The Level of Depression and Self Esteem among Institutionalized and Non-Institutionalized Orphan Children

EYERUSALEM HADUSH

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

July, 2015

The Level of Depression and Self Esteem among Institutionalized and Non-Institutionalized Orphan Children

EYERUSALEM HADUSH

A Thesis Submitted to

School of Psychology

In Partial Fulfillment of the Requirements for the Degree of Master of Arts In Developmental Psychology

Addis Ababa University

Addis Ababa Ethiopia

July, 2015

Addis Ababa University

School of psychology

This is to certify that the thesis prepared by EyerusalemHadush Amare entitled The level of depression and self-esteem among institutionalized and non-institutionalized orphan children.Submitted in Partial Fulfillment of The Requirements for The Degree of Master of Arts (Developmental Psychology).

Approved by Examining board

Chairman, Department of Graduate Committee	Signature	Date
Advisor	Signature	Date
Examiner ,External	Signature	Date
Examiner ,Internal	Signature	Date

ACKNOWLEDGEMENT

First and foremost, I would like to recognize my God, who makes all things possible- for putting the enthusiasm in my heart, inspiration and encouragement in my mind, and determination in my soul to complete this research work.

Although words cannot fully express my gratitude to my adviser Dr.Dame , I would first like to thank him, for offering his precious time and allowing me to dive into this research project and continuously guided this work through all its steps. He has been a relentless driving force providing me with opportunities, advice, and amazing support. I perceive the opportunity to work with him as a privilege. His contribution to this work and to my personal growth was invaluable. Therefore, he is my utmost respect and truly my model as a research adviser forever

I would like to express my deepest love and appreciation to my family; Ato Hadush Amare , W/o Meheret Geburu and Galata for their undying and unconditional love, endless support and encouragement. Despite of they are living in economic restrictions the cost they paid for my education is really great and without their support accomplishment of this work is unthinkable.

Acronyms

BDI	Beck Depression Inventory
IOC	Institutionalized Orphan Children
MOLSA	Ministry of Labor and Social Affairs
MOWCYA	Ministry of Women, Children & Youth Affairs
NGAC	National Guidelines for Alternative Care for Children
NIOC	Non-Institutionalized Orphan Children
NYOL	Number of Years of Living

ABSTRACT

The aim of this study was to examine the level of depression and self- esteem among institutionalized and non-institutionalized orphan children. Participants of this study were 112 orphan children from the institution and 84 orphan children from non -institution selected randomly. Totally, 196 orphan children participated in the study. Data about participants were collected through questionnaire. Data were analyzed using both descriptive(percentage, mean and SD) and inferential statistical methods such as independent t- test and ANOVA. The results revealed that there is a significant difference between institutionalized and non- institutionalized children in their level of depression. Institutionalized orphan children obtained higher score on depression scale than non-institutionalized orphan children. On the other hand, non- institutionalized children obtained high score on self -esteem scale than their counterparts of institutionalized orphan children. Age of respondents has a significant impact on variation of depression level. Meaning,orphan children's found between 10-14 age categories were scored high on depression scale than their counter parts of children whose their age categories are found between 15-18. There is also statistically significant interaction effect of age and living arrangement of children on their depression level. This tells us that, non- institutionalized children of age category between (10-14) are more depressed than their counter parts of children those whose their age categories are found between (15- 18). Orphan children of (15-18) age categories were scored high on self- esteem scale than their counter parts of children who's their age categories are found between (10-14).finally practical implications of the findings are presented

Table of content

List of Table

Page

CHAPTER ONE

1. INTRODUCTION

1.1. Background of the Study

Human beings have been facing different social, economic and other related problems. The ups and downs drifts of life and the lives of human beings are two sides of the same coin, which are not detachable. In a global perspective and the natural setting, every human being understands and loves each other but due to inherent problems people are enforced to crack their good relationship and lack mutual understanding(Donahue, 1998).

The main reasons of the mentioned problems are because of deficiency of individual income, disease and death of family member(s).Economic problems are seen as a significant cause for the defragmentation of families. The root causes of children may be more exposed to harsh treatment and abuse (Donahue, 1998). In many societies, when households are no longer able to respond to economic disaster unaided, they traditionally call on family, friends and neighbours for short term assistance, and in this way the community provides a safety net (Mutangadura & Webb, 1999).

Likewise, problem moves beyond the capacity of the host community, children are enforced to live in the street or institution for temporary or else for long period of time. Children are the main segment of the family member that may be vulnerable to the problem. They are not able to resist the outside environment, for them every movement and interaction outside their usual resident are becoming difficult to practice (Donahue, 1998).

Due to age, economic and gender factors, extended families are not able to provide care for those orphans like their parents did before. Thus, they are enforced to allow children stay in the institution, street and other places as a last resort.

The reason why the researcher chooses to study this research topic was that, the magnitude and prevalence rate of orphaned children has been increasing in every part of the world. It is estimated that there are between 143 million and210 millionorphans worldwide (UNICEF, 2003).

Many of the orphaned children continue to experience emotional problems and there are several other reasons. First, there is a cultural belief that, children do not have emotional problems and therefore there is a lack of attention from adults. Secondly, psychological problems are not always easily detected and identified by elders. In many cases children are punished while showing or displaying their negative emotions, thereby elders are adding children's pain. In community-based orphan support programs, volunteers often assess children's needs in terms of material goods, neglecting their psychosocial needs (Lee, 2000). However, there is a lack of knowledge to identify the problem of depressed and low self- esteemed orphan children; this study focuses on assessing the symptom of depression and self- esteem of Institutionalized orphan children and non- institutionalized orphan children.

The effects of institutionalization are not uniform and are dependent on other factors. The extent of suffering is not the same for every child who is institutionalized. The differential effects are due to child characteristics (genetic predisposition, basic personality, attractiveness, prenatal risk factors), caregiver characteristics (training, motivation & attitude), institutional characteristics (child-to-caregiver ratio, quality and degree of programming), and the child's

history (the age of the child when he/she entered the institution and the length of time in the institution (Victor, 1996).

In Ethiopian traditional context, once a child becomes vulnerable to the above circumstances, it is believed that this child is the child of the community and the assignment for the indigenous community to care in traditional communal living and extended family system like their parents did before. Conversely, the growing number of vulnerable children in Ethiopia has been facing trouble due to the capacity for the extended family to fulfill their needs as previous because of households decline income, the extended family more likely a higher fraction of elderly members and less educated heads and mostly house hold heads by women (Donahue, 1998).

In Ethiopian traditional context, the community in general and parents in particular provide affections and care for their children as much as possible. Parents never want to see their children away from their embraces and never tolerate their problems. They always wish and talk their positive destiny, unless and otherwise they have faced economic problems, diseases or death, migration of works and family fractured. In case the above problems happen, children are no longer getting full support from parents. Consequently, those children have been left out, they are disparaged and rejected from home and enforced to continue their life in the street or institution (Donahue, 1998).

In Ethiopia context, not only parents are responsible for children to take care, but also the indigenous community take responsibility in providing care and protections (Addison, 2007). In addition, it has been observed that institutional care is increasing in countries, where there is economic transition, unemployment, migration of work, family break down and single parenthood (Tinova et al., 2005; as cited in Carter, 2007).

Young children are frequently placed in the institutional care throughout the world. This occurs despite wide recognition that institutional care is associated with negative consequences for children's health conditions and emotional disorder. Currently living in orphanages will reside in an institution for long period of time (Johnson, Browne and Hamilton-Giachritists, 2006). Due to the above mentioned evidences, depression and low self- esteem symptoms of Institutional orphan children related researches are little done by Ethiopian researchers. Therefore, by taking these gaps in to consideration, the researcher has tried to study the case as a research topic, and this will help to open a chance to other researchers to study further in the area.

1.2.Statement of the Problems

The magnitude and prevalence rate of orphaned children has been increasing in every part of the world. It is estimated that there are between 143 million and210 millionorphans worldwide (UNICEF, 2003). Regarding the number of orphan children 43.4 million of them are found in sub-Saharan Africa , of which 5 million of them are found in Ethiopia (UNICEF et al., 2004).

All humans have a need to be respected and to have self-esteem and self-respect. Esteem presents the normal human desire to be accepted and valued by others. People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued, be it in a profession or hobby. Imbalances at this level can result in low self-esteem or an inferiority complex**.**Institutionally raised children have still have problems interacting with peers and adults outside the institutions. Additionally, children with high self-esteem have a much closer relationship with their parents and peers than do children with low self -esteem (Hodges and Tizard, 1989a; Gunnar et al., 2007).

Though the problem is devastating, depression and low self- esteem symptoms of institutional orphan children related researches are not done amply by Ethiopian researchers. Therefore, by taking these problem in to consideration, the researcher has tried to study the case as a research topic, and this will help to open a chance to other researchers to study further in the area.

Thus, the researcher investigates the level of depression and self -esteem symptoms difference between IOC and NIOC in the case of kolfe,and kechene institution and Tsehay chora Elementary school in Addis Ababa. Thus, the study was intended to give answers for the following research questions.

1: Is there a statistically significant difference in the level of depression between institutionalized orphan children and non-institutionalized orphan children?

$_2$: Is there statistically significant difference in the level of self-esteem between institutionalized orphan children and non-institutionalized orphan children?

$_3$: Do the levels of depression among institutionalized orphan children and non-institutionalized orphan children vary as a function of the sex and age of orphan children?

$_4$: Do the level of self-esteem among Institutionalized orphan children and non-institutionalized orphan children vary as a function of the sex and age of orphan children?

1.3. Objectives of the Study

The general objective of this study is to assess the level of depression and self-esteem symptoms of institutionalized orphan children and non-institutionalized orphan children. Specifically this study intends :

- To examine whether there is statistically significant difference in the level of depression between IOC and NIOC.

- To find out whether there is statistically significant difference in the level of self- esteem between IOC and NIOC.
- To examine whether or not the levels of depression among IOC and NIOC vary as a function of the sexand age of orphan children
- To find out whether or not the level of self-esteem among IOC and NIOC vary as a function of thesex and age of orphan children

1.4. Significance of the Study

The study points out some valuable information based on depression and self- esteem symptoms of institutional orphan children and non-institutionalized children. These valuable findings will signify children, the government, researchers and the institution.

- For the government, the findings of this study would contribute in designing and implementing a program to ensure services in the institution and in the community and developing other possible ways (strengthen economic capacity of extended family and poor parents so as to care their own children than sending to the institution, reunification programs, etc).
- For the institution, the findings may support in sensitizing care givers- mothers and management staff of the institution so as to provide quality services for children by considering children's age, sex and years of living in the institution during group living arrangement.
- Moreover, institutions, counsellors and researchers may use the results of this study as a source of information, means of understanding and helping students. The results can also serve as a stepping stone for further inquiry.

1.5. Delimitation of the Study

The scope of this study was limited to examine the level of depression and self- esteem symptom on governmental institutionalized orphan children secured from Kechene and Kolfe institutions and non- institutionalized orphan children from Tsehaye chora Elementary School found in Addis Ababa(Gulelle subcity). In addition this study also limited to the following variables such as depression and self- esteem symptom levels of institutionalized and non institutionalized children.Furthermore, this study also limited to orphan children below 18 years old and both sexs were also participated.

1.6. Limitation of the Study

The number of male orphan children was smaller than female orphan children. This happened simply because there were relatively lower numbers of male orphan children. The disproportionate sample size may affect the generalizability of the findings, but not to a considerable degree.

Self -esteem and depression of orphan children is influenced by several factors such as living arrangement, care giving situation and the like. In this study the intention was to limit oneself to the effects of living arrangements on children's self- esteem and depression

1.7. Operational Definition of Terms

Institutionalized orphan children: - children at the age between ten to eighteen years old who lost both parents and reside in the institution to get care in a group living arrangement.
Non- institutionalized children: - Children at the age between ten to eighteen years old who lost both parents and live within the community.

Orphan:- Children those who have no biological parents bolew 18 years old.

Self-esteem - Confidence in one's own worth or abilities; self respect, self-image.
Depression - Despondency and dejection, typically felt over a period of time accompanied by feelings of hopelessness, inadequacy, disappointment and regret.

CHAPTER TWO

2. REVIEWS OF RELATED LITERATURE

This chapter presents the review of previous research on the concepts of orphan children, self esteem, depression and nature and charestrics of institutional care followed by a review of research findings on the difference between institutionalized and non institutionalized orphan children in their level of depression and self esteem and the diiference between institutionalized and non institutionalized orphan children in their self esteem across sex and age.

2.1 The Concepts of Orphan Children

The word orphan comes from Greek word *Orfanos* , meaning a child whose parents are dead or have abandoned them permanently. There are different understandings in defining an orphan, Some define an orphan as a child that has lost one or both parents and that is below 18 years of age. The Declaration on the Rights of the Child indicates that those people below the age of 18 years are considered as a child and deserve all the privileges that are accorded to this group. In common usage an orphan does not have any surviving parent to care for him or her. However, the United Nations Children's Fund (UNICEF,2012) label any child that has lost one parent as an orphan. In this approach, a maternal orphan is a child whose mother has died, a paternal orphan is a child whose father has died, and a *double orphan* has lost both parents. The according to (Ministry of Women ,Child And Youth Affairs (2009), single orphan refers to a child who lost one of his/her biological parent/s regardless of the cause of the loss and double orphan refers to a child who lost both of his/her biological parent/s regardless of the cause of the loss.

