

Addis Ababa University
College of Education and Behavioral Studies
School of Psychology
School of graduate studies

The Psychological Care Giving Patterns of Child Care Institutions: A Qualitative Study
Conducted at KebebeTsehay Government Orphanage

By:

EyerusalemShibru /GSE 0674/2009

October, 2019

The Psychological Care Giving Patterns of Child Care Institutions: A Qualitative Study
Conducted at KebebeTsehay Government Orphanage

A Thesis paper submitted to the College of Education and Behavioral Studies
School of Psychology. Presented in a Partial Fulfillment for the Requirements of the Master of
Counseling Psychology

By: EyerusalemShibru /GSE 0674/2009

Advisor: Advisor: Dr. Teka. Z (Phd).

Addis Ababa University

Addis Ababa, Ethiopia

Nov, 2019

Abstract

The aim of this study is to assess the psychological care giving pattern of child care institutions. It is conducted in a government orphanage center called Kebebe – Tsehay found in Addis Ababa. The research primarily used a descriptive case study design of qualitative research method. It mainly focused on the interaction between the care givers and the children. Qualitative data was collected using an observation, interview and focus group discussion techniques. The data was analyzed using manual coding system. A total of four observations, 3interviews and one focus group discussion session were carried out with the caregivers and other concerned bodies of the institution. The study revealed that because of the incomparability of child – care giver ratio and other related factors, the institution has low quality of psychological care giving pattern. The caregivers were providing care with a very little warmth, sensitivity and affection due to their over load and inability of getting the chance of building their capacity with frequent trainings. As a result the children in the institution are destitute of the privilege of being raised in a nurturing environment.

Key words: care giver- child interaction, psychological care giving pattern, quality of care giving

Acknowledgment

First and foremost I would like to thank the Almighty God who was helping me throughout the process of conducting this thesis paper. I would like to express my heartfelt gratitude to my advisor Dr. Teka who was helpful in forwarding advices whenever I am in need of. I am deeply indebted to Kebebe – Tsehay governmental orphanage for letting me carry out the research and I am also thankful for the overall cooperative staffs.

Table of Contents

Abstract	3
Acknowledgment	4
Table of Contents	5
Acronyms	8
Chapter One: Introduction	9
1.1. Background of the study	9
1.2. Statement of the problem	10
1.3 . Objective of the Study	15
1.3.1. General objective	15
1.3.2. Specific objectives	15
1.4. Research Questions	15
1.5. Significance of the Study	15
1.6. Scope of the Study	16
1.7. Limitation of the study	16
1.8. Operational definition of key terms	16
Chapter Two: Literature Review	18
2.1. Empirical Aspect	18
2.1.1 History of Orphanage	18
2.1.2. Institutional care and its adverse effect	20
2.1.3. Adverse effects of institutionalization	22
2.1.4. Early childhood experience of institutionalized children	24
2.1.5. Child - Care Giver Interaction	25
2.1.6. Features of supportive and facilitative caregiver-child interactions	27
2.2. Theoretical perspective	30
2.2.1. Attachment theory	30
2.2.1. 1. Attachment Problems in Institutionalized Children	32
2.2.2. Psychoanalytic theory, particularly Object Relations Theory	34
2.2.3. The Theory of Mediated Learning Experiences (MLE)	35
2.3. Conceptual Framework	37

The opposite will come to pass in the children’s life if they are not able to be raised up in such kind of environment. Developmental delay, low self – esteem, perception of unworthy of love, inability to receive and give love, poor communication such and other distortions will hold them back from flourishing in life.	38
Chapter Three: Methodology	38
3.1. Study design	38
3.2. Study Site	39
3.3. Study Participant	39
3.4. Sampling techniques	40
3.5. Data collection instruments	40
3.6. Data collection procedures	41
3.6.1. Observation	41
3.6.2. Interview	42
3.6.3. Focus group discussion	42
3.7. Data analysis procedure	42
3.8. Ethical considerations	43
Chapter Four: Findings	43
4.1. Demographic data of Participants	43
4.2. Care giver profile, consistency and quality assurance	44
4.3. Constructs to Rate the Caregiver – Child Interaction	48
4.3.1. Care giver Engagement	48
4.3.2. Behavioral control	50
4.3.3. Caregiver Psychological Availability and Receptivity to the children	51
4.3.4. Care giver Affect with Children	53
Chapter Five: Discussion	54
5.1. Care giver profile, consistency and quality assurance	55
5.1.1. Large Group size	55
Among the characteristics the first is the group sizes tend to be large (typically 9-16 children per ward, although in extreme cases the number may approach 70). The number of children per caregiver is large (approximately 8:1 to 31:1, although a few institutions have fewer children per caregiver) (Van, Page 10, 2011).....	55
5.1.2. Consistency of caregiver to one group	55
5.1.3. Inconsistency of other Adults in children’s lives	56
5.1.4. Routine works of care giving	57
5.1.5. Sensitivity of caregivers	57

5.2. Constructs rating the Caregiver – Child Interaction	58
5.2.1. Care giver Engagement	58
5.2.2. Behavioral control	59
5.2.3. Caregiver Psychological Availability and Receptivity to the children	60
5.2.4. Care giver Affect with Children	60
Chapter Six: Conclusion and Recommendation	62
6.1. Conclusion	62
6.2. Recommendation	64
Reference	64
Groark, C. J., McCall, R. B., Fish, L., & Whole Child International Evaluation Team. (2011). Characteristics of environments, caregivers, and children in three Central American orphanages. <i>Infant Mental Health Journal</i> , 32(2), 232-250.	67
UNICEF. (2013). Preventing and Responding to Violence, Abuse, and Neglect in Early Childhood A Technical Background Document, Child Protection Section New York, MPH Columbia University School of Public Health and Maestral International.	70
Van Ijzendoorn, M. H., Luijk, M. P., &Juffer, F. (2008). IQ of children growing up in children's homes: A meta-analysis on IQ delays in orphanages. <i>Merrill-Palmer Quarterly (1982-)</i> , 341-366.	70
Appendix I: Observation Check lists	71
Declaration	76

List of tables

Table one:Socio demographic profile of participants..... 46
Table two:Care giver child ratio..... 48

Acronyms

ASCT- Attachment Story Completion Task

BEIP- Bucharest Early Intervention Project

CCSERRS - Caregiver-Child Social/Emotional and Relationship Rating Scale

CIP - Caregiver Interaction Profile

EEG- Electro Encephalo Gram

FGD – Focus group Discussion

IQ – Intelligence quotient

MISC - Mediation Intervention for Sensitizing Caregivers

MLE – Mediated Learning Experience

OVC – Orphan and vulnerable children

PI – Post Institutionalized

UNICEF – United Nations International Children’s Emergency Fund

WHO – World Health Organization

Chapter One: Introduction

1.1. Background of the study

Childhood experiences determine the future social, emotional and psychological dynamics and functioning of individuals in their adulthood life. Adverse and painful childhood experiences can disrupt psychosocial wellbeing of children. Psychosocial wellbeing

affects children's ability, intellectuality, productivity and social functionality. Children with post parental loss experience sorrow, anxiety, depression, lack of support and care. The trauma of losing parents can have adverse psychosocial effects on children like feelings of mistrust, inferiority, shame, guilt, insecurity and improper conduct. (Bruskas, , 2013).

Institution-reared children all experience separation or loss of their birth parents and other caregivers. In a famous report on institutions for the World Health Organization, Bowlby (1952) concluded that children suffered from the effects of institutional care, even when their physical needs (food, clothes, etc.) were adequately met. The children were deprived of opportunities to develop stable and continuous attachment relationships due to the limited amount and poor quality of contact with their caregivers (Gunnar, et al., 2001).

The institutional care of abandoned and orphaned children is widely used in countries with different ethnic, cultural, and economic backgrounds, and its nature may vary not only between but also within countries. Children exposed to institutional care do not receive the type of nurturing and stimulating environment needed for normal growth and healthy psychological development (Marinus et al, 2011).

Since care givers are considered as a substitute for a parent in child care institutions, their way of interaction with the institutionalized children has a great impact on the child's wellbeing. Although caregivers were friendly and occasionally smiled, their interactions with children outside of routine care giving were minimal and delivered with little affect; thus, children experienced very little warm, sensitive, responsive, and contingent caregiver-child interaction. (Christina et al, 2011).

Studies have been conducted on the quality of care giving patterns provided for institutionalized children worldwide. But much study was not conducted, to the researcher's knowledge, in Ethiopian level on this specific area. For this reason the researcher decided to study the care giving patterns of child care institution in one selected government orphanage called Kebebe - Tsehay, found in Addis Ababa.

1.2. Statement of the problem

A large body of psychological research has been conducted among orphans internationally, continentally and also in Ethiopian level.

One of them is a research conducted in three institutions in two Latin American countries (Groark, 2011). One of the focuses of this research was the caregiver – child interaction quality. The research showed that Caregiver–child interactions in the institutions were similarly minimal. On a scale of 0 to 3 (best), these three orphanages rated slightly over 1. Caregivers displayed substantial detachment, lack of availability and receptivity to children, failure to respond to children’s overtures, little support or empathy for children, and little animated or expressive interactions, all in a climate of low affect (both negative and positive). As might be expected, children behaved similarly, with little responsiveness, substantial detachment, little positive or negative affect, and minimal displays of relationship with caregivers.

The research revealed that, although caregivers were friendly and occasionally smiled, their interactions with children outside of routine care giving were minimal and delivered with little affect; thus, children experienced very little warm, sensitive, responsive, and contingent caregiver–child interaction.

Behaviorally, children showed high rates of indiscriminate friendliness to a stranger and frequent instances of noncompliance, provocative behavior, and outright violent interpersonal behavior. At the same time, they showed relatively low rates of impulsive activity, impatience and frustration, and stereotypic/self-stimulation or excessively withdrawn behaviors, all of which often have been anecdotally reported in children in other institutions (Groark, 2011).

The other internationally conducted research concerning early deprivation is a study of Romanian institutionalized orphans who have been severely neglected. These children suffered from acute deficits in cognitive and social functioning. Families who adopted Romanian orphans reported difficulties and stress. As emphasized by Kaler, Romanian orphanages “provided an unfortunate natural experiment on the effects of severe environmental deprivation on young children”. The sad example of these orphans highlights the importance of child care during the first months of their life (Mehta et al, 2009).

A European team conducted a research among orphans in an institution in Kinshasa (Democratic Republic of Congo) (Muadi et al. 2012). The research compared and contrasted attachment quality between two groups of children living in an institution and children living in their family, all aged between four and seven years. The age of the children allow them to use a specific method: the Attachment Story Completion Task (ASCT). The children were asked to

complete stories that were supposed to assess children's internal working model of attachment; they also used a doll to enact some scenes. The results showed a significant difference in the rate of attachment between the two groups, with the institutionalized children being less securely attached. The authors also underlined that orphans in Kinshasa have achieved higher rates of attachment than other children in other populations such as Romanian children; they conclude that the children might be more resilient in this population.

The effect of orphan hood is also studied in Africa. The research was conducted in Raki district of Uganda in 2016. Adopting parents and schools have not provided the emotional support these children often needed. Most adopting parents lacked information on the problem and were therefore unable to offer emotional support; and school teachers did not know how to identify psychological and social problems and consequently fail to offer individual and group attention. The concept of the locus of control was used to show the relationship between the environment and individuals' assessment of their ability to deal with it and to adjust behavior. Most orphans risk powerful cumulative and often negative effects as a result of parents' death, thus becoming vulnerable and predisposed to physical and psychological risks (James et al, 2016).

Orphan hood was also studied in Ethiopia. A study which explored the psychosocial problems experienced by orphan children, under the Ethiopian Orthodox Church Child and Family Affairs Organization, Sebeta child center was made by Mezgebo G/Mariam (Mezgebo, G. 2014). The study finally concluded that orphaned children are suffering from psychological problems such as depression like loss of relaxation, lacking in initiative and loss of hope. Further, it revealed that orphaned children are suffering from intolerance, wornness, and loss of interest and tension, feeling like poor personal, self worth, in competency, worthlessness, loss of confidence, dissatisfaction and loss of positive self-image were problems associated with orphaned children in the study. Again, orphaned children were also suffering from self-efficacy problems, such as inability to handle problems, tackling unforeseen difficulties and from inability to accomplish one's own goals.

Another study was also conducted on exploring the psychosocial problems and coping strategies of orphans and vulnerable children living in two orphanages, namely YenegeTesda and Bridge of Hope Ethiopia orphan and vulnerable children care and support centers in Gondar

town, North West Ethiopia by SebsebeTadesse in 2014 (Tadesse et al, 2014). The study revealed that orphans and vulnerable children in the orphanages accessed all the basic services necessary to sustain their lives. Conversely, the study also revealed that the children suffered from a set of multidimensional and intertwined psychosocial problems like, stress and depression, loneliness ,lack of parental love ,lack of sleeping ,poor concentration , lack of self confidence , helplessness ,poor social interaction, that were the least addressed in the orphanages. Thus, the study suggested that interventions to promote the psychosocial wellbeing of the children should focus on addressing psychological problems listed above, advancing socialization skills, organizing extracurricular activities and entertainments, and improving coping strategies.

An intervention program which intended to implement MeditationalApproach was also conducted in Ethiopia in (Klein et al, 2004). The overall objective of implementing the Meditational Intervention for Sensitizing Care givers (MISC) in Ethiopia was to explore the possibility of enhancing the quality of mediation in early mother-child interaction and consequently to improve the cognitive and emotional development of Ethiopian children. The intervention program was based on the MISC program. It is tailored towards promoting the quantity and quality of infant – caregiver interactions, both in home and institution based settings. A special attempt was made to integrate the psychological intervention within the existing primary health care services in the local community.

Accordingly, Kechene community of kebele 15 and Kebele 18, is located in the Northwestern part of Addis Ababa. These communities are considered among congested urban slums in the city of Addis Ababa with overcrowded households and poor sanitation.

The MISC program was also implemented in the kechene children's home, which is a residential institution for homeless children ranging from one to eighteen years of Age. The children in this home are orphans gathered from hospitals and off the streets of Addis Ababa.

