9 | I certainly feel useless at times | | | | | |
| 10 | At times I think I am no good at all | | | | | |
| 11 | I feel as if I have experienced some emotional loss. | | | | | |
| 12 | I feel in effective | | | | | |
| 13 | I don't seem to obtain gratification from anything | | | | | |
| 14 | I never seem to have the motivation to do things I would like to do | | | | | |
| 15 | I have the energy to do the things I would like to do | | | | | |
| 16 | I am confident | | | | | |
| 17 | I feel incompetent when something bad happens to me | | | | | |
| 18 | I feel as if I never actually attain my aspiration | | | | | |
| 19 | I am satisfied with my appearance | | | | | |
| 20 | My goals reflect my | | | | | |

| | | | | | | |
|----|--|--|--|--|--|--|
| | personal desires rather than the desires of others. | | | | | |
| 21 | I feel chronically frustrated in my personal life | | | | | |
| 22 | I get what I want | | | | | |
| 23 | I feel inadequate | | | | | |
| 24 | I see myself as less competent than I would like to be | | | | | |
| 25 | When something good happens to me, it is usually because I have worked for it. | | | | | |
| 26 | I am hopeful | | | | | |
| 27 | I actively pursue the goal which I have set for myself | | | | | |
| 28 | I have a hopeless outlook on the world | | | | | |
| 29 | I see fulfillment of my aspiration as quite possible. | | | | | |
| 30 | I often seem to lose sight of my identity and purpose for existence. | | | | | |
| 31 | My sleep is restless and disturbed | | | | | |
| 32 | I work under a great deal of strain | | | | | |

| | | | | | | |
|----|--|--|--|--|--|--|
| 33 | I sweat very easily even on cool days | | | | | |
| 34 | I am usually calm | | | | | |
| 35 | I have many problems that cause me a great deal of worry | | | | | |
| 36 | I always have enough energy when faced with difficulty | | | | | |
| 37 | I give up easily when things get hard | | | | | |
| 38 | I have frequent headaches for which there is no reason | | | | | |
| 39 | When I try to make something everything seem to go wrong | | | | | |
| 40 | I feel worrying and nervous | | | | | |
| 41 | I worry about what other people think about me | | | | | |
| 42 | Often I feel sick in the stomach | | | | | |
| 43 | I worry about what is going to happen | | | | | |
| 44 | I have bad dreams | | | | | |
| 45 | My feelings get hurt easily | | | | | |

II. Social Adjustment Measures

Instruction: - Each of the following statements expresses the experiences, feelings, perceptions, and reactions that people have in their relationship with people or friends. For each statement there are five possible responses: Always true, True most of the time, true sometimes, hardly every true, and not true at all. Thus, for each of the items give your response by marking (✓) on the space provided on a five-point scale how much a true description of each statement is about your experience.

| Item No | Items | Response Categories | | | | |
|---------|---|---------------------|-----------------------|-----------------|-------------------|-----------------|
| | | Always True | True most of the time | True some times | Hardly every true | Not true at all |
| 1 | I am socially some what awkward | | | | | |
| 2 | I feel inhibited in social situations | | | | | |
| 3 | I feel tense when I am with people I don't know well | | | | | |
| 4 | I like to be with people | | | | | |
| 5 | I welcome the opportunity to mix socially with people | | | | | |
| 6 | I find it hard to talk to strangers | | | | | |
| 7 | I prefer working with others rather alone | | | | | |
| 8 | I am shy with members of the opposite sex | | | | | |
| 9 | When conversing I worry about saying something dumb | | | | | |

| | | | | | | |
|----|---|--|--|--|--|--|
| | | | | | | |
| 10 | I would be unhappy if I were prevented from making many social contacts | | | | | |
| 11 | I try to avoid situations which force me to be very sociable | | | | | |
| 12 | I feel often uncomfortable at parties and other social functions | | | | | |
| 13 | I often think up excuses in order to avoid social engagement | | | | | |
| 14 | I usually feel relaxed when I am with a group of people | | | | | |
| 15 | I tend to withdraw from people | | | | | |
| 16 | I often find social occasions upsetting | | | | | |
| 17 | I try to avoid formal social occasions | | | | | |
| 18 | I usually feel calm and comfortable at social occasions | | | | | |
| 19 | Few of my friends understand me the way I want to be understood | | | | | |
| 20 | I get much satisfaction from the groups I attend | | | | | |
| 21 | My friends give me the | | | | | |

| | | | | | | |
|----|--|--|--|--|--|--|
| | moral support I need | | | | | |
| 22 | I have a deep sharing relationship with a number of friends | | | | | |
| 23 | My friends come to me for emotional support | | | | | |
| 24 | I am not very open with my friends | | | | | |
| 25 | It is easy for me to make new friends at school | | | | | |
| 26 | I am good at working with other children | | | | | |
| 27 | It is hard for me to make new friends | | | | | |
| 28 | I don't get along with kids | | | | | |
| 29 | I can find a friend when I need one | | | | | |
| 30 | I have nobody to talk to | | | | | |
| 31 | I don't have any friends | | | | | |
| 32 | I am good at working with other people | | | | | |
| 33 | I have trouble looking someone right in the eye | | | | | |
| 34 | I don't find it difficult to ask other people for information | | | | | |
| 35 | It is hard for me to act natural when I am meeting new people. | | | | | |

Declaration

I the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used in this thesis have been duly acknowledge.

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Date: June 2005

This thesis has been submitted for examination with my approval as a university advisor

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