The Ethiopian policy definition of an orphan child states that an orphan is a child less than 18 years of age who has lost both parents regardless of how they died. This definition entails that children above the age of 18 years are not labeled as orphan even their parents have deceased. The definition also seems to suggest that transition from orphan hood to non-orphan hood at the attainment of age 18 years.

Orphaned children in Ethiopia are named by different phrases with slight differences in their terminologies. Sometimes, they give the phrase, welagi alba hitsanat (ወላጅ አልባ ህፃናት) in media to mean that children who have no any, biological parents at all other times, they are also represented by a phrase 'Asadagi yelalachew hitsanat' (አሳዳጊ የሌላቸውህፃናት) to mean that children who have no any primary guardian even in other times they are represented by welajochachewin bemot yatu hitsanat (ወላጆቻቸውን በሞት ያጡህፃናት) meaning that children who have lost their parents to death (Abebe, 2009).

2.2Concepts of Self Esteem and Depression

All humans have a need to be respected and to have self-esteem and self-respect. Esteem presents the normal human desire to be accepted and valued by others. People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued, be it in a profession or hobby. Imbalances at this level can result in low self-esteem or an inferiority complex. Institutionally raised children will still have problems interacting with peers and adults outside the institutions. Additionally, Children with high self-esteem have a much closer relationship with their parents and peers than do children with low self -esteem (Hodges and Tizard, 1989a; Gunnar et al., 2007).

2.2.1. Concept and theory of Self-esteem

Self-esteem is a personal judgment of worthiness that's expressed in the attitudes the individual holds towards himself (Coopersmith, 1967). It expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy.

According to (Pope, 1988 cited in coopersmith,1967), self-esteem is an evaluation of the information contained in the self-concept, and derived from the individual's feeling about the entire thing one is.

The definition proposed by psychologist Cohen (1968) is the degree of correspondence between an individual ideal and actual concept of himself. For Rentsuch and Heffner (1992), cited in Gonzalez-Mena (1993), self-esteem is an evaluation of oneself as person, and for Derlga and Janda (1986) it is how we think of ourselves, whether in a positive or negative fashion.

Jacobson in Campall (1984) defined it as an expression of the harmony or discrepancy between the self-representations and the wishful concept of the self. As to Gonzalez-Mena (1993), self-esteem is how we feel about how we define ourselves.

Self- esteem has also been defined in a number of other ways. The common theme refers to an individual's perception of himself in a number of physical, intellectual and social activities and depends up on the evaluation conveyed to the individual by significant others, by the standard of his reference groups and by his perceived effectiveness in achieving goals (Douvan and Gold,1966 cited in Heatherton,1991).

Many stressful situations have both positive and negative aspects. Whether a person tends to focus on the positive or negative aspects of a stressful life events may be an important determinant of the person's psychological adjustment. High self-esteem is considered to be a "healthy" of the self- one that realistically encompasses shortcomings but is not harshly critical of them. According to pope (1988 cited in Heatherton,1991) a person who has a high self-esteem evaluates himself in a positive way and feels good about his strong points. Feeling satisfied with the major portion of the self does not mean that the individual has no desire to be different in any way. A person with high self-esteem evaluates himself in a positive way and feels good about his strong points.

High self- esteem according to campball (1984) is the basis for a good personality and effective social functioning he further stated that a high self-esteem enables to influence people. Coopersmiths (1967) stated high self-esteem as:

Youngsters with a high degree of self-esteem are active, expressive. Individuals who tends to be successful both academically and socially. They are eager to express opinions, do not side -step disagreements are highly interested in public affairs. They appear to trust their own perfections and reactions and have confidence that they will be well received (p.20)

Coopersmith (1967) describes low self-esteem individuals as individuals with a picture of discouragement and depression. They feel isolated, unlovable, incapable of expressing or defending themselves and too weak to confront or overcome their deficiencies. In the presence of a social group, at school or elsewhere, they remained in the shadows, listening rather than participating, sensitive to criticism, self- conscious, pre occupied with inner problem. The low

self- esteem individuals are more likely to be unhappy, weak academically, discouraged, quick tempered, etc. which means a person lacks a global sense of self-worth (Gonzalez-Mena, 1993).

Different studies reveal that persons who seek psychological help frequently acknowledge that they suffer from feelings of inadequacy and unworthiness. These people see themselves as helpless and inferior- incapable of improving their situations and lacking the inner resources to tolerate or reduce the anxiety readily around by every day events and stress (Rogers , 1978 cited in Gonzalez-Mena, 1993).

2.2.1.1 Self esteem Theory

Many of the most popular theories of self-esteem are based on Cooley's (1902 cited in coopersmith,1967) notion of the *looking-glass self*, in which self-appraisals are viewed as inseparable from social milieu. (Mead's 1934,cited in coopersmith,1967) *symbolic interactionism* outlined a process by which people internalize ideas and attitudes expressed by significant figures in their lives. In effect, individuals come to respond to themselves in a manner consistent with the ways of those around him. Low self-esteem is likely to result when key figures reject, ignore, demean, or devalue the person. Subsequent thinking by Coopersmith (1967) and Rosenberg , as well as most contemporary self-esteem research, is well in accord with the basic tenets of symbolic interactionism. According to this perspective, it is important to assess how people perceive themselves to be viewed by significant others, such as friends, classmates, family members, and so on.

According to the sociometer theory, self-esteem functions as a monitor of the likelihood of social exclusion. When people behave in ways that increase the likelihood they will be rejected, they experience a reduction in state self-esteem. Thus, self-esteem serves as a monitor,

or sociometer, of social acceptance–rejection. At the trait level, those with high self-esteem have sociometers that indicate a low probability of rejection, and therefore such individuals do not worry about how they are being perceived by others. By contrast, those with low self-esteem have sociometers that indicate the imminent possibility of rejection, and therefore they are highly motivated to manage their public impressions. There is an abundance of evidence that supports the sociometer theory, including the finding that low self-esteem is highly correlated with social anxiety. Although the sociometer links selfesteem to an evolved need to belong rather than to symbolic interactions, it shares with the earlier theories the idea that social situations need to be examined to assess self-esteem(Heatherton,1991).

2.2.2 Concepts and Theory of Depression

Depression is an extremely complex disease. It occurs for a variety of reasons. Some people experience depression during a serious medical illness. Others may have depression with life changes such as a move or the death of a loved one. Still others have a family history of depression. Those who do may experience depression and feel overwhelmed with sadness and loneliness for no known reason. Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. People with depressed mood can feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, ashamed or restless(Lindert,2014)

2.2.2.1 Cognitive Theories of Depression

Cognitive theories of depression hypothesize that particular negative ways of thinking increase individuals' likelihood of developing and maintaining depression when they experience stressful life events. According to these theories, individuals who possess specific maladaptive

cognitive patterns are vulnerable to depression because they tend to engage in negative information processing about themselves and their experiences. Beck hypothesized that depression-prone individuals possess negative self-schemata (beliefs), which he labeled the "cognitive triad." Specifically, depressed patients have a negative view of themselves (seeing themselves as worthless, inadequate, unlovable, deficient), their environment (seeing it as overwhelming, filled with obstacles and failure), and their future (seeing it as hopeless, no effort will change the course of their lives). This negative way of thinking guides one's perception, interpretation, and memory of personally relevant experiences, thereby resulting in a negatively biased construal of one's personal world, and ultimately, the development of depressive symptoms. For example, the depression-prone individuals are more likely to notice and remember situations in which they have failed or did not live up to some personal standard and discount or ignore successful situations. As a result, they maintain their negative sense of self, leading to depression (Lata,2000).

A second cognitive model, the hopelessness theory of depression, proposed by Abramson, Metalsky, & Alloy is based on Seligman's work on learned helplessness and attribution styles The hopelessness theory of depression posits that when confronted with a negative event, people who exhibit a depressogenic inferential (thinking) style, defined as the tendency to attribute negative life events to stable (enduring) and global (widespread) causes, are vulnerable to developing depression because they will infer that: a) negative consequences will follow from the current negative event, and b) that the occurrence of a negative event in their lives means that they are fundamentally flawed or worthless.

For example, consider a woman whose fiance breaks off their engagement. If she attributes the cause of the break-up to her personality flaws, a stable-global cause that will lead to many other bad outcomes for her, or if she infers that a consequence of the break-up is that she will never marry or have children, or if she infers that without a lover, she is worthless, she is likely to become hopeless and develop the symptoms of depression. Thus, according to hopelessness theory, a specific cognitive vulnerability operates to increase the risk for depression through its effects on processing or appraisals of personally relevant life experiences (Lata,2000)

2.3 Age and Self esteem

Children of different ages have varying developmental levels of cognitive and emotional resources that may influence how they react to parental separation and divorce. While some reports demonstrate that children of particular ages, in a study conducted by Palosaari and Aro (1995), reported that lower self-esteem at the age of 16 was more common among girls from divorced families. However boys from divorced and non- divorced families did not differ from each other. The prevalence of depression was highest among persons from divorced families who had reported low self-esteem at the age of 16.

Mruk in 1995 also found that children with parents who are absent frequently or for long periods of time display lower levels of self-esteem. In another study, it was found out that two years after the divorce, children displayed lower levels of social and peer functioning as well as lower self-esteem than they did immediately following the divorce (Krider, 2002).

2.4 Sex difference in Depression and Self esteem

Empirical support in laboratory, clinical, or epidemiologic studies, the mechanism underlying the gender difference in depression remains unclear (Nolen-Hoeksena, 2002). There are several possibilities for the reason why women are more depressed than men. An amazing thing happens at puberty. Before developing sexually, boys are more likely to be depressed than girls, but afterwards girls become twice as likely to be depressed and boys turn to delinquenc.Not all girls get depressed, however. Despite a number of biological, psychological, and social theoretical explanations that have been formulated in attempts to account for the gender differences in depression, the mechanism underlying this association remains unclear (Ormel, Oldehinkel & Brilman, 2001).

Girls have certain personality traits that interact with the stresses of being a teenaged girl that produce depression and lower self-esteem. The personality traits are thought to be emotional dependence on relationships, less assertiveness, and passivity (or an inclination to worry about a problem situation rather than do something about it quickly and decisively, as a boy might do). Males attain slightly higher levels of self-esteem than females; this provides some insight into the gender differences in self-esteem; however, there is a lack of empirical evidence and theoretical models explaining this difference (Robins & Trzesniewski, 2005).

Thus, maturing young girls may get distressed *when* interacting with desirable but sexually aggressive young males, *when* they dislike or don't know how to handle their own bodily changes (breasts, pimples, over or under-weight, no butt, etc., etc.), *when* sexually teased, used, or abused, *when* their social activities are restricted more than boys, *when* peers, culture, and parents start to emphasize attractiveness, sexiness, and friendships more than intelligence, genuine caring, and preparing for one's life work (Robins & Trzesniewski, 2005).

Previous research on gender differences in self-esteem suggests that male children have higher self-esteem than female children do (Chubb , 1997). However, in some studies the gender difference was small (Watson, 2001) or nonsignificant (Keltikangas-Ja¨rvinen, 1990). Likewise, several studies reported higher self-esteem for men in young adulthood (McMullin & Cairney, 2004), although in some studies the gender difference was small (Orth et al., 2010).

In our todays modern world we are gradually finding more and more childhood factors related to teenage depression. A frequently cited statistic is that women are twice as likely to become depressed as men (and two or three times more likely than men to *attempt* suicide). It is an interesting coincident that women are also about twice as likely as men to "over-think," which is ruminating mostly about unhappy events in the past (in contrast to worry which often focuses on bad things that might happen in the future). This could be another bit of evidence that negative thoughts produce negative emotions although the above observation that females dramatically increase their negative thoughts at the time of puberty also suggests something else may be an underlying cause of both negative thoughts and depressed feelings (Nolen-Hoeksena, 2002). and Cyranowski et al., 2000).

Maslow noted two versions of esteem needs, a lower one and a higher one. The lower one is the need for the respect of others, the need for status, recognition, fame, prestige, and attention. The higher one is the need for self-respect, the need for strength, competence, mastery, self-confidence, independence and freedom. The latter one ranks higher because it rests more on inner competence won through experience. Deprivation of these needs can lead to an inferiority complex, weakness and helplessness. Maslow also states that even though these are examples of how the quest for knowledge is separate from basic needs he warns that these "two hierarchies are interrelated rather than sharply separated" (Maslow, 1999).

Juffer, Marinus and Ijzendoornafound that adopted children show lower self-esteem than their non- adopted peers. Adopted children are hypothesized to be at risk of low self-esteem. They may endure from the consequences of neglect, abuse and underfeeding in institutions before adoption. They have to cope with their adoptive status which often includes difficulties associated with the lack of similarity to their adoptive parents. Additionally, transracial and international adopters may feel less integrated into their family, resulting in low self-esteem. This was equally true for international, domestic, and transracial adoptees (Juffer, Marinus and Ijzendoorna, 2007).

Mazhardescribed that the meaning of self-esteem is a sense of self, the value one puts on self and the worth one attaches to self. In fact, self-esteem is the basic belief about self. Thus, it may be argued that, if one has a positive belief system about one's self, one will have a positive self-esteem. On the other hand, if one views oneself as worthless, one will have a negative self-esteem (Mazhar, 2004).