The research used a systematic random sampling technique. 15 of the families from Kebele 18, and 15 of the families from Kebele 15 were selected for experimental and control groups respectively. Regarding the orphans in the children's home, 13 children, ranging in age from one to three years were selected for the intervention program. Thirteen Adult caregivers as well as 13 older girls from the orphanage were included in the study.

Findings of the study indicated; an increased tendency to pay attention to the children's initiations and request. Less frequent use of harsh disciplining behaviors that were regimental in the provisions of information and explanations and a marked reduction in excessive usage of commands was also shown. Following the intervention, young children behaved differently in interactions with adults as compared to their behavior before the intervention. Thus the findings of the study suggested that the MISC seems to have the potential to be efficiently and effectively implemented in the Ethiopian setting.

When we come back to this specific research, it aimed to address single phenomena among the various problems observed in orphanages, which is how psychological care is being provided for orphans who are being raised in Kebebe - Tsehay Governmental Orphanage. Children in the institution gain different kinds of supports when being raised in the institution like physical care, health care, psychological care and the like. But the aim of this research is focusing on explaining the psychological care giving pattern of the institution. Children exposed to institutional care often suffer from "structural neglect" which may include minimum physical resources, unfavorable and unstable staffing patterns, and social-emotionally inadequate caregiver-child interactions. (Marinuset al, 2011).

Early childhood experiences determine the future life of the child. Theoretically, an infant with a warm, responsive caregiver develops an internal working model of expectations for nurturing, supportive reactions from that caregiver, whom the infant comes to trust and use as a secure base from which to explore the social and physical world. (Weinfield et al, 2008). Such experiences in turn promote the development of a sense of worthiness and self-esteem and appropriate long-term social-emotional development and mental health. Without the early experience of a few warm, caring, socially-emotionally responsive adults, long-term development may be compromised (Ainsworth, 1979).

As a result attention should be given for the child's early experience. When we are talking about the care giving and early childhood experiences the first bodies that come to the front are caregivers. So the research mainly focused on the care giver - child relationship in the institution. Care givers are the first to provide care for children and to spend much of their working hour with them. Therefore their interaction with child in the institution may have two outcomes. The first is, if the institutionalized child is able to get warm, sensitive and caring

environment the probability of having a bright future will boostup and if the child could not be able to get this nurturing environment then he will have high probability of disrupted life.

1.3 . Objective of the Study

1.3.1. General objective

The overall objective of this study is to describe the psychological care giving patterns of the child care institution.

1.3.2. Specific objectives

- ✓ Investigating the care giver profile, consistency and quality assurance of the institution.
- ✓ Assessing the care giver's engagement with the children in routine works of care giving.
- ✓ Describing how the care givers are controlling behavior
- ✓ Assessing the caregiver's psychological availability and receptivity to the children
- ✓ Describing the care giver's affect with children

1.4. Research Questions

- ✓ Are the care givers in the institution engaged to the children when providing care?
- ✓ How is behavior controlled in the institution?
- ✓ Are the care givers psychologically available and receptive to the children?
- ✓ Do the caregivers show affect to the children in a normal daily bases?
- ✓ Is there a strong attachment between the care givers and the children?

1.5. Significance of the Study

The research, therefore, serves the following different stakeholders.

- ✓ To provide additional input, for other researchers who work in the area of institutionalized children especially on the psychological care giving patterns.
- ✓ To increase awareness level of child care institutions to give weight to psychological care giving.
- ✓ To demonstrate ways for government and policy makers to improve the psychological supports of child care provider governmental institutions.

- ✓ To imply for practitioners the need of working in the quality of early child care especially in orphanages.

1.6. Scope of the Study

Even though institutionalization has countless draw backs on the children, the scope of this study purely focuses on the assessment of psychological care giving patterns of child care institutions.

1.7. Limitation of the study

The first limitation of this study is, as the researcher tried to contact different child care institutions, the response given was not positive. Institutions are not willing to open their doors for the case at hand. So this hinders the researcher from seeing the research problem from different institution's experience.

1.8. Operational definition of key terms

Care giver – child interaction: is the relationship of the child and the caregiver in routine works of care giving. Quality care giver – child interaction can be measured in the caregiver's sensitive and interesting interactions with the child which directly influence children's social-emotional, cognitive, and language development. Child-to-staff ratios, Group size, caregiver qualifications and professional development also affect the quality of care giving (Atkins-Burnett et al, 2015).

Caregiver - is the person (most of the time woman) who interacts with the children and provides different kinds of care like physical, emotional, cognitive, psychological care for the infants and young children who are being raised in the child care institution, Kebebe – Tsehay.

Child care institution: A childcare institution is an establishment founded by a governmental or non-governmental organization to give care for unaccompanied children. In this respective research Kebebe – Tsehay governmental orphanage is considered as a child care institution.

Institutional care: is a group living arrangement for more than ten children, without parents or surrogate parents, in whom care is provided by a much smaller number of paid adult care givers.

Institutionalized child: A child who is fully orphaned (both parents proved to be dead); or abandoned, (both parents proved to be untraceable); or with parents who are certified by the appropriate or accredited body that they are terminally ill and couldn't raise their child/ren.

Psychological Care giving pattern: Is the way the institution provides psychological care for the children living in the institutions. This pattern incorporates care givers engagement to the children, care givers psychological availability and receptivity to the children, way of behavior control and care givers affect to the children when they are providing the routine works of care giving.

1.9. Organization of the Paper

The paper encompasses six chapters and each of them are composed of different sections. The first chapter dealt with introduction: background, statement of the problem, objective of the study [general and specific], research questions [general and specific], scope of the study, and significance of the study. The second chapter discusses literatures reviewed and is composed of both the theoretical and empirical aspect of psychological care giving patterns of child care institutions. The third chapter addresses the research methodology, study design, study area, participants of the study and inclusion criteria, sample technique, data collection procedure, tools of data collection, data analysis procedures, ethical considerations in the research. The fourth chapter presents the findings of this study which involves four major themes: (1) introduction of the research participants; (2) Care giver profile, consistency and quality assurance (3) Constructs to Rate the Caregiver – Child Interaction; care giver engagement (4) Behavioral control (5) Caregiver Psychological Availability and Receptivity to the children (6) Care giver Affect with Children. The fifth chapter deals with discussion of the study. It confers the research findings with relevant literatures. Lastly, the sixth chapter provides conclusion of the study and recommendation of the research for different bodies.

Chapter Two: Literature Review

2.1. Empirical Aspect

2.1.1 History of Orphanage

Caring for orphaned, abandoned, and maltreated children through informal kin care and adoption has a long history (Hrdy, 1999). Formal governmental systems to deal with these children, such as orphanages and government sponsored foster care, emerged more recently. The reliance on different systems of care over time has been influenced by social and political factors, as well as changing perspectives on child development. The historical literature describes

many examples in which families took in abandoned children. Boswell (1988) painted a very positive picture of the treatment children received by surrogate parents, and the likelihood that they survived abandonment because of the “kindness of strangers.” Hrdy (1999) pointed out that, prior to the age of sterilized bottles and formula; it was difficult for young infants to survive abandonment unless a lactating woman was available to care for them. The care received in these informal foster and adoptive homes was variable, ranging from children being treated as family members to children being treated as servants. Nonetheless, fostering and adoption have had at least some acceptance throughout much of history for parents who felt unable to care for their children.

At times, especially during periods of economic hardship, abandoned babies have outnumbered those available to care for them through informal systems of care. Foundling homes were first established in the 14th and 15th century in Italy in response to the growing number of abandoned babies in cities (Hrdy, 1999). From the beginning, many of the children placed in these institutional settings were not true orphans, but rather had one or both parents surviving. These first foundling homes had very high documented mortality rates, ranging from 20% to 40% annually, and reaching nearly 100% during some epidemics (Hrdy, 1999). Many infants failed to survive, either because of the outbreak of disease in the homes, or because breast milk was not available. Over the next several centuries, foundling homes increased in number in Italy, and later in England, Russia, and other parts of Europe

Still, throughout most of the 18th century in North America and Europe, institutional care was uncommon; abandoned and orphaned children were typically placed with neighbors or in city almshouses, or indentured into apprenticeships. During the 1800s, religious organizations and charities began to establish orphanages in response to increased urbanization, the American Civil War, and multiple epidemics of cholera, tuberculosis, yellow fever, and influenza (Dozier et al, 2012). The expansion, both in the number of new orphanages created and in the number of children cared for, continued into the early 1900s. A nodal event contributing to the eventual decline of institutional care in the United States was the first White House Conference on Children, which was organized on the authority of President Roosevelt in 1909. Child welfare professionals from around the country met and agreed on several policies those remain in place today. Specifically, they endorsed the concepts that;Children should be raised by their own

families. When it was necessary to remove children from their families, the settings in which they were cared should be other families' homes or resemble families as much as possible; and no child should be removed from parental care because of poverty alone (Dozier, 2012).

Subsequent legislation, such as the Social Security Act of 1935, allowed for federal funding to be given to states to address issues of child welfare. Yet, the adoption of such federal policies and the numerous arguments against orphanages did not lead to the immediate end of institutionalized care in the United States. These policies led to a steady decline in institutions, so that by the 1970s orphanages had almost disappeared. There was a brief resurgence in the late 1980s and early 1990s when several large urban child welfare systems were overwhelmed by the influx of cocaine-exposed newborns. In some places, institutions were reinvented to cope with the sudden influx of children into state's custody (Harden, 2002).

Although most of these were subsequently closed, many states still have some form of group care with shift workers even for young children, although the numbers are small. Throughout the 20th century, government- and church-sponsored foster care increased not only in North America but also in Europe. In the mid-20th century, a series of studies began to highlight the harms of institutional rearing. The emergence of this evidence was associated with a move away from institutional care in the United States and Western Europe, but countries in the Soviet bloc and China lacked access to these data, and foster care remained scarce there. Furthermore, the communist ideology not only destigmatized institutional rearing but in some cases they encouraged it (Kligman, 1998).

Currently, institutional care for young children is common in Eastern Europe, Asia, Central and South America, Africa, and the Middle East (Petersburg, 2008). Although there are relatively few orphanages in Western Europe, institutions nonetheless exist in Portugal, France, and Belgium, among other countries (Browne et al, 2006).

2.1.2. Institutional care and its adverse effect

A number of observational studies have compared institutionalized children to non-institutionalized children. These studies tell a compelling story of the effects of institutional care; most studies found that institutionalized children have significant developmental deficits across virtually every domain that has been examined (Dozier et al, 2012). Following adoption into

advantaged families, many (though clearly not all) of the developmental delays and behavior problems seen in children living in institutions are no longer evident (Juffer, 2005). This suggests enormous capacity for adoption. The limitation of these adoption studies is that there is a potential selection bias in terms of which children are adopted.

For example, it is plausible that more competent children are more likely to be adopted than less competent children, thus overestimating children's capacities for resilience. One randomized clinical trial, the Bucharest Early Intervention Project (BEIP), has been conducted in which children in institutional care in Romania were comprehensively assessed and then randomly assigned to continued institutional care or to quality foster care (Nelson et al, 2007). The BEIP is especially important because randomized design allows causal inferences about the role of continued institutional care on children's functioning. In fact, the children placed in foster care performed better than the children with continued institutional care on almost every measure, thus supporting the conclusions reached in correlational studies regarding the power of foster and adoptive care in remediating the effects of institutional care (e.g. Nelson et al, 2007).

We next present an overview of the literature that provides strong evidence that institutional care of infants and young children has profound effects on essentially all domains of development. When young children experience institutional care, social and interpersonal development is impaired, physical growth is retarded and cognitive and language development is delayed (Nelson et al., 2007).

Despite the variability in care that can be found among institutions, it is possible to put together a composite description of what is typical. The following narrative is not a report of a particular institution but rather combines various accounts to give the reader a better sense of what is common amidst considerable heterogeneity in institutional care (Van et al, 2011).

Group sizes tend to be large (typically 9-16 children per ward, although in extreme cases the number may approach 70). The number of children per caregiver is large (approximately 8:1 to 31:1, although a few institutions have fewer children per caregiver).

Most institutions have homogeneous groups with respect to ages and disability status. Children are periodically “graduated” from one age group to another perhaps as many as two or three times in the first two or three years of life.

Caregivers for any single child tend to change constantly because there may be a high staff turnover; caregivers may work long shifts (e.g., 24 hours) and be off three days; caregivers may not be consistently assigned to the same group; and caregivers may get up to two months’ vacation. The result is that a child may see anywhere from 50 to 100 different caregivers in the first 19 months of life

Other adults tend to come and go in children’s lives, including medical and behavioral specialists, prospective adoptive parents, and volunteers who may visit for only a week or a few months.

Caregivers likely receive little training, and the training they do receive is more focused on health issues than on social interaction. They spend the vast majority of their hours feeding, changing, bathing, cleaning children and the room, and preparing food rather than interacting with the children. Caregivers are invariably female, so children rarely see men

When caregivers perform their care giving duties, it is likely to be in a business-like manner with little warmth, sensitivity, or responsiveness to individual children’s emotional needs or exploratory initiatives.

2.1.3. Adverse effects of institutionalization

Lack of attachment: Institutional care is associated with differences in whether children form specific attachments to their caregivers, and the quality of attachments they form to caregivers. Virtually all children raised in families develop clear attachments to specific caregivers (Nelson et al., 2007).

However, the attachments of the majority of institutionalized children are incompletely developed or even absent, as demonstrated in two recent studies (van & Juffer, 2010; Zeanah et al., 2005). Zeanah et al. (2005) developed a scale for assessing the range of attachment behavior, with the highest rating reflecting definite attachment behaviors that clearly fit with the traditional

coding scheme for attachment. Of the never institutionalized children, 100% received this highest rating for clear, classifiable attachment, whereas only 3% of the institutionalized children received this rating. Although about 60% of the institutionalized children showed at least fragmented attachment behaviors, more than 30% showed little to no attachment behaviors.

