Running head: PREVALENCE AND FACTORS OF BEHAVIORAL DISORDERS AMONG ORPHANS…

Prevalenceand Factors of Behavioral Disorders among Orphansin Selam and SOS children villages

Abenezer Assefa

A Thesis Submitted to the Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Masters in Social Work

Addis Ababa University

School of Social Work

June,2015

Addis Ababa,Ethiopia

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Advisor:Abebe Assefa (Phd)

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ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES MSW EXAMINING COMMITTEE

This is to certify that the thesis prepared by Abenezer Assefa entitled:Prevalence and factors of Behavioral Disorders among Orphans in Selam and SOS children village submitted in partial fulfillment of the requirements for the Degree of Master of Social Work complies with regulation of the University and meets the accepted standards with respect to the originality and quality.

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Abstract

This paper describe and explainsthe Prevalence of Behavioral Disorders among the Orphans and Factors Associated with these Disorders.The general objective of this study is to find out the prevalence of behavioraldisorder among orphan children living in Selam Children Village and SOS children village, and to assess the possible factors associated with the presence of disorders among this study population.In terms of Method, this research is informed by quantitative design.The Instrument that has been used to measure behavioral disorder is parent / teacher Disruptive Behavior Disorder rating scale. Multidimensional Scale of Perceived Social Support was used to measure perceived social support by the children.A total of 106 children participated in this research.Data analysis was done according to the objective of the study with the help of computer softwareprogram statistical package for social science (SPSS) for windows version 22.Regression and T test were used to show the relationship between variables. Frequency table is made to describe the data. Findings showed that behavioral disorder is prevalent at 49% among the orphans in Selam and SOS children village. Among age, gender and education only gender significantly predict Conduct disorder and Oppositional defiant disorder. Education and age do not significantly predict all the three types of behavioral disorders in statistics. However, practically all the three demographic factors predict behavioral disorder. Perceived social support is not found to be a statistically significant predictor of behavioral disorder while it has a practical influence. Length of stay in the organization also have a non significant prediction on behavioral disorder statistically while it has a practical influence. Conclusions are made and the major findings are discussed in relation to other research findings. Finally the implication for social work education, research, practice and policy is discussed.

CHAPTER ONE

1. Introduction

Orphan and vulnerable children are one of the most serious socio-economic and developmental challenge victims in developing countries. Orphan-hood is frequently accompanied with multidimensional problems; Common reactions of children to the death of a parent include depression, hopelessness, suicidal ideation, loneliness, anger, confusion, helplessness, anxiety and fear of being alone that can further jeopardize children's prospect.(Shekmnesh, Alemseged & Hailemariam ,2013)

Studies conducted in sub-Saharan Africa in the early 1990s documented a rise in the number of orphans and the breakdown of protective social networks and supports for them. In 1997, the first comprehensive global estimates of orphans revealed that the number of orphans was increasing and that experience responding to orphaning as a social problem was limited (TFTAI,2014).

EMOH (2007) stated that Ethiopia has OVC burden, with almost 5.4 million orphans, with around 15% of these believed to have been orphaned as a result of HIV/AIDS. A study of orphanages in Ethiopia found that the most commonly noted reasons for children being placed in orphanages were parental HIV and AIDS status or other chronicillness and poverty.Chronic diseases such as AIDS and lack of adequate medical treatment are frequently correlated with poverty (TFTAI, 2014).

Children living in substandard orphanages have been reported to display a variety of other atypical behaviors, including stereotyped self-stimulation, a shift from early passivity to

later aggressive behavior, over activity, and distractibility, inability to form deep or genuine attachments, indiscriminate friendliness, and difficulty establishing appropriate peer relationships. Over the years, it has frequently been suggested that the lack of ''mothering,'' appropriate social–emotional experience, and relationships with a few consistent caregivers are the primary causes of these developmental delays and deficiencies (Collins, 2008).

The perception that social support is available seems to mitigate the negative impact of a stressful event and to hasten recovery even if social support is not actually verified or used. In other words, simply having the belief that one is supported, even if the child does not use this support, holds positive implications for successful development. Teenagers who receive more social support are less likely to exhibit angry and hostile behaviors throughout adolescence and have a decreased probability of exhibiting such behaviors in adulthood. Perceptions of supportive family relationships have been linked with decreases in internalizing and externalizing behaviors. However, as children transition into middle and high school, perceptions of peer and teacher support tend to gain relative importance over parental support (White, 2009).Therefore this study will examine the effect of perceived social support and length of stay in orphanages on behavioral disorder.

1.1 Statement of the problem

Many Researches has been conducted on orphan and vulnerable children. A lot has been said about this orphan and vulnerable children (OVC)globally continentally and locally. Nevertheless, there is limitation on the existing knowledge in our continent and country because they concentrate only on certain dimension of OVC(Tatek, 2008).

The existing studies in Africa include children, orphanages, and families(TFTAI,2014), Psychosocial Impact(Alice & Serigne, 2008), Psychological Well-being (Lucie, 2007;

James&Janet1997;Dewitt&lessing, 2010)while in Ethiopia they primarily focus on Psychological Distress (Shekmneshet.al, 2013;Hiwot, Fentie, Lakew, & Wondosen 2011),psychosocial wellbeing (Sebsibe, Fekadu&Molalign,2014) , Outcomes of Orphan hood(Camfield, 2010), Resilience(Solomon, 2008), AIDS and the politics of orphan care (Tatek & Aase, 2007) and Risks, Protection Factors and Resilience by (Belay&Missaye2014).

From the existing studies of Ethiopia,Sebsibe, Fekadu &Molalign,(2014), studiedpsychological wellbeing of orphan and vulnerable children at orphanages .They found that the majority of the participants felt sad, depressed, and in stress due to lack of good relationship with service providers and the community, and due to grief and bereavement of their parental loss.

Shekmnesh et.al(2013) researched the Prevalence of Psychological Distress and Associated Factors among AIDS Orphan Adolescents in Mekelle City and found thatOrphan adolescents are having psychological problems and may be particularly vulnerable group that can affect their present and future life.

Hiwot et.al.(2011)'s research was done on Psychological distress and its predictors in AIDS orphan adolescents. They found that a large proportion of orphan adolescents are having psychological problems that can affect their present and future life. Thus, a more focused and concerted effort is needed to improve their mental health.

Camfield, (2010) studied Outcomes of Orphan hood in Ethiopia and revealed that the outcomes of orphans and non-orphans in poor communities are not significantly different, supporting the need to address vulnerability at a societal level. Nonetheless, specific groups, for example, older female children who have lost their mothers, may face particular risks that should be addressed with targeted interventions.

Solomon, (2008) has done his research onResilience among orphan children Exposed to Traumatic Loss .He found thatThe majority of children showed resilience measured by their scores on emotional symptoms, conduct problems, hyperactivity, and prosocial behaviors and total difficulties scores. Boys showed higher emotional resilience. Younger children were found to be more resilient than older children. Paternal orphans were more resilient than maternal and double orphans.

Belay&Missaye(2014) studied risks,protection factors,and resiliance among orphan and vulnerable children in Ethiopia.They found that most orphans and vulnerable children faced family,school and community related risk factors.Their result also showed that most of the OVC failed to use protective factors to buffer the risks.

In summery some researches has been done on this area and their focus is onPsychological Distress, needs,problems and responses to the situation of OVCs , community response and Risks, Protection Factors and Resilience. However,prevalence of behavioral disorders among the orphans and factors associated with these disordershaven't been covered adequately by researchers. Therefore, my research will try to cover the prevalence of Behavioral Disorders among the Orphans and Factors Associated with these Disorders in selam children villege.

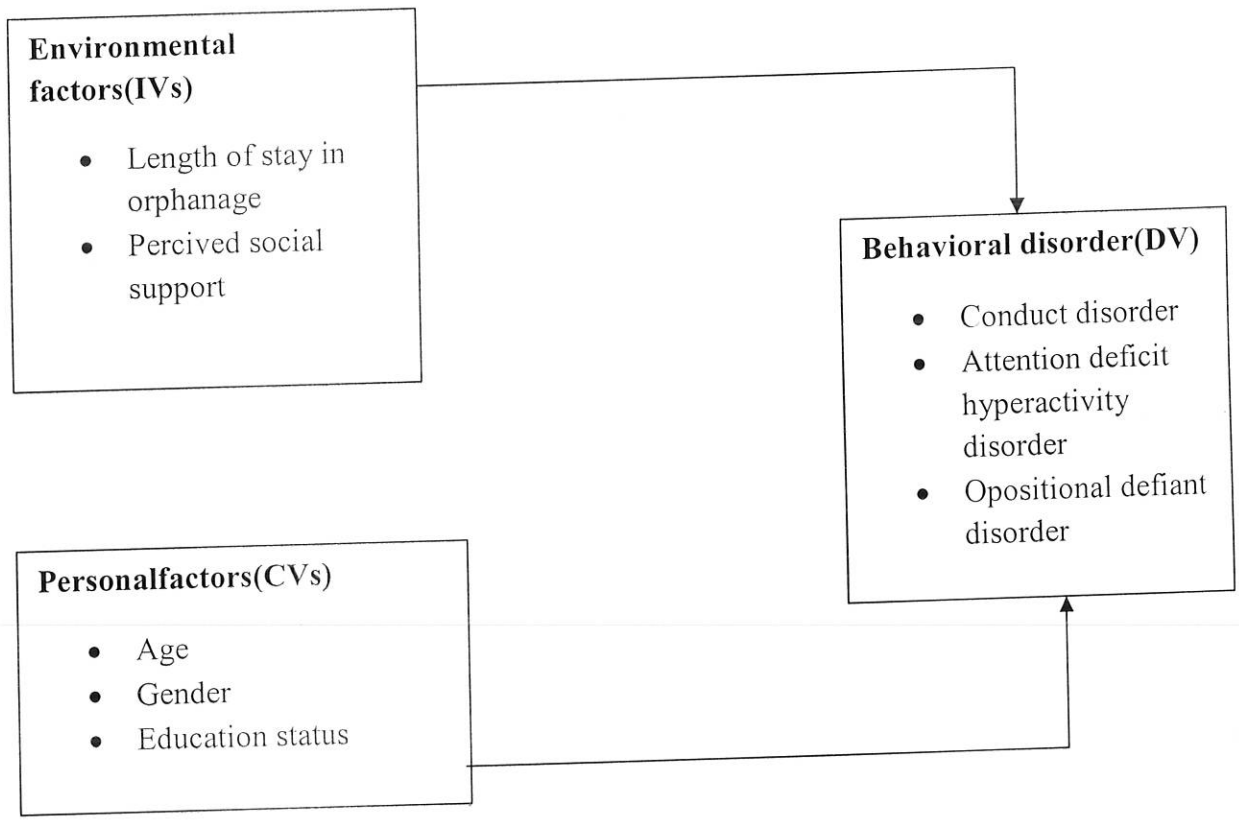
1.2 Significance of the study

I chose to conduct a research on orphan children because they are vulnerable part of the community who need the love, the care,the support, and protection of the society.

The study assessesprevalence and associatedfactors of behavioral disorders among orphans in Selam and SOS children villages.As a result, the concerned bodies, policy makers,

schools, family, governmental and non-governmental organization will work together on orphans or strengthen the existing programs in order to increase the psychological well-being of orphan children. The findings of this study will have a great deal of contribution in the area of social work knowledge building and practice as well as in the area of service delivery and policy related to orphan and vulnerable children because it provides fresh information on behavioral disorder and associated factors.This research is important for those involved in therapy and in counselling to identify children who are at low level of psychological wellbeing and to develop and improve prevention and intervention methods for orphans. The finding of this study will also provide important direction for conducting further research in the areas of behavioral disorder and mental health of orphans.

Conceptual framework



1.3 Operational definition of terms

Both independent and dependent variables of this study are defined bellow. Behavioral disorders (oppositional defiant disorder, attention deficit hyperactivity disorder and conduct disorder) are the dependent variables of this research while environmental factors(length of stay in orphanage and perceived social support) are independent variables. Personal factors such as age, gender, and education status are control variables of this study.