Rogers described that self -concept has three different components: 1) the view you have of yourself (Self -image) 2) how much value you place on yourself (self-esteem or self-worth); and 3) what you wish you were really like (ideal self). According to Rogers (1959) high self-esteem refers to positive view of our selves which tends to lead to confidence in our own abilities; self-acceptance; optimism and not worrying about what others think. On the other hand, lower self-esteem refers to negative view of our selves which tends to lead to lack (Rogers, 1959).

Twenge (2009) stated that self-esteem has a strong relation to happiness. He argues that the people high in self-esteem claim to be more likeable and attractive; to have better relationships and to make better impressions on others than people with low self-esteem.

2.5 Nature of Institutional Care

Institutionalization is the placement of children in institutions, such as orphanages. Institutionalization has a deep impact on the life of a child.Their placement in institutions during early critical developmental periods, and for lengthy periods of time, is often associated with developmental delays due to environmental deprivation, poor staff to child ratios, and/or lack of early childhood stimulation (Twenge,2009). A child should grow up in a family. Permanent parental care is the ideal situation for every child. Every child has a right to be permanently placed in a family (Boswell, 1988). However, this is not always possible. There have been decades of research on the topic of institutionalization and the extreme negative effects it has on children.Caring for orphaned, abandoned, and maltreated children through informal care and adoption has a long history (Boswell, 1988).

The historical literature describes many examples in which families' too kin 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 (Crenson,1998;Hacsi,1997).The expansion, both in the number of new orphanages created and in the number of children cared for, continued into the early 1900s (Smith, 1995).

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: (1) children should be raised by their own families; (2) 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 (3) no child should be removed from parental care because of poverty alone (Crenson, 1998).

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 newborn (Crenson, 1998).

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 (Goldfarb, 1945). 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 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 (The St. Petersburg-USA Orphanage Research Team, 2008). Although there are relatively few orphanages in Western Europe, institutions nonetheless exist in Portugal, There are often large differences from one institution to another; from one unit to another within an institution, and even variability in the care individual children receive within the same grouping. Children in orphanages and other vulnerable child populations (homeless, exploited, adopted, refugees) as entire populations are increasingly seen to have high rates of mental health problems and challenges. The living conditions of orphans expose them to more traumatic stressors than non – orphans(Kligman, 1998).

A study comparing children in institutional care with those in foster care, who experienced fewer changes in careers and more individual care and found that children cared for in foster homes scored significantly lower levels of unsociability, hyperactivity and inattention than those from institutional care homes and offers further evidence that continuity of care and individualized care - giving is important to a child's healthy development. In other words orphans suffering a loss of a former secure attachment (mother's death) could put them at higher risk of developing mental disorders(Zeanah et al., 2003).

Nonetheless, there are certain modal features of institutional care that have characterized these settings across countries and continents. These include: generally high child to caregiver ratios; caregivers with low wages and little education or training who work rotating shifts; regimented and non- individualized care; and a lack of psychological investment in the children (Zeanah et al., 2003). These qualities of institutional care present challenges to children's development. Older children may be able to develop adequately in a setting that does not allow for close caregiver-child relationships. However, interactions with consistent and committed caregivers are key to the development of young children(Nelson, 2007; Zeanah, Smyke, and Settles, 2006).

In Ethiopia, as in most traditional societies, a strong culture of caring for orphans, the sick, the disabled, and other needy members of the community by nuclear and extended family members, communities, churches, and mosques has existed for centuries. Based on cultural and religious beliefs, provision of care to orphaned, abandoned, and vulnerable children has been seen as the duty of the extended family system among most of the ethnic groups in the country. Thus, child welfare services in Ethiopia emerged as a result of traditional practices among the various ethnic groups. Fragmented historical records reveal that among the Oromo and Amhara

ethnic groups, adoption has been exercised since the 15th century. However, it was only in 1960 that the Ethiopian Government officially recognized adoption through Proclamation Number 165 (Assefa, 2008).

The Amharic word for adoption is *madego*. It is also called *gudiffecha*, derived from the Oromo word *gudissa* (upbringing). Among the Oromo, Adoption focused on the continuation of parental lineage, thus the emphasis was on the adopter and less on the adoptee. Since lineage is preserved through male descendents, the most widely adopted children tended to be males. In the traditional Oromo culture, families who do not have male offspring often adopt a son of an extended family member or member of the same clan. Daughters are also adopted (e.g. in the case of infertility)(Assefa, 2008).

In addition to *madego*, the Amhara have two types of arrangements that provide orphans and neglected children with minimum protection. These are *yetut lij* ("breast child") and *yemar lij* ("honey child"). In this case, the adopted child, usually an orphan or the child of parents who are not able to care for him/her, receives proper feeding and attention but does not receive the same treatment as biological children. In this instance, there is a religious connotation or motive behind taking in another child. The emphasis is on the salvation of the soul of the adoptive family; therefore, the fate of the adopted child is given less attention. The advent of urbanization, recurrent drought, famine, and HIV/AIDS has claimed a heavy toll on human life in Ethiopia during the past three decades. As a consequence, thousands of children have been left unaccompanied and in need of care (Alemtsehay,1988).

The severe drought of 1984-85 is recognized as the catalyst for the proliferation of institutional care in Ethiopia. Many child care institutions were established by both governmental and nongovernmental organizations in response to the drought. Prior to this period, very few

institutions were initiated and these were mostly faith-based, supported by local elite philanthropists. In an effort to find an immediate solution to the growing numbers of unaccompanied children, institutional care was seen as a quick alternative to family-based care, particularly for those children who were left unaccompanied as a result of the death of their parents from famine and those who were put into temporary shelters. Approximately 31 percent of the institutions in operation today were started during this time. Immediately after the 1984 famine, approximately 21,000 children in 106 institutions were cared for in institutional settings, a record number. It is important to note that these institutions only provided long-term child care (National Guidelines for Alternative care of children Ethiopia, 2002; UN guidelines, 2007).

Currently, as a result of the Ethiopian government's guidance to discourage institutionalization of children, there are only three government institutions operating in Ethiopia. In January 1986, the Relief and Rehabilitation Commission (RRC) created a directive aimed at deinstitutionalizing children through reunification and reintegration. From 1986 to 1990, a large-scale reunification program took place, resulting in the decline in the number of residential child care institutions. However, this guidance has not influenced nongovernmental and faith-based organizations, which continue to operate child care institutions and, in some cases, open new institutions (Alemtsehay, 1988).

To define what is meant when using the term "institutionalization," as well as to identify common elements of institutional care. Institutionalization refers to an establishment founded by a governmental, nongovernmental, or faith-based organization to give care for unaccompanied children. A child care institution may also be referred to as an orphanage, children's home, or residential care. Common aspects of institutionalization, as defined by academicians, policy makers, and international organizations, include care by paid personnel living with non-related

children, children clustered by age group, and a high child-to-caregiver ratio (Rosas and McCall, 2009).

One of the most common characteristics of institutional life is the lack of stable, long-term relationships between a child and a caregiver (Obrova Krol et al., 2008). Institutions may range in size from a small group to hundreds of children. In one study, "standard" institutional care was defined as more than 20 staff members caring for a large group of children, and typically a child-to-caregiver ratio of 10:1 (Ford and Kroll, 1995)

2.5.1 The Positive Effect of Institutionalization

Even if there is much debated question in the literature on whether institutionalized orphan children has an impact on real-life outcomes or whether institutionalized orphan children is merely an epiphenomenon of success and well-being in the relationship, work, and health domain (swann et al., 2007). Research suggests that institutionalization had both individual and social effects on orphan children's.

Research suggests that institutionalized orphan children are correlated with many factors in important life domains (e.g., relationship satisfaction, Shackelford, 2001; socio- economic status, Twenge & Campbell, 2002. The available longitudinal studies suggest that institutionalized orphan children might have significant positive effects on important life outcomes (Horwood, 2008). In addition, institutionalizing children improves their level of freedom, self- confidence, boding and attachment, social cohesion and social interaction in their life. Moreover, research suggests a causal link between institutionalized orphan children and task persistence (Baumeister et al., 2003). More precisely, laboratory experiments have repeatedly shown that high institutionalized orphan children facilitates more adaptive persistence behavior: Individuals with high institutionalized orphan children persist longer in the face of

failure , but whenever persistence is maladaptive (when confronted with complex tasks), they persist less than individuals with low institutionalized orphan children (Di Paula & Campbell, 2002). This adaptive self-regulatory behavior might contribute to the link between institutionalized orphan children and psychological adjustment (Baumeister et al., 2003). Furthermore, they suggested that task persistence may result in a sense of mastery and control which is inversely related to phenomena such as depression.

More precisely, Baumeister et al. (1996) suggested that some forms of high institutionalized orphan children specifically, inflated and unstable high institutionalized orphan children may cause interpersonal aggression and violence, because people with overly high institutionalized orphan children are more prone to experience ego threats and, consequently, are more strongly motivated to defend their institutionalized orphan children by devaluating and attacking people who question their inflated self-views.

However, other studies suggest that low, but not high, institutionalized orphan children predicts antisocial behavior and interpersonal violence, in particular when the confounding effect of narcissism is statistically controlled for (Moffitt & Caspi, 2005). Overall, the available research suggests that high institutionalized orphan children may have positive consequences for the well-being and success of the individual and that low institutionalized orphan children may be a risk factor for negative outcomes.

Attachment is the reciprocal bond between child and caregiver that is established early in life. This relationship has profound and lasting effects on all aspects of development including neurological, physical, emotional, cognitive, behavioral and social. The attachment relationship helps them to outline the foundation for their basic ability to trust , acts as a model for future emotional relationships , develops our ability to regulate arousal, stress and trauma,

informs our sense of identity, self - worth and competency and lays the foundation for pro- social morals such as compassion, empathy and conscience(Moffitt, &Caspi, 2005).

2.5.2 The Negative Impacts of Institutionalization

The adverse effects of institutional care were not fully recognized until the 1940s, largely because, until comparatively recent times, there were not sufficient numbers of children who survived the experience for long enough. Nevertheless, as early as 1860 in Russia, a family-type environment was considered to be a way of learning about real life and the mutual obligations and assistance that were vital for it (Ransel, 1988). In the 1940s, the work of researchers, in particular Goldfarb in the USA and John Bowlby in the UK, had a significant impact on our understanding of institutional life.

Even though, the level and quality of care provided institutions differs from one institution to another, depending on the type of internal organization (family-based or conventional dormitories), the size of the family or other internal unit, internal equipment, the number of qualified staff, the working hours and numbers of care-givers to orphan and the type of relationship they have with the children, management style, the overall atmosphere within the institution and financial resources (Bush, 1980). Institutions are considered to be the last resort for the care of parentless children; they have a role to play in short-term, emergency placements for sibling groups (Browne & Hamilton-Giachritis, 2005).

The Age of placement in to a kinship, fosters and or adopting family and the quality of the consequent family care are important factors in the outcome of children who have experienced institutional care (Goebel, 1981; Gunnar et al., 2007). Due to the incapability of the intake family and the extended family to take care children, Children are cast out and enforced to

continue their life in the institution or in the community. 143,000,000 orphans in the world today spend an average of 10 years in an orphanage or foster home, Every year 2,102,400 more children become orphans (in Africa alone) and every 15 seconds, another child becomes an AIDS orphan in Africa. Every day 5,760 more children become orphans (UNICF, 2003).

Goldfarb discovered that, in many respects, children brought up in an institution compared less favourably with children from foster homes, particularly in intelligence tests; he concluded that the effects of early parental deprivation were long-lasting(Goldfarb, 1945). John Bowlby developed his theory of maternal deprivation after observing children who were separated from their parents (particularly their mother): he found that their psychological development was severely affected by separation (Bowlby 1951cited in UNICF 2003).

Children who are institutionalized at an early age often demonstrate delays in emotional, social, and physical development. Institutionalization places children at great risk for certain diseases. Institutional care may affect a child's ability to make smooth transitions from one developmental stage to another throughout his/her life. Children brought up in institutions may suffer from severe behavioral and emotional problems; however, the effects of institutionalization are not uniform and are dependent on other factors. The extent of suffering is not the same for every child who is institutionalized. The differential effects are due to child characteristics (genetic predisposition, basic personality, attractiveness, prenatal risk factors), caregiver characteristics (training, motivation and attitude), institutional characteristics (child-to-caregiver ratio, quality and degree of programming), and the child's history (the age of the child when he/she entered the institution and the length of time in the institution. Institutional staffs do

not connect emotionally or physically with children in quite the same way that families connect with children (Victor, 1996).

Finally, the Age at placement and the length of institutionalization have an effect on children. Some of the problems encountered by children who are living in a certain institution including psychological stress, negative impact of education, loss of inheritance and physical as the result of these and other burdens children are exposed to depression, low self- esteem and alienation are common (Berger, 2003).

Conceptually, there are 'four pillars of the organization': 1) the 'village' in which orphan and/or destitute boys and girls can live together as 2) 'brothers and sisters' in 3) a 'family-like environment' with the care of 4) a 'mother'. Each village consists of a cluster of households (usually 10 to 15) in which orphans are placed under the care of an SOS mother, who acts as a substitute for the children's natural parents and who is supported by another non-professional woman, called the 'auntie'. The original philosophy has led to wide replication of the project as a 'global model' elsewhere (SOS International, 2009).