Attachment security refers to children's ability to find comfort in their caregivers when they are distressed. Among children who have never been institutionalized, (van, 2008) has indicated that the majority (62%) develop secure attachments to their caregivers, with a minority (about 24%) of children developing insecure attachments, and a smaller proportion (about 15%) developing disorganized attachments to caregivers.

Disorganized attachment is most indicative of risk (Fearon et al, 2010) and is characterized by odd behaviors that appear to reflect a breakdown in strategy to obtain proximity. Among children who are institutionalized, disorganized attachments and other aberrant forms of attachment quality (i.e., disorganized, unclassifiable, and insecure other) predominate (Almas et al, 2015). For example, Zeanah et al. (2005) found that only 22% of institutionalized children were classified as having organized attachments (secure or insecure), whereas 65% were classified as having disorganized attachments and 13% were unclassifiable.

Indiscriminately Sociable Behavior:Indiscriminately sociable behavior refers to children's lack of reticence with unfamiliar adults, willingness to approach and engage strangers, and failure to maintain proximity to attachment figures in unfamiliar settings. O'Connor and colleagues (O' Connor, 2003) have emphasized the lack of social boundaries among children with this behavior pattern. Zeanah et al. (2005) found that 44% of institutionalized children showed high levels of indiscriminately sociable behavior as contrasted with 18% of children who had never been institutionalized.

Low cognitive and intellectual development: Children living in institutional care show very significant deficits in intellectual and cognitive development (Mehta et al, 2009). For example, Rutter (1998) found that the mean IQ of children leaving institutional care in Romania shortly after the fall of Ceausescu was about 50 (population mean = 100, $SD = 15$). In a meta-analysis of 75 studies, (van et al, 2008) found that children living in institutional care scored on average 20 points lower on intelligence tests than children who wereraised in families. Differences between

institutionalized children and comparison children were similar regardless of whether the comparison data represented children raised by birth parents, children raised by foster parents, or normative data (van et al., 2008).

To assess cognitive functioning at the level of differential brain activation, Marshall, Fox, and the BEIP Core Group (2004) examined differences in alpha and theta power through electroencephalogram (EEG) data among institutionalized and never institutionalized children. Institutionalized children showed lower alpha power at prefrontal cortex sites, and higher theta power at posterior sites, relative to never institutionalized children. This pattern of results is suggestive of either cortical hypo activation or delayed cortical maturation, that is, either deviant or delayed development (McLaughlin et al., 2010). The specific deficits in attention and executive functioning that have been seen among children who have been institutionalized are consistent with these EEG results (Gunnar et al., 2007).

In both of the studies of Romanian adoptees intellectual development was also examined. In Ames's sample, when the adopted children had been in their adoptive homes for approximately three years, orphanage children had significantly lower IQs than both Canadian-born and early adopted children . This was particularly the case for children who were adopted after two years of age. Therefore, the longer those children had been institutionalized the more likely such institutionalization had an impact on intellectual development. It is important to note, however, that there was wide variability in IQ scores within each group of children, with some orphanage children scoring in the superior range for IQ (Gunnar et al., 2007)

2.1.4. Early childhood experience of institutionalized children

Early life events influence life-long patterns of emotionality and stress responsiveness and alter the rate of brain and body aging. Brain imaging techniques have enabled scientists to document the effects of abuse and neglect on the developing brain. These images show that violence, abuse and neglect early in life damages the brain's physical structure by impairing cell growth, interfering with the formation of health circuitry, and altering the neural structure and function of the young brain (McEwen, 2007). When we are thinking of childhood neglect orphan children would be among the first ones to suffer from this problem.

Good care giving should include sensitive and consistent caregiver–child relationships (Hungerford & Cox, 2006). However, institutions facing major difficulties due to unfavorable caregiver–child ratios and poorly trained, overburdened personnel often fail to provide care that meets the needs of orphaned or otherwise vulnerable children (Hermenau et al, 2017). Usually, the child care institutions are able to offer basic provisions of food and shelter, but they lack adequate means to offer sensitive, child-oriented care, possibly leading to the emotional and physical neglect of many children. The lack of a loving and positive care environment is related to various negative outcomes in child development as well as physical and mental health (Johnson et al., 2010; R. Johnson et al., 2006).

Furthermore, the aforementioned structural problems may contribute to high levels of emotional and physical abuse in institutional care (Hermenau et al., 2015). For example, the reported worldwide rates of violence against children in institutional care were 6 times higher than those of children living in family-based foster care. Untrained and undereducated caregivers, in particular, frequently used severe physical punishment to discipline the children (Hermenau et al, 2015). Thus, in addition to trauma-related disorders due to the loss of a parent, other traumatic experiences and adversities during early childhood as well as possible maltreatment in the family of origin, orphans and other children are burdened with further experiences of emotional and physical maltreatment in institutional care (Hermenau et al., 2011)

Children may develop a low-quality attachment bond or even lack an attachment relationship altogether in the absence of adequate early care. Taken together with the experience of violence and abuse, this lack may impact the child’s stress response system, and, in this way, the development and structure of the brain as well. These changes to neurodevelopment may lead to mental health problems, such as depression, posttraumatic stress disorder, and internalizing and externalizing problems (Hermenau et al, 2015). Further, individuals with a history of early institutional care showed more academic difficulties and deficits in social skills, such as maintaining trustful interpersonal relationships (Hecker et al, 2016).

2.1.5. Child - Care Giver Interaction

Among very young children, the earliest building blocks of social functioning lie in the quality of the attachment relationships formed with caregivers. Like other aspects of social

functioning, disturbances in the formation of attachment relationships are particularly common among children raised in institutions, as children in these circumstances have few opportunities to form lasting relationships with safe and supportive adults. Studies are consistent with the hypothesis that a major contributor to contemporary delayed development and longer-term extreme behaviors and problems is the relative lack of caregiver–child warm, sensitive, responsive social–emotional interactions and the opportunity to experience relationships with a few, consistent caregivers that is typical of many substandard orphanages (Van et al, 2011).

Studies involving attachment in institution-based care show deficiencies in caregiver stability and consistency, as well as in caregiver responsiveness and emotional availability (Bettmann et al, 2015). Due to insufficient child–caregiver ratios and inconsistent caregiver shift rotations, children in institutional settings typically encounter repeated separations from caregivers (Johnson et al., 2010). Negative effects of separations on children include symptoms such as agitation, depression, altered cardiac activity, and sleep interruptions. Research conducted in Romanian orphanages suggests that social interaction with caregivers may be a primary factor influencing cognitive and physical development (Johnson et al., 2010). In one study, orphanage caregivers, prior to being trained to provide warm, responsive care giving, displayed high levels of anxiety and communicated little with the children in their care (Groark et al., 2005).

Further, the children responded to their orphanage caregivers with indiscriminate friendliness, lack of eye contact, aggression and impulsive behaviors. After training and staffing rearrangement interventions, however, caregivers became more responsive and children's interpersonal skills improved along with their physical growth, cognition, language, and motor development (Groark et al., 2005). Some orphanage studies have found that while the material needs of orphans were met, orphans experienced deprivation in terms of emotional need fulfillment, including interpersonal interactions with staff.

These studies' longitudinal data support the idea that establishing higher quality child–caregiver interactions with appropriate training in emotional engagement and contingent care giving leads to promising outcomes in children's growth and development (Groark et al., 2005; Johnson et al., 2010).

2.1.6. Features of supportive and facilitative caregiver-child interactions

A scale which was developed and studied in the context of orphanages for young children called Caregiver-Child Social/Emotional and Relationship Rating Scale (CCSERRS) (McCall et al, 2010) intended to assess a few dimensions that comprehensively cover the range of caregiver-child social-emotional interactions and relationships puts constructs to measure the quality of caregiver –child interaction. Care giver engagement is one among the constructs and it reads detail elements as follows:

caregiver looks child in the eye and holds child face-to-face while feeding or in play; caregiver listens attentively when children speak (e.g., looks at them, responds by nodding); caregiver gets at the level of the child (kneels, sits on floor with children) to have better eye contact, to hear a child, to talk or play with children; caregiver attends to and engages appropriately a child who is constructively engaged (she goes with the child's flow). caregiver paces caregiving to match child's behavior (e.g., waits to give next spoonful of food until the child is ready), is patient with slow eaters or dressers; tolerates messiness; caregiver responds to child's behavior, signals, and communication attempts; caregiver makes empathetic verbalizations or facial expressions to child's actions and events; caregiver shares joy and excitement, pride in children's accomplishments; caregiver imitates child's behavior (vocalization, smile, actions); caregiver praises, encourages, rewards child for child's behavior.(McCall et al, p. 10, 2010)

The scale also represents constructs that measures care giver detachment as follows;

In the presence of a child or children, caregiver does not make eye contact; does not talk to children in a social way; does not engage children when that would be possible; ignores them when they are eating, dressing, playing; does other tasks during free time, such as talk to other caregivers, takes a break to smoke or groom herself; props bottle instead of feeding child..(McCall et al, p. 10, 2010)

Another article that describes the background and development of the Caregiver Interaction Profile (CIP) (Helmerhorst, 2014) scales to rate 6 key skills of caregivers for interacting with 0- to 4-year-old children in child care centers. Looking more closely at the

constructs that represent quality caregiver-child interactions for infants and toddlers, we see that the model posits five positive behaviors and three negative behaviors that characterize the caregiver-child interaction. *Sensitive responsiveness* is one of the positive constructs listed in the scale.

Sensitive responsiveness refers to the extent to which a caregiver recognizes children's individual emotional and physical needs and responds appropriately and promptly to their cues and signals. This broad quality of caregiver behavior, which is also referred to as sensitivity, warmth, or supportive presence is considered the key aspect of care giving in attachment theory (Ainsworth et al., 1978; Bowlby, 1969) and is generally recognized as the most basic aspect of caregiver behavior in interactions with children from birth onward. Caregiver sensitive responsiveness has been shown to contribute to the development of a secure caregiver-child attachment and to foster children's ego resilience in later childhood (Riksen-Walraven & Van Aken, 1997).

To Ainsworth, sensitivity is entailed regarding the child "as a separate person" and being "capable of seeing things from the child's point of view". This goes beyond a basic ability to recognize and respond to the child's physical states such as hunger and distress, to a capacity to be able to "read" the babies' behavior. Meins et al. (2001) call this "mind-mindedness", or the inclination to treat the baby as a person with feelings and wishes. Caregivers frequently demonstrate mind mindedness in their talk to infants, in comments such as "you like that, don't you", "oh, that's a big talk!", "you're teasing me", and soon. Ainsworth and colleagues (Ainsworth, Bell & Stayton, 1974) described four components of the ability of caregivers to perceive, accurately interpret and respond to their infant's behavior:

1. *Awareness of the infant's signals.* That is, the caregiver must be reasonably accessible to the infant's signals and to the threshold, even if muted, of the infant's cues.
2. *An accurate interpretation of signals.* That is, the caregiver must be free of distortions resulting from projection, interference or denial, as might occur when the caregiver is hurried during a feed and prematurely interprets the baby's restlessness as a sign of satiation. In addition, the caregiver needs to be empathic, not detached, so that her emotions are available to be engaged by the infant.
3. *An appropriate response to the infant's communications.* For example, to pick the infant up when she is distressed, or to put her down when she wants to explore. Towards the

end of the first year, what is appropriate is tempered by other socialization goals, for example, not to touch things that might break, and these interventions too, must be achieved with sensitivity.

4. *A prompt response to the infant*, so that the caregiver's reaction is perceived to be contingent on the child's communication and a satisfaction of his needs. Sensitivity is not a characteristic only of a care giver. It is a relationship construct and thus also a function of the infant's capacity and skill to signal behavior states in clear and consistent ways. (Ainsworth, Bell & Stayton, 1974)

The other construct which is included in CCSERRS is Behavioral Control. The scale expects from a quality care giving the following constructs to be fulfilled.

caregiver kindly and positively encourages child to feed, dress, bath self;
caregiver is sympathetic or empathetic with a child having difficulty or one who is hurt and crying; caregiver changes child behavior in a positive and supportive way by providing "guidance" or "suggestions;" caregiver explains a rule or consequences and calmly redirects behavior all in a positive and supportive way. Physically and negatively grabbing a child to move him or her; correcting a child in a clearly negative way; hitting or spanking a child. Verbally abusing, yelling or talking down to child in a disrespectful manner are descriptions of poor care giving (McCall et al, p. 10, 2010).

Caregiver Interaction Profile (CIP) also puts this idea as Structuring and limit setting, which refers to the ability of a caregiver to clearly communicate expectations toward children and structure the situation accordingly, and to set clear and consistent limits on the children's behavior. This caregiver skill becomes increasingly important in the second year of life, as children acquire a sense of autonomy and quickly expand their locomotor abilities. Adequate and consistent structuring and limit setting contributes to the predictability of the environment and therefore to the development of security and competence. Moreover, a lack of structuring and limit setting has been associated with the development of noncompliance in children (Helmerhorst, 2014).

The other construct is Caregiver Affect with Children, a care giver who displays a positive affect to the child can be measured with the following elements

She smiles at child; talks to the child in a positive, warm, affectionate, supportive way; she hugs, kisses, and warmly holds a child (McCall et al, p. 11, 2010).

A caregiver's negative affect is expressed by

speaking negatively, harshly, with annoyance, hostility, and scolding or shouting at the child; caregiver is critical of children, puts them down, uses sarcasm, blames child, says "bad boy" (McCall et al, p. 11, 2010).

2.2. Theoretical perspective

2.2.1. Attachment theory

Attachment theory is one of the better-known theories of contemporary developmental psychology. Its basic theme is that human infants need a consistent nurturing relationship with one or more sensitive caregivers in order to develop into healthy individuals. Inadequate relationships are considered to contribute to aberrant behavior and in combination with other risk factors to psychopathology. The theory was gradually developed by the British psychiatrist and psychoanalyst John Bowlby and comprehensively formulated in his trilogy (Bowlby 1969, 1973, 1980), after which attachment theory steadily became more influential. John Bowlby, asserted that healthy attachment relationships with primary caregivers serve as the bedrock for children's developing relational patterns.