An orphan; is defined as a child that has lost one or both parents. The loss of one parent classifies a child as a "single orphan" and the loss of both parents as a "double Orphan. Globally, it is estimated that there are approximately 153 million children who have lost a mother or a father; 17.8 million of them have lost both parents (TFTAI, 2014).

Behavioral disorder; Behavioral disorders refers to a category of mental disorders that are characterized by persistent or repetitive behaviors that are uncommon among children of the same age, inappropriate, and disrupt others and activities around the child (Williams,2014)

perceived social support; is defined as "an individual's perceptions of general support or specific supportive behaviors (available or enacted upon) from people in their social network" (Malecki & Demaray, 2002, p. 2).

Age; It refers to the number of years that a child lived during the data collection time as responded by the child. It is a continuous variable measured at a ratio level and is limited from 12 to 18 (including) for this study purpose.

Gender; It is the biological difference of children, which is categorized as male and female as responded by the participants. It is measured at nominal level.

Education status; The maximum grade the child has achieved.

Length of stay; The maximum duration that the child spent in the orphanage.

Institutionalization; is the placement of children in institutions, such as orphanages

Oppositional Defiant Disorder; is a recurrent pattern of negativistic, defiant, disobedient and hostile behaviors towards authority figures, lasting for at least six months.

Conduct Disorder; Is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated.

Attention Deficit/Hyperactivity Disorder; is a condition where the child shows symptoms of inattention that are not consistent with his or her developmental level.

1.4 Research Questions and Hypotheses

1. What Is the prevalence of behavioral disorder among orphan children in Selam children villege and SOS?
2. Does behavioral disorder differ by age, gender and educational status?

Hypothes1, Behavioral disorder differ by age, gender and educational status.

3. Does behavioral disorder differ by percieved social support?

Hypothesis 2,Behavioral disorder differ by percieved social support.

4. Does behavioral disorder differ by length of stay in the orphanage?

Hypothesis 3,Behavioral disorder differ by length of stay in the orphanage.

CHAPTER TWO

2. Literature Review

This section includes a review of literature that is related to the research topic. Published and unpublished materials like journals, researches, books, and articles are used as the components of the review.

2.1 Causes of being placed in orphanages

Poverty, lack of access to basic services, abuse, neglect, disease, disabilities, and emergencies are the most frequent causes of separation of children from parental care. In parts of Africa and Asia, poverty combined with the accompanying inability to provide education (supplies, transport, clothing, etc.) or parental illness is a driving force for families to place a child in orphanages. A study of orphanages in Ethiopia found that the most regularly noted reasons for children being placed in orphanages were parental HIV and AIDS status or other chronic illness and poverty. A recently published study of Rwandan orphanages found that poverty, together with death of a parent or abandonment by a parent, was the reason for placement in an orphanage in many cases (TFTAI, 2014).

2.2 Risks of Institutional Care and length of stay in the orphanage

Institutional care cannot replace families and has it's own risks. Therefore, it is recommended that it may be used primarily for temporary or rehabilitative purposes, with every endeavor made to transfer children back into family care. Large institutions with high child-to-caregiver ratios and a lack of individualized or developmentally appropriate care have the most negative and often life-long consequences for children. Therefore institutionalization is

notrecognized as a viable or recommended option for children's care. Parents and community members may be under the impression that an orphanage is beneficial to a child because it fulfills some of the children's basic needs, without realizing the damaging effects it can have on a child's social, emotional, and cognitive development. In some regions, teachers, missionaries, and orphanage staff have actively encouraged or solicited parents and families to place their children in institutional care. For many concerned, it may seem like this is the fastest way to provide a child living in poverty with basic material support. However, investing in programs that provide these needs for children living in family care is more cost-effective and reduces the likelihood of orphanage placement (TFTAI, 2014).

Children living in substandard orphanages have been reported to display a variety of other atypical behaviors, including stereotyped selfstimulation, a shift from early passivity to later aggressive behavior, over activity,and distractibility, inability to form deep or genuine attachments, indiscriminate friendliness, and difficulty establishing appropriate peer relationships. Over the years, it has frequently been suggested that the lack of ''mothering,'' appropriate social–emotional experience, and relationships with a few consistent caregivers are the primary causes of these developmental delays and deficiencies (USA Orphanage Research Team, 2012).

According to Williamson & Greenberg (2010), an orphanage whose operation supports long-term over temporary care inhibits reintegration. At a minimum, every child in an orphanage should have an individualized case plan that minimizes the time spent in an orphanage and facilitates eventual integration into a family. In Ethiopia, only one-third of all orphanages reported having case plans. Evidence demonstrates that compared to a nurturing family environment, most orphanage settings, particularly for infants and young children, do not support

a child's proper development. In many instances, placement in orphanages may generate lasting and sometimes permanent effects on children's brains and their physical, intellectual, and social-emotional development. Children raised in large-scale orphanages often have persistent growth problems, including stunting, and impairments in fine and gross motor skills and coordination. The larger the orphanage, the less likely it is that children receive care from a consistent caregiver focusing on the child's individualized needs. Poor quality care and a lack of individualized stimulation can lead not only to health and development problems, but to isolation and lack of identity. In the Ethiopian study, three orphanages reported that they had administrative personnel but did not have any caregivers on staff. The others were within a range that includes 33 to 125 children per caregiver.

A particular shortcoming of institutional care is that young children typically do not experience the continuity of care that they need to form a lasting attachment with an adult caregiver. Ongoing and meaningful contact between a child and an individual care provider is almost always impossible to maintain in a residential institution because of the high ratio of children to staff, the high frequency of staff turnover and the nature of shift work. Institutions have their own "culture," which is often rigid and lacking in basic community and family socialization. These children have difficulty forming and maintaining relationships throughout their childhood, adolescence and adult lives (Williamson& Greenberg, 2010).

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 behavior and emotional problems, such as aggressive or antisocial behavior, have less knowledge and understanding of the world. Children brought up in institutions may suffer from severe behavior and emotional problems, such as aggressive or antisocial behavior,

have less knowledge and understanding of the world, and become adults with psychiatric impairments. 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 & 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 (Ethe & Makuyana, 2014).

Behavior problems have also been examined in recent studies of institutionalized children. These studies have found that orphanage children display rather unique behavior problems when compared with either home-reared nonadopted children or within country-adoptees(International Encyclopedia of Marriage and Family, 2014).

Exposure to poor social-emotional conditions during early childhood may contribute to higher rates of behavior problems found among children adopted from orphanages. Studies indicated that socially-emotionally deprived children had higher rates and mean levels of Attention Problems and Aggressive Behavior than the Child Behavior Checklist (CBCL) standardization sample. Rates of these problems and also Social Problems showed a stepwise increase after 12 months of exposure to the orphanage. Children exposed to global deprivation and varying levels of deprivation showed a similar set of behavior problems. These results suggest that inadequate early social-emotional interactions and relationships may increase risk of behavior problems in post-institutionalized children (Merz, 2000).

USA Orphanage Research Team (2012) states thattime in the orphanage sometimes relates to the frequency and severity of longer term delays in physical growth, mental and

academic performance, internalizing and externalizing behavior problems, social and peer relations, and inattention/ hyperactivity. The more time children spent in an orphanage the higher their rates of externalizing, internalizing, attention, social, and thought problems.

2.3 The psychosocial well-being of orphans

Psychosocial distress may result in increased insecurity, with future generations being brought up with limited social attachment to significant others. These adolescents seem to be trapped between their fear of being found out and their wish to feel connected and to feel a sense of 'sameness' with their peers. Having to be protective of self and others may become barriers to constructing a healthy sense of intimacy. A number of researchers voice the concern that orphan hood may result in antisocial behavior because the absence of role models makes it impossible for orphans to be socialized appropriately(De Witt & Lessing,2010).

The study of Hiwot et.al, (2011) found out that the higher the self esteem and perceived social support the lower was the probability of being anxious and depressed. The attitude towards themselves and community do really affect the mental health of the orphan adolescents.

2.4 Risks, Protection Factors and Resilience among Orphan and Vulnerable Children

Resilience does not only depend on the characteristics of the individual, but is greatly influenced by processes and interactions arising from the family and the wider environment. Children may be resilient to some kinds of environmental risk experiences or outcomes but not others. Regarding protective factors to buffer risks, more than half (69.2%) had social skills to communicate with others. Similarly, 65.4% had good relationship with their family or care givers where as 34.6% did not have this close bond with their family or care givers (Belay & Missaye, 2014).In addition to this, Solomon (2008) stated that Securing good support from immediate

caregivers was significantly related to scores within the normal range on emotional symptoms, hyperactivity, peer problems, pro social behavior, and total difficulties. Warm relationships promote resilience among children exposed to trauma.

2.5 Types of behavior problems

The most common disruptive behavior disorders include oppositional defiant disorder (ODD), conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD). These three behavioral disorders share some common symptoms, so diagnosis can be difficult and time consuming. A child or adolescent may have two disorders at the same time (Better health, 2014).

Oppositional Defiant Disorder: PACER Center (2006) stated that the central feature of oppositional defiant disorder (ODD), which occurs at rates of 2 to 16%, is a recurrent pattern of negativistic, defiant, disobedient and hostile behaviors towards authority figures, lasting for at least six months. The disruptive behaviors of a child or adolescent with ODD are of a less severe nature than those with Conduct Disorder. Some of the typical behaviors of a child with ODD are being easily angered, annoyed or irritated; Arguing frequently with adults, particularly the most familiar adults in their lives, such as parents; Refuses to obey rules; Seeming to deliberately try to annoy or aggravate others; Low self-esteem; Low frustration threshold and Seeking to blame others for any misfortunes or misdeeds.

Conduct Disorder, which affects between 6% and 16% of boys and 2% to 9% of girls, has as the essential feature a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated. Children with Conduct Disorder often have a pattern of staying out late de- spite parental objections, running away from home, or being truant from school. Children with Conduct Disorder may bully or threaten others or may be physically cruel to animal and people. Conduct Disorder is often associated with an

early onset of sexual behavior, drinking, smoking, and reckless and risk-taking acts (PACER Center, 2006).

Attention Deficit/Hyperactivity Disorder; According to PACER Center (2006), is a condition, affecting 3%-5% of children, where the child shows symptoms of inattention that are not consistent with his or her developmental level. Around two to five per cent of children are thought to have attention deficit hyperactivity disorder (ADHD), with boys outnumbering girls by three to one. The characteristics of ADHD can include Inattention, which consists difficulty concentrating, forgetting instructions, moving from one task to another without completing anything; Impulsivitythat contains talking over the top of others, having a 'short fuse', being accident-prone and Over activitywhich includes constant restlessness and fidgeting (Better health, 2014).

Gender and behavioral disorder

The greatest proportion of the behaviourally disordered population falls in the mild and moderate ranges. Boys outnumber girls in every classification, with first-born males more prone to disturbed behaviour(Pearson,2010).

The sex ratio is approximately 4 to10 males for each female overall, with males further exceeding females in the frequency and severity of behaviors. On balance, research suggests that the causes of conduct problems are the same for both sexes, but males have more conduct disorder because they experience more of its individual-level risk factors (e.g., hyperactivity, neuro-developmental delays)(Scott,2012).

Age,education andbehavioral disorder

The best available research data indicate that 2 to 10 percent of school-age children exhibit serious and persistent behavioural problems. In school, the prevalence is low in the early

years but reaches a peak in the middle grades. Prevalence then drops off during the secondary years(Pearson,2010).

Using a multivariate logistic model on a study, age was significantly associated with Attention Deficit Hyperactivity Disorder (ADHD). Children between 10-14 years of age had more than three-fold increased risk of ADHD compared to younger children. Oppositional defiant disorder and conduct disorder were significantly associated with increasing age.

2.6 Social support

Research has described social support as an expansive construct that describes the physical and emotional comfort given to individuals by their family, friends, and other significant persons in their lives. Research has consistently shown that low levels ofsocial support are related to a variety of poor psychological, social, academic, and health-related outcomes for children. Conversely, high levels of support can mitigate the negative impact of psychosocial stresson mental, behavioral and academic outcomes (White, 2009).