2.6 Self esteem difference between institutionalized and non institutionalized orphan children

The findings of the current research suggest all theorphan children reportedlower self-esteem as compared to the children living with their parent probably due to loss of their parents Mohanty and Newhill's (2005). Similarly Gunnar et al., (2007)reported that there is a significant difference in self-esteem of the orphan children and the children living with their parents. The orphan children reported lower self-esteem than the children living with their parents. The findings of this research have implications for understanding the emotional state of mind and

personality development of the children living in orphanages as compared to those who are living with both parents. In addition, Gunnar et al., (2007) indicate that there is significant difference in self-esteem of the boys from orphanage and boys living with their parents. The orphan boys showed lower self-esteem as compared to boys living with their parents.

In addition, they also reported that,there is asignificant difference in self-esteem of girls from orphanages and girls living with their parents. However, the orphan girls showed slightly lower self-esteem as compared to girls living with their parents.

2.7 The Difference Between Institutionalized Orphan Children and Non Institutionalized Orphan Children in their Level of Depression

As study conducted by Gunnar et al., (2007) indicated institutionalized orphan children show high depression symptoms than non institutionalized orphan children children . This did not definitely mean that only institutionalization by itself brought depression for children and did not mean institutionalization is a the reason for children depression but the reason of being institutionalized and services given in the institution causes children's depression.

2.8 The difference between Institutionalized Orphan Children and Non Institutionalized Orphan Children in their Level of Depression and self Esteem Across Sex

As previous reaserch study conducted by Mruik(1995) indicated that singinificant sex difference across institutionalized and non institutionalized male and female orhan children were not observed. In addition, Mruik(1995) also reported that there is statistically insignificant mean difference in the symptom of self esteem between male and female of both institutionalized and

non-institutionalized participants. Meaning, males were shown slightly better self esteem symptoms over females orphan children.

2.9 The difference between Institutionalized Orphan Children and Non Institutionalized Orphan Children in their Level of Depression and self Esteem Across Age

As Mruik(1995) reportd that there is no significant level of depression symptom difference among institutionalized and non institutionalized orphan children across their ages. He also reported that,significant difference across age group in their self esteem was there. He reported that as age increases self esteem also increases in children.

2.10. Locus of Control, Adjustment and Depression

The concept of 'locus of control' refers to the relationship between the environment and the individual's assessment of his or her ability to deal with it and to adjust behavior accordingly. Locus of control has two dimensions: the external and internal. The external locus of control assumes that a person's life is controlled by external factors, such as luck, fate and nature(Lefcourt, 2009).

Externally oriented individuals ('externals') do not see themselves as responsible for what happens to their lives but merely accept what happens. From this perspective, a person is helpless and is at the mercy of the environment. The internal locus of control assumes the ability to predict environmental events and be able to respond appropriately. Internally oriented individuals ('internals') feel they have the ability to control events and the resultant behavior. Therefore, they are in control of their own fate. 'It is this perception of the ability "to do something" that gives rise to the concept of perceived control' (Lefcourt, 2009).

Locus of control is important for effective coping behavior in the case of stress. When faced with stress, internals tend to adopt a problem-solving strategy while the externals tend to react emotionally, for example by being angry (Sarason and Sarason, 1989). Consequently, internals are able to leave their disappointments behind them and live happily. Externals, on the other hand, continue to carry their burdens into their future and hence are often depressed. Our theoretical expectation is that depression is positively correlated with external locus of control and negatively correlated with internal locus of control. This means that those who scored high on the depression scale also scored high on the locus of control scale. Likewise, those who scored low on depression also scored low on the locus of control (Sarason & Sarason, 1989).

2.11.Orphan Children's and Social Change

Death of parents introduces a major change in the life of a vulnerable child. This change may involve moving from a middle or upper-class urban home to a poor rural relative's home. It may involve separation from siblings, which is often done arbitrarily when orphaned children are divided among relatives without due considerations of their needs. It may mean the end of a child's opportunity for education because of lack of school fees. Those children who choose not to move or who may not have any other relative to go to may be forced to live on their own, constituting child-headed families. All these changes can easily affect not only the physical, but also the psychological well-being of a vulnerable child. They can be very stressful as they pose new demands and constraints to children's life(Minde ,1988).

It is feared that many children may find it difficult to adapt to the new changes (Minde,1988).makes it clear that it is not the social change itself that may cause psychological problems; rather it is the failure of the individual to adapt to social change. Like bereavement, social change and the resultant need to adapt to it create stress. According to Minde (1988). this

stress may be shown in symptoms of confusion, anxiety, depression, and behavioral disorders such as disobedience. The same symptoms may cause learning problems. Children who are frustrated, fearful, and depressed may fail to concentrate in class and therefore perform badly. Failure by the school and the home systems to recognize these symptoms and address them will aggravate the child's psychological problems.

2.12 Attachment and Psychological Difficulties

Researchers believe that infants are born with an innate capacity to relate to others, but this predisposition needs a healthy environment in order to develop (Trevarthen and Aitken, 2001). Perhaps indicating that orphanages seldom represent this healthy environment, attachment relationships in institutions are commonly portrayed as disturbed or disrupted (Rutter and Taylor, 2002; Vorria et al., 2006). Neurological aspects are vital to the development of attachment (Schore, 2001a). With appropriate stimulation, the brain will cultivate abilities that help make social and emotional information understandable for the child (Schore, 2001b).

However, if an infant is neglected, abused, or traumatized, this will not occur, instead increasing the risk for an attachment disorder (Glaser, 2000; Tarullo, Bruce, and Gunnar, 2007). In fact, many adult mental health problems have been related to disturbances of early attachment (Chisholm, 1998; O'Connor et al., 2003).

An attachment disorder commonly found in studies of institutionalized children is reactive attachment disorder (Boris and Zeanah, 1999, 2004; Wilson, 2001). Reactive attachment disorder has been defined as "problems with the formation of emotional attachments which onset before the age of five years in response to serious deficiencies in care-giving" (Browne and Mulheir, 2005). There are two subtypes of Reactive attachment disorder, inhibited and disinhibited. The inhibited subtype is in part characterized by trust issues, by the child being

emotionally withdrawn, or not wanting to seek out support from caregivers – not even when hurt or crying (Dulcan, Martini, and Lake, 2003). Illustrating this is the case of small children who have abandoned crying as a form of communication. A healthy infant will use crying to convey a need. If a caretaker appears and the need is satisfied, the tactic is deemed successful. If not, "disuse related extinction" may occur, meaning that the behaviour is discarded because it did not have the desired result (Perry and Pollard, 1998).

In institutional settings, the disinhibited type of Reactive attachment disorder appears to be more common than the inhibited type (Boris and Zeanah, 2004). Disinhibited Reactive attachment disorder is expressed through a seemingly insatiable need for adult attention, affection, and proximity. This has also been described as social promiscuity as children exhibit indiscriminately friendly behavior towards strangers, sometimes even approaching them for comfort when distressed (Scheeringa et al., 2003).

The children behave unsafely (e.g. run off without checking back to the caregiver) and appear unable to understand social cues (Zeanah and Fox, 2004). Attachment difficulties found in orphanages are commonly explained with lack of stimuli due to orphanages being short-staffed (Giese and Dawes, 1999; Vorria et al., 2006). As a result children grow up "typically deprived of the supportive, intensive, one-on-one relationship with a primary caregiver" (Browne and Hamilton-Giachritsis, 2007

2.13 Policies and programs Related to Children Right /CRC/

Ethiopia has ratified two key international instruments covering the care and protection of children. These are the UN Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). The UNCRC was ratified by Ethiopia in May 1991, but has yet not published in the Negri Gazette. The African charter on the Rights

and Welfare of the Child was ratified by Ethiopia in 2002. Article 22 of the Guidelines for the Alternative Care of Children, recently welcomed by the UN General Assembly,17 promotes this view, stating that, "Where large child care institutions remain, alternatives should be actively developed in the context of an overall de-institutionalization strategy that will allow for their progressive elimination (MoLSA and UNICEF, 2005).

2.13.1. International Convention on the Rights of the Child

The international Convention on the Rights of the Child (CRC) advocates a children's rights perspective.It is because it recognizes the responsibility of state parties and other duty bearers to intervene in promoting the rights and welfare of the child. All legal frameworks in Ethiopia are enacted based on CRC and human right issues and principles. CRC rests on the general principles of non-discrimination and gender equality (Article 3), best interests (Article 2), survival, development (Article 6) and participation (Article 12) rights of the child. The convention recognises the rights of the child to health facilities and medical assistance, provision of adequate nutritious food, clean drinking water and living in a healthy environment (Article 24). It also recognises the rights of children to benefit from social security (Article 26). Children have the recognised right of education (Article 28 and 29). Accordingly, CRC emphasises primary education as compulsory, available for all and free (Article 28) (MoLSA and UNICEF, 2005).

Moreover, the CRC give due emphasis to the protection of children from all forms of exploitation and abuse including protection from substance and drug abuse (Article 33), economic exploitation (Article 32), sexual exploitation (Article 34), child sale and trafficking (Article 35), emotional and physical abuse and punishment (Article 37).

2.13.2. The Africa Charter on the Rights and Welfare of the Child

The Africa Charter on the Rights and Welfare of the Child (ACRW) also recognizes the holistic rights of children. The Africa Charter on the Rights and Welfare of the Child in Article 20 states the responsibilities of parents and other legal responsible duty bearers to ensure that the best interests of the child are paramount at all times; to ensure, within their abilities and financial capacities, conditions of living necessary for the child's development and to ensure that domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child (MoLSA, UNICEF, 2005).

According to the constitution of Ethiopia every child has the right to life, to know and to be cared for by his/her parents or legal guardians, to be protected from exploitative and abusive practices including corporal punishment and inhuman treatment in schools and other institutions and to promote equal rights of children born out of wedlock with children born in marriage (Article, 36). Moreover, it considers the family as fundamental unit of the society which is institutionally entitled to protection by society and the state (Article, 34) (FDRE, 1995). According to the Africa Charter on the Rights and Welfare of the Child, the state has the duty to provide assistance to caregivers and take the following measures based on its means and national conditions (Article 20): To assist parents and other persons responsible for the child and in case of need to provide material assistance and support programs particularly with regard to nutrition, health, education, clothing and housing and to assist parents and other responsible parties of the child in the performance of childrearing and in ensuring the development of institutions responsible for providing care of children.

In general, international legal frameworks recognize all the rights and welfare provision guidelines of vulnerable children. However, realization of these rights, including survival and

development, depends upon the economic development of member nations. If there is not the necessary national capacity to preserve these rights of children, the state can call for resources from the international community. Regarding the responsibility of the state to allocate resources, CRC (Article 4) depicts that 'States parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation'. Similar to the convention, allocation of resources to promote the welfare of orphan and vulnerable groups is not mandatory in the context of the constitution of Ethiopia. It is stated as: 'the state shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardians' (FDRE, 1995).

2.14 SUMMARY REVIEWS OF RELATED LITERATURE

In this chapter, concepts about the nature of institution, positive and negative effects of institution were presented. As previous research indicates orphan children living in the institutions faces several challenges such as lack of important psychological services such as less showing unconditional love to the orphan children by their significant other children in institutions which in turn leads to low self esteem and depression in orphan children living in the institutions.

Orphan children living in the community achieve higher in their self esteem than orphan children living in the institution. In addition, as discussed in the literature above, In terms of gender and level of self esteem and depression, controversial findings were observed. These controversial findings may be because of cultural and ethnic group difference or other methodological problems related with the studies.

CHAPTER THREE

METHODS

3.1. Research Design

This study focused on the level of depression and self- esteem symptoms between two groups- institutionalized orphan and non-institutionalized orphan children. In order to secure the required information from participants' since the required information was collected from participants through close ended questionnaire, descriptive survey design was employed.

3.2. Description of the Study Site

This study was conducted inAddis Ababa at the institution named Kolfe, Kechene and non- institutionorphan children currently continuing their education in Tsehay Chora Primary School. The rationale behind researcher's focus on orphaned children is that since the researcher is working with orphaned children it may enable researchers to secure relevant data from participants.

The study population comprises of the institutionalized orphan children and non-institutionalized orphan children. The IOC who are living in the Kolfe (62)and Kechene institution (98)and NIOC who are living with the community and attending their education in Tsehay Chora elementary school(106).Ingeneral population of the study is 266 orphan children

3.3. Sample and Sampling Techniques

Before selecting samples the researcher set the inclusion and exclusion criteria, and then selected the desired sample from the target population in accordance with the criteria listed here under: to draw sample from children who are living or staying in the institution the researcher

used the following preconditions such as children who have lost both parents(double orphan), children found between 10 to 18 age categories

To draw sample from children who are living in the community, the researcher used the following preconditions: Children who have lost both parents (Double orphan) , Children must attend their education in Tsehay chora elementary school and children found between 10 to 18 age categories.

In order to select children from Kolfe institution, from a total of male orphaned children (62) found in this institution 44 male children those who fulfillied the criteria were selected. To do this, simple random techniques was utilized. Regarding kechene institution, from a total of (98) female orphaned child found in these institution (84) children those who fulfilled the predetermined criteria were selected.The same sampling technique meaning simple random sampling technique used for males was also utilized for female orphan children.

Similarly in order to select non institutionalized orphan children from Tsehaye chora elementary school, from a total of orphan children found in this school (106) (59 females and 47 males), (54 females and 42 males) were selected. To do this first males and females are stratified based on their sex, following this simple random sampling technique was utilized. Accordingly total of (96) orphan children were selected from Tsehay chora school.