More recent research suggests links between children's early attachment relationships and later developmental trajectories, including their capacity for affect regulation, sociability, adjustment, and psychopathology. These relationships require stability and consistency, as well as responsive, trustworthy and developmentally appropriate caregiving behaviors (Crockenberg et al, 2008).

According to Bowlby and Ainsworth, the attachment bond is a specific type of bond included in a larger class of affection bonds (Mikulincer et al, 2007). The specific features of attachment bonds are: persistence of the bond, involvement of specific persons who are not interchangeable, significant emotional involvement, the desire to maintain proximity and/or

contact with the person, distress during separations and the necessity of individuals to seek security and comfort in the relationship (Mikulincer et al, 2007).

Attachment bonds are associated with specific attachment behaviors that Bowlby designate as behavioral homeostasis, instinctive behaviors intended to protect the child from danger and stress, and that are characterized by emotional and cognitive regulatory mechanisms; the child learns early to recognize the primary attachment figures and develops different emotional responses to keep proximity with this person (Mikulincer et al, 2007).

Attachment can be formed as early as seven months. Almost all infants become attached; attachments are formed to only a few persons, and are resulting of social interactions with these persons.

The theory described first parent infant attachment as a system to ensure the caregiver and child's proximity to one another for the infant's protection. Infants have innate signaling capacities such as crying that bring and keep the caregiver closer, and caregivers respond to these signals with greater or lesser urgency. The three criteria of an attachment relationship are;

1. The child wants to be with the attachment figure, especially when they are under stress;
2. The child drives comfort from the attachment figure; and
3. The child protests when the attachment figure is not available (Van et al, 2008).

Infants appear biologically driven to form attachment relationships regardless of their culture. Proximity to a caregiver and having attachment needs met provides the child with a sense of security. The infant then comes to trust and use this caregiver as a secure base from which to explore the social and physical world. Separation from primary caregivers and others with whom the child has attachment bonds can be a source of distress for children.

Separation threatens the development and maintenance of emotional connections and healthy attachment relationships. Distress, symptoms of anxiety, depression and psychopathology often accompany an infant's separation. Without a warm, responsive caregiver and with a lack of sustained interactions and positive attunement between an infant and his caregiver, the infant's development will be negatively affected. Healthy attachment experiences

encourage infants' development of cognitive skills, appropriate social and emotional development, and mental health (Verissimo et al, 2014).

Attachment behaviors include: crying, smiling and vocalization differentially towards the caregiver; orientation and attention towards the caregiver; following the caregiver; clambering over and exploration of the caregiver; and happiness when reunited with the caregiver after a separation.

2.2.1. 1. Attachment Problems in Institutionalized Children

Most developmental theories (e.g., psychoanalytic theory, Freud, 1940; social-cultural theory, Vygotsky, 1978; social-learning theory, Bandura, 1977; attachment theory, Bowlby, 1958) emphasize the importance of early social-emotional experience and the opportunity to experience human relationships for typical social and mental development. Attachment theory, in particular, focuses specifically on early experience with a few warm, caring, and socially-emotionally responsive adults who are relatively stable in the child's life as the foundation of appropriate social-emotional development and long-term mental health (Juffer, 2008).

Theoretically, an infant with a warm, responsive caregiver develops an internal working model of expectations for nurturing, supportive reactions from that caregiver, whom the infant comes to trust and use as a secure base from which to explore the social and physical world. Such experiences in turn promote the development of a sense of worthiness and self-esteem and appropriate longterm social-emotional development and mental health. Without the early experience of a few warm, caring, socially-emotionally responsive adults, long-term development may be compromised.

Early observations of institutionalized children by Burlingham and Freud (1944), Bowlby (1951), and Spitz (1946) provoked the speculation that such children lacked 'mothering' and the opportunity to form an attachment relationship with a caregiver. Furthermore, the many and changing caregivers that such children experience limit the likelihood that they would readily develop conceptual models of their environment and how to behave effectively in it, and the lack of appropriate care giving would also minimize their opportunities to develop self-regulation of their emotions and behavior (Bakermans et al., 2011).

There are no direct tests of the role of attachment theory in explaining institutionalized and PI children's development, for example, those children who have attachments in the

institution develop physically and mentally better while residents have lower rates of long-term problems if adopted. Instead, there are only observations that are ‘relatively consistent or inconsistent’ with the hypothesis. Consistent evidence includes the finding that institutionalized children rarely have organized or secure attachment relationships, and the few studies that have assessed relationships with the Strange Situation Procedure or a modification of it show that nearly three-fourths of institutionalized children have a disorganized or unscorable attachment category (Bakermans et al., 2011). So, indeed, institutionalized children lack even organized, to say nothing of secure, attachment relationships with caregivers.

Further, the lack of a caregiver–child attachment relationship would seem to deny institutionalized children much of the stimulation and experiences that would likely contribute to typical development (McCall, 2011). For example, institutionalized children get limited stimulation of any kind. Infants spend a great deal of time lying in bed staring at a blank white ceiling or lying facedown in their cribs or a large play pen with little stimulation. The many and changing caregivers contribute to inconsistency in the child’s interactions with caregivers, and peers are perhaps even more inconsistent. There is a lack of experience with contingencies of any kind, because care giving duties are often performed TO the infant rather than WITH the infant, and caregiver interactions are often caregiver- rather than child-directed. Thus children have few experiences that would promote the perception of effectiveness or agency with the environment. Children are allowed to cry without being attended (Muhamedrahimov, 1999), so there is little opportunity to learn self-regulation. Presumably a caregiver–child relationship would provide appropriate stimulation and experiences instead of these common conditions of deprivation, and children reported to be ‘caregiver favorites’ indeed do somewhat better developmentally (Smyke et al., 2007).

The strange situation procedure is still used today to assess attachment. Based on the description of those different categories of attachment, new assessments need to be designed in order to measure the attachment processes of infants living in institutions, and for whom the traditional Strange Situation experiment cannot be conducted if they do not have a primary caregiver to rely on. Furthermore, separating one child from the others might already be a strange situation for these orphans who are never separated. The observation of children in different “natural” settings offers many opportunities to observe attachment behaviors such as how children make contact with caregivers, how they interact with caregivers, how they react

when a stranger arrives at the orphanage, and how they explore their environment. (Barbier, 2014).

2.2.2. Psychoanalytic theory, particularly Object Relations Theory

René Spitz, Melanie Klein, Donald Winnicott (1965) and other early child psychoanalysts based their theories on insightful observations of infants in relationships with other people. They postulated that babies had an inborn sensitivity to the emotions of others, and to the ongoing interactions between themselves and their caregivers. They believed that these interactions were highly significant for the child's healthy psychological development, and that insensitive care, neglect or abuse could distort or delay development (Fitzgerald et al, 2000).

In their relationships with others, infants develop a sense of self that is akin to a mirror image of their experience with the caregiver. If the infant is treated with love and kindness, he or she feels worthy of love, and becomes capable of feeling and expressing love and kindness towards others. It is in this sense that Winnicott (1965) observed that, without the mother's contribution, "there is no such thing as an infant".

In these early relationships, the infant forms mental representations of the world, including a self-concept, and these concepts and representations determine the child's later motivations and interpretations of experiences. For this reason, loving, mutually responsive early care is essential for the child to develop into an emotionally secure and confident individual. Donald Winnicott (1965) described the caregiver's role in the early relationship with the infants as "a stage of primary maternal preoccupation". This is a period of heightened awareness on the part of the caregiver to the state, emotional expressions and behaviors of the infant. This awareness enables the caregiver to adjust sensitively and responsively to the child's needs. Winnicott described how the infant "finds himself reflected" in the absorbed adoration of the mother's gaze.

In this relationship, the care giving creates a "holding" environment, which comprises both physical protection and psychological containment or envelopment. Early relationships mirror for the infant a sense of being recognized, understood and validated through the experience of warm and empathic care. Further, the mental state of the caregiver, determined by her own developmental history, exerts an effect on the attitudes, emotions and behaviors that she brings to child care. When an adult watches a loved infant or toddler during everyday life, there

is a moment-by-moment triggering of her own thoughts, feelings and memories. These subjective experiences exert a determining effect on care giving behavior.

2.2.3. The Theory of Mediated Learning Experiences (MLE)

The theory of mediated learning experiences has most often been cited “as part of a wider theoretical framework, the theory of structural cognitive modifiability,(SCM)”, developed by Reuven Feuerstein (Feuerstein,R.,et al, 1991). The basic premise of the theory is the capacity of every individual to modify his/her cognitive structure “irrespective of the three major barriers of change: etiology, critical period, and severity of condition” (Feuerstein, &Feuerstein , 1991, p. 13).

MLE is defined as “a quality of interaction between the organism and its environment. This quality is ensured by the interposition of an initiated, international human being who mediates the stimuli impinging on the organism” similarly, Klein (1992) defines human mediation “as a conscious attempt of an adult to adjust his or her behavior and modify the environment in a way that will ensure that the child can benefit from it, that is, focus on it, perceive, or understand and respond” (Zewdie, 1998).

The theory is basically understood as a bimodal perspective of cognitive development where both the direct exposure of the individual to stimuli as posited in the piagetian theory of cognitive development, and the mediated learning experiences should coexist to ensure human modifiability. It is thus often argued that the direct-exposure approach of the piagetian thinking of cognitive modifiability should have also explained why lower animals have not modified their cognitive structures despite their long history of direct and everyday confrontation with stimuli(Zewdie, 1998).

In contrast to the piagetian approach, however, the theory of mediated learning experiences posits the possible modification of the cognitive structures of individual child for enhanced ” appetite for knowledge”, but mainly through human mediational roles.

Thus, in its departure from the more direct-and-individual- oriented piagetian approach, MLE theory stresses its parallel role to contribute to the modifiability of a child’s cognition through the interposition of adults who can help him/her to organize, expand, and competently interpret his/her world of meanings. Furthermore, the definition is also noted with some

qualifying clauses implying that MLE is not the mere interposition of the adult to provide the accidental “do’s” and “dont’s” in interaction with the child, or a traditional direct teaching of skills to the child(Zewdie, 1998)..

As Klein, (1992) characterizes it, “mediated learning, as distinct from direct from direct learning through the senses, occurs when the environment is interpreted for the child by another person who understands the child’s needs, interests, and capacities and who takes an active role in making components of that environment as well of the past and future experiences compatible with the child”. It is also interpreted as not necessarily meaning verbal interaction only, as all modalities of interaction, gestural, kinetic, mimicry, and modeling can also constitute quality of interaction, provided that the mediator is conscious and well intentioned in the process. As a general note, MLE is richer and involves varied types of adult-child interactional processes which take into account some specific principles in order to “close the loop” of stimuli – mediator – mediate relationships.

The following five condensed parameters as observed in the program called MISC (Klein et al, 2004) are defined as follows:

Intentionality and Reciprocity- deliberate acts of selecting, sequencing, exaggerating, accentuating of stimuli by the parent for the reciprocal response of the child through vocal, verbal or non-verbal forms of behavior.

Mediation of Meaning- acts of expressing affect by the parent in relation to objects, animals, concepts or values through facial expressions, gestures, tone of voice, verbal expression of affect, classification, labeling and valuing of the child’s or adult’s experience.

Transcendence- adult’s acts directed toward the expansion of a child’s cognitive awareness beyond the immediate need through explanation, comparison, contrast, etc, during parental interaction with the child.

Mediated Feelings of Competence- acts of adult’s verbal and non verbal expressions of satisfaction with the accomplishments of the child and,

Mediated Regulation of behavior- acts of child's behavioral control by the adult through modeling, demonstration, and/or verbal suggestion (Klein, P.S.,1988;Klein & Hundeide, 1989).

2.3. Conceptual Framework

Theoretically, an infant with a warm, responsive caregiver develops an internal working model of expectations for nurturing, supportive reactions from that caregiver, whom the infant comes to trust and use as a secure base from which to explore the social and physical world. Such experiences in turn promote the development of a sense of worthiness and self-esteem and appropriate long term social–emotional development and mental health. Without the early experience of a few warm, caring, socially–emotionally responsive adults, long-term development may be compromised.

Institutionalized children lacked ‘mothering’ and the opportunity to form an attachment relationship with a caregiver. Furthermore, the many and changing caregivers that such children experience limit the likelihood that they would readily develop conceptual models of their environment and how to behave effectively in it, and the lack of appropriate care giving would also minimize their opportunities to develop self regulation of their emotions and behavior (Bakermans et al., 2011).

Institutionalized children get limited stimulation of any kind. Infants spend a great deal of time lying in bed staring at a blank white ceiling or lying facedown in their cribs or a large play pen with little stimulation. The many and changing caregivers contribute to inconsistency in the child's interactions with caregivers, and peers are perhaps even more inconsistent. There is a lack of experience with contingencies of any kind, because care giving duties are often performed TO the infant rather than WITH the infant, and caregiver interactions are often caregiver- rather than child-directed. As a result there is little opportunity to learn self-regulation (Smyke et al., 2007).

In care giver child relationship, the care giving creates a “holding” environment, which comprises both physical protection and psychological containment or envelopment. Early relationships mirror for the infant a sense of being recognized, understood and validated through the experience of warm and empathic care. In their relationships with others, infants develop a sense of self that is akin to a mirror image of their experience with the caregiver. If the infant is

treated with love and kindness, he or she feels worthy of love, and becomes capable of feeling and expressing love and kindness towards others.

The environment needs to be interpreted for the child by another person who understands the child's needs, interests, and capacities and who takes an active role in making components of that environment as well of the past and future experiences compatible with the child". It is also interpreted as not necessarily meaning verbal interaction only, as all modalities of interaction, gestural, kinetic, mimicry, and modeling can also constitute quality of interaction, provided that the mediator is conscious and well intentioned in the process(klein, 1992).

As long as early experiences determine the child's present development and future life, a great deal of attention should be given to early care. A child who is grown up in warm sensitive environment and received love from the environment will be able to regulate an appropriate self-concept and will be able to think that he is worthy of love. This will boost up his self-esteem and over all relationships now and then. Having this in mind will also help him/her to run into accomplishments in education, work, marriage and other aspects of life.