An evaluation of social support suggested subtypes of support through a model founded on the idea that six types of societal relationships foster mental wellness. The relationships include; (a) "attachment," someone feels that they have a safe and secure place with their loved ones; (b) "social integration," an individual has concern for others and vice versa; (c) "opportunity for nurturance," an adult takes care of a child and subsequently feels needed; (d) "reassurance of worth," someone is assured by others that he or she is competent; (e) "reliable alliance," someone receives consistent support and assistance from family; and (f) "the obtaining of guidance," an individual feels that they can confide in and trust someone for advice during stressful situations(Jacobs, 2011).

In addition to this Mastoras (2013) stated that social support can be categorized into four broad domains: (a) emotional support (conveyance of caring, trust, value, and unconditional acceptance); (b) informational support (provision of information or advice); (c) appraisal support (provision of evaluative feedback); and (d) instrumental support (provision of time, material or financial resources).

Relationship problems often are markers of disturbance, and the diagnosis of disorder often centers on relationship considerations. From social phobias to conduct problems to psychotic disorders, across the whole range of problems in childhood and adulthood, disturbances in interpersonal relationships are prominent criteria for classification in psychopathology (Sameroff, Lewis, & Miller, 2012).

2.7 Theoretical framework

Ecological theory

The principal attraction of the ecological perspective is the binding together of people and their environments. The ecological framework seeks to understand how and how well people adapt to the challenges of their natural, built (physical, human-made constructions), and social environments. This framework also requires an analogous concern about the abundance and quality of resources and opportunities these environments provide for the safety, growth, development, and health of individuals and families.Environmental resourcesinclude informal and formal support systems— networks of friends and neighbors; schools; health, child welfare, disaster relief, and social service agencies; cultural and social institutions that comfort, guide, and provide respite or knowledge, churches or ethnic associations(Saleebey, 2001).

According to Bronfenbrenner, the environment has three structure

- The micro system– this is the layer closest to the child and contains the structures with which the child has direct contact. The micro system encompasses the relationships and

interactions a child has with her immediate surroundings. Structures in the micro system include family, school, neighborhood, or childcare environments. At this level, relationships have impact in two directions - both away from the child and toward the child.

- The meso system– this layer provides the connection between the structures of the child's micro system.Examples: the connection between the child's teacher and his parents, between his church and his neighborhood.
- The exo system– this layer defines the larger social system in which the child does not function directly. The structures in this layer impact the child's development by interacting with some structure in her micro system.
- The macro system– this layer may be considered the outermost layer in the child's environment. While not being a specific framework, this layer is comprised of cultural values, customs, and laws. The effects of larger principles defined by the macro system have a cascading influence throughout the interactions of all other layers.
- The chrono system– this system encompasses the dimension of time as it relates to a child's environments. Elements within this system can be either external, such as the timing of a parent's death, or internal, such as the physiological changes that occur with the aging of a child. As children get older, they may react differently to environmental changes and may be more able to determine more how that change will influence them.

According to this ecological theory, if the relationships in the immediate micro system break down, the child will not have the tools to explore other parts of his environment. Children looking for the affirmations that should be present in the child/parent (or child/otherimportant adult) relationship look for attention in inappropriate places. These

deficiencies show themselves especially in adolescence as anti-social behavior, lack of self-discipline, and inability to provide self-direction (Berk, 2000).

This theory explains that people are so much affected by their environment and this helps to understand the relationship between behavior of children and the environment in which they are living. The quality and abundance of resources and opportunities provided by the institution and safety, growth, and development of the children is related in relation to this theory.

2.8 Diagnostic and Statistical ManualofMental Disorders

Attention-Deficit/Hyperactivity Disorder

The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent patternof inattention and/or hyperactivity-impulsivity that is more frequent and severe than istypically observed in individuals at a comparable level of development (Criterion A).Some hyperactive-impulsive or inattentive symptoms that cause impairment must havebeen present before age 7 years, although many individuals are diagnosed after thesymptoms have been present for a number of years (Criterion B). Some impairment fromthe symptoms must be present in at least two settings (e.g., at home and at school orwork) (Criterion C). There must be clear evidence of interference with developmentallyappropriate social, academic, or occupational functioning (Criterion D). The disturbancedoes not occur exclusively during the course of a Pervasive Developmental Disorder,Schizophrenia, or other Psychotic Disorder and is not better accounted for by anothermental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, orPersonality Disorder) (Criterion E).Inattention may be manifest in academic, occupational, or social situations. Individualswith this disorder may fail to give close attention to details or may make carelessmistakes in schoolwork or other tasks (Criterion Ala). Work is often messy and

performed carelessly and without considered thought. Individuals often have difficultysustaining attention in tasks or play activities and find it hard to persist with tasks until completion (Criterion Alb).They often appear as if their mind is elsewhere or as if theyare not listening or did not hear what has just been said (Criterion Ale). There may befrequent shifts from one uncompleted activity to another. Individuals diagnosed withthis disorder may begin a task, move on to another, then turn to yet something else, prior to completing any one task. They often do not follow through on requests orinstructions and fail to complete schoolwork, chores, or other duties (Criterion Aid).Failure to complete tasks should be considered in making this diagnosis only if it is dueto inattention as opposed to other possible reasons (e.g., a failure to understand instructions). These individuals often have difficulties organizing tasks and activities(Criterion Ale). Tasks that require sustained mental effort are experienced as unpleasantand markedly aversive. As a result, these individuals typically avoid or have a strongdislike for activities that demand sustained self-application and mental effort or thatrequire organizational demands or close concentration (e.g., homework or paperwork)(Criterion AID. This avoidance must be due to the person's difficulties with attentionand not due to a primary oppositional attitude, although secondary oppositionalism mayalso occur. Work habits are often disorganized and the materials necessary for doing the task are often scattered, lost, or carelessly handled and damaged (Criterion Alg).Individuals with this disorder are easily distracted by irrelevant stimuli and frequentlyinterrupt ongoing tasks to attend to trivial noises or events that are usually and easily ignored by others (e.g., a car honking, a background conversation) (Criterion Alh). Theyare often forgetful in daily activities (e.g., missing appointments, forgetting to bringlunch) (Criterion Ali). In social situations, inattention may be expressed as frequent shifts in conversation, not listening to others, not keeping one's mind on conversations,and not following details or rules of games or

activities.Hyperactivity may be manifested by fidgetiness or squirming in one's seat (CriterionA2a), by not remaining seated when expected to do so (Criterion A2b), by excessiverunning or climbing in situations where it is inappropriate (Criterion A2c), by havingdifficulty playing or engaging quietly in leisure activities (Criterion A2d), by appearingto be often "on the go" or as if "driven by a motor" (Criterion A2e), or by talkingexcessively (Criterion A2f). Hyperactivity may vary with the individual's age and developmental level, and the diagnosis should be made cautiously in young children.Toddlers and preschoolers with this disorder differ from normally active young childrenby being constantly on the go and into everything; they dart back and forth, are "out ofthe door before their coat is on," jump or climb on furniture, run through the house,and have difficulty participating in sedentary group activities in preschool classes (e.g.,listening to a story). School-age children display similar behaviors but usually with lessfrequency or intensity than toddlers and preschoolers. They have difficulty remainingseated, get up frequently, and squirm in, or hang on to the edge of, their seat. Theyfidget with objects, tap their hands, and shake their feet or legs excessively. They oftenget up from the table during meals, while watching television, or while doing homework;they talk excessively; and they make excessive noise during quiet activities. Inadolescents and adults, symptoms of hyperactivity take the form of feelings of restlessnessand difficulty engaging in quiet sedentary activities.Impulsivity manifests itself as impatience, difficulty in delaying responses, blurtingout answers before questions have been completed (Criterion A2g), difficulty awaitingone's turn (Criterion A2h), and frequently interrupting or intruding on others to the pointof causing difficulties in social, academic, or occupational settings (Criterion A2i). Othersmay complain that they cannot get a word in edgewise. Individuals with this disordertypically make comments out of turn, fail to listen to

directions, initiate conversations atinappropriate times, interrupt others excessively, intrude on others, grab objects fromothers, touch things they are not supposed to touch, and clown around. Impulsivity maylead to accidents (e.g., knocking over objects, banging into people, grabbing a hot pan)and to engagement in potentially dangerous activities without consideration of possible consequences (e.g., riding a skateboard over extremely rough terrain).Behavioral manifestations usually appear in multiple contexts, including home,school, work, and social situations. To make the diagnosis, some impairment must bepresent in at least two settings (Criterion C). It is very unusual for an individual to displaythe same level of dysfunction in all settings or within the same setting at all times.Symptoms typically worsen in situations that require sustained attention or mental effortor that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing classassignments, listening to or reading lengthy materials, or working on monotonous,repetitive tasks). Signs of the disorder may be minimal or absent when the person is under very strict control, is in a novel setting, is engaged in especially interestingactivities, is in a one-to-one situation (e.g., the clinician's office), or while the person experiences frequent rewards for appropriate behavior. The symptoms are more likely to occur in group situations (e.g., in playgroups, classrooms, or work environments).The clinician should therefore inquire about the individual's behavior in a variety ofsituations within each setting.

Conduct Disorder

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behaviorin which the basic rights of others or major age-appropriate societal norms or rules areviolated (Criterion A). These behaviors fall into four main groupings: aggressive conductthat causes or threatens physical harm to other people or animals (Criteria A1-A7),nonaggressive conduct that causes property loss or damage (Criteria A8—A9), deceitfulnessor theft (Criteria A10-A12), and

serious violations of rules (Criteria A13-A15). Three(or more) characteristic behaviors must have been present during the past 12 months,with at least one behavior present in the past 6 months. The disturbance in behaviorcauses clinically significant impairment in social, academic, or occupational functioning(Criterion B). Conduct Disorder may be diagnosed in individuals who are older thanage 18 years, but only if the criteria for Antisocial Personality Disorder are not met(Criterion C). The behavior pattern is usually present in a variety of settings such as home, school, or the community. Because individuals with Conduct Disorder are likely to minimize their conduct problems, the clinician often must rely on additionalinformants. However, the informant's knowledge of the child's conduct problems maybe limited by inadequate supervision or by the child's not having revealed them.Children or adolescents with this disorder often initiate aggressive behavior andreact aggressively to others. They may display bullying, threatening, or intimidatingbehavior (Criterion Al); initiate frequent physical fights (Criterion A2); use a weaponthat can cause serious physical harm (e.g., a bat, brick, broken bottle, knife, or gun)(Criterion A3); be physically cruel to people (Criterion A4) or animals (Criterion A5);steal while confronting a victim (e.g., mugging, purse snatching, extortion, or armedrobbery) (Criterion A6); or force someone into sexual activity (Criterion A7). Physicalviolence may take the form of rape, assault, or in rare cases, homicide.Deliberate destruction of others' property is a characteristic feature of this disorderand may include deliberate fire setting with the intention of causing serious damage(Criterion A8) or deliberately destroying other people's property in other ways (e.g.,smashing car windows, school vandalism) (Criterion A9).Deceitfulness or theft is common and may include breaking into someone else's house, building, or car (Criterion A10); frequently lying or breaking promises to obtaingoods or favors or to avoid debts or obligations (e.g., "conning" other people) (CriterionAl 1); or stealing

items of nontrivial value without confronting the victim (e.g., shoplifting,forgery) (Criterion A12).Characteristically, there are also serious violations of rules (e.g., school, parental)by individuals with this disorder. Children with this disorder often have a pattern,beginning before age 13 years, of staying out late at night despite parental prohibitions(Criterion A13). There may be a pattern of running away from home overnight (CriterionA14). To be considered a symptom of Conduct Disorder, the running away must haveoccurred at least twice (or only once if the individual did not return for a lengthy period).Runaway episodes that occur as a direct consequence of physical or sexual abuse donot typically qualify for this criterion. Children with this disorder may often be truantfrom school, beginning prior to age 13 years (Criterion A15). In older individuals, thisbehavior is manifested by often being absent from work without good reason.