Accordingly 128 from institution and 96 from school were selected. However the responses of 28 participants were excluded from final analysis because of incomplete response in the questionnaire. Hence data collected from 196 participants was analyzed.

3.4. Instruments of Data Collection

In order to secure data from participants, an adapted scales Beck-II depression inventory which consists of 45 items. The scale consists of items used for assessing depression level of respondents. And the Rosenberg Self-Esteem Scale which consists of 10 items. The scale consists of items used for investigating self esteem level of respondents.These scale were administered after validity and reliability of both scales was proved so as to measure the depression and self- esteem symptom of IOC and NIOC respectively.

3.5. Pilot Test

In order to check internal reliability of the scale, pilot study was conducted, to do this, forty participants (20 males and 20 females were randomly selected from Tsehaye chora elementary school .Finally, Amharic version of the instrument was pilot tested on a randomly selected sample of forty students (half male and half female) . Before distributing questionnaire for participants, adequate orientation on how to respond to the questions was provided by the researcher.

Following this, questionnaire was distributed and collected from participants. The responses of the respondents were scored and the reliability of the scale on the two subscales such as depression self- report inventory and Rosenberg's self- esteem self- report inventory were computed using the SPSS software package, version 20.0.

Accordingly, after computing these scales using software discussed above, the overall reliability of depression self- report inventory, the internal reliabity of the scale were (α=0.826) which is almost similar with the original reliability of the scale(α=.85). Following this, all items 45 were used in the final study. In case of Rosenberg's self- esteem self -report inventory,

internal reliability of the items were (α=0.81)Which is almost similar with the original reliability of the scale(α=.87) and hence, all items (10) were used for final study.

To prevent test contamination, section from which subjects for the pilot study selected were excluded in the main study.

3.6. Procedure of data Gathering

Following the selection of the school and institution, permission to conduct the study was asked from respective school director and manager of the institution and permission to conduct the study was achieved. Participants were informed about the purpose of the study. Following this, orientation on how to respond to the questions was provided by the researcher for participants. Accordingly, the questionnaires were distributed to respondents to be filled individually. The questionnaires were administered to the respondents (during their regular class time) by the researcher. During data collection the researcher was personally availed himself in each classroom and clarified the purpose of the questionnaire.

In addition, the respondents were informed to respond honestly to all items as the personal information they provided will going to be used only for the purpose of this study. Finally the filled data was collected and organized to make it appropriate for analysis.

3.7. Methods of data Analysis

First the responses of the participants of the study were coded and interpreted using descriptive statistical methods. Following this, the collected data were analyzed using SPSS version 20. The first part involves description of the characteristics and background of participants in the study followed by a descriptive statistical presentation summarizing the data with means and standard deviation of the scores on the variables in the study was employed. To

investigate difference between institutionalized and non- institutionalized orphan children in their levels of depression and difference between institutionalized and non- institutionalized orphan children in their level self -esteem independent t-test was employed.

In order to examine the effects of living arrangement, age and sex on children's' depression level and the effects of living arrangement, age and sex on children's 'self-esteem three ways analysis of variance ANOVA employed. Before applying ANOVA procedure, assumption of utilizing ANOVAs procedure such as normality of distribution, equality of variance and randomness was tasted.

CHAPTER FOUR

4 RESULTS

In this section description of findings are being presented. The analysis involves three parts. The first part involves description of the characteristics and background of participants in the study followed by a descriptive statistical presentation summarizing the data with means and standard deviation of the scores on the variables in the study.

To investigate difference between institutionalized and non -institutionalized orphan children in their levels of depression and difference between institutionalized and non - institutionalized orphan children in their level of self- esteem independent T-test was employed. In order to examine the effects of living arrangement, age and sex on children's' depression level and the effects of living arrangement, age and sex on children's' level of self esteem ANOVA procedure was employed.

4.1. Socio-background characteristics of Respondents

The table below illustrates the socio background of respondents.

Table 1*:* ***Background of Participants***

Categories			Frequency	Percent
With whom you are living	Institution		112	57.1%
	Non institution	Relatives	72	36.77%
		With others	12	6.12 %
	Total		196	100
Sex	Female		122	62.2
	Male		74	37.8
	Total		196	100%
Age	10- 14		104	53.1%
	15-18		92	46.9%
Total			196	100

As can be illustrated in the above Table 1, among participants participated in the study 57.1% of them are living in the institution and the rest 42.9% of them are non- institutionalized children.

Regarding sexes of respondents, among participants took part in this study, 62.2% of them are females and 37.8% them are males.

Pertaining to age of respondents 53.1% of them are found between (10-14) and the rest 46.9% of them are found between 15-18 age categories.

4.2 Descriptive Summary of Variables of the study

Table 2:*Means and Standard Deviations of Study Variables by Sex, Age and Living Arrangement of Respondents*

Study variables							
	Depression			Self esteem			
Age category	No	Mean	SD	Age category	No	Mean	SD
10- 14	104	124.47	15.2	10-14	104	23.96	2.96
15- 18	92	110.53	11.1	15-18	92	27.46	3.29
Total	196			Total	196		
sex							
Male	74	124.54	12.1	Male	74	23.56	4.89
Female	122	113.9	14.3	Female	122	29.44	7.02
Total	196			Total	196		
institutional	112	128.32	18.2	institution	112	23.78	5.7
Non institutional	84	103.41	16.3	Non institution	84	28.55	4.8
Total	196			Total	196		

As can be illustrated in the above Table 2 , pertaining to depression level of respondents, regarding the age category of respondents children's 10-14 age categories were score high on depression scale than their counter parts of children whose their age categories are between 15-18 with mean of (M=124.47) and (M=110.53) respectively.

In addition, regarding sexes of respondents, male children are scored high on depression scale than their counter parts of female children with mean of (M=124.54) and (M=113.9) respectively. Furthermore, regarding living arrangement of respondents, institutionalized children score high on depression scale than their counterparts of non- institutionalized orphan children with the mean of (M=128.32) and (M=103.41).

With pertaining to self -esteem of respondents, regarding the age category of respondents, children's 10-14 age categories are score high on self -esteem scale than their counter parts of children whose their age categories are between 15-18 with mean (M=27.46) and (M=23.96) respectively.

In addition, regarding sexes of respondents, male children obtained high score on self -esteem scale than their counter parts of female children with the mean of (M=29.44) and (M=23.56) respectively.

Furthermore, regarding living arrangement of respondents, non- institutionalized children score high on self- esteem scale than their counterparts of institutionalized orphan children with the mean of (M=28.55) and (M=23.58) respectively.

From this findings we can infer that, though both institutionalized and non-institutionalized children have no opportunity to live with their biological parents, non-institutionalized children's were score better on self -esteem scale than their counterparts of children who are living in the institution.

4.3 Descrptive Summary of Institutionalized Children on Self Esteem and Depression Scale by Sex and Age

Table 3:*Mean and SD of Institutionalized Children on Self Esteem and Depression Scale by Sex and Age*

Study variables							
	Depression			Self esteem			
Age category	No	Mean	SD	Age category	No	Mean	SD
10- 14	56	126.57	11.32	10-14	56	26.23	4.3
15- 18	56	130.39	13.31	15-18	56	21.32	7.2
Total	112			Total	112		
Sex							
Male	39	120.39	17.5	Male	39	25.76	6.23
Female	73	132.50	11.3	Female	73	22.75	4.64
Total	112			Total	112		

As can be illustrated in the above Table 3, institutionalized female children score high on depression scale than their counterparts of male institutionalized children with the mean of (M=132.5) and (M=120.4) respectively.

Regarding age categories of institutionalized children a little bit difference was observed. Accordingly as illustrated above, children's of age categories found between (15-18)

score high on depression scale than their counterparts of children's age categories found between (10 – 14) with the mean of (M=130.57) (M=126.39) respectively.

From this finding we can infer that, children's of age categories found between 15-18 more vulnerable to depression than children of age categories found between 10-14. This may be because, compare to children's of 10-14 age categories those found between 15-18 face biological changes on their body, hence to overcome problem (psychological changes) come with new biological changes observed on the body of these children this might make this groups feel depressed than their counter parts of children whose their age categories are found between 10-14.

4.4 Descriptive Summary of *Non Institutionalized Children on Self Esteem and Depression scale by Sex and Age of Respondents*

Table 4 :*Mean and SD of Non Institutionalized Children on Self Esteem and Depression scale by Sex and Age of Respondents*

Study variables							
	Depression			Self esteem			
Age category	No	Mean	SD	Age category	No	Mean	SD
10- 14	48	122.32	12.3	10-14	48	20.34	7.31
15- 18	36	79.63	9.31	15-18	36	34.53	9.31
Total	84			Total	84		
sex				Sex			
Male	35	128.54	13.21	Male	35	24.53	5.4
Female	49	86.22	9.72	Female	49	33.43	6.4
Total	84			Total	84		

As can be illustrated in the above Table 4 , regarding level of depression , significant difference was observed among children of age categories between (10-14) and (15-18) with the mean of (M=122.32) and (M=79.63) respectively. From this finding we can infer that

In addition, the results also show that male children's were scored high on depression scale than their female non institutionalized children counterparts.

With regarding self- esteem of respondents , children's of age categories found between (10-14) score high on self -esteem scale than their counterparts of children found between (15-18) age categories with the mean of (M=34.55) and (M=20.34) respectively.

4.5 Sex Difference between Institutionalizedand Non Institutionalized Orphan Children in their Levels of Depression

Table 5: ***Independent T- test Results on the Difference between Institutionalizedand Non Institutionalized Orphan Children in their Levels of Depression***

DV	*IV*	*N*	*M*	*SD*	*df*	*t*	*P*
Level of depression	OrphanChil Institutionalized	112	128.48	28.49	194	*5.32*	.001
	Non institutionalized	84	103.85	36.34			

As it is shown in the above Table 5, statistically significant difference between institutionalized and non -institutionalized children in their depression was observed [$t(194) = -5.32$, $p < 0.05$) .This shows that institutionalized children (M=128.48) are more depressed than their counter parts of orphan non institutionalized children (M=103.85).

4.6 Sex difference between Institutionalized and Non Institutionalized Orphan Children in their Levels of Self Esteem

Table 6: ***Independent T-test Results on The Difference between Institutionalized and Non Institutionalized Orphan Children in their Levels of Self Esteem***

DV	*IV*	*N*	*M*	*SD*	*Df*	*T*	*P*
Level of self esteem OrphanChild	Institutionalized	112	23.76	6.7	194	4.37	.00
	Non institutionalized	84	28.55	8.8			

As it is shown in the above Table 6, statistically significant difference between institutionalized orphan children and non- institutionalized orphan children in their level of self -esteem was observed ($t(194) = 4.37$, $p < 0.05$). This shows that non institutionalized children (M=28.55) are better in their level of self -esteem than their counter parts of orphan institutionalized children (M =23.76).

4.7 The Effects of Living Arrangement, Age and Sex on Orphan Children's' Depression Level

Table 7:*Three Ways ANOVA Summary Of The Effects of Living Arrangement, Age and Sex on Orphan Children's' Depression Level*

DV	IV	Type III Sum of Squares	df	Mean Square	f	p
Depression	Sex	2436.750	1	2436.750	3.181	.076
	Age	4339.659	1	4339.659	5.665	.018
	Living arrangement	16830.710	1	16830.710	21.973	.000
	Sex * age	202.896	1	202.896	.265	.607
	Sex * Living arrangement	16121.427	1	16121.427	21.047	.000
	Age * Living arrangement	11720.955	1	11720.955	15.302	.000
	Error	144005.373	188	765.986		
	Total	2954712.000	196			
	Corrected total	228911.000	195			

As can be illustrated in the above Table 7 , sex have no significant effect on depression level difference of respondents [f (1,195)= 3.18, P > .05)]. Hence sex difference in their level of depression was not observed.

Regarding ages of respondents, age of respondents has a significant effect on variation of depression level [f (1,195) = 5.66, P <.05)]. This shows that children's of (10-14) age categories are more depressed than their counterparts of orphan children whose their age categories are between (15-18).

In addition regarding living arrangement of respondents, significant difference was observed [f(1,195)=21.97,P<.05)]. This illustrated that institutionalized children are more depressed than non -institutionalized children.

There is statistically significant interaction effect of sex and living arrangement of respondents [f (1,195)= 21.07, P<.05)]. This shows that, institutionalized female children score high on depression scale than their counterparts of male institutionalized children with the mean of (M=132.5) and (M=120.4) respectively. Similarly, non-institutionalized male children's were scored high on depression scale than their female non institutionalized children counterparts with the (M= 128.54) and (M=86.22) respectively.

There is also statistically significant interaction effect of age and living arrangement of children on their depression level [f (1,195) = 15.3, P<.05)]. This tells us that, non-institutionalized children of age category between (10-14) are more depressed than their counter parts of children those who are found between (15- 18) age categories

4.8 The Effects of Living Arrangement Age and Sex on Orphan Children's' Self Esteem Level

Table 8*: Three Ways ANOVA Summary of the Effects of Living Arrangement Age and Sex on Orphan Children's' Self Esteem Level*

DV	IV	Type III Sum of Squares	df	Mean Square	f	P
Self Esteem	Sex	167.098	1	167.098	5.107	.025
	Age	510.528	1	510.528	15.60	.000
	Living Arrangement	510.199	1	510.199	15.59	.000
	Sex * Age	39.990	1	39.990	1.222	.270
	Sex * Living Arrangement	6.849	1	6.849	.209	.648
	Age * Living Arrangement	3113.25	1	3113.256	95.14	.000
	Total	143211.00	196			
	Corrected Total	12528.75	195			

As can be illustrated in the above Table 8, sex has a significant effect on self-esteem difference of institutionalized and non -institutionalized children ($f(1,195) = 5.1$, $P<.05$). This tells us that male orphan children obtained high score on self- esteem scale than their counter parts of female children with the mean of ($M=29.44$) and ($M=23.56$) respectively.