The opposite will come to pass in the children's life if they are not able to be raised up in such kind of environment. Developmental delay, low self – esteem, perception of unworthy of love, inability to receive and give love, poor communication such and other distortions will hold them back from flourishing in life.

Chapter Three: Methodology

3.1. Study design

The research draws on qualitative research design, which is descriptive case study. The case study mainly focused on the caregivers of Kebebe – Tsehay in their interaction with the children. Qualitative research is a research design which focuses on natural settings where human behavior or events occur where it focuses on the perceptions and experiences of participants. In qualitative research the researcher is the primary instrument of data collection and focuses on understanding how things occur in a particular setting (Creswell, 2009). The study is descriptive in its nature. It is descriptive since it attempts to describe the quality of the

psychological care giving pattern given in the institution. In order to achieve the stated objectives, qualitative approaches of data collection method was used. The choice of qualitative research design is influenced by the nature of the problem and the place of the study. The research problem will determine the methods and procedures: the types of measurement, the sampling, the data collection and the data analysis to be employed for the proposed research (Zikmund, 2010).

3.2. Study Site

The study is conducted in a governmental orphanage called Kebebe - Tsehay. It is found in the capital city of Ethiopia, Addis Ababa Gulele Subcity Woreda 04. The institution is the oldest state-run orphanage in Ethiopia and funded by the government. It is established in 1963 GC. The compound is donated by, the wife of the Famous Ethiopian Novelist Hadis Alemayehu, W/ro Kebebe – Tsehay. By the time this data was collected there were a total of 173 children under the institution's care though; the number varies time to time. Children in the institution are of up to age eight and admitted due to different reasons. Some of the reasons are that when the police received a report of abandoned child or a family unable to raise their children, it will send the children by a formal letter to Kebebe – Tsehay. The other reason is when a mother left her new born baby at the hospital and lost, the hospital will send the children to the institution. The other reason for admission is by court order. If the parent's of the child is under court proceeding and if there is no other guardian for the child, the court will send the children to the institution until the parent is free from detainment. Care and management of the children has been undertaken in wards classified by the age of the children and their health condition. There were a total of 11 wards where two of them were for special need children and children under medical care (OPD). The rest of the wards were classified based on age groups of the children.

3.3. Study Participant

The target populations were the caregivers of infants and toddlers working at Kebebe - Tsehay government child care institution. The participants of the research were care givers who provide care for the children and program officers who are taking care of the overall tasks of the institution.

3.4. Sampling techniques

As a qualitative study, a qualitative sampling method works very well in order to collect the required data. Because of this, a non-probability sampling technique was applied. From the non-probability sampling techniques, purposive sampling method was chosen for the sake of gathering the data in depth and because this technique allowed the researcher to gather the data from those who were selected. There were a total of 96 caregivers in the institution. These caregivers are rotated in four shifts of 12 hours. So in one shift there will be 24 caregivers. Among the total number of population 12 caregivers were participated in the research. These participants fit the case study since they spend much of their time interacting with the children and the study mainly focused on the care giver child interaction. Additionally, the director of the institution, the care giver coordinator and one social worker were also participants in the key informant interviews.

3.5. Data collection instruments

Qualitative research methods need instruments that must permit the researcher to collect data in depth. Keeping this in mind, three instruments were applied. The instruments were interview, observation and focus group discussion. The researcher used an observation check list as a main tool of data collection. Since we are describing the interaction between the care givers and the children there will be no appropriate instrument other than an observation checklist.

The researcher used a semi-structured interview guideline for both in-depth interviews and the FGDs. The guide questions were prepared in Amharic to make them easily understandable to the participants and to avoid the interruption of discussion flow owing to translation problems. The in-depth interviews were held while the caregivers are on their routine works of care giving and the convenient time for the participants of FGD was in their coffee time. Apart from this data collection tools field notes were taken during the normal process of care giving.

3.6. Data collection procedures

Prior to the data collection process the researcher submitted a formal application letter, taken from the Addis Ababa University School of Psychology, to the City government of Addis Ababa Women and Children Affairs Bureau. Then the Bureau wrote a support letter to Kebebe – Tsehay Government Orphanage. Then the support letter was submitted to the director of the orphanage, in order to get permission to conduct the research at the institution. Then the institution granted permission for conducting the research.

3.6.1. Observation

Observational method is used in order to see how the targeted population is acting in a natural setting. In the case at hand, how are the caregivers providing psychological care for the children. How are the care givers relating to the children in a normal daily bases. The researcher adopted an observation check list from a child caregiver interaction scales (McCall et al, 2010). The checklist which is prepared for toddlers sections (from one year to 4 years old children) has a total of 22 items in which classified under 4 main constructs and 8 sub constructs. And an observation check list which is prepared for infants (new born babies – one year old) has a total of 16 items which is classified in to 2 main constructs and four sub-constructs. Each item is scored on a four-point scale Never, Rarely, Frequently and Consistently.

After granted with permission to conduct the research, the researcher went to the institution to start collection of data using the observation check list. The care giver coordinator took the researcher to the sections and introduced her with the caregivers. The wards for observation are purposefully selected based on their convenience to the items in the observation check list. Then after explaining the purpose of the research and granted with permission and consent from the caregivers, the researcher started observing the situation in the natural setting. The researcher has made repeated observations on four caregivers, while the care givers and the children are in their natural setting. Since the caregivers are rotated in to four shifts of 12 hours, the data collection was made following these shifts. The observation took in 10 minutes for each of the caregivers.

3.6.2. Interview

In order to obtain a deeper understanding of the issues raised, Interview guidelines were prepared and conducted. After the researcher was done with the observation, she continued with conducting the interview with selected participants. First, the researcher interviewed the caregiver coordinator with a total of 7 questions for 20 minutes. Then, the coordinator took the researcher to caregivers who were working in different sections. Subsequently the researcher spent 10 minutes to each of the caregivers with a total of 9 questions for each of them. Afterward with the other day the researcher met the director of the institution for an interview. She was approached with 8 questions for 15 minutes. And finally the social worker was interviewed for 10 minutes with 6 numbers of questions. Consent of All the participants was obtained and the purpose of the research is explained. The anonymity of the persons interviewed was guaranteed.

3.6.3. Focus group discussion

In order to study the situation in a more natural conversation pattern, one focus group discussion session, containing five members, was administered with child caregivers in the institution after obtaining consent from each of the participants and explaining the purpose of the research. The FGD was guided by the researcher with four relevant questions. Because of the busy schedule of the caregivers, the discussion was run by using their coffee time after lunch for about 30 minutes.

3.7. Data analysis procedure

The goal of qualitative data analysis is to uncover emerging themes, patterns, concepts, insights, and understandings (Patton, 2002) .As indicated above the relevant data for the study is collected using the instruments mentioned above. Observation was the main source of data collection using an observation check list. The researcher used observation check list and observed the overall activity of the care givers and their interactions with the children being guided by the constructs rating quality care giving in the check list.

The data collected from interview were clearly provided in detail. During the interview the researcher took detail notes in Amharic and audio taped the interviews. Then the note taken

from the interviewees were translated into English without changing the original meanings and ideas.

The data obtained from focus group discussion is also analyzed by translating it in to English. Then researcher immersed herself into the data by repeatedly reading the transcribed and translated notes. Then the data obtained was coded in to five themes using manual coding system.

The coding of the data was started immediately after the translation of the data to avoid memory loss. The coded data were further coded, grouped and categorized. That means, the codes with similar characteristics were grouped together thematically.

3.8. Ethical considerations

Ethics is very important when carrying out any type of psychological research. In the process of data collection all participants of this research were informed about the purposes of the research and issues of confidentiality before the process of the observation and interview proceeds. The researcher informed the participants of the study that their participation in the research is based on their consent. Participants were told that there is no need of telling their names to the researcher in order to ensure confidentiality and during the data analysis and interpretation process the researcher protected the anonymity, roles and incidents of individuals who participate in the study.

Chapter Four: Findings

4.1. Demographic data of Participants

As a data collection tools, the researcher has employed different data collection tools: an in depth interviews with 3 caregivers and observation was made on 4 care givers repeatedly. A FGD session was also conducted with five caregivers working in the institution.

Table .1 Socio demographic profile of participants.(N = 15)

Variables	Categories	Frequency	Percentage %
-----------	------------	-----------	--------------

Age	20- 30 years old	7	46.7
	30 – 40 years old	6	40
	40- 50 years old	2	13.3
Sex	Male	2	13.3
	Female	13	86.6
Educational level	No Education	3	20
	Read and write	3	20
	Elementary	2	13.3
	Secondary	4	26
	collage/university	3	20
Marital Status	Single	5	33.3
	Married	6	40
	other	4	26
Work Experience	0-3 Years	3	20
	4-10 Years	10	66.6
	10+	2	13.3

As it can be seen on table 1, description of participants was made by age, sex, and grade level and marriage status.

Based on the information provided on the table, seven of the participant care givers were between the age of 20 – 30 years old(47%). As it is indicated on the table almost all the participants were female except two maleparticipants. When we see the educational level of the participants 20% of them had no educational background, 20 % of them can write and read and 20 % of them were passed through higher education. 40% of the participants were married. 66.6% of the participant caregivers had work experience of 4-10 years.

4.2.Care giver profile, consistency and quality assurance

Caregiver- child Ratio: care giver – child ratio is the number of caregivers working in one section related to the number of children being treated in that section. The data gained from the social worker of the institution is tabled as follows.

Table.2 Caregiver- child Ratio

No	Wards	Age of children	Number of Children per ward	Number of caregiver per ward	Care giver- child ratio per ward
1	ward 1(reception)	New born babies	21	2	1:10.5
2	ward 2	0 - 6 months old	22	2	1:11
3	ward 3	0 - 6 months old	32	4	1:8
4	ward 4	6 month - 1year old	10	2	1:5
5	ward 5	1 year- 2 years old	16	2	1:8
6	ward 6	2 years - 3 years old	11	2	1:5.5
7	ward 7	3 years - 4 years old	17	2	1:8.5
8	ward 8	5years - 8 years boys old	12	2	1:06
9	ward 9	5years - 8 years girls old	10	2	1:05
10	ward 10 (Special needs children)	3 years – 8 years old	11	2	1:5.5
11	ward 11 (OPD)	0-6 month old	11	2	1:5.5

	Total		173	24	1:7.2
--	--------------	--	------------	-----------	--------------

As it is tried to indicate on the table 2 description of care giver – child ratio is made through classification of wards found in the institution.

The total number of ward in the institution is 11. The first is a called reception ward. When new born babies are admitted to the institution, they will be sent to this section. There were a total of 21 babies when the time this data is collected. There were only two care givers in the section for a total of 21 children who are in need of an intense care. There were 54 children who are of age 0-6 months in the second and the third wards. Here there were 6 caregivers which mean one caregiver is responsible for an average of nine children. Ward four is a section where 6month up to one year old children are being raised in. In here there were 2 care givers who were taking care of 10 children. 16 children who are of age 1 – 2 years old were being taken care of by 2 care givers in ward 5. In ward 6, 11 children who are 2-3 years old were getting care by 2 caregivers. Ward 7 had 17 children who are 3 – 4 years old. There were 2 care givers for 17 children in this ward. Ward 8 and 9 are for boys and girls respectively, who are 5-8 years old. In these sections there were 12 boys and 10 girls who were being taken care of by 2 caregivers for each. This mean one care giver is responsible for an average of 5 children. Ward 10 is a section where special needs children were being taken care of. In this respective section there were 11 children who are getting care by 2 care givers. The OPD section is the last section where children who were sick were being treated. Here there were 2 care givers who were taking care of the children.

One thing to give attention over here is that, the institution generally has 96 care givers. But these caregivers are rotated in 4 shifts of 12 hours. These means for instance, if one care giver is on duty on the day time her next shift will be the next day night time.

Care giver consistency: caregivers are not consistently assigned to the same group; as the caregiver’s coordinator replied when he was asked whether they are consistent to one group;

There are four shifts of 12 hours and plus to that one caregiver will stay in one section for two months. This is because in the infant’s section there is relatively

higher burden than the other sections. Therefore, the need for rotation is a necessity for caregivers in order to be able to share the burden among them.

Inconsistency of adults to the children's life: As it is observed, adults tend to come and go in to the children's lives. Visitors came and go many times a day. With the repeated times of observation the researcher was able to see different persons who are volunteering in the institution either from the country or abroad. By a conversation with two volunteers, it is figured out that volunteers are coming to the institutions with limited period of time. One volunteer student with a conversation to the researcher said when she is asked with what interval she is coming to the institution for volunteering, and she has directly stated that "We are high school students and we are coming here twice a week (Tuesday and Thursday) in this summer school break."

Criteria for hiring the caregivers: by an interview made with the Director of the orphanage it is able to know that now days caregivers are being hired with some qualifications. The director replied that;

Before, caregivers were hired without any qualification. There are also some caregivers, still working and waiting for retirement, who were hired without any school background.

Training for Care givers: the director answered when asked whether the caregivers are supported with trainings: she said as follows:

We sometimes prepare trainings in collaboration with private NGOs or with the City Government of Addis Ababa Women's and children's Affairs Bureau. But it is not frequently.

Controlling the quality of care giving: the director replied when asked how the organization is controlling the quality of caregiving; she voiced as follows:

We control the quality of care giving through the Nurses. They provide caregivers with every specification needed like with what time interval they should change the diapers, the amount of milk they feed to the children and so on. But, it is hard for us to create the attachment bond with one child and one caregiver. The

structure by itself is not allowing us to apply this. Creating attachment bonds with one caregiver is not working in here since there are four shifts of 12 hours and the caregivers are not consistent to one group.

4.3. Constructs to Rate the Caregiver – Child Interaction

4.3.1. Care giver Engagement

As it is observed most participant care givers working in the infants section (new born-one year) are rarely engaged because of their unbalanced number to the children. When the different times the researcher was there for observation, the child care giver ratio in these sections was varied between 20-22 children for 2 caregivers and sometimes for one caregiver. But most of the time there were volunteers helping there.