Oppositional Defiant Disorder

The essential feature of Oppositional Defiant Disorder is a recurrent pattern ofnegativistic, defiant, disobedient, and hostile behavior toward authority figures thatpersists for at least 6 months (Criterion A) and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper (Criterion Al), arguing withadults (Criterion A2), actively defying or refusing to comply with the requests or rulesof adults (Criterion A3), deliberately doing things that will annoy other people (CriterionA4), blaming others for his or her own mistakes or misbehavior (Criterion A5), beingtouchy or easily annoyed by others (Criterion A6), being angry and resentful (CriterionA7), or being spiteful or vindictive (Criterion A8). To qualify for Oppositional DefiantDisorder, the behaviors must occur more frequently than is typically observed inindividuals of comparable age and developmental level and must lead to

significantimpairment in social, academic, or occupational functioning (Criterion B). The diagnosisis not made if the disturbance in behavior occurs exclusively during the course of a Psychotic or Mood Disorder (Criterion C) or if criteria are met for Conduct Disorder orAntisocial Personality Disorder (in an individual over age 18 years).Negativistic and defiant behaviors are expressed by persistent stubbornness, resistanceto directions, and unwillingness to compromise, give in, or negotiate with adultsor peers. Defiance may also include deliberate or persistent testing of limits, usually byignoring orders, arguing, and failing to accept blame for misdeeds. Hostility can bedirected at adults or peers and is shown by deliberately annoying others or by verbal aggression (usually without the more serious physical aggression seen in ConductDisorder). Manifestations of the disorder are almost invariably present in the homesetting, but may not be evident at school or in the community. Symptoms of the disorderare typically more evident in interactions with adults or peers whom the individual knowswell, and thus may not be apparent during clinical examination. Usually individuals withthis disorder do not regard themselves as oppositional or defiant, but justify theirbehavior as a response to unreasonable demands or circumstances (DSM IV, 1994).

2.9 Policy related to OVC and mental health in Ethiopia

The Development and Social Welfare Policy (1996) aims at creating a congenial environment for sustainable development; the major targets of the policy arethe vulnerable groups of the community among which children are mentioned as the vulnerable group of the societyand are one of the targets of the policy. Among other things, the policy is committed to implement internationalstandards provided to children, to fight against harmful traditional practices and create a congenial environment where,among other things, orphan children get the

necessary support. In addition, the policy is committed to fight against any forms of abuse and exploitation against children (Save the children, 2008).

The FDRE Constitution (1995) Article 36 provides special rights of children in a way that resonates well with the OVC, the Constitution provides:

- In all actions concerning children undertaken by public and private welfare institutions, courts of law, administrative authorities or legislative bodies, the primary consideration shall be the best interest of the child.
- The State shall accord special protection to orphans and shall encourage the establishment of institutions, which ensure and promote their adoption and advance their welfare, and education (Save the children, 2008).

The revised Family Code highlights the lines of family relationship that are responsible to provide care and support to children who have lost their parents. Where the parents of the child are not in a position to take care of their children, the responsibility to take care of an orphan befalls the grandparents. If the orphan does not have grandparents, the responsibility would go to older sisters and brothers. The last availableresort provided by the Code, where a child is left without any relative by affinity that could be guardians, is that the orphan children would be sent to institutions(Revised family code, 2000).

According to Federal Democratic Republic of Ethiopia Ministry of Health, Local and international NGOs associated with children must also make their programs and activities consistent with this strategy. In particular, it focuses on children's mental health promotion and de-stigmatization, school-based mental health, guidelines for the treatment of children in community- and hospital based settings, and mental health services for specialized

populations. Since a growing number of children spend a greater part of their days in school, with the support of the Ministry of Education, components of mental health will be incorporated into existing school-based health related activities.Since advocacy is the best approach to promote good mental health, FMOH will develop andprovide information and education to the general population about various aspects of mental

health. All levels of advocacy will be encouraged and supported utilizing all human resources, organizations and groupings. To this end, FMOH will: Target the young, adolescents, and other vulnerable populations, including schools, churches, and youth organizations (FMOH,2012/13 – 2015/16).

2.10 Treatment of ADHD, Conduct and Oppositional Defiant disorders

All children with symptoms of ADHD and ODD/ CD need to be assessed so that all types of problem behaviors can be treated. These children are difficult to live with and parents need to understand that they do not need to deal with their ADHD and ODD/CD child alone. Interventions such as parent training at home and behavioral support in the school can make a difference and parents should not hesitate to ask for assistance (NRCA,2008).

National Resource Center on ADHD (2008) has prepared the following interventions for effective change in child behavior.

Home Interventions

Parent Training (PT): Parent training has been shown to be effective for treating oppositional and defiant behaviors. Standardized parent training programs are short-term interventions that teach parents specialized strategies including positive attending, ignoring, the effective use of rewards and punishments, token economies, and time out to address clinically significant behavior problems.Such training programs may include periodic booster sessions.

Severe cases of CD may require multisystemic therapy, an intensive family- and community-based treatment that addresses the multiple causes of serious antisocial behavior in youth. This approach is very comprehensive and demanding. The therapist using such an approach must possess access to developmental and clinical expertise. These intervention services are delivered in a variety of settings (i.e., home, school, peer groups) as needed. Academic and school-based problems are included and some therapists work directly with an entire peer group to influence change.

Parent-child interaction therapy is a treatment that teaches parents to strengthen the relationship with their child and to learn behavior management techniques. It has been found to be effective in the long term for young children with ODD and ADHD. Three to six years after reported that the changes in their children's behavior and their own feelings of control had lasted. Mothers' reports of disruptive behavior decreased with time after treatment.

Collaborative Problem Solving (CPS): Another technique that seems to be promising for children with ADHD and ODD is collaborative problem-solving (CPS).CPS is a treatment that teaches difficult children and adolescents how to handle frustration and learn to be more flexible and adaptable. Parents and children learn to brainstorm for possible solutions, negotiate, make decisions, and implement solutions that are acceptable to both. They learn to resolve disagreements with less conflict.

Family Therapy: Often a child's behavior can have an effect on the whole family. Parents of children with ADHD often report marital difficulties. Mothers may be more depressed and siblings may also develop behavior problems. Family therapy is critical to helping a family address these issues and cope with the realities of having a child with ADHD and disruptive

behaviors. Seeking out a counselor or family therapist in your neighborhood can help the entire family address these issues.

SCHOOL INTERVENTIONS

School-wide Positive Behavioral Supports: In addition to the environment at home, the school can have a significant impact on a child's behavior patterns. Many school systems now have programs in place to provide school-wide positive behavioral supports. The aim of these programs is to foster both successful social behavior and academic gains for all students. These programs consist of: (1) clear, consistent consequences for inappropriate behaviors; (2) positive contingencies for appropriate behaviors; and (3) team-based services for those students with the more extreme behavioral needs.

Tutoring: Children's ADHD symptoms, as well as oppositional symptoms, have been found to be significantly lower in one-on-one tutoring sessions than in the classroom.

Classroom Management: Providing appropriate instructional supports in the classroom can also lessen disruptive behavior. These include: creating an accepting and supportive classroom climate, promoting social and emotional skills, establishing clear rules and procedures, monitoring child behavior, utilizing rewards effectively, responding to mild problem behaviors consistently and effectively managing anger or aggressive behavior.

CHAPTER THREE

3. Method

This chapter presents the methodology that guided and transformed the overall research questions to generate empirical data. In this section, I have discussed the research design, the sample selection plan and procedures,the study setting, instruments,study respondents selection, the procedures of data collection, and data cleaning and management. In addition, this chapter presents about the data collapsing and data analysis. Reliability and validity tests for quantitative data are also discussed. Finally, the chapter presents the procedures used to protect human subjects.

3.1 Research design

The research design is a quantitative cross sectional research design with descriptive and explanatory function. The selected independent variables are percieved social support and length of stay in the orphanages.The control or demographic variables are age, gender and education level. The dependent variable is behavioral disorder. The quantitative approach arises from the belief that human phenomena andvariables in human behavior can be studied objectively (Parahoo 2006).It is descriptive because it presents a picture of the specific details of the situation and it is explanatory because it answers why things are the way they are.It intends to provide information as to the prevalence of behavioral disorder among the orphan and vulnerable children and the association between environmental factors(length of stay & percived social support) and behavioral disorder and also the association between socio demographic variables (age difference, gender difference,& educational level) and behavioral disorder.

3.2 Study area and Participants

The study area for this paper isSelam Children Village and SOS children village. Selam Children's Village (SCV) is a non-governmental, faith-based organization that envisions to enable orphans and destitute community children to improve their lives and holistically develop as self-sufficient citizens. The organization works towards this vision by providing food, shelter, clothing, education, medical care services, and other basic necessities. The door to SCV was opened to include many programs and projects to support underprivileged other community members.In 1986, Mrs. Tsehay Roschili founded Selam Children's Village with 23 orphans and 4 workers in order to provide necessities and a family for children who lost their parents due to the drought that occurred in the northern part of Ethiopia. Following their daughter's path, her parents, David and Marie-Louise Roschili settled in Ethiopia in 1989 and began the ground work for the technical and vocational center. Over the year, Selam continued to grow, through supporting many people and employing hundreds.

Selam Children village has two village compounds. Each family house has a "house Mother" and "house Aunt" that look after and take care of the children.The homes are split between the children's homes for younger children and the youth homes for older children. Additionally, the organization supports children reaching age 18 through the semi-Independent youth program. SCV I have 7 family homes that accommodate about 100 children and 2 youth houses for 42 youths. SCV II has 4 family houses that serve about 75 children and 20 youths in semi independent program.The entry criteria for the village is, not having parents and relatives while the exit criteria is being greater than 18 years old.

The SOS Children's Village Addis Ababa was opened in 1981 in a residential district in the south west of Addis Ababa, the capital of Ethiopia. It is the third SOS Children's Village in Ethiopia. It comprises 15 family houses, a Village Director's house, accommodation for the SOS aunts (SOS aunts take care of the children when SOS mothers are on leave), a guest house, a bakery, a small shop and an administrative and service block. About 120 children are taken care of by the village. As soon as youths reach the age of about 16, they move to one of the three SOS Youth Facilities, where they are taken care of by a youth leader. Being admitted to an SOS Youth Facility means taking responsibility for themselves and is synonymous to making a big step towards independence. Being fully aware of this, SOS mothers, the Village Director and a psychologist prepare them carefully for that change. Usually, youths stay up to four years in an SOS Youth Facility. The entry criteria of the orphanage is not having parents and relatives as well as being younger than age 6 while the exit criteria is being greater than age 18.The study participants were 106 orphan children, 17teachers,25 caregivers and 1 social workerfrom the two villages.

3.3 Sampling method

For this study the sampling frame was the organization's record of orphan children who are in the age between 12 and 18. I made the age 12 as the lower age limit because, children below age 12 are unable to analyze and express their experience and age 18, because orphan children will be out of the orphanage after this age.The sampling thechnique that I employed is simple random sampling .The simple random sampleis both the easiest random sample to understand and the one on which other types are modeled. In simple random sampling, a researcher develops an accurate sampling frame, selects elements from the sampling frame

according to a mathematically random procedure, then locates the exact element that was selected for inclusion in the sample. After numbering all elements in a sampling frame, a researcher uses a list of random numbers to decide which elements to select(Kruger and neuman, 2006).

3.4 Sampling size

Since the number of the study population is 145 children who are between the age of 12 and 18,the sample size of this study is calculated using the formula $n = \frac{Z^2}{4e^2 + \frac{Z^2}{N}}$ where N is population number which is 145,Z is confidence level at 95% with standard value of 1.96 and e is margin of error at 5 % with standard value of 0.05 and the result is found to be 106. Furthermore 10 children apart from the children included in the sample were used for a pilot test.