There is also statistically significant age effect on the self- esteem difference of respondents (f (1,195) =15.6, P <.05). Meaning , children's 10-14 age categories were scored higher on self- esteem scale than their counter parts of children whose their age categories are between 15-18 with mean (M=27.46) and (M=23.96) respectively.

Furthermore, there is also statistically significant interaction effects of age and living arrangement of respondents on their self- esteem (f (1,195) = 95.14, P<.05). This tells us that, non- institutionalized children of (10-14) age categories are less in their self- esteem than their counter parts of children who's their age categories are found between (15-18) with the mean of (M=20.34) and (M=34.55) respectively.

CHAPTER FIVE

5. DISCUSSION

In this section, the results presented in the previous section are discussed. Possible explanations and potential reasons for obtained results are forwarded. Also the results are compared with similar previous research findings.

5.1 Level of depressionin in Institutionalized and Non Institutionalized Orphan Children

As can be indicated in the result section of the study there is statistically significant difference between institutionalized and non -institutionalized children in their depression was observed. This shows that institutionalized children are more depressed than their counter parts of orphan non institutionalized children. This may be because institutionalized children may face several problems such as care giver may not provide what is all important for children in the institution, as children of living with their parents or relatives. Which may in turn leads children to feel depressed. In line with this findings Browne and Hamilton-Giachritis (2005) reported that, institutions are considered to be the last resort for the care of parentless children; they have a role to play in short-term, emergency placements for sibling groups.

Consistent with this findings study conducted by Berger, (2003) shows thatsome of the problems encountered by children who are living in a certain institution including psychological stress, negative impact of education, loss of inheritance and physical as the result of these and other burdens children are exposed to depression, low self- esteem and alienation are common.

5.2 Self- esteem level in Institutionalized and Non -Institutionalized Orphan Children

As can be depicted in the result section of the present study statistically significant difference between institutionalized and non -institutionalized orphan children in their level of self -esteem was observed. This shows that non institutionalized children are better in their level of self- esteem than their counter parts of orphan institutionalized children. Consistent with the result found the study conducted by Juffer, Marinus and Ijzendoorna (2007) found that adopted children show lower self-esteem than their non- adopted peers. Adopted children are hypothesized to be at risk of low self-esteem. They may endure from the consequences of neglect, abuse and underfeeding in institutions before adoption.

They have to cope with their adoptive status which often includes difficulties associated with the lack of similarity to their adoptive parents. In addition, in line with the present finding, study conducted by Berger, (2003) shows thatsome of the problems encountered by children who are living in a certain institution including psychological stress, negative impact of education, loss of inheritance and physical as the result of these and other burdens children are exposed to depression, low self- esteem and alienation are common.

5.3 The Effects of Living Arrangement, Age and Sex on orphan Childrens' Depression Level

5.3.1 Sex and level of Depression

As can be illustrated in the result section of the study, sex has no significant effect on depression level difference of respondents. From this we can infer that sex has no significant effect on depression level difference of orphan children.

In opposite of the present findings study conducted by empirical support in laboratory, clinical, or epidemiologic studies, the mechanism underlying the gender difference in depression

remains unclear (Nolen-Hoeksena,2002). There are several possibilities for the reason why women are more depressed than men. An amazing thing happens at puberty. Before developing sexually, boys are more likely to be depressed than girls, but afterwards girls become twice as likely to be depressed and boys turn to delinquency(Ormel, Oldehinkel & Brilman, 2001).

Not all girls get depressed, however. Despite a number of biological, psychological, and social theoretical explanations that have been formulated in attempts to account for the gender differences in depression, the mechanism underlying this association remains unclear (Ormel, Oldehinkel & Brilman, 2001).

5.3.2 Age and level of Depression

Regarding ages of respondents, age of respondents has a significant effect on variation of depression level. This shows that children's of (10-14) age categories are more depressed than their counterparts of orphan children whose their age categories are between (15-18). This may be because in compare to children those whose their age categories are found between 10-14, children those who are found between 15-18 age categories use different mechanism in order to overcome depressive situation encounter them in their life through discussing their issue with their friends which may inturn help them to cope up with the depressive situation. In opposite of the present findings Mruik(1995) reported that there is no significant level of depression symptom difference among institutionalized and non institutionalized orphan children across their ages.

5.3.3 The Effects of Sex, Living Arrangement and Ages on Depression Level Difference of Respondents

There is statistically significant interaction effect of sex and living arrangement of respondents. This shows that institutionalized and non- institutionalized male children are more

depressed than female children of living in the institution and non-institution.in opposite of the present findings Mruik(1995) indicated that singinificant sex difference across institutionalized and non institutionalized male and female orhan children were not observed. In addition, Mruik(1995) also reported that there is statistically insignificant mean difference in the symptom of self esteem between male and female of both institutionalized and non-institutionalized participants. Meaning, males were shown slightly better self esteem symptoms over females orphan children.

There is also statistically significant interaction effect of age and living arrangement of children on their depression level. This tells us that, orphan children of age category between (10-14) are more depressed than their counter parts of children those who are found between (15-18) age categories.in poosite of the present findings Mruik(1995) reportd that there is no significant level of depression symptom difference among institutionalized and non institutionalized orphan children across their ages.

5.4 The Effects of Living arrangement, Age and sex on Children's' level self-esteem.

As indicated in the result section of the study, sex has a significant effect on self -esteem difference of institutionalized and non -institutionalized children. This shows that females are better in their self- esteem than their male children counterparts. In opposite of the present findings Males attain slightly higher levels of self-esteem than females; this provides some insight into the gender differences in self-esteem; however, there is a lack of empirical evidence and theoretical models explaining this difference (Robins & Trzesniewski, 2005). In line with(Robins & Trzesniewski, 2005) idea, the study conducted by murik (1995) reported

that,non institutionalized male and female orphan children are better in their self esteem than their counterparts of institutionalized male and female orhan children.

There is also statistically significant age effect on the self -esteem difference of respondents. In addition, there is also statistically significant living arrangement effect on self-esteem of respondents. Meaning, non -institutionalized children's are better in their self -esteem than their counterparts of orphan children those who are living in the institution. Furthermore there is also statistically significant interaction effects of age and living arrangement of respondents on their self- esteem. This tells us that, orphan children of (10-14) age categories are less in their self- esteem than their counter parts of children whose their age categories are found between (15-18).consistent with the present findings Mruik(1995) reported that,significant difference across age group in their self esteem was there. He reported that as age increases self esteem also increases in children.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

In this chapter the major findings of the study are summarized, and conclusions and recommendations are given

6.1 Summary

The purpose of this study was to investigate whether not there is self- esteem and level of depression difference between institutionalized and non- institutionalized children. One hundred ninety six students (84 non institutionalized and 112 institutionalized) from Kolfe and Kechene institution and Tsehay Chora school completed a battery of self -report questionnaire regarding self -esteem and depression scale. Based on pilot study item analysis was carried out and the instruments were improved.

Following data collections, descriptive analysis were computed. Independent T-test was employed to see the difference between institutionalized and non- institutionalized orphan children in their levels of depression and self- esteem. In addition, in order to examine the effects of sex, age and living arrangement on children's self -esteem and level of depression ANOVA was utilized. To this end the following findings were drawn:

The main findings were as follows:

- There is statistically significant difference between institutionalized and non - institutionalized children in their level of depression. Institutionalized children score high on depression scale than their counter parts of non- institutionalized children

- There is statistically significant difference between institutionalized orphan children and non -institutionalized orphan children in their self -esteem. Non institutionalized children are better in their self -esteem than their counterparts of institutionalized children.

Age of respondents has a significant effect on variation of depression level. Children's 10-14 age categories were score high on depression scale than their counter parts of children who's their age categories are between (15-18).

- There is also statistically significant interaction effect of sex and living arrangement of respondent's .This shows that, both institutionalized and non-institutionalized male children are more depressed than female children of living in the institution and non- institution.
- A Statistically significant interaction effect of age and living arrangement of children on their depression level. This tells us that, orphan children of age category between (10-14) are more depressed than their counter parts of children those who are found between (15- 18) age categories
- Sex has a significant effect on self- esteem difference of institutionalized and non -institutionalized children. Meaning male children obtained high score on self -esteem scale than their counter parts of female children.
- There is also statistically significant age effect on the self- esteem difference of respondents. Children's 10-14 age categories were score high on self -esteem scale than their counter parts of children whose their age categories are between 15-18

- In addition, there is also statistically significant living arrangement effect on self -esteem of respondents. Non institutionalized children score high on self -esteem scale than their counterparts of institutionalized orphan children .
- Furthermore there is statistically significant interaction effect of age and living arrangement of respondents on their self- esteem .This tells us that, non-institutionalized children of (10-14) age categories are better in their self -esteem than their counter parts of children whose their age categories are found between (15-18).

6.2. Conclusions

Based on the findings of the study the following conclusions were drawn.

- Orphan children those who were living in the institutions are more vulnerable to depression than their counter parts of non -institutionalized orphan children
- Orphan children found between 10-14 age categories were more vulnerable to depression than their counter parts of orphan children found between 15- 18 categories.
- Non institutionalized orphan children are better in their self -esteem than institutionalized orphan children.
- Male orphan children are better in their self- esteem than their counter parts of female orphan children.
- Children's 10-14 age categories obtained high score on self- esteem scale than their counter parts of children whose their age categories are between 15-18
- Furthermore there is also statistically significant interaction effects of age and living arrangement of respondents on their self- esteem .This tells us that, non -institutionalized

children of (10-14) age categories are better in their self- esteem than their counter parts of children whose their age categories are found between (15-18).

6.3.Recommendations

In general, the government, researchers and other potentially concerned bodies have been given attention for institutional orphan children as they deserve. Followings are some of the recommendations forwarded to the concerned bodies.

- A higher depression and a lower self -esteem symptom have been seen in many children as the research findings revealed. Thus, the institution has to work on providing appropriate psychosocial support, education, and developmentally appropriate care and providing support and skills training specially at summer season, when school programs are off.
- To let children minimize their depression and low self-esteem symptoms the institution has to think over in advance manner on the communication and interaction of children with the community, the method that is being used like attending educational schooling and follow up religious congregations with the community has to be continued and strengthen.
- It is crucial to strengthen the human resource capacity of the institutional staffs, especially primary care givers about handling and treating children and the services what they are being delivered.
- The government has to work on how to increases community-based programs like edir, Jemiya which in turn enable community's members come together and share the responsibilities in rearing orphan children.

- NOG has also advised to play their role in supporting orphanage children especially, in terms of psychosocial support through giving counseling services on how to increase self -esteem of these children and on how to overcome factors that lead them to feel depression.

REFERENCES

Abebe Tatek (2009).*Orphaned,poverty and care dilemma*, Review of global policy trendsAlemtsehay, Z. (1988). Child-family reunification program. Unpublished *workshop report*.

Assefa, B. (2008). *Reversed Roles and Stressed Souls - Child Headed Households in Ethiopia.*New York: Pantheon Books

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. E. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles?Psychological Science in the Public Interest,availableat*;http;\\www.jahonline.org* Retrrived on January*21,2015*

Baumeister, R. F., Smart, L., & Boden, J. M. (1996). "Relation of threatened egoism toviolenceand aggression: The dark side of high self-esteem*." Psychological Review, 103, 5-33.*

Berger, G. (2003). African's orphan crisis: Worst is yet to come.availableat www. Unicef.org Retrieved on15 April 2015

Boris, N.W., and Zeanah, C.H. (1999)." Disturbances and disorders of attachment in infancy: An overview". *Infant Mental Health Journal, 20, 1–9.*

Boris, N.W., and Zeanah, C. H. (2004). "Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood". *Journal of the American Academy of Child and Adolescent Psychiatry, 44,* 1206–1219.

Boswell, J. (1988*). The kindness of strangers: The abandonment of children in Western Europe from late antiquity to the Renaissance.* New York: Pantheon Books

Bowlby, J. (1951). *Maternal Care and Mental Health, WHO Monograph Series No 2*. Geneva: World Health Organisation.

Browne, K. & Hamilton-Giachritis, C. (2005). *Deinstitutionalising and transforming children's services—A guide to good practice*. Birmingham, UK: University of Birmingham.

Browne, K. and Hamilton-Giachritis, C. (2007). *Mapping the number and characteristics of children under three in institutions across Europe at risk of harm. European Commission Daphne programme. (First.revision*). School of Psychology, University of Birmingham.

Bush, M. (1980). "Institutions fordependent and neglected children: Therapeutic option of choice or lastresort".*AmericanJournal ofOrthopsychiatry, 50(2), 239-255*.

Campbell, Rubert N.(1984) The new science, self-esteem psychology. London university press of America.

Carter, R. (2007). *Family matters: A study of institutional childcare in Central and Eastern Europe and the former Soviet Union*. London:Oxford printing press.

Chisholm, K. (1998). "A three year follow-up of attachment and indiscriminate friendliness in children adopted from Romanian orphanages."*Journal ofChild Development, 69,* 1092–1106.