With repeated observation in the institution, most of the care givers rarely make eye contact; and respond to child's vocalization, smile, crying and frustration. In case if they respond it is in a business-like mechanical manner. While also feeding participants rarely look the child in the eye and hold child face to face. Most of the time, they put the feeding bottle in the mouth of the child in one hand and prepare another feeding bottle with the other hand or talk to another caregiver or anyone around. In order to make the child finish suckling very fast they push the bottle very hard in to the child's mouth.

Frequently, the caregiver paces care giving too much. After finishing feeding one child the caregivers rush to the other. While also changing diapers the caregivers seems working in a factory. They showed any engagement with child neither an eye contact nor vocalization. The children were wounded because of the diaper and when the time the caregiver is changing the diaper they cleaned it with a wiper. At this time the children will start to cry out loud. But most of the caregivers are not responding to the child's emotions. Do not use any vocalization to calm the child down.

In the Focus group discussion session they were asked how they are accomplishing the routine activities of care giving. The findings indicate that they have many tasks to do since the time they get in to their work place. The first participant of the FGD explained as:

We will start our day by changing the diapers going around. There are too many children in the section so that we need to be in a hurry in order to be proceeded to that next task.

The other participant 3 added that;

After finishing changing the diapers we will continue preparing the bottle and start feeding the children. When we are feeding one child the other is already crying so we rush to the next child.

There are many children left crying in their bed unable to get any response. Some of the babies are also left tied in the baby carriage looking for someone to touch, hug or play with them. Though they are stretching their hands towards any passer by adult to be hugged, no one is answering for the call they have made. Unluckily, hugging, touching and playing are not common for the child rather considered as an extra time taking task. Interview respondent 1 working in this section for about 5 years explained the situation like this, when asked why a child cry and what kind of respond do they give, she has voiced as:

A child cries when he has got some problem either when he is hungry or when he wants to get his diaper changed. So in this time we tried to give response. But many children may cry at once. At this time it will be hard for us to give response to all of them.

The same thing is observed on caregivers working in the toddlers (one year – 2 year children) section. The caregivers in this section have relatively lesser burden than care givers in the infants section. Every child is bounded with its cradle (baby bed). Most of the babies want to be touched and hugged. They are left by themselves. If it is not a time to feed or change diapers, no caregiver was not around even if they are crying. There are children consistently crying, but couldn't get any response. Because they are crying for longer time they are ignored and the caregivers seems adapted to it and continued talking to each other, drinking coffee. The caregivers move from one room to the other, talk to other caregivers, drink coffee or watch TV. When feeding the child they rarely engage themselves or give attention. Rather they paced care giving too much and did not wait to give spoonful of food until the child is ready. Vocalizations, smile, actions with the child are seen rarely.

One day when the researcher was there for observation, saw a heart melting situation. There were three children on their baby bed. One of them was crying persistently, the other two stretched their hands when they saw me in order to be hugged. The caregivers were talking to each other. New sheet of overall provided by the institution was drawn their attention and plus to that they were drinking coffee. Then I picked one of the children and tried to wheedle the crying baby. The other babies left untouched started to cry wanting to be hugged or touched. When these all things were happening the caregivers continued chatting and talking to each other.

It is not that different what has been observed in the other section where 3-4 years children were being treated. There were two care givers for about 17 children in a small room which is suffocated. The care givers in this section rarely showed engagement to the children. They rarely talk to the children in a social way, did not engage children when that would be possible, and ignored them when they are playing. They frequently respond in a non-social, business-like mechanical manner. They fail to display pride in children's accomplishment and do not praise, encourage or reward child's positive behavior. In time of meals, the children are made to make a line and walk to the feeding room. They are left by themselves when they are eating. And also they are told by the care giver harshly to finish eating fast and not to talk while eating.

Another respondent 2 working in this section for about 2 years added some point over here when she is asked how they treat the children;

The children in this section eat by themselves. We only feed those who are with some problem on mental development. They also use toilet by themselves.

4.3.2. Behavioral control

The caregivers working in the third section (with children 3-4 years), directs children by holding stick and keep telling the children to sit in order. The caregivers expect conformity from the children to their intentions without setting limits before. They are allowed to play with the toy they are given, but by only sitting in a fixed place. When a stranger is coming to their class all the children run towards the strangers stretching their hands in order to be picked up. Then immediately the care giver will blow them away from the strangers by yelling and frustrating them with the stick.

In FGD session participants replied when they are asked what kind of mechanisms do they use in order to correct a child? Participant 2 said: *“when children are not behaving as we want them to be, we will punish them like, by not giving them a toy or by making them to sit alone.”*

The other participant 4 also added that *“when the time they are disturbing, we will frustrate them or punish small punishments.”* In addition, another participant 5 also said that *“we don’t keep silent when they are disturbing. They fear us even if we don’t speak to them. They know by looking to our face.”*

The caregivers’ rarely encourages the children kindly and positively to feed or play. They rarely show sympathy or empathy with a child having difficulty or one who is hurt and crying. It is observed in one occasion that, one child with a mental problem was also with children and the caregiver rarely shows empathy to her and when the child was not in conformity with her intentions, she negatively grabbed the child to move her to her first place. The caregiver gives no space for her inconformity rather yells to the child in a disrespectful manner. In another occasion the researcher witnessed the other care giver yells and grabs the child in a disrespectful manner when he was refusing to go in line with the other children to the dining hall.

4.3.3. Caregiver Psychological Availability and Receptivity to the children

The care givers in the infants section, as observed repeatedly, rarely looked child in the eye and held the child face to face while feeding. Playing with the children was unthinkable because of the high intensity of the task in the respective sections. The caregivers are too busy for availing themselves to the children either psychologically or physically. An interview respondent 1 when she was asked if she spends much time to the children and show love, replied as follows;

It is hard for us to show love and give time as children whorose at home. Because when I am feeding one baby the other baby is already crying. So being available to one child only is impossible so after being finished feeding one child we will rush to the other.

Interview respondent 3 also added the same point over here saying;

When children are crying we will try to calm them down. But it is hard for us to spend much time with one child because of their number. When we are feeding

one baby the other one will start crying. So we are not able to hug and spend much time with one child only. As soon as we finished feeding one child we will proceed to the other.

Interview respondent 3 also had the same thing to say; she is voiced as follows;

Showing love to the child needs much time. As you are noticing here, there are many children who are being treated here. So for how many of them could we give much time and left the others. It is very hard.

Since the caregivers are rotated in four shifts of 12 hours it is hard for them to form strong attachment bonds with the children. One child has a probability of seeing at least 4 faces per day. The caregivers when they are back to the sections in the next shift they may saw new children. Care givers in the group discussion mentioned the less probability of forming attachment to the children as follows;

Participant 3 replied that;

Forming strong attachment is unthinkable over here. New children are admitted to the institution daily or when we are coming back in the next shift we may not get the child that we were taking care of last time.

Participant2 also added that;

We ourselves are changing wards within two months. So that it will be hard for to form attachment bonds with the children. The children also do not show any separation signs when we are going to home or when we come back in the next shift. They saw various people coming and going.

The other thing to add over here from the researchers observation is that all the children call every women around “emama”(mom) and every men around as “ababa”(dad). And also the children do not show wariness of strangers and cling to caregiver or hold on to skirt rather they are indiscriminately friendly to a stranger. They seek to be hugged and picked up and play with every stranger the saw.

4.3.4. Care giver Affect with Children

Smiling at the child, talking to the child in a warm affectionate supportive way, hugging, kissing, and warmly holding the child is unthinkable in Kebebe – Tsehay orphanage. Care givers rarely show affect to the child. They frequently speak harshly with annoyance and shouts at the child.

During the interview when a caregiver respondent 2 asked how she is treating the children and show affection to the child, she replied as follows:

It is hard spending much time with each of them because caregivers are small in number and the children are many. So what we do is that we feed them and proceed to the other child.

Besides, respondent 3 also has a say on the issue. *She directly voiced as:*

For how many of them can we show our love and give enough time? If I tried to spend more time with one baby the other one is crying over there for a food or to change diaper. So we proceed to the next child immediately. It is hard to give enough time and affection for one child and let go of the other.

The participants in the FDG were also asked this same question and the findings implied that:

The first participant said;

We love them. We know that they want affectionate environment. But the problem is we couldn't do that always. If one child becomes accustomed to hugging, kissing, touching and the like, he will always demand for it and cry out if he couldn't get that again. So we don't do this much because we cannot do it always and for every child. It demands our time.

The other participant 4 added to the point by saying;

Even when visitors are coming they want to hug, kiss and touch the children. But they don't last with them. When they leave the room the children will start to cry. Then it will become our duty calming them down. So from the very begging we don't make them to adapt this warm and affectionate relationship.

One incident supports this idea, the first day I went to the institution I got in to the infants room and saw a baby on a baby cart. As soon as he saw me he stretched his hand towards me for a hug. Then when I knelt down to pick him up the caregivers shouted and told me that he will not let me go once I hugged him. They told me not to touch him at all. But I couldn't do that so I hugged him and start playing with him for long time.

The other issue to be raised here is that whether the children differentiates the respective caregivers from other strangers and may show separation signs. The care givers answered to this question as follows;

They differentiate us from strangers because he saw us repeatedly. But they didn't show any separation signs when we left them and go to home, because they saw many caregivers interchangeably.

Chapter Five: Discussion

The previous chapter outlined the results of this study. In this chapter, the findings of the study will be discussed in relation to the literature review focusing on the themes that were emerged from the data.

5.1. Care giver profile, consistency and quality assurance

. Let us see the listed common characteristics of orphanages worldwide in detail by Marinus H. Van (2011) by comparing the results what we have gained in our study area Kebebe Tsehay government orphanage.

5.1.1. Large Group size

Among the characteristics the first is the group sizes tend to be large (typically 9-16 children per ward, although in extreme cases the number may approach 70). The number of children per caregiver is large (approximately 8:1 to 31:1, although a few institutions have fewer children per caregiver) (Van, Page 10, 2011).

Though it had a better ratio compared to what has been stated in the common characteristics of institutions worldwide the caregiver child ratio in Kebebe – Tsehay is also unproportional. As it is tried to put in chapter four table 2, the greatest caregiver child ratio is 1: 11.

Though children can form multiple attachments, all attachment figures are not equivalent and/or interchangeable, and that there is an “attachment hierarchy. Attachment theory’s basic theme is that human infants need a consistent nurturing relationship with one or more sensitive caregivers in order to develop into healthy individuals. John Bowlby, asserted that healthy attachment relationships with primary caregivers serve as the bedrock for children's developing relational patterns. (McGoron et al, 2012).

One thing to take in to consider is that the children who are being treated in one ward, with a total number of 34, are those newly born children. It is not that hard to imagine that the need for a highly intensive care is very significant for these infants. And this couldn't be realized with only for caregivers. This hinders the children from getting the nurturing care that one child should get. This also makes the caregiver to be mechanical.

5.1.2. Consistency of caregiver to one group

The second characteristics mentioned in the caregivers for any single child tend to change constantly because there may be a high staff turnover; caregivers may work long shifts (e.g., 24

hr) and be off 3 days; caregivers may not be consistently assigned to the same group. (Van Page, 10, 2011).

As it is tried to put in the finding section, care givers are not consistent to one group. There are four shifts of 12 hours and plus to that they are stayed in one group for only two months. One child may see at least 4 different faces per day. Since care givers are not stable to the children's life, this hinders the child from forming strong attachment bond and also from unable to have consistent attachment figure (Ainsworth, 1979).

5.1.3. Inconsistency of other Adults in children's lives

The third characteristics is that other adults tend to come and go in children's lives, including medical and behavioral specialists, prospective adoptive parents, and volunteers who may visit for only a week or a few months.

As it is tried to show in the finding section, Kebebe Tsehay is also visited with numerous number of visitor per a day either from the country or abroad. Children see many kinds of faces per day. Volunteers are also coming to the institution to aid the caregivers, though it is not constantly. This makes it hard for the child to form strong attachment bond with limited number of attachment figures.

Though Bowlby's theory is criticized for underestimating the possibility of multiple caregivers, multiple attachment figures and over emphasized the mother/child relationship (Quinn and Mageo 2013), the case over here is very different because of the large number of peoples coming in and out of their lives and the frequency of time they are stayed in their life. Bowlby's did not refute the fact that children can form multiple attachments, however, he suggested that all attachment figures are not equivalent and/or interchangeable, and that there is an "attachment hierarchy"; Bowlby referred to this feature as monotropy (Cassidy and Shaver 2008) and argued that even in institutions, children would select a specific caregiver if given the opportunity, and that children show more distress from the separation of the principal caregivers than from subsidiary figures.

But this can be possible if they have got the opportunity to stick to one or two caregivers, unlike the case of Kebebe Tsehay a place where visited by numerous visitors per day.

5.1.4. Routine works of care giving

The fourth characteristic is that caregivers likely receive little training, and the training they do receive is more focused on health issues than on social interaction. They spend the vast majority of their hours feeding, changing, bathing, cleaning children and the room, and preparing food rather than interacting with the children. Caregivers are invariably female, so children rarely see men.

The care givers in Kebebe Tsehay are interacting with children. But the problem is that the routine works of care giving took their much time like feeding, changing, bathing preparing food and so on. Additionally, the institution is not preparing frequent trainings in order to promote the care giving quality.

5.1.5. Sensitivity of caregivers

The last but not the least characteristics listed in the research is that, when caregivers perform their care giving duties, it is likely to be in a business-like manner with little warmth, sensitivity, or responsiveness to individual children's emotional needs or exploratory initiatives.

Attachment theory, in particular, focuses on early experience with a few warm, caring, and socially-emotionally responsive adults who are relatively stable in the child's life as the foundation of appropriate social-emotional development and long-term mental health (Ainsworth, 1979).

Theoretically, an infant with a warm, responsive caregiver develops an internal working model of expectations for nurturing, supportive reactions from that caregiver, whom the infant comes to trust and use as a secure base from which to explore the social and physical world. This will lead the child to have appropriate social-emotional development and long-term mental health.

As Klein, (1992) characterizes "mediated learning, as distinct from direct from direct learning through the senses, occurs when the environment is interpreted for the child by another person who understands the child's needs, interests, and capacities and who takes an active role in making components of that environment as well of the past and future experiences compatible with the child".