3.5 Measurment

The measurements selected for this study areDisruptive Behavioral Disorder rating scale which measures behavioral disorder and Multidimensional Scale of Perceived Social Support scale (MSPSS) which measures percieved social support.The DBD is an easy to administer, 45-item screening tool for disruptive behaviordisorders including conduct disorder, oppositional defiant disorder and ADHD in childrenand adolescents. It is based on both the third revised and the fourth editions ofthe Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR and DSM-IV).It was developed byUniversity at BuffaloCenter for Children and Families. Each symptom is rated on a 4-point scale indicating the occurrence and the severity of symptoms:0 (not at all), 1 (just a little), 2 (pretty much) or 3 (very much). Scoring was done according to the symptoms counting method. MSPSS is a 12-item scale, self-report instrument developed

byZimet,Powell,Farley,Werkman,and Berkoff. It measures individuals social support from three specific areas namely family, friends, and significant others. Each of the 3 areas has 4 subscales. Items were measured on 7-point Likert-type scale from 1 'very strongly disagree' to 7 'very strongly agree'. The MSPSS evaluates perceived social support (PSS) from family (FA), friends (FR), and significant others (SO) and quantifies the degree to which respondents perceive support from each of these three sources, namely FA, FR and SO.

3.6 Data Quality assurance

Content validity or was conducted to find out if the questions were representing what they were intended to measure in a proportional way and to see their appropriateness in Ethiopian context. In doing so, the questions were given to three raters,two of them were staffs in Addis Ababa University department of Social Work and the remaining was a social worker in SOS children village.As a result based on the agreement of the raters, all of the questions were used.

Reliability of the questionnaire was checked using Cronbach Alpha, (α). The reliability of Multidimensional Scale of Perceived Social Support scale (MSPSS)in the pilot is α=.907(N=10), which indicates a stronger consistency. The reliability of DBD in the pilot sudy is also α= .974 (N=16).

The two measurments(Disruptive Behavioral Disorder rating scale and Multidimensional Scale of Percieved Social Support) were translated into Amharic and back translated into English by 2 different linguistic professionals to make sure the amharic version has the same meaning as the english one.

3.7 Data Collection Procedure

After the orphanages are selected, certain procedures had to be followed. Accordingly, I submitted the official letters of collaboration from the School of Social work to the orphanages. They were so cooperative and responsible to coordinate the process. After I got the list of the children,it became easy for me to draw random sample and proceed.

The data was not collected as per the general plan of data collection procedure because combination of scales was used and four parts has to participate in the study(the children,social worker,the parents and the teachers).Therefore it took me a longer time than the planned one.

3.8 Data analysis

Data was entered using Statistical Package for Social Science (SPSS) Version 22 computer application program, and then cleaned to insure quality. This process involves repeated cycle of screening, diagnosing, and treatment.Which means clarifing the true nature of worrisome data points, patterns and statistics, deciding what to do with problematic observations and establishing scaling and extracting associated exponents in problems showing self-similar or self-affine characteristics.

Since the data collected was quantitative, it was analyzed using univariate, bivariate and multivariate data analysis. At the univariate level, descriptive statistical analysis was conducted to obtain demographic profile of the study participants. Descriptive frequency tables were used to observe the patterns of study respondents' response to each of the study variables.

t test compares the average values of acharacteristic measured on a continuous scale between two subgroups of a categorical variable.So It is used to analyze behavioral disorder with gender.Multiple regression, is used to see if child's age,gender,education level, perceivedsocial

support and length of stay in the orphanage significantly predict behavioral disorder. A general goal of regression analysis is to estimate the association between one or more *explanatory* variables and a single *outcome* variable. An outcome variable is presumed to depend in some way or be systematically predicted by the explanatory variables. The goals of a regression analysis are to predict or explain differences in values of the outcome variable with information about values of the explanatory variables (Hoffmann, 2010) . The unit of analysis for this study is individual orphans living in the villages.

3.9 Ethical issues

Ethical considerations in a research study are a major component of the social work research process so, professional and research ethical values of this research were fully recognized and assured. The main goal of informed consent is to make sure that the study participant has understood and make choices freely whether to begin or continue participation in a study.It states the purpose of the study and its consequence. The participants were informed that their participation in the study was completely voluntary with the ability to discontinue their participation at any time with no questions asked, and without consequences to their current or future life.

Respondents were also informed that confidentiality would be maintained to the extent that this researcher can provide. The informed consent and questionnaires were kept separate in order for this researcher to not become aware which participant completed which questionnaire. The questionnaires were kept in a secured and locked location that is only accessible to this researcher. No individual identifying data was collected or will be included in any papers or publications that result from this study.

CHAPTER FOUR

4. FINDING

This chapter is the presentation of the quantitative findings of the study. First, the results of the descriptive analysis for all the variables (demographic, independent, and dependent variables) are presented. Following the descriptive analyses, the results of the bivariate analysis are presented containing the analysis of behavioral disorder with demographic factors, length of stay in the orphanage and percieved social support and the multivariate analysis presents the analysis of the dependent and the independent variables and answers for the research questions and the accompanied hypotheses of the study.

4.1 Descriptive Univariate Analysis

Demographic Characteristics of Respondents

In this study, 106 children were studied from two orphanages. Their age ranged from 12 to 18.The mean age is found to be 14.14(SD=2.162).The other demographic variable in this study was education level. In terms of their education level,The participants' grade range was from the minimum grade one to grade twelve.On average the participants are grade 7(M=6.77,SD=1.914).Length of stay in the orphanage is one of the two main independent variables of this study.It ranged from 1 year to 17 years.The mean length of stay in the orphanage is 9.31(SD=3.909).A summary of the respondents by age,length of stay, and education level is presented in Table 1

Table 1: Age, Length of stay, and Education distribution

	N	Minimum	Maximum	Mean	Std. Deviation
Age of the child	106	12	18	14.14	2.162
Length of stay in the orphanage	106	1	17	9.31	3.909
Education	106	1	12	6.77	1.914
Valid N (list wise)	106				

When we come to the gender of the respondents the majority of the study population were males (60.4 %), while the rest were females (39.6%).Table two presents the gender distribution of the research population.

Table 2:Gender distribution of the children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	64	60.4	60.4	60.4
	Female	42	39.6	39.6	100.0
	Total	106	100.0	100.0	

4.2 Perceived social support

The other independent variable is perceived social support, which is measured in this study by Multidimensional Scale of Perceived Social Support assessment. Each item is scored from 1-7. 1 means Very Strongly Disagree,2 Strongly Disagree,3 Mildly Disagree,4 Neutral,5 Mildly Agree,6 Strongly Agree and 7 Very Strongly Agree. Coming to the interpretation of the result, a total score of 69-84 shows High Acuity while a total score of 49-68 shows Moderate Acuity and a total score of 12-48 shows Low Acuity.The score ranges from 18 to84.the mean score of perceived social support is found to be 68.65, which is categorized under high acuity.When we describe it in detail, out of the total respondents eight children arefound to be

low.Forty children perception about their social support is found to be moderate while the rest 58 children perceive that they have a high social support. Table 3 presents the description of perceived social support.

Table 3 Percived social support score

	N	Minimum	Maximum	Mean	Std. Deviation
Perceived social support total	106	18	84	68.65	12.259
Valid N (list wise)	106				

4.3 Behavioral Disorder

The dependent variable of the study,behavioral disorder, is measured by a 45 item DBD scale which consists items for identifiying attention deficit hyperactivity disorder,conduct disorder and oppositional defiant disorder. Since the scale do not have a total score, I prefered to present and analize each of them separately. six or more items has to be endorsed as very much or pretty much in order to meet criteria for attention deficit hyperactivity disorder. 3 or more items has to be endorsed as very much or pretty much inorder to meet criteria for conduct disorder while 4 or more items has to be endorsed as very much or pretty much in the case of oppositional defiant disorder.This means a total attention deficit score has to be more than 30 which is calculated by 6x3+12=30.six refers to the least number of item,3 refers to the score for pretty much and 12 refers the rest of the attention deficit items with the score of 1(never).The total conduct disorder has to be more than 21which is calculated by3x3+12.In the case of oppositional defiant disorder,a total score of 24 which is calculated as 4x3+12, is necessary .The mean score for this disorders is found to be33.62, 22.91 and 14.28 respectively.

Table 4 Description of behavioral disorders

	N	Minimum	Maximum	Mean	Std. Deviation
Oppositional Defiant disorder	106	8	32	14.28	9.727
Attention Deficit hyperactivity disorder	106	18	72	33.62	21.525
Conduct Disorder	106	15	54	22.91	14.066
Valid N (list wise)	106				

Based on this rule of the scale,19 children are found to have attention deficit hyperactivity disorder.9 children has been endorsed as pretty much and very much on conduct disorder items by their parents and teachers and 3 children are found to have oppositional defiancy. 21 children have combination of the three behavioral disorders.Therefore behavioral disorder is prevalent among orphan children in Selam and SOS children villages by49%.

Table 5: Frequency table for types of behavioral disorder

Behavioral disorder type	frequency	percentage
Attention deficit hyperactivity disorder	19	18%
Conduct disorder	9	8%
Oppositional defiant disorder	3	3%
Combined disorder	21	20%
Total behavioral disorder	52	49%
Free children	54	51%

The correlation of the the three types of behavioral disorders shows that there is a very strong positive relationship between the types of behavioral disorder(Attention Deficit Hyperactivity Disorder,Conduct Disorder and Oppositional Defiant disorder).

Table 6 Correlation of attention deficit hyperactivity disorder, conduct disorder and oppositional defiant disorder

		attention deficit hyperactivity disorder	conduct disorder	oppositional defiant disorder
Attention deficit hyperactivity disorder	Pearson Correlation	1		
	Sig. (2-tailed)			
	N	106		
Conduct disorder	Pearson Correlation	.907***	1	
	Sig. (2-tailed)	.000		
	N	106	106	
Oppositional defiant disorder	Pearson Correlation	.922***	.943***	1
	Sig. (2-tailed)	.000	.000	
	N	106	106	106

***. Correlation is significant at the 0.001 level (2-tailed).

A simple linear regression and multiple regression, using behavioral disorder as a dependent variable, and age, education, gender, as control variables and length of stay and percieved social support as independent variable were done to test if these factors predict behavioral disorder

Bivariate and multiple regression analysis

The descriptive statistics presented above provides a univariate summary of the responses of children,parents and teachers for each measure.To test the relationship between each independent variable with the dependent variable,the following hypothesis were formulated and tested.

Hypothesis 1: prevalence of behavioral disorder differ by age, gender and educational status.

The multiple regression analysis done on the prediction of the control variables(age,gender and education level) on attention deficit hyperactivity disorder shows that none of them have a significant prediction on the dependent variable, statstically.

Table 7: Multiple regression analysis for demographic factors predicting attention deficit hyperactivity disorder

		Unstandardized Coefficients		Standardized Coefficients			
Model		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	11.868	14.723		.806	.422	
	Age of the child	2.216	1.405	.223	1.578	.118	.005
	Education	-2.066	1.603	-.184	-1.289	.200	.003
	Gender/male	7.298	4.296	.167	1.699	.092	.030

a. Dependent Variable: Attention deficit hyperactivity disorder

Multiple linear regression model summary and overall fit statistics shows that R^2forthe prediction of age on attention deficit hyperactivity disorderis.005,which means that practicaly0.5 % of the total variation in the dependent variable is explained by our model. It also showed that R^2 for the prediction of educationon attention hyperactivity disorder is .003, which means that 0.3% of the variation is due to change in education level. Gender predict 3% of the variance in attention deficit hyperactivity disorder is due to the difference in gender(R^2=0.030).The result shows that for every increase in the age of a child there will be a variance of 2.216on attention deficit hyperactivity disorder. It also shows that theoretically male's exposure to attention deficit

hyperactivity is higher by 7.298.For every education level increase there will be a decrease of 2.066 in Attention Deficit Hyperactivity Disorder.

Table 8: Multiple regression analysis for demographic factors predicting conduct disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	7.865	9.563		.822	.413	
	Age of the child	1.339	.912	.206	1.468	.145	.005
	Education	-1.111	1.041	-.151	-1.067	.288	.002
	Gender/male	6.006	2.790	.210	2.152	.034	.045

a. Dependent Variable: Conduct disorder

Conduct disorder and demographic variables do not have a significant relationshipstatistically except in the case of gender which shows $p<0.05$. Multiple linear regression model summary shows that 0.5% of the variation in conduct disorder is due to age($R^2=.005$).Education predicts conduct disorder by 0.2%($R^2=.002$).It also shows that practically 4.5 of the variation in conduct is due to gender difference.male's exposure to conduct disorder is higher by 6.006while for every education level increase, there will be a decrease of 1.111in conduct disorder.