Cohen, R.(1968). *Some implications of self-esteem for social influence in the self in Social interaction,* (ed) by Chad Gordon and Kenneth Gergen. New York; John Wilay and sons, Inc.

Cooper smith, S. (1967). *The Antecedents of self-esteem*. San Francisco; Free men.

Coopersmith, s. (1984). Self-esteem inventories. Palo Alto , CA; Consulting psychologists.

Crenson, M.A. (1998). *Building the invisible orphanage; A prehistory of the American welfare system*.Harvard university press.

Crocker, J., Park, L. E. (2004*). "*The costly pursuit of self-esteem". *Psychological Bulletin*, 130,392-414.

Cyranowski, J.M., Frank, E., Young, E., Shear, M.K., (2000*)."*Adolescent onset of the gender difference in lifetime rates of major depression: a theoretical model". *Archives of General Psychiatry 57, 21–27.*

Derlega, Valerian J., & Janda, Louis H. (1986). Personal Adjustment the Psychological of everyday live (3rd ed). London; university press of America.

Di Paula, A., & Campbell, J. D. (2002*). "*Self-esteem and persistence in the face of failure*."* *Journal of Personality and Social Psychology, 83, 711-724*

Donahue, J. (1998). *Community-based Economic Support for Households Affected by HIV/AIDS.* Discussion Papers on HIV/AIDS Care and Support.*Kenya*.

Dulcan, M. K., Martini, D. R., & Lake, M. B. (2003). *Concise guide to child and adolescent psychiatry (3rd ed.).* Washington, DC: American Psychiatric Press.

Federal Democratic Republic of Ethiopia. (1995). *The Constitution of FDRE,* Addis Ababa,Federal Negarit Gazetta.

Federal Democratic Republic of Ethiopia Ministry of Women's Affairs (2009). *Alternative Childcare Guidelines On Community-Based Childcare, Reunification and Reintegration Program, Foster Care, Adoption and Institutional Care Service*. Addis Ababa Ethiopia

Ford, M. & Kroll, J. (1995). *There is a getter way: Family-based alternatives to institutional care. Washington, D.C.: North American Council on Adoptable Children*.

Giese, S. & Dawes, A. (1999)".Child care, developmental delay and institutional practice". *South African Journal of Psychology, 29,* 7-22.

Glaser, D. (2000).” Child abuse and neglect and the brain: A review”. *Journal Child Psychology and Psychiatry, 41,* 97-116.

Goebel, B. L. (1981).” Age differences in motivation related to Maslow's need hierarchy”. *Developmental Psychology, 17,* 809-815.

Goldfarb, W. (1945),” effects of psychological deprivation in Infancy and Subsequence Stimulation,” *American Journal of Psychiatry, Vol 102, pages 18-33.*

Gonzalez- mena, Janet. (1993) The child in the family and the community, New York; Macmilan

Gunnar, M., Van Dulmen, M. & The International Adoption Project Team. (2007). “Behaviour problems in post institutionalized internationally adopted children”. *Development and Psychopathology*, 19, 129–148.

Hacsi, T.A. (1997). *Second Home: Orphan Asylums and Poor Fami lies in America*. Cambridge: Harvard Univer sity Press

Heatherton, T. F., & Polivy, J. (1991). Development and validation of a scale for measuring state self-esteem. *Journal of Personality and Social Psychology, 60*, 895–910.

Horwood LJ. (2008). “Abortion and mental health: evidence from a 30-year longitudinal study”, *British Journal of Psychiatry, 193(6):444–451.*

Hrdy, S. B. (1999). *Mother Nature: Maternal instincts and how they shape the human species.* New York: Ballantine Books.

Hodges, J., and Tizard, B. (1989a).” IQ and behavioural adjustment of ex-institutional adolescents”.*Journal of Child Psychology and Psychiatry*, 30, 53–75.

Johnson R., Browne K.D. and Hamilton-Giachritsis C.E. (2006).” Young children in institutionalcare at risk of harm”. *Trauma Violence and Abuse*, 7(1): 1–26.

Juffer, F., Marinus, H., & Ijzendoorna, V. (2007). *Adoptees do not lack self-esteem: A meta-analysis of studies on self-esteem of transracial, international, and domestic adopteesInterdisciplinary and Applied.Psychology 135,* 37-51.

Kligman, G. (1998). *The politics of duplicity: Controlling reproduction inCeaucsescu's*Romania.

Kridre, D. (2002). Self -esteem in young Adults; The Effects of parental divorce in childhood. *RetrievedSeptember20,2011*.http;\\www.iusb.edu\Journal\static\volumes\\krider\krider.htm\

Kurdek, L.A (1987).”Children's adjustment to parental divorce; an ecological perspective. In J.P. Vincent (Ed) Advances in family intervention, assessment and theory, volume 4(pp1-31).Greenwich, CT; JAI Press.

Lata K.,(2000).Theories of depression. American Journa of Psychotherapy. Vol. 54, 2

Lee, T. (2000). *Evaluation of the Quality of Services and Programmes.Evaluating Community-based Orphan Care in Zimbabwe: Monitoring and*. SAfAIDS.

Lefcourt, Herbert, M. (2009). *Locus of Control: Current Trends in Theory and Research*. Hillsdale: Lawrence Erlbaum Associates.

Lindert J. (2014).”Sexual and physical abuse in childhood is associated with depression and anxity over the life course:Systematic review and meta-analysis”.Int j public Health *59(2):359-72*

Maslow, A. H. (1999). *Toward a psychology of being (3rd ed.).* New York: John Wiley andSons.

Mazhar, U. (2004). *Self-esteem,* Human development foundation.available at http://www.yespakistan.com Retrieved on February, 26.2015 .

Minde, K. (1988). The effects of social change on the behaviour and academic performance of school age children. Unpublished paper. Retrived fromhttp://www.srcd.orgRetrieved on January,24 2015

Ministry of Labour and Social Affairs (MOLSA) and (UNICEF). (2005). *African Charter on the Rights and Welfare of the Child,* Addis Ababa. : UNICEF

MOLSA, (2003). Ministry of Labour and Social Affairs (MoLSA) and UNICEF. 2005. *African Charter on the Rights and Welfare of the Child,* Addis Ababa: UNICEF

Moffitt, T. E., Caspi, A., Harrington, H., & Milne, B. J. (2002*).* Males on the life-course persistent and adolescent-limited antisocial pathways: Follow-up at age 26.Development and Psychopathology*, 14*, 179-206. Retrrived on 30Febrbary 2015 from http://www.moffittcaspi.com

Mruk, C.(1995). Self-esteem research theory and practice. New York, NY; Springer publishing company.

Mutangadura, G. and Webb, D. (1999). *The socio-economic impact of adult morbidity and mortality on households in Kafue District,* Zambia, Harare: In *SAfAIDS*.

National Guidelines for Alternative Care of Children. (2002). and UN Guideline for the Appropriate Use and Conditions of Alternative Care for Children. (2007). Ethiopia.

Nelson,C.A.(2007).“Aneurobiologicalperspectiveonearlyhumandeprivation”. *Child Developm ent Perspectives,1 , 13–18.*

Newhill, C. (2005). Adjustment of international adoptees: Implications for practice and a future research agenda. Children and youth service review, 28, 384-395. Retrieved on march 1,2015.from http://www. Sciencedirect.com/science? _ ob=Article URL&_ udi=B6V98 4GJM3CH1&_user…

Nolen-Hoeksema, S. (2002). *Gender differences in depression*. *Handbook of Depression.* New York: Guilford Press.

Obrova-Krol, N.A., van Ijzendoorn, M.H., Bakermans-Kranenburg, M.J., Cyr, C., & Juffer, F. (2008), Causes of post-institutionalization.

O'Connor, T. and Zeanah, C. (2003)." Current perspectives on attachment disorders". Rejoinder and synthesis.*Attachment and Human Development, 5,* 321–326

Ormel, J., Oldehinkel, A.J., Brilman, E.I., 2001. "The interplay and etiological continuity of neuroticism, difficulties, and life events in the etiology of major and subsyndromal, first and recurrent depressive episodes in later life.*" American Journal of Psychiatry* 158, 885–891.

Palosaari, U. K. & Aro, H. M. (1995). Parental divorce, self-esteem and depression: an intimate relationship as a protective factor in young adulthood. *Journal of youth and Adolescence , 9,231- 245.*

Perry, B. D., & Pollard, R. (1998). "Homeostasis, stress, trauma and adaptation*:* A neuro developmental view ofchildhood trauma."*JournalofChild and adolescent psychiatric 20-40*

Ransel D. R., (1988). *Mothers of Misery: Child Abandonment Inrussia,* Princeton: Princeton University Press.

Robins, R.W., & Trzesniewski, K.H.(2005)." Self-esteem development across the life span. Current Directions in Research", *14(3), pp. 158-162.*

Rogers,C.(1959).*Personalitydevelopment*.RetrievedonFebruary13,2015fromhttp://www.simplypsychology.pwp.

Rosas and McCall (2009).Characteristics of Institutions, Interventions, and Resident Children's Development, University of Pittsburgh. Unpublished document,

Rutter, M., & Taylor, A. (Eds.) (2002). *Child and Adolescent Psychiatry* (4th ed.). Newyork

Sarason, L. & Sarason, B.R. (1989*).Abnormal Psychology*. Sixth Edition. New York: Prentice Hall .

Scheeringa, M., Zeanah, C. H.,Boris, N. W., Heller, S. S., Smyke, A. T., & Trapani, J. (2003*). A first report on Child Welfare in the Soviet Union*. New York: Bookman Associates.

Schore, A.N. (2001a)." Effects of a secure attachment relationship on right brain development, affect regulation, andinfant mental health".*Infant Mental Health Journal*, 22, 7-66.

Schore, A.N. (2001b). "The effects of early relational trauma on right brain development, affect regulation, and infant mental health". *Infant Mental Health Journal*, 22, 201–269.

Shackelford,T .K.,and D.M. Buss. 2001. *Betrayal in mateships,friendships*, retrrived on 24Appril 2015 from *http://www.utexas.edu.*

Smith, E. P. (1995). "Bring back the orphanages? What policymakers of today can learn from thepast".*ChildWelfare,74,115142*.

SOS international, (2009). *Institutional care Guidlines*. Innsbruck, Austria.

Swann, W. B., Jr., & Seyle, C. (2005)." Personality psychology's come-back and its emerging symbiosis with social psychology". *Personality and Social Psychology Bulletin, 31, 155–165.*

Tarullo, A.R., Bruce, J. & Gunnar, M.R. (2007). "False belief and emotion understanding in post-institutionalised children".*SocialDevelopment, 16, 57–78.*

Trevarthen, C., and Aitken, K. J. (2001*)."*Infant intersubjectivity: Research, theory, and clinical applications".*Journal of Child Psychology and Psychiatry, 42, 3-48.*

Twenge J.M., & Campbell, W.K.(2002). "Self- esteem and socioeconomic status*;* A meta-analytic review". *Personality and Social psychology Re-view, 6, 59-71*

Twenge, J. (2009*).* Does high self-esteem cause better performance, interpersonal success happiness or healthier lifestyles?http://www.simoleonsense.com.Retrieved on January 19, 2015

UNICEF. (2003). *Africa's orphaned generations.* New York.

UNAIDS, UNICEF, and USAID. (2004). *Children on the Brink 2004: A joint report of new orphan estimates and a framework for action.* New York.

UNICEF (2012).The state of world's children. Newyork.

*Victor, G. (*1996). explains risk factors and impacts in children institutionalized in orphanages for long periods of time. Retrieved on 24 Appril2015 from www.adoptvietnem.org.

Vorria, P., Papaligoura, Z., Sarafidou, J., Kopakaki, M., Marinus, J. D., Van IJzendoorn, M. H., et al. (2006). "The development of adopted children after institutional care: a follow-up study.*"Journal of Child Psychology and Psychiatry, 47, 1246–1253.*

Wilson, S. L. (2001)." Attachment disorders: Review and current status". *Journal of Psychology:3, 254–284.*

Zeanah, C. H., Nelson, C. A., Fox, N. A., Smyke, A. T., Marshall, P., Parker, S. W., & Koga, S. (2003). *Designing research to study the effects of institutionalization on brain and behavioral development*: The Bucharest Early Intervention Project. Development andPsychopathology, 15, 885–907.

Zeanah, C. H., Smyke, A. T., & Settles, L. (2006). Children in orphanages**.** In K. McCartney &D. Phillips (Eds.),Blackwell. *Handbook of early childhood development* (pp. 224–254). Malden, MA: Blackwell Publishing

Zeanah, C., & Fox N. (2004). “Temperament and attachment disorders”. *Journal of Clinical Child Psychology, 33,* 32-41

Zeanah, C. (1999). *The handbook of infant mental health*, (*2nd ed.).* New York: Guilford.

APPENDICES

ADDIS ABABA UNIVERSITY

SCHOOL OF PSYCHOLOGY

DEVELOPMENTAL PSYCHOLOGY PROGRAM

Questionnaire to be filled by Institutionalized andNon Institutionalized Orphan Children

The main purpose of this questionnaire is to examine whether or not there is depression and self-esteem symptoms difference between institutionalized and non-institutionalized orphan children. This questionnaire is to be filled in by Institutionalized and non-institutionalized orphan children**.** Since the quality of this research depends on your honest responses to each of the questionnaire items, you are kindly requested to read and fill each item of this questionnaire.