It is also interpreted as not necessarily meaning verbal interaction only, as all modalities of interaction, gestural, kinetic, mimicry, and modeling can also constitute quality of interaction, provided that the mediator is conscious and well intentioned in the process (Zewdie, T. 1998).

This is very uncommon for caregivers of Kebebe Taehay child care institution. Because of their unproportional number to the children, they are performing the care giving task with little warmth and sensitivity. They are unable to provide the care with warmth because they couldn't do it for all the children consistently.

5.2. Constructs rating the Caregiver – Child Interaction

5.2.1. Care giver Engagement

Bowlby proposed that attachment security is resulted from responsive, appropriate caregiving and that as a result of this care; individuals developed a sense of the self as worthy of care and a belief that others would be responsive and sensitive when caring. He proposed, and considerable research has supported, that children should feel secure and contented when safely in the presence of caregivers (secure base), and when threatened they should seek proximity to caregivers as a safe haven (Bowlby 1980/1991).

Healthy caregiver engagement should contain these criteria's. Caregiver should respond to child's vocalizations, smile, other social initiative, distress (crying, frustration); caregiver responds should not be in a nonsocial, business-like, mechanical manner. Caregiver should psychologically engage the child. Caregiver should share enthusiasm, joy, or excitement of children; caregiver should display pride in children's accomplishment. (Christina J. Groark, 2010).

In their relationships with others, infants develop a sense of self that is akin to a mirror image of their experience with the caregiver. If the infant is treated with love and kindness, he or she feels worthy of love, and becomes capable of feeling and expressing love and kindness towards others. It is in this sense that Winnicott (1965) observed that, without the mother's contribution, "there is no such thing as an infant". In these early relationships, the infant forms mental representations of the world, including a self-concept, and these concepts and representations determine the child's later motivations and interpretations of experiences. For

this reason, loving, mutually responsive early care is essential for the child to develop into an emotionally secure and confident individual.

When we get back to Kebebe – Tsehay the case is different. The children are missing the above listed essential elements of early child care. Early relationships mirror for the infant a sense of being recognized, understood and validated through the experience of warm and empathic care. The care givers in the institution couldn't engage with this level because of their burden. Engagement as indicated above requires much time and effort. And also it could be possible if the caregiver is able to take care of one or two children at a time. But as long as there are many infants in their domain, it is impossible for them to meet these criteria.

But in the process the children are deprived of these privileges of being taken care of in a warm and caring environment. As a result children in the institution show indiscriminately friendliness, which is common among children being raised in institutions. Indiscriminately sociable behavior refers to children's lack of reticence with unfamiliar adults, willingness to approach and engage strangers, and failure to maintain proximity to attachment figures in unfamiliar settings (O'Connor et al., 2000). The children in Kebebe – Tsehay stretched their hands for a hug whenever they saw a stranger, visitor or any passerby. They wanted to be hugged, touched; they smiled and wanted to play with everyone indiscriminately.

5.2.2. Behavioral control

Structuring and limit setting, which refers to the ability of a caregiver to clearly communicate expectations toward children and structure the situation accordingly, and to set clear and consistent limits on the children's behavior (Katrien O. W. Helmerhorst, 2014).

From this we can understand that, in order to correct children's behavior the caregiver should children individually or in group by communicating her intentions first. The care giver should not expect conformity to her intentions without telling them first. The care giver should not grab the child to move him or her. She should not correct the child in a clearly negative way. The care giver should not Abuse, yells or talks down to the child in a disrespectful manner(Christina J. Groark, 2010).

MLE Theory Also described mediated regulation of behavior as acts of child's behavioral control by the adult through modeling, demonstration, and /or verbal suggestions (Zewdie, T.

1998). As to this theory the caregivers are the one who should mediate in helping the child to behave correctly.

But what has been observed in Kebebe – Tsehay is a bit different from this. The caregivers expect conformity from the children to their intentions without communicating it first to the children. The children are not allowed to move from their sit or their bed. When they stand from their sit, the care giver yelled on them and told them to keep quiet and sit.

5.2.3. Caregiver Psychological Availability and Receptivity to the children

Looking child in the eye and holding child face to face while feeding or playing; listening attentively when the child speaks by looking at them and nodding; kindly and positively encouraging the child to feed, dress, bath self; being sympathetic or empathetic with a child having difficulty or one who is hurt and crying; changing the child's behavior in a positive and supportive way by providing "guidance" or "suggestions;" explaining a rule or consequences and calmly redirecting behavior all in a positive and supportive way are a good quality of care giver psychological availability and receptivity. (Christina J. Groark, 2010).

The MLE theory also explains this idea as intentionality and reciprocity. The parameters to measure a good mediation can be a deliberate acts of selecting, sequencing, exaggerating, accentuating of stimuli by the caregiver for the reciprocal response of the child through vocal verbal or non verbal forms of behavior(Zewdie, T. 1998).

When we see the care giving quality of kebebe – Tsehay in relation to these parameters, it is a bit different. Availing themselves for the children and spending much time with a child is inconvenient for the caregivers of the institution. The structure by itself is not allowing for psychological availability and intentionality. Since the children are not proportional to their number, they are not able to do even the routine works of care giving with due care and intentionality.

5.2.4. Care giver Affect with Children

Affect is something to be showed and expressed. Bowlby (1969/1991) spent considerable time describing the nature and function of behaviors that lead to attachment. Infants use several behaviors to seek proximity to their attachment figures (e.g., crying, vocalizing, following) and also use behaviors to maintain proximity (e.g., smiling, clinging). Once infants are mobile and

confident in the care of their attachment figure, they tend to use the attachment figure as a “secure base from which to explore,” returning to the caregiver’s safe haven (i.e., proximity to the attachment figure) for comfort and reassurance when needed. He proposed that infants are biologically predisposed to seek and gain proximity to caregivers and in these relationships develop a sense of whether they are worthy of love and support and a sense of whether their caregivers can be trusted and relied upon to provide care and support. Over the course of infancy and childhood, these views of the self and the other develop into sophisticated internal working models of what to expect from close others, and these internal working models guide behavior over the lifespan (Elaine Scharfe, 2017).

Donald Winnicott et al (Winnicott ,1965) and other early child psychoanalysts based their theories on insightful observations of infants in relationships with other people. They postulated that babies had an inborn sensitivity to the emotions of others, and to the ongoing interactions between themselves and their caregivers. They believed that these interactions were highly significant for the child’s healthy psychological development, and that insensitive care, neglect or abuse could distort or delay development. For this reason, loving, mutually responsive early care is essential for the child to develop into an emotionally secure and confident individual.

In order to show affect to the child caregiver should not speak negatively, harshly, with annoyance, hostility, and scold or shout at the child; put them down, use sarcasm, blame child. Rather the care giver should express her affect with smiling at child; talking to the child in a positive, warm, affectionate, supportive way; and hugging, kissing, and by warmly holding the child (Christina J. Groark, 2010).

The MLE theory explained this idea as Mediation of Meaning. It can be expressed by the acts of expressing affect by the parent in relation to objects, animals, concepts or values through facial expressions, gestures, tone of voice, verbal expression of affect, classification, labling and valuing of the child’s or adult’s experience(Zewdie, T. 1998).

It seems impossible for the care givers of Kebebe – Tsehay to meet these criteria. As it is explained in the finding section, they confessed that this is hardly possible for them to do because of the large number of children treated in the institution. As a result the children are highly susceptible to distorted and delayed development. If their early child hood experience is

the determinant of their sense of whether they are worthy of love and support, their future is at risk. If they think that they are unworthy of love and support low self-esteem and low self-confidence are waiting for them at the door.

Chapter Six: Conclusion and Recommendation

6.1. Conclusion

The present study was conducted to assess the psychological care giving patterns of child care institution called Kebebe – Tsehay government orphanage. From the findings of the study the following conclusions are made.

The orphanage is giving care for numerous numbers of children who are admitted to the institution starting from the first day of birth to the age of eight. It has also a limited number of workers which had unbalanced to the number of children. There is incomparability of child – care giver ratio. The study revealed that there is low quality care giving pattern observed in the institution.

The children are not being raised in a nurturing environment. The psychological care giving pattern of the institution is provided with little warmth, sensitivity and affection. The children are left on their bed crying because the caregivers are unable to respond because of their burden. They are in need of people. Crying is very normal for the children and also for everyone in there. The children highly showed indiscriminate friendliness to every stranger/visitor. They run towards every stranger, rather than limiting proximity as a child. They cling to everyone. They stretched their hand to everyone inseparably to be picked up. They want to be touched, kissed, and hugged very much.

Though it is their time to develop self – image and sense of worthy of love and support, they are developing distortion. Though they deserve love, hug and kiss as a child, they are not lucky to have it. Though their nature as a human being obliged them to create a strong bond with one attachment figure, they are unable to have it.

6.2. Recommendation

It is highly recommended that employing caregiver training or supervision, structural changes, or additional stimulation are expected to have beneficial effects on children's emotional, social, and cognitive development and the quality of care, the child-caregiver relationship and interactions as well as the overarching institutional environment.

Close emotional ties between staff and orphaned children living in residential institutions may serve as an effective psychological buffer against OVC's adverse life events and circumstances. Moreover, training orphanage staff to provide warm, responsive and consistent care giving can improve children's social interaction and physical development.

Adoptive, foster, and other family type arrangements are better for young children's development than most institutions. But the government has lengthy adoption process which discourages adoptive parents. Therefore favorable environment needs be created in order to encourage adoption.

Every effort should be made to avoid placing infants and toddlers in institutions in the first place and to transition children out of institutions as early as possible because damage can occur early and after relatively short exposure.

Reference

- Abebe, T. (2008). Ethiopian childhoods: A case study of the lives of orphans and working children.
- Ainsworth, M. D. S., Bell, S. M., & Stayton, D. F. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals.
- Ainsworth, M. S. (1979). Infant–mother attachment. *American psychologist*, 34(10), 932.
- Almas, A. N., Degnan, K. A., Walker, O. L., Radulescu, A., Nelson, C. A., Zeanah, C. H., & Fox, N. A. (2015). The effects of early institutionalization and foster care intervention on children's social behaviors at the age of eight. *Social Development*, 24(2), 225-239.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.
- Atkins-Burnett, S., Monahan, S., Tarullo, L., Xue, Y., Cavadel, E., Malone, L., & Akers, L. (2015). *Measuring the quality of caregiver-child interactions for infants and toddlers (Q-CCIT)(appendices)* (No. a03c75314a344a34838f3c0f54fc9250). Mathematica Policy Research.
- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, 84(2), 191.
- Barbier, C. (2014). Assessing Attachment Process among Early Institutionalized Orphans in Burkina Faso, Africa.
- Bettmann, J. E., Mortensen, J. M., & Akuoko, K. O. (2015). Orphanage caregivers' perceptions of children's emotional needs. *Children and Youth Services Review*, 49, 71-79.
- Bos, K. J., Fox, N., Zeanah, C. H., & Nelson, C. A. (2009). Effects of early psychosocial deprivation on the development of memory and executive function. *Frontiers in behavioral neuroscience*, 3, 16.
- Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental psychology*, 28(5), 759.
- Bretherton, I., & Munholland, K. A. (1999). Internal working models in attachment relationships: A construct revisited.
- Browne, K., Hamilton-Giachritsis, C., Johnson, R., & Ostergren, M. (2006). Overuse of institutional care for children in Europe. *Bmj*, 332(7539), 485-487

- Bruskas, D., & Tessin, D. H. (2013). Adverse childhood experiences and psychosocial well-being of women who were in foster care as children. *The Permanente Journal*, 17(3), e131.
- Connor, D. F., Doerfler, L. A., Volungis, A. M., Steingard, R. J., & MELLONI JR, R. H. (2003). Aggressive behavior in abused children. *Annals of the New York Academy of Sciences*, 1008(1), 79-90.
- Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.
- Crockenberg, S. C., Rutter, M., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Juffer, F., Collins, W. A., & The St. Petersburg-USA Orphanage Research Team. (2008). The effects of early social-emotional and relationship experience on the development of young orphanage children. *Monographs of the Society for Research in Child Development*, i-298.
- Crockenberg, S. C., Rutter, M., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Juffer, F., Collins, W. A., & The St. Petersburg-USA Orphanage Research Team. (2008). The effects of early social-emotional and relationship experience on the development of young orphanage children. *Monographs of the Society for Research in Child Development*, i-298.
- Dozier, M., Zeanah, C. H., Wallin, A. R., & Shaffer, C. (2012). Institutional care for young children: Review of literature and policy implications. *Social issues and policy review*, 6(1), 1-25.
- Fearon, R. P., Bakermans-Kranenburg, M. J., Van IJzendoorn, M. H., Lapsley, A. M., & Roisman, G. I. (2010). The significance of insecure attachment and disorganization in the development of children's externalizing behavior: a meta-analytic study. *Child development*, 81(2), 435-456.
- Feuerstein, R., Klein, P. S., & Tannenbaum, A. J. (Eds.). (1991). *Mediated learning experience (MLE): Theoretical, psychosocial and learning implications*. Freund Publishing House Ltd.
- Fitzgerald, H. E., & Barton, L. R. (2000). Infant mental health: Origins and emergence of an interdisciplinary field. *WAIMH handbook of infant mental health*, 1, 1-36.
- Geissmann, C. (2005). *A history of child psychoanalysis*. Routledge.