Table 9: Multiple regression analysis for demographic factors predicting oppositional defiant disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	5.260	6.552		.803	.424	
	Age of the child	.840	.625	.187	1.344	.182	.001
	Education	-.856	.713	-.168	-1.201	.233	.006
	Gender/male	4.884	1.912	.247	2.554	.012	.065

a. Dependent Variable: Oppositional defiant disorder

Oppositional defiant disorder and demographic variables do not have a significant relationship except that of gender which shows $p<0.05$.The statistics shows that $R^2$for the prediction of age on oppositional defiant disorderis.001which means that 0.1 % of the total variation in the dependent variable is explained by our model. R^2 for the association between education and oppositional defiant disorder is .006, which shows that 0.6% of the total variation on oppositional defiant disorder is due to education level. The result also shows that practically for every increase in the age of a child there will be a variance of .840 on oppositional defiant disorder. It also shows that practically male's exposure to oppositional defiant disorder is higher by 4.884.For every education level increase, there will be a decrease of .856 in oppositional defiant disorder.

Table 10: Gender difference and the three types of behavioral disorder

	gender of the child	N	Mean	Std. Deviation	Std. Error Mean	t	sig
Attention deficit Hyperactivity disorder	male	64	36.63	23.216	2.902	1.888	.062
	female	42	29.05	17.967	2.772		
Conduct disorder	male	64	25.31	15.846	1.981	2.428	.017
	female	42	19.24	9.899	1.527		
Oppositional defiant disorder	male	64	16.28	10.731	1.341	2.921	.004
	female	42	11.24	7.046	1.087		

The independent t test result shown in the above table tells us that there is a statistically significant difference between male and female related to conduct disorder and oppositional defiant disorder, where males are higher.

Hypothesis 2: prevalence of behavioral disorder differ by percieved social support

The result showed that percent of change in attention deficit hyperactivity disorder as a result of change in orphans perceived social support is 1.3(R^2=.013).As the bivariate regression analysis indicates the association between perceived social support and attention deficit hyperactivity disorder is not statistically significant, B=-.201,p>0.05.

Table 11:Bivariate regression analysis for perceived social support prediction of attention deficit hyperactivity disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	47.396	11.926		3.974	.000	.013
	Perceived social support total	-.201	.171	-.114	-1.173	.243	

The above result is also the case in the relationship between conduct disorder and perceived social support.The value of R^2 is 0.012, which point out that1.2% change in the

orphans perceived social support explains change in conduct disorder.The relationship is not statistically significant,B=-.126,p>0.05.However from the linear regression analysis, we could see that there is a practical negative relationship between the two variables.When orphans perceived social support increase by one point, there is .126 decrease on the orphans conduct disorder.

Table 12: Bivariate regression analysis for perceived social support prediction of conduct disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	31.561	7.797		4.048	.000	.012
	Perceived social support total	-.126	.112	-.110	-1.127	.262	

a. Dependent Variable: CD total

In the case of oppositionaldefiant disorder, the value of R^2 is 0.008, which explains that 0.8 % of change in perceived social support explains change in oppositional defiant disorder. The relationship is not statistically significant B=-.069,p>0.05.How ever, a negative relationship between the two variables is seen which is explained as an increase in perceived social support by one point decreases oppositional defiant disorder by.069.

Table 13: Bivariate regression analysis for perceived social support prediction of oppositional defiant disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	19.001	5.405		3.516	.001	.008
	Perceived socialsupporttotal	-.069	.078	-.087	-.887	.377	

Hypothesis 3, prevalence of behavioral disorder differ by length of stay in the orphanage.

This hypothesis is found to be statistically unsupported by the data in the case of attention deficit hyperactivity disorder because the relationship between the dependent and the independent variables is not significant as shown in the table below. The value of R^2 is 0.013 which shows that 1.3% of the change in attention deficit hyperactivity disorder is due to one year increase in length of stay in the orphanage.

Table 14: Bivariate regression analysis for length of stay prediction of attention deficit hyperactivity disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	27.696	5.412		5.117	.000	
	Length of stay in the orphanage	.637	.536	.116	1.187	.238	.013

a. Dependent Variable: AD total

The relationship between length of stay and conduct disorder is not significant which shows a p value >0.05.The value of R^2 is 0.023, which indicates that 2.3 % of the change in length of stay in the orphanage explains change in orphans conduct disorder. The result showed that conduct disorder increases by0.540 for every increasein length of stay in the orphanage.

Table15:Bivariate regression analysis for length of stay prediction of conduct disorder

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	17.880	3.520		5.079	.000
	Length of stay in the orphanage	.540	.349	.150	1.547	.125

a. Dependent variable: CD total

The relationship between length of stay and oppositional defiant disorder is not significant which shows a p value >0.05. The value of R2 is 0.11, which illustrates that 1.1% of the change in oppositional defiant disorder is explained by the change in length of stay in the orphanage. The result showed that oppositional defiant disorder increases by 0.263 for every increase in length of stay in the orphanage.The case of oppositional disorder is similar to the above results which shows non-significant relationship p>0.05 as shown in the above table. Therefore, all of the three results showed that the hypothesis is statistically unsupported by the data.

Table 16: Bivariate regression analysis for length of stay prediction of oppositional defiant disorder

Model		Unstandardized Coefficients		Standardized Coefficients			
		B	Std. Error	Beta	t	Sig.	R^2
1	(Constant)	11.831	2.448		4.832	.000	
	Length of stay in the orphanage	.263	.243	.106	1.086	.280	.011

CHAPTER FIVE

5. DISCUSSION

In this section of the study, the research findings are presented in relation to relevant findings of previous researches and litratures in the area. However, it should be noted that there is limited literature related to behavior disorder ,percieved social support and length of stay in the orphanage.

5.1 Major descriptive findings

A total of 106 children have participated in this study. During the sampling, it was possible to manage exactly as the planned sample size. The demographic data of the study revealed that the majority of the participants were male. During the sampling I had no control over the proportion of the sample in each gender for the study population. When age is taken in to consideration as one of the demographic characterstics to look at, all of the study population were selected based on their age which is between 12 and 18. The other variable, which was used as control variable was education level.Although it was assumed that education level is positively related to age it was not the case in this study because most of the children in the orphanages come from rular areas and start education late.

Factors influencing behavioral disorder

Among the main independent variables, respondents length of stay in the orphanages ranged from 1 year to 17 years.The other main independent variable which is percieved social support has three categories, which are low acuity, moderate acuity, and high acuity. 8 children are found to have a low score.40 children perception about their social support is found to be moderate while the rest 58 children perceive that they have a high social support.

5.2 Discussion of Biviriate and Multiple regression Findings

Prevalence of behavioral disorder

Acording to the finding of this study,Behavioral disorder is prevalent among orphans in selam and SOS children village. Pearson(2010), states that estimates of the prevalence of behavioural disorders vary tremendously, chiefly because of the lack of a clear and precise definitional construct and the best available research data indicate that 2 to 10 percent of school-age children exhibit serious and persistent behavioural problems.The result of this study shows 49% prevalence which is very high compared to Pearson's litrature.

Discussion in relation to the hypothesis

The first hypothesis was tested to see if any of the demographic factors (age, gender,and education level) is associated with behavioral disorder. Results show that all demographic factors except''gender□ did not significantly predict behavioral disorderstatstically($p>.05$).How ever the practical part of the result shows that increase in age also increases all types of disorders.Coming to education, It is founded that for every increase in grade level all types of behavioral disorder decreases.

The prediction of gender in conduct and oppositional defiant disorder is statsticaly and practicaly true while gender differenceis not significantly supported in attention deficit hyperactivity disorder.However, the result states that practicaly, males have high exposure to all types of behavioral disorder than females.This is comparable to Scott (2012), who states thatmales further exceed females in the frequency and severity of behaviors. On balance, research suggests that the causes of conduct problems are the same for both sexes, but males have more conduct disorder because they experience more of its individual-level risk factors (e.g., hyperactivity, neuro-developmental delays).

When we come to the second research question which asks whether prevalence of behavioral disorder is predicted by percived social support or not,the multiple regression result presented that the prediction is not significant statsticaly related to all the tree types of behavioral disorders.But practicaly,all types of behavioral disorders decrease when percieved social support increase. This is similar to the literature which states thatlow levels of social support are related to a variety of poor psychological, social, academic, and health-related outcomes for children. Converselyhigh levels of support is expected to mitigate the negative impact of psychosocial stress on mental, behavioral, and academic outcomes (White, 2009).

The last research question asks if behavioral disorder is predicted by length of stay in the orphanage.The result shows that there is no significant relationship between the two statsticaly. But it also showed that practicaly, all the types of behavioral disorders increase as one stays longer in the orphanage which is similar to the litrature by theUSA Orphanage Research Team(2012). This literature states thattime in the orphanage sometimes relates to the frequency and severity of longer term delays in physical growth, mental and academic performance, internalizing and externalizing behavior problems, social and peer relations, and inattention/ hyperactivity.

5.3 Discussion in relation to theoretical frame work

The principal attraction of the ecological perspective is the binding together of people and their environments. The ecological framework seeks to understand how and how well people adapt to the challenges of their natural, built (physical, human-made constructions), and social environments (Saleebey, 2001). In relation to this literature, I found out that other factors like being new to the environment and difficulty to adjust to the environment, losing a relative or a

sibling because of different factors, meeting parents or relatives for the first time affect the behavior of the children negatively.

According to Saleebey (2001).Environmental resources include informal and formal support systems— networks of friends and neighbors; schools; health, child welfare, disaster relief, and social service agencies; cultural and social institutions that comfort, guide, and provide respite or knowledge, churches or ethnic associations .Similarly, I found that attending church frequently affect the behavior of the children positively.

If the relationships in the immediate microsystem break down, the child will not have the tools to explore other parts of his environment.Children looking for the affirmations that should be present in the child/parent (or child/other important adult) relationship look for attention in inappropriate places. These deficiencies show themselves especially in adolescence as anti-social behavior, lack of self-discipline, and inability to provide self-direction (Berk, 2000). Similar to this literature it is practically found that the perception that the children has about their social relationship influences the behavior of the children.

CHAPTER SIX

6. SUMMARY, CONCLUSION, AND SOCIAL WORK IMPLICATION

6.1 Summary and Conclusion

The study was conducted with the objective of examining the prevalence of behavioral disorder and the relationship between behavioral disorder ,length of stay in the orphanage,and percieved social support.It was conducted in two orphanages namely; Selam children village and SOS children village.The former one is faith based orphanage while the later is not. Hence the study and its findings are delimited to these orphanages. To examine the basic questions of the study, standardized instruments were used. Data pertaining to percived social support and behavioral disorder were gathered through Multidimentional Scale of Perceived Social Support scale (MSPSS) and DBD respectively. Before the main data was collected, a pilot study was conducted on 10 students to test the reliability of the instruments. Based on the pilot study and feedbacks, the main data was collected. Finally, the questionnaire were administered on 106 children.

The data was analyzed using a series of statistical tools, mainly independent t-test, simple and multiple regression analysis. The major findings of the study were summarized below:

1. Behavioral disorder is prevalent among orphan children in selam and SOS children village.
2. There is no significant relationship statistically between demographic factors (except for gender) and behavioral disorder. However, practically, age increase results in an increased chance of behavioral disorder. There is a significant variation between male and female in conduct and oppositional defiant disorder but not in Attention Deficit Hyperactivity disorder.
3. Perceived social support do not significantly predict behavioral disorder statistically but practically an increase in perceived social support reduces all types of behavioral disorder.

4. Length of stay in the orphanage is not a significant factor in determining the behavioral disorder of the children statistically. But practically increase in the length of stay in the orphanage increases the chance of all the types of behavioral disorders.