No need to write your name.

Thank you very much in advance for your cooperation and taking your precious time to participate in this research.

Part-1

Personal profile

***Instruction 1*:** You are requested to fill the below questions in the space provided

1. Sex _____
2. Age _____
3. Grade level _____
4. With whom you are living? : A. with Relatives _____ B. In the Institution..... C. others (specify) _____
5. Duration of living within the institution or the community

Part 2

Depression Related Items

Instruction 2: Please read each of the following items in detail that best describes the way you have feeling including today and give your response under the column of your chose by using tick mark (√)

No.	Items	Strongly agree	Agree	Disagree	strongly disagree
1	I am sad all the time.				
2	I feel more discouraged about my future than I used to be				
3	I feel my future is hopeless and will only get worse.				
4	I do not feel like a failure.				
5	I have failed more than I should have.				
6	As I look back, I see a lot of failures.				
7	I feel I am a total failure as a person				
8	I get as much pleasure as I ever did from the things I enjoy				
9	I don't enjoy things as much as I used to.				
10	I feel guilty all of the time.				
11	I don't feel I am being punished.				
12	I feel I may be punished.				
13	I feel I am being punished.				
14	I have lost confidence in myself.				
15	I am disappointed in my self				
16	I dislike myself.				
17	I do not feel sad.				
18	I don't criticize or blame myself more than usual.				
19	I criticize myself for all of my faults.				
20	I blame myself for everything bad that happen				

21	I don't have any thoughts of killing myself.				
22	I would like to kill myself.				
23	I would kill myself if I had the chance.				
24	I feel restless or wound up than usual				
25	I have not lost interest in other people or activities				
26	I have lost most of my interests in other people or things				
27	It is hard to get interested in any thing				
28	I make decisions about as well as ever				
29	I find it more difficult to make decision than usual				
30	I do not feel I am worthless				
31	I feel more worthless as compared to other people				
32	I have not experienced any change in my sleeping pattern				
33	I sleep somewhat less than usual				
34	I sleep most of the day				
35	I am no more irritable than usual				
36	I am more irritable than usual				
37	I have not experienced any change in my appetite				
38	My appetite is somewhat less than usual				
39	My appetite is somewhat greater than usual				
40	I have no appetite at all				
41	I can concentrate as well as ever				
42	It is hard to keep my mind on anything for very long				
43	I find I cannot concentrate on anything				
44	I am no more tired or fatigued than usual				
45	I am too tired or fatigued to do a lot of the things I used to do				

Part 3:

Questions related to Value given for the self (Self-esteem Related Questions)

***Instruction*:** Below mentioned questions are related to the feeling you have about yourself therefore you are asked to fill questions listed under by choosing the best alternative.

Strongly agree Disagree

Agree strongly disagree

Rosenberg's scale

No.	Items	Strongly agree	Agree	Disagree	strongly disagree
1	On the whole, I am satisfied with my self				
2	At times, I think I am not good at all				
3	I feel that I have a number of good quality				
4	I am able to do things as well as most other qualities				
5	I feel I don't have much to be prod of				
6	I certainly feel useless at times				
7	I feel that I am a person of worth, at least on an equal plane with others				
8	I wish I could have more respect for myself				
9	All in all I am inclined to feel that I am a failure				
10	I take a positive attitude towards myself				

አዲስ አበባ ዩኒቨርስቲ

የትምህርትና ስነ ባህሪ ኮሌጅ

የስነ ልቦና ትምህርት ክፍል

<u>በመ ጠ ለያና ከ መ ጠ ለያ ው ጪ በሚ ኖሩ ልጆች የሚ ሞ ላ መ ጠ ይ ቅ</u>

<u>የ መ ጠ ይ ቁ ዓ ላ ማ ው –</u>

የዚህ መጠይቅ ዋና ዓላማ በማጠለያና ከማጠለያ ወጪ በሚኖሩ ልጆች መካከል ያለውን የድብርትና የራስ ዋጋ አለመሳሰት ችግር/depression and self esteem/ ምን እንደሚመስል ያለውን የሥነ ልቦና ጥናት/ምርምር በማድረግ በአዲስ አበባ ዩኒቨርስቲ በስነ ልቦና የትምህርት ክፍል ለማድረግ የሁለተኛው ድግሪ ትምህርት ማሟያ እንዲሆን የተለያዩ ሚጃዎችን ለማሰባሰብ ነው፡፡

<u>አ ጠ ቃ ላ ይ መ መ ሪ ያ</u>

ከዚህ በታች የተዘረዘሩትን ጥያቄዎች ስትመልሱ በሚባ በማንበብና በማናዘብ በወሰጣቸሁ እየተመላለሰ ያለውን ትክክለኛ ስሜት በተቀመጠለችሁ መመሪያ መሠረት ለማውርቡ ጥያቄዎች ግልጽና ታማኝ ምላሽ እንድትሰጡ እየጠየኩ ማጠየቁ ላይ ስማችሁን መጻፍ ወይም የተለያዩ ኮዶችን ማጠቁም አይቻልም፡፡

<u>ማ ሰ ቢ ያ</u>

ይህ መጠይቅ በትክክል ከተሞላ ጥናቱ/ምርምሩ ያለምንም ችግር የታለመለትን ዓላማ ስለሚያሳካ የእናንተ ለመጠይቁ ትኩረት መሰጠት ከፍተኛ ዋጋ ይኖረዋል፡፡

ይህን መጠይቅ ለመሞላት መሉ ፈቃደኝነት ያለው መሆን አለበት፡፡

ይህንን መጠይቅ ትኩረት በመሰጠት ስለሞሉልን በቅድሚያ እናመሰግናለን፡፡

<u>ክ ፍ ል 1</u>. የ ግ ል ሚ ጃ ን በ ተ መ ለ ከ ተ

***<u>መ መ ሪ ያ</u>* 1.**

ከዚህ ቀጥሎ የተጠቀሱ ጥያቄዎችን ስትመልስ/ሽ አንተን/ቺን የሚመለከተው ክፍት ቦታ ላይ የ''✓'' ምልክት በማስቀመጥ ወይም በተዘጋጀው ክፍት ቦታ ላይ የግል ሚጃህን/ሽን እንድትሞላ/ይ እጠይቃለሁ፡፡

1. ጾ ታ ወ ☐ ሴ ☐

2. ዕድሜ ._____

3.የትምህርት ደረጃ. _____

4. አሁን የአኗኗር ሁኔታህ/ሽ ከዘመድ ጋር ☐ ማህደጊያ ወስጥ ☐

5. **ማህደጊያ ወይም ዘመድ ጋር የኖርከበት/ሽበት ጊዜ** ._____

ክፍል 2 የድበርት ስሜን የተመለከቱ ጥያቄዎች

መመሪያ 2 ከዚህ በታች የተጠቀሱት/ጥያቄዎች/ እያንዳንዳቸው 4 አማራጮችን የያዙ ሲሆኑ ጥያቄዎችን በጥሞና ካነበብክ/ሽ በኋላ ከወስጥህ/ሽ ስሜ ጋር በማናዘብ እራሴን ይገልጸኛል የሚሉትን አማራጭ ከፍት ቦታ ላይ ብቻ የ "√" ምልክት በማስቀመጥ እንድትሞላ (ይ) እጠይቃለሁ::

ተ.ቁ	የጥቄዉ ዓይነት	በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም
1	ሁሌም አዝናለሁ				
2	ስለወደፊት ሕይወቴ ካሳለፍኩት ይልቅ አሁን ተስፋ መቁረጥ ይሰማኛል				
3	የወደፊት ሕይዎቴ ተስፋ በስ ነው ብየ አስባለሁ እናም የከፋ ነገር ብቻ ይገጥመኛል				
4	ወደቀት አይሰማኝም				
5	መወደቅ ከማባኝ በላይ ወደቄአለሁ				
6	ያሳለፍኩትን ሳስታወስ ብዙ ወደቀቶችን አስታወሳለሁ				
7	እንደ አንድ ሙሉ በሙሉ እንደወደቀ ሰው ይሰማኛል				
8	ልክ በፊት ያስደስቱኝ ከነበሩት ነገሮች እኩል አሁን ደስታን አገኛለሁ				
9	ልክ በፊት ያስደስቱኝ እንደ ነበሩት ነገሮች አሁን አልደሰትም				
10	ሀልግዜ የጥፋተኝነት ስሜ ይሰማኛል				
11	ስቀጣ አይሰማኝም				
12	ስቀጣ ሊሰማኝ ይችላል				
13	ስቀጣ ይሰማኛል				
14	በወስጤ በራስ መተማመን ጠፍቷል				
15	በወስጤ ደስተኛ አይደለሁም				
16	ራሴን ጠላሁ				
17	አላዝንም				
18	ከተለመደው ይበልጥ ራሴን አልወጂልም ወይም አልተችም				
19	በሁሉም ጥፋቶቸ ራሴን እተቻለሁ				
20	መጥፎ ነገሮች ሲፈጠሩ ራሴን አከሳለሁ				
21	ራሴን ለመግደል ምንም ዓይነት አመለካከት የለኝም				
22	ራሴን መግደል እፈልጋለሁ				

23	እድሉን ካገኘሁ ራሴን መግደል እፈልጋለሁ				
24	አሁን ከውትሮው የእረፍት ስሜት አይሰማኝም				
25	በልሎች ሰዎች ወይም በተግባራት ላይ ፍላጎት አላጣሁም				
26	ከበፊት ይልቅ አሁን በሰዎች ይሁን በነገሮች ላይ ብዙዎችን ደስታየን አጥቻቸዋለሁ				
27	በማንኛውም ነገርላይ ደስታን ማግኘት አዳጋች ነው				
28	እንደሀልጊዜው ወላኔ እሰጣለሁ				
29	ከውትሮዉ ይልቅ አሁን ስወስን እቸገራለሁ				
30	ዋጋ የሌለኝ ሞኪሎ አይሰማኝም				
31	ከሌሎች ጋር ራሴን ሳወዳድር የላቀ ዋጋ ያለኝ መሆኑ ይሰማኛል				
32	በመኝታ ሰርዓቴ ላይ ምንም ዓይነት ለወጥ አላደረኩም				
33	ከተለመደው በተወሰነ መልኩ ባነሰ እተኛለሁ				
34	በአብዛኛው ቀን እተኛለሁ				
35	ከተለመደው በላይ ነጫጫ አይደለሁም				
36	ከተለመደው በላይ ነጫጫ ሀኛለሁ				
37	በምግብ ፍላጎቴ ምንም ዓይነት ለወጥ አላየሁም				
38	የምግብ ፍላጎቴ ከውትሮው ባነሰ ቀንሷል				
39	የምግብ ፍላጎቴ ከውትሮው በተወሰነ መልኩ ተሻሽሏል				
40	ምንም ዓይነት የምግብ ፍላጎት የለኝም				
41	እንደሀልጊዜው ሚነተዋል እችላለሁ				
42	ከሆነ ነገር ላይ ለረዥም ጊዜ አተኩሮ መቆየት ያስቸግረኛል				
43	ከማንኛውም ነገር ላይ አተኩሮ መቆየት አልችልም				
44	ከተለመደው ውጪ አይደክመኝም ወይም አልዝልም				
45	በፊት እሰራቸው እንደነበረው አብዛኛዉን ስራዎች ልሰራ ስል በጣም ይደክመኛል				

ክፍል 3. ለራስ ዋጋ መስጠትን የተመለከቱ ጥያቄዎች

መመሪያ 3. ከዚህ በታች የተጠቀሱት/ጥያቄዎች/ እያንዳንዳቸው 4 አማራጮችን የያዙ ሲሆኑ ጥያቄዎችን በጥሞና ካነበብክ/ሽ በኋላ ከወሰጥህ/ሽ ስሜት ጋር በማናዘብ እራሴን ይገልጸኛል የሚሉትን አማራጭ ከፍት ቦታ ላይ ብቻ የ "√" ምልክት በማስቀመጥ እንድትሞላ (ይ) እጠይቃለሁ::

ተ.ቁ	የጥቄው ዓይነት	በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም
1	በአጠቃላይ በራሴ በጣም ደስተኛ ነኝ				
2	ሁሌም ጥሩ እንዳልሆንኩ አንዳንዴ አስባለሁ				
3	በርካታ ጥሩ ነገሮች እንዳሉኝ ይሰማኛል				
4	ሌሎች እንደሚደርጉት ሁሉ እኔም ማድረግ እችላለሁ				
5	ብዙ የሚኮሩ ነገሮች እንደሌሉኝ ይሰማኛል				
6	አንዳንዴ ጥቅም እንደሌለኝ በርግጠኝነት ስማኛል				
7	ዋጋ እንዳለው ስው ይሰማኛል ቢያንስ እንኳ ከሌሎች እኩል እንደሆንኩ ይሰማኛል				
8	ለራሴ ትልቅ ዋጋ እንዲኖረኝ እመኛለሁ				
9	በአጠቃላይ ስሜ የሚዘነብለው እንዳልተሳካልኝ ነው				
10	ለራሴ ቀና የሆነ አመለካከት ይኖረኛል				

DECLARATION

I hereby certify that this thesis material, which I now submit for assessment on the program of study leading to the award of Master in Developmental psychology, is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others, save as to the extent that such work has been cited and acknowledged within the text of my work.

Name of Student _____

Signature _____

Date _____