- Groark, C. J., McCall, R. B., Fish, L., & Whole Child International Evaluation Team. (2011). Characteristics of environments, caregivers, and children in three Central American orphanages. *Infant Mental Health Journal*, 32(2), 232-250.
- Groark, C. J., Muhamedrahimov, R. J., Palmov, O. I., Nikiforova, N. V., & McCall, R. B. (2005). Improvements in early care in Russian orphanages and their relationship to observed behaviors. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, 26(2), 96-109.
- Gunnar, M. R. (2001). Effects of early deprivation: Findings from orphanage-reared infants and children. *Handbook of developmental cognitive neuroscience*, 114(8).
- Haight, W. L., Kagle, J. D., & Black, J. E. (2003). Understanding and supporting parent-child relationships during foster care visits: Attachment theory and research. *Social work*, 48(2), 195-207.
- Hecker, T., Radtke, K. M., Hermenau, K., Papassotiropoulos, A., & Elbert, T. (2016). Associations among child abuse, mental health, and epigenetic modifications in the proopiomelanocortin gene (POMC): A study with children in Tanzania. *Development and psychopathology*, 28(4pt2), 1401-1412.
- Helmerhorst, K. O., Riksen-Walraven, J. M., Vermeer, H. J., Fukkink, R. G., & Tavecchio, L. W. (2014). Measuring the interactive skills of caregivers in child care centers: Development and validation of the caregiver interaction profile scales. *Early Education and Development*, 25(5), 770-790.
- Hermenau, K., Eggert, I., Landolt, M. A., & Hecker, T. (2015). Neglect and perceived stigmatization impact psychological distress of orphans in Tanzania. *European journal of psychotraumatology*, 6(1), 28617.
- Hermenau, K., Goessmann, K., Rygaard, N. P., Landolt, M. A., & Hecker, T. (2017). Fostering child development by improving care quality: A systematic review of the effectiveness of structural interventions and caregiver trainings in institutional care. *Trauma, Violence, & Abuse*, 18(5), 544-561.
- Hrdy, S. B. (1999). Mother Nature: A history of mothers, infants, and natural selection. *New York*, 315

- Hungerford, A., & Cox, M. J. (2006). Family factors in child care research. *Evaluation Review*, 30(5), 631-655.
- Johnson, D. E., Guthrie, D., Smyke, A. T., Koga, S. F., Fox, N. A., Zeanah, C. H., & Nelson, C. A. (2010). Growth and associations between auxology, caregiving environment, and cognition in socially deprived Romanian children randomized to foster vs ongoing institutional care. *Archives of pediatrics & adolescent medicine*, 164(6), 507-516
- Johnson, R., Browne, K., & Hamilton-Giachritsis, C. (2006). Young children in institutional care at risk of harm. *Trauma, Violence, & Abuse*, 7(1), 34-60.
- Juffer, F., & Series, W. A. C. (2008). The effects of early social-emotional and relationship experience on the development of young orphanage children. *Monographs of the Society for Research in Child Development*, 73(3), 295.
- Juffer, F., & Van Ijzendoorn, M. H. (2005). Behavior problems and mental health referrals of international adoptees: A meta-analysis. *Jama*, 293(20), 2501-2515.
- Klein, P. S., & Rye, H. (2004). Interaction-oriented early intervention in Ethiopia: the MISC approach. *Infants & Young Children*, 17(4), 340-354.
- Klein, P.S. (1992). Cognitive and Emotional Interplay in Early Development: Mediation Role of parents, *Advances in Cognition and Emotional Practice*, Vol. 1A, page 169-194.
- Kligman, G. (1998). *The politics of duplicity: Controlling reproduction in Ceausescu's Romania*. University of California Press.
- Leiden Conference on the Development and Care of Children Without Permanent Parents. (2012). The development and care of institutionally reared children. *Child Development Perspectives*, 6(2), 174-180.
- McCall, R. B., Groark, C. J., & Fish, L. (2010). A caregiver-child socioemotional and relationship rating scale. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, 31(2), 201-219.
- McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: central role of the brain. *Physiological reviews*, 87(3), 873-904.
- McLaughlin, K. A., Fox, N. A., Zeanah, C. H., Sheridan, M. A., Marshall, P., & Nelson, C. A. (2010). Delayed maturation in brain electrical activity partially explains the association

- between early environmental deprivation and symptoms of attention-deficit/hyperactivity disorder. *Biological psychiatry*, 68(4), 329-336.
- Mehta, M. A., Golembo, N. I., Nosarti, C., Colvert, E., Mota, A., Williams, S. C., ...& Sonuga-Barke, E. J. (2009). Amygdala, hippocampal and corpus callosum size following severe early institutional deprivation: the English and Romanian Adoptees study pilot. *Journal of Child Psychology and Psychiatry*, 50(8), 943-951.
- Meins, E., Fernyhough, C., Wainwright, R., Das Gupta, M., Fradley, E., & Tuckey, M. (2002). Maternal mind-mindedness and attachment security as predictors of theory of mind understanding. *Child development*, 73(6), 1715-1726.
- Mezgebo, G. (2014). *The Psychosocial Problems of Orphan Children in the Ethiopian Orthodox Church Sebeta Child Center: Its Implication for Counseling* (Doctoral dissertation, Addis Ababa University).
- Mikulincer, M., & Shaver, P. R. (2007). Boosting attachment security to promote mental health, prosocial values, and inter-group tolerance. *Psychological inquiry*, 18(3), 139-156.
- Muadi, M., Aujoulat, I., Wintgens, A., Matonda ma Nzuzi, T., & Pierrehumbert, B. (2012). Attachment in the abandoned children rise in residential institution in Kinshasa. *Neuropsychiatrie de l'enfance et de l'adolescence*, 60, 505-515.
- Nelson, C. A., Zeanah, C. H., Fox, N. A., Marshall, P. J., Smyke, A. T., & Guthrie, D. (2007). Cognitive recovery in socially deprived young children: The Bucharest Early Intervention Project. *Science*, 318(5858), 1937-1940.
- O'CONNOR, T. G., & Zeanah, C. H. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development*, 5(3), 223-244.
- Petersburg, S. (2008). USA Orphanage Research Team. The Effects of Early Social-Emotional and Relationship Experience on the development of Young Orphanage Children. *Monographs of the Society for Research in Child Development*, 73.
- Petersburg, S. (2008). USA Orphanage Research Team. The Effects of Early Social-Emotional and Relationship Experience on the development of Young Orphanage Children. *Monographs of the Society for Research in Child Development*, 73.
- Riksen-Walraven, J. M., & Van Aken, M. A. G. (1997). *Effects of two mother-infant intervention programs upon children's development at 7, 10, and 12 years*.na.

- Rosmalen, Lenny & van der Veer, René & van der Horst, Frank. (2015). Ainsworth's Strange Situation Procedure: The origin of an instrument. *Journal of the History of the Behavioral Sciences*.51. 10.1002/jhbs.21729.
- Rutter, M. (1998).Developmental catch-up, and deficit, following adoption after severe global early privation.*The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 39(4), 465-476.
- Saraswat, A., &Unisa, S. (2017). A qualitative study examining psychosocial distress and coping mechanisms among orphan and vulnerable children living in institutional care in New Delhi, India.*Journal of Health and Social Sciences*, 2(2), 195-208.
- Sengendo, J., &Nambi, J. (1997). The psychological effect of orphanhood: a study of orphans in Rakai district.
- Tadesse, S., Dereje, F., & Belay, M. (2014).Psychosocial wellbeing of orphan and vulnerable children at orphanages in Gondar Town, North West Ethiopia.*Journal of public health and epidemiology*, 6(10), 293-301.
- UNICEF. (2013). Preventing and Responding to Violence, Abuse, and Neglect in Early Childhood A Technical Background Document, Child Protection Section New York, MPH Columbia University School of Public Health and Maestral International.
- Van der Horst, F. C., LeRoy, H. A., & Van der Veer, R. (2008).“When strangers meet”: John Bowlby and Harry Harlow on attachment behavior.*Integrative Psychological and Behavioral Science*, 42(4), 370-388.
- Van Ijzendoorn, M. H., Luijk, M. P., &Juffer, F. (2008). IQ of children growing up in children's homes: A meta-analysis on IQ delays in orphanages. *Merrill-Palmer Quarterly (1982-)*, 341-366.
- Van IJzendoorn, M. H., Palacios, J., Sonuga-Barke, E. J., Gunnar, M. R., Vorria, P., McCall, R. B.,&Juffer, F. (2011). I. Children in institutional care: Delayed development and resilience. *Monographs of the Society for Research in Child Development*, 76(4), 8-30.
- Veríssimo, M., Santos, A. J., Fernandes, C., Shin, N., & Vaughn, B. E. (2014).Associations between attachment security and social competence in preschool children. *Merrill-Palmer Quarterly (1982-)*, 60(1), 80-99.

Weinfield, N. S., Sroufe, L. A., Egeland, B., & Carlson, E. (2008). Individual differences in infant-caregiver attachment: Conceptual and empirical aspects of security

Weir, K. (2014). The lasting impact of neglect. *Monit. Psychol*, 45, 36-41.

Winnicott, D. W. (1965). Psychoanalysis and the sense of guilt. *The maturational processes and the facilitating environment*, 15-28.

World Health Organization. (2004). The importance of caregiver-child interactions for the survival and healthy development of young children: A review.

Zewdie, T. (1998). The theory of mediated learning experiences (MLE): orientation to the new model of our child development research. *IER FLAMBEAU*, 5(1), 36-43.

Appendix I: Observation Check lists

Observation Check list for care giver child interaction at Kebebe -Tsehay Orphanage - for toddlers section

care giver Code
ward number
no of observation

	Constructs to be rated	never	rarely	Frequently	Consistently
A	Caregiver Engagement				
	1. Caregiver detachment				
1	In the presence of a child or children, caregiver does not make eye contact				
2	Does other tasks during free time, such as talk to other caregivers				
3	takes a break to smoke or groom herself				
	2. Caregiver failure to respond				
4	Caregiver does not respond to child's vocalizations, smile, other social initiative, distress (crying, frustration)				
5	Caregiver responds but in a non-social, business-like, mechanical manner				
6	Caregiver fails to display pride in children's accomplishment				
B	Caregiver psychological availability and receptivity to children				
7	caregiver looks child in the eye and holds child face-to-face while feeding or in play				
8	caregiver listens attentively when children speak (e.g., looks at them, responds by nodding)				
9	caregiver gets at the level of the child (kneels, sits on floor with children) to have better eye contact, to hear a child, to talk or play with children				
	3. Caregiver support, empathy, guidance				
10	caregiver kindly and positively encourages child to feed, dress, bath self;				

11	caregiver is sympathetic or empathetic with a child having difficulty or one who is hurt and crying;				
12	caregiver changes child behavior in a positive and supportive way by providing “guidance” or “suggestions;”				
	4. Caregiver responds to child				
13	Caregiver paces caregiving to match child's behavior (e.g., waits to give next spoonful of food until the child is ready),				
14	is patient with slow eaters or dressers; tolerates messiness				
15	Caregiver shares joy and excitement, pride in children's accomplishments; caregiver imitates child's behavior (vocalization, smile, actions);				
16	Caregiver praises, encourages, rewards child for child's behavior. Mechanical response is scored low.				
C	Behavioral Control				
	5. Caregiver behavioral control/obedience/discipline				
17	caregiver directs children individually or in group behavior (stand in line, sit against the wall, hold onto another child) and expects conformity to caregiver intentions				
18	caregiver “corrects” behavior (e.g., keep in line, go over there , no food fights, etc.).				
19	Child is interested in one thing and caregiver reorients child to another				
	6. Caregiver punishes a child				
20	caregiver physically and negatively grabs a child to move him or her;corrects child in a clearly negative way; hits or spansks a child. Verbally abuses, yells or talks down to child in a disrespectful manner.				
D	Caregiver Affect with Children				
	7. Caregiver negative affect				

21	caregiver speaks negatively, harshly, with annoyance, hostility, and scolds or shouts at the child; caregiver is critical of children, puts them down, uses sarcasm, blames child, says “bad boy”.				
	<i>8. Caregiver displays positive affect and affection</i>				
22	she smiles at child; talks to the child in a positive, warm, affectionate, supportive way; she hugs, kisses, and warmly holds a child.				

Observation Check list for care giver child interaction at Kebebe -Tsehay Orphanage - for infants section

care giver Code

ward number
no of observation

	Constructs to be rated	never	rarely	Frequently	Consistently
A	Caregiver Engagement				
	<i>1. Caregiver detachment</i>				
1	In the presence of a child or children, caregiver does not make eye contact				
2	Does other tasks during free time, such as talk to other caregivers				
3	takes a break to smoke or groom herself				
	<i>2. Caregiver failure to respond</i>				
4	Caregiver does not respond to child's vocalizations, smile, other social initiative, distress (crying, frustration				
5	Caregiver responds but in a non-social, business-like, mechanical manner				
6	Caregiver fails to display pride in children's accomplishment				
B	Caregiver psychological availability and receptivity to children				
7	caregiver looks child in the eye and holds child face-to-face while feeding or in play				
8	caregiver listens attentively when children speak (e.g., looks at them, responds by nodding				
9	caregiver gets at the level of the child (kneels, sits on floor with children) to have better eye contact, to hear a child, to talk or play with children				
	<i>3. Caregiver support, empathy, guidance</i>				
10	caregiver kindly and positively encourages child to feed, dress, bath self;				

11	caregiver is sympathetic or empathetic with a child having difficulty or one who is hurt and crying;				
12	caregiver changes child behavior in a positive and supportive way by providing “guidance” or “suggestions;”				
	4. Caregiver responds to child				
13	Caregiver paces caregiving to match child's behavior (e.g., waits to give next spoonful of food until the child is ready),				
14	is patient with slow eaters or dressers; tolerates messiness				
15	Caregiver shares joy and excitement, pride in children's accomplishments; caregiver imitates child's behavior (vocalization, smile, actions);				
16	Caregiver praises, encourages, rewards child for child's behavior. Mechanical response is scored low.				

Declaration

This is to duly acknowledge that the thesis conducted entitled: “Assessment of the Psychological Care Giving Patterns of Child Care Institutions: A Qualitative Study Conducted at Kebebe - Tsehay Government Orphanage” is my original work and the research is not conducted by anybody and not found anywhere. It is submitted in partial fulfillment of the requirements for Degree of Masters of Counseling Psychology compiled with the regulation of the Addis Ababa University and meets the accepted standards with respect of to its originality and quality.

Eyerusalem Sibru

.....

Name of candidate	Signature	Date
Advisor.....
Examiner (Internal).....
Examiner (External).....

School of psychology graduate program coordinator