Social work implication

Social work is an empowering profession that facilitates positive change for individuals, groups, family, and communities. It is also true that social work practice is devoted to such underlying principles as social change, social justice, and equality ofopportunity for the vulnerable and marginalized segments of the society. If change is to comefrom below at the community level, empowering, and protecting children especially the vulnerable is very important.

This knowledge is important for the profession of social work because it will create more effective social work education, research, practice, and policy in addressing barriers that orphans face.

6.2 Implication to Social Work Education

Education for developing countries like Ethiopia is the first important tool of achieving accelerated development for the wellbeing of people. The curriculum should be designed in the context of the country and should be relevant to the development of the country. In spite of the large population proportion of children in Ethiopia, little is known about the condition of children especialy that of orphans and this has to be incorporated in social work curriculum because the profession need to contribute in making fruitfull generation. social workers should have knowledge informed practice.Therefore the findings of this research will be helpfull in equiping the teaching process with fresh information.

6.3 Implication to Social Work Practice

In the context of this research on provision of care and support to orphan and vulnerable children, social workers can do several things. Social workers can facilitate, plan and follow up intervention on behavioral disorder. This research will facilitate this by providing a way of assessing behavioral disorder as well as treatments for it. Social workers, parents, teachers and other significant people in the orphanages has to work together to know more about the factors presented in this research and bring a change in the behavior of the children.

6.4 Implication to Social Work Research

One of the contributions of this study, from the research point of view, is the adoption of Disruptive Behavioral rating scale into Amharic version and made ready for further researchers who need to conduct more extensive study.This research also points out research gaps that should be adressed by researchers.

6.5 Implication to Social Work Policy

The government of Ethiopia has formulated policies and, signed major declarations, and conventions like UNCRC to protect children from any unfriendly family environment or any other situation. However, the finding of this research explicates the prevalence of behavioral disorder in the research population and the exposure of males to this problem is more than females. Therefore, government has to work on policies that ensure positive behavior and mental health of orphanage children especially males. This research will inform the situation of the children to social workers and other professionals so that they will advocate for a policy that reduces institutionalization of the children effectively.

6.6 Implication to mental health

This research will provide the mental health education and practice with fresh and additional information on behavioral disorder. The finding of this study showed that behavioral disorder is prevalent among orphans in the two orphanages. Other literatures also showed similar results on orphanages which points out that in the field of mental health something has to be done on mental health policy, practice and research related to orphanages.

6.7 Limitation of the Study

The study has one main limitation. In terms of measurement, parent and teacher, behavioral disorder rating which does not participate the children is used. It would have been better if done using child behavioral checklist, which consist items filled by parents, teachers, and children themselves but it would be difficult to collect data and to analyze because the scale has 113 items that is so long to fill and interpret.

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Annex 1

Informed consent

My name is Abenezer Assefa. I am a Masters student at school of social work, Addis Ababa University. I am doing a research to fulfill my study of social work on Prevalence of Behavioral Disorders among the Orphans and Factors Associated with these Disorders. So, based on the permission I got from Addis Ababa University School of Social Work, I am kindly requesting you to permit the children of this orphanage to share their perception about social support that they have with me.

I would like to ask your consentto participate voluntarily in this study as the teacher and families of the children . My special interest is on learning what is the prevalence of behavioral disorder among orphan children and what is the relationship among age difference, gender difference, educational level and extent of stay in the orphanage on prevalence of behavioral disorder of orphan and vulnerable children.During the process of this study, I would like to assure you that your identity as well as identity of the children would not be disclosed to anyone. I will make sure that your privacy and confidentiality are secured. By participating in this study, you will contribute to the success of my study and the enhancement of knowledge about orphan children. Apart from the time you spend with me, there is no risk that you will under go by participating in this study. Participating in this study will only depend on your decision. You have the right to answer a question as well as skip it if you don't feel comfortable talking about it. you can also withdraw at any time if you are not interested to continue. You can ask for clarification if you didn't understand the questions. Thank you so much for your agreement on participating in the study. I would like you to verify your agreement by signing on the prepared space. _____

Annex 2

SOCIODEMOGRAPHIC QUESTIONNAIRE

To be filled by parents (caregivers)

Datecompleted: _____

Your Name: _____

Relationship to child: _____

Child's Name: _____

Child's age: _____

Gender: Male ☐ Female ☐

Current Grade and section: _____

Length of stay in the orphanage _____

Annex 3

PARENT / TEACHER DBD RATING SCALE

Name of the child _____

Check the column that best describes your/this child. **Please write DK next to any items for which you don't know the answer.**

	Not at All	Just a Little	Pretty Much	Very Much
1.often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or oncewithout returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking andentering; forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for thepurpose of thrill-seeking), e.g., runs into street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms inseat				

13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in theneighborhood)				
21. often shifts from one uncompleted activity to another				
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
24. is often angry and resentful				
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace(not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				

29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				
34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, maybe limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such asschoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42.often has difficulty organizing tasks &activities				
43.has broken into someone else's house, building,or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife,gun)				

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716-829-2244

SCORING INSTRUCTIONS FOR THE DISRUPTIVE BEHAVIOUR DISORDERER RATING SCALE

There are two ways to determine if a child meets the criteria for DSM IV diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, or Conduct Disorder. The first method involves counting symptoms for each disorder using the Disruptive Behavior Disorders (DBD) rating method is preferable for diagnosis of females (e.g., using a 2 SD cutoff), as the symptom counting method often results in under diagnosis of females children. Please note that items 10, 14, and 21 are from DSM-III –R and are not included in the scoring for a DSM-III-R and are not included in the scoring for a DSM-IV diagnosis.

Method 1: Counting Symptoms

To determine if a child meets the symptom criteria for DSM IV diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, or Conduct Disorder as measured by the DBD parent/Teacher Rating Scale, count the number of symptoms that are endorsed "pretty much" or "very much" by either parent or teacher in each of the following categories: Note that impairment and other criteria must be evaluated in addition to symptom counts.

Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder - Inattention Symptoms

(items 9, 18, 23, 27, 29, 34, 37, 42, 44)6 or more items must be endorsed as "pretty much" or "very much" to meet criteria for **Attention-Deficit/Hyperactivity Disorder, Predominantly**

Inattentive Type. The six items may be endorsed on the teacher DBD, the parent DBD, or can be a combination of items from both rating scales

(e.g., 4 symptoms endorsed on the teacher DBD and 2 separate symptoms endorsed on the parent DBD). The same symptom should **not** becounted twice if it appears on both versions (parent and teacher) of the rating scale.

Attention-Deficit/Hyperactivity Disorder - Hyperactivity/impulsivity Symptoms

(items 1, 7, 12, 19, 22, 25, 30, 33, 35)6 or more items must be endorsed as "pretty much" or "very much" on the parent and/or the teacher DBD to meet criteria for **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type**

If 6 or more items are endorsed for Attention-Deficit/Hyperactivity Disorder - inattention **and** 6 or more items are endorsed for Attention-

Deficit/Hyperactivity Disorder - hyperactivity/impulsivity, then criteria is met for **Attention-Deficit/Hyperactivity Disorder, Combined Type**

Some impairment from the symptoms must be present in two or more settings (e.g., school, home)

Oppositional Defiant Disorder

Oppositional Defiant Disorder (items 3, 13, 15, 17, 24, 26, 28, 39)

A total of 4 or more items must be endorsed as "pretty much" or "very much" on either the parent or the teacher DBD to meet criteria for**Oppositional Defiant Disorder**

Conduct Disorder

Conduct Disorder - aggression to people and animals (items 6, 20, 31, 32, 36, 40, 45)

Conduct Disorder - destruction of property (items 16, 41)

Conduct Disorder - deceitfulness or theft (items 4, 8, 43)

Conduct Disorder - serious violation of rules (items 2, 11, 38)

A total of 3 or more items in any category or any combination of categories must be endorsed as "pretty much" or "very much" on either the parent or

the teacher DBD to meet criteria for **Conduct Disorder**

Method 2: Using Factor Scores

Factor scores for the two ADHD and ODD dimensions for teacher ratings on the DBD are reported in Pelham, et al (1992), Teacher ratings of DSMIII-R symptoms for the disruptive behavior disorders: Journal of the American Academy of Child and Adolescent Psychiatry, 31, 210-218. The factorscores for DSM IV factors are the same as for the DSM III-R factors reported in that paper. To determine how a child's scores compare to normativedata, compute the average rating for the items from each factor (listed below) using the following scoring: Not at all = 0, Just a little = 1, Pretty Much= 2, Very much = 3. Then, using the information from the attached table of norms, determine where the child falls in relation to other children. Avariety of cutoff scores can be used (e.g., 2 standard deviations above the mean).

Factors:

Oppositional/Defiant (items 3, 13, 15, 17, 24, 26, 28, 39)

Inattention (items 9, 18, 23, 27, 29, 34, 37, 42, 44)

Impulsivity/Over activity (items 1, 7, 12, 19, 22, 25, 30, 33, 35)

Annex 4

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**

Circle the "2" if you **Strongly Disagree**

Circle the "3" if you **Mildly Disagree**

Circle the "4" if you are **Neutral**

Circle the "5" if you **Mildly Agree**

Circle the "6" if you **Strongly Agree**

Circle the "7" if you **Very Strongly Agree**

	Very strongly disagree 1	Strongly disagree 2	Mildly disagree 3	neutral 4	Mildly agree 5	Strongly agree 6	Very strongly agree 7
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7

5. I have a special person who is a real source of comfort to me. 1 2 3 4 5 6 7

6. My friends really try to help me. 1 2 3 4 5 6 7

7. I can count on my friends when things go wrong. 1 2 3 4 5 6 7

8. I can talk about my problems with my family. 1 2 3 4 5 6 7

9. I have friends with whom I can share my joys and sorrows. 1 2 3 4 5 6 7

10. There is a special person in my life who cares about my feelings. 1 2 3 4 5 6 7

11. My family is willing to help me make decisions. 1 2 3 4 5 6 7

12. I can talk about my problems with my friends. 1 2 3 4 5 6 7

Scale Reference:

Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support.*Journal of Personality Assessment* 1988;52:30-41.

Scoring Information:

To calculate mean scores:

Significant Other Subscale: Sum across items 1, 2, 5, & 10, then divide by 4.

Family Subscale: Sum across items 3, 4, 8, & 11, then divide by 4.

Friends Subscale: Sum across items 6, 7, 9, & 12, then divide by 4.

Total Scale: Sum across all 12 items, then divide by 12.

Other MSPSS Scoring Options:

If you want to divide your respondents into groups on the basis of MSPSS scores there are at least two ways you can approach this process:

1. You can divide your respondents into 3 equal groups on the basis of their scores (trichotomize) and designate the lowest group as low perceived support, the middle group as medium support, and the high group as high support. This approach ensures that you have about the same number of respondents in each group. But, if the distribution of scores is skewed, your low support group, for example, may include respondents who report moderate or even relatively high levels of support.

2. Alternatively, you can use the scale response descriptors as a guide. In this approach any mean scale score ranging from 1 to 2.9 could be considered low support; a score of 3 to 5 could be considered moderate support; a score from 5.1 to 7 could be considered high support. This approach would seem to have more validity, but if you have very few respondents in any of the groups, it could be problematic

Annex 5

እኔ አቤንኤዘር አሰፋ እባላለሁ። በአዲስ አበባ ዩኒቨርሲቲ የሶሻል ወርክ ትምህርት ቤት የድህረ ምረቃ ተማሪ ነኝ። በዚህወቅትመመረቂያይሆነኝዘንድ ጥናቴን የባህሪ ችግር በወላጅ አልባ ልጆች እና በችግሩ ላይ ተፅእኖ የሚያመጡ ሁኔታዎች ላይ ነው የምሰራው። በመሆኑም ጥናቱን ለማካሄድ ከአዲስ አበባ ዩኒቨርስቲ የሶሻል ወርክ ትምህርት ቤት ባገኘሁት ፈቃድ መሠረት በዚህ ማሳደጊያ የሚኖሩ ልጆችበጥናቱእንዲሳተፉ እናበማህበራዊ ድጋፍ ዙሪያ ያላቸውንሀሳቦች የካፍሉኝ ዘንድ ፈቃድእንዲሰጠኝበትህትናእጠይቃለሁ።የልጆቹ አስተማሪ እና ቤተሰብ እንደመሆንዎ መጠን በጥናቱ ላይ በፍቃደኝነት ለመሳተፍ እንደሚስማሙ ለመጠየቅ እወዳለሁ። ልዩ ፍላጎቱ የባህሪ ችግር በማሳደጊያው በሚኖሩ ወላጅ አልባ ልጆች ላይ መታየቱን ለማወቅ እንዲሁም በ እድሜ ልዩነት፣ፆታ ልዩነት፣ የትምህርት ደረጃ ፣በማሳደጊያው የቆዩበት ጊዜ እና በባህሪ ችግር መካከል ያለውን ግንኙነት ለማወቅ ነው። በዚህ ጥናት ሂደት ውስጥ የተሳታፊዎች ማንነት ለማንም እንደማይገለፅ ለማረጋገጥ እወዳለሁ። የተሳታፊዎች የግል ሚስጥር የተጠበቀ እንደሚሆን ለማረጋገጥ እወዳለሁ። በዚህ ጥናት በመሳተፍ ለጥናቴ ስኬታማነት እና የእውቀት መሳልበት አስተዋፆ ያበረክታሉ። ከኔ ጋር ከምታሳልፉት ጊዜ በስተቀር በዚህ ጥናት በመሳተፍዎ የሚገጥምዎ ችግር የለም። በዚህ ጥናት መሳተፍዎ የሚወሰነው በውሳኔዎ ብቻ ነው። ጥያቄውን የመመለስ እንዲሁም ለመመለስ መቾት ካልተሰማዎ የመዝለል መብት አለዎት። በማንኛውም ጊዜ ጥናቱን መቀጠል ካልፈለጉ መቋረጥ ይችላሉ። ጥያቄዎቹ ካልገባዎት ማብራሪያ መጠየቅ ይችላሉ። በጥናቱ ለመሳተፍ በመስማማትዎ በጣም አመሰግናለሁ። ስምምነትዎን በተዘጋጀው ቦታ ላይ በመፈረም እንዲያረጋግጡልኝ እጠይቃለሁ።

ስነምህዳራዊ መጠይቅ

በወላጆች ወይም አሳዳጊዎች የሚሞላ

መመሪያ፡- የሚከተሉትን ግላዊ እና ቤተሰባዊ ይዘት ያላቸውን ጥያቄዎች በተሰጠው ክፍት ቦታ ላይ ፃፍ

1. የተሞላበት ቀን ፡ _____
2. ስም፡ _____
3. ከልጁ ጋር ያለህ/ያለሽ ግንኙነት፡ _____
4. የልጁ ስም፡ _____
5. የልጁ እድሜ፡ _____
6. ፆታ፡ ወንድ☐ ሴት☐
7. የክፍል ደረጃ እና ሴክሽን፡ _____
8. ልጁ/ልጅ፡ት በማሳደጊያው የቆየበት/የቆየችበት ጊዜ፡ _____

የወላጅ/መምህር ዲቢዲ መለኪያ

የልጅ ስም _____

ልጅዎትን በሚገባ የሚገልፀው አምድ ላይ ምልክት ያድርጉ፡፡ እባክዎ መልሱን ለማያውቁት ጥያቄ ዲኬ ብለው ይፃፉ

	በፍፁም	በጥቂቱ	በጣም ብዙ ጊዜ	እጅግ በጣም ብዙ ጊዜ
1.ብዙ ጊዜ ሌሎች አንድ ነገር ሲያደርጉ ጣልቃ ይገባል(ለምሳሌ በውይይቶች ወይም ጌሞች ጣልቃ መግባት)				
2.ከወላጁ ወይም ባለ አደራ አሳዳጊዎች ቤት ውስጥ እያለ ቢያንስ ሁለት ጊዜ ከቤት ወጥቶ አድሯል፡፡(ወይም ለአንድ ጊዜ ለረጅም ጊዜ ወደ ቤት ሳይመለስ ቆይቷል፡፡)				
3.ብዙ ጊዜ ከአዋቂዎች ጋር ይከራከራል፡፡				
4. ብዙ ጊዜ ሰዎች የሆነ ነገር ወይም መልካም ነገር እንዲያደርጉለት ወይም ከሃላፊነት ለመሸሽ ይዋሻል(ሌሎችን ያጭበረብራል)				
5.ከቤተሰቡ አባላትጋር ዘወትር ድብድብ ያነሳሳል፡፡				
6.የሰዎች አካል ላይ ጉዳት ያደርሳል፡፡				
7.ዘወትር ከመጠን በላይ ያወራል፡፡				
8.እቃዎች ይሰርቃል(ከቤተሰቡ፣ ከሌሎች ሰዎች፣ ከድርጅቱ)				
9.ዘወትር በውጪ ምክንያቶች በቀላሉ ትኩረቱን ያጣል፡፡				
10.ዘወትር የሚደርሱበትን አሉታዊ ውጤቶች ሳያጤን ለአካል አደገኛ በሆኑ ተግባራት ይሳተፋል፡፡(ደስታ ለማግ ኘት አላማ አይደለም፡፡)ለምሳሌ ሳይመለከት ወደ መንገድ ዘሎ መግባት፡፡				

11.ከ13 ዓመቱ ጀምሮ ዘወትር ከትምህርት ቤት ይጠፋል፡፡				
12. ዘወትር እጆቹን ወይም እግሮቹን ያወራጫል ወይም በተቀመጠበት ይቁነጠነጣል፡፡				
13.ዘወትር አናዳጅነት እና ክፋት ያሳያል፡፡				
14. ዘወትር ነውረኛ ቋንቋዎችን ይጠቀማል፡፡				
15. ዘወትር ለሚሰራቸው ስህተቶች እና ለሚያሳያቸው የባህሪ ችግሮች ሌሎችን ይኮንናል፡፡				
16. የሌሎች ንብረት ላይ እያወቀ ጥፋት ያደርሳል(የእሳት አደጋ ከማድረስ ሌላ)				
17. የአዋቂዎችን ጥያቄዎች ወይም ህጎች ዘወትር አይቀበልም ወይም ለመታዘዝ ፈቃደኛ አይደለም፡፡				
18. ዘወትር በቀጥታ ሲነገረው የሚሰማ አይመስልም፡፡				
19. ዘወትር ጥያቄዎች ተጠይቀው ሳያልቁ እርሱ መልሱን በጩኸት ይናገራል፡፡				
20. በቤተሰቡ ውስጥ ከማይኖሩ ሰዎች ጋር ዘወትር ድብድብ ያነሳሳል፡፡(ለምሳሌ በትምህርት ቤት ወይም በሰፈር ካሉ ጓደኞቹ)				
21. ዘወትር አንድ ስራ ሳያጠናቅቅ ሌላ ስራ ይጀምራል፡፡				
22. ዘወትር በመዝናናት ወቅት ፀጥ ብሎ መጫወትወይም መሳተፍ ይከብደዋል፡፡				
23.ዘወትር በትምህርት ስራዎች፣በስራ ወይም በሌላ ተግባራት ለዝርዝሮች በቅርበት ትኩረት አይሰጥም ወይም ግዴለሽ ጥፋቶችን ያጠፋል፡፡				
24.ዘወትር ቁጡና ቅር የሚያሰኝ ነው፡፡				
25. ዘወትር ቁጭ ማለት ከሚጠበቅበት ክፍል ወይም ሌሎች ቦታዎች ወንበሩን ለቆ ይሄዳል፡፡				

26. ዘወትር በቀላሉ ስሜቱ የሚነካ እና በሌሎች የሚናደድ ነው፡፡				
27. ዘወትር መመሪያዎችን አይከተልም፡፡የትምህርት ቤት ስራዎችን ፣የቤት ውስጥ ስራዎችን እና የስራ ቦታ ተግባራትን ለማጠናቀቅ አይችልም፡፡				
28. ዘወትር ተናዳጅ ነው፡፡				
29. ዘወትር በስራዎች ወይም በጨዋታ ተግባራት ትኩረት ለመስጠት ችግር አለበት፡፡				
30. ዘወትር ተራ ለመጠበቅ ችግር አለበት፡፡				
3ነ.ሌላ ሰውን ለወሲባዊ ተግባር አስገድዷል፡፡				
32.ዘወትር ይበጠብጣል፣ያስፈራራል፣ይዝታል፡፡				
33. ሁልጊዜ ለነገሮች ይፈጥናል ወይም "በሞተር እንደሚነዳ" ይመስላል፡፡				
34. ዘወትር ለስራ ወይም ለተግባራት አስፈላጊ የሆኑ ነገሮችን ያጣል/ያጠፋል፡(፡ለምሳሌ አሻንጉሊቶችን፣የትምህርት ቤት የቤት ስራ፣እስራስ፣መፅሐፍ ወይም መገልገያዎች)				
35. ተገቢ ባልሆኑ ቦታዎች ዘወትር ይሮጣል ወይም ከመጠን በላይ ይንጠላጠላል፡፡(በጎረምሶች ወይም አዋቂዎች ላይ ሊሆን ይችላል፡፡ይህ በግል እረፍት የለሽነት የተወሰነ ሊሆን ይችላል፡፡)				
36.የእንሰሳት አካል ላይ አሰቃቂ ጉዳት አድርሷል፡፡				
37. ዘወትር የአእምሮ ጥረትን የሚጠይቁ ተግባራትን ያስወግዳል፣ይጠላል፣ወይም ለመስራት ያቅማማል(ለምሳሌ የትምህርት ቤት ስራ ወይም የቤት ስራ)				
38. ከ13 ዓመቱ ጀምሮ ዘወትር ማታ ማታ ወላጆቹ ቢከለክሉትም ያመሻል፡፡				
39. ዘወትር አውቆ ሌሎችን ያበሳጫል፡፡				
40. ተሰራቂው እያየ ስርቆት ይፈፅማል(ከልጆች የተለያዩ ነገሮችን ይቀማል)				
4ነ. አውቆ ትልቅ ጉዳት ለማስከተል እሳት ይለኩሳል፡፡				

42. ዘወትር ስራዎችን እና ተግባራትን ለማደራጀት ችግር አለበት፡፡				
43. የሰው ቤት፣ህንፃ ወይም መኪና ውስጥ ሰብሮ ገብቷል፡፡				
44. ዘወትር የዕለት ተግባራቱን ይረሳል፡፡				
45. በሌሎች ላይ ከባድ አካላዊ ጉዳት የሚያደርስ መሳሪያን ተጠቅሟል(የእንጨት ቁራጭ፣ጡብ፣የተሰበረ ጠርሙስ፣ቢላዋ፣ሽጉጥ)				

የማህበራዊ ድጋፍ እይታ ጥናት

መመሪያዎች፡- እኛስለሚከተሉት ዓረፍተ ነገሮች ምን እንደሚሰማዎ ለማወቅ እንፈልጋለን፡፡እያንዳንዱን አረፍተ ነገር በጥንቃቄ ካነበቡ በኋላ የሚሰማዎትን ከምርጫዎቹ ይምረጡ፡፡

እጅግ በጣም አልስማማም 1	በጣም አልስማማም 2	በመጠኑ አልስማማም 3	ገለልተኛ 4	በመጠኑ እስማማለሁ 5	በጣም እስማማለሁ 6	እጅግ በጣም እስማማለሁ 7

1.በሚቸግረኝ ግዜ በቅርቤ የሚገኝ ልዩ ሰው አለ፡፡	1	2	3	4	5	6	7
2.ደስታዬን እና ሀዘኔን የማካፍለው ልዩ ሰው አለ፡፡	1	2	3	4	5	6	7
3.ቤተሰቦቼ የምር እኔን ለመርዳት ይሞክራሉ፡፡	1	2	3	4	5	6	7
4.የሚያስፈልገኝን ስሜታዊ እርዳታ እና ድጋፍ ከቤተሰቦቼ አገኛለሁ፡፡	1	2	3	4	5	6	7
5.ለእኔ ትክክለኛ መፅናናት እውነተኛ ምንጭ የሆነ ልዩ ሰው አለኝ፡፡	1	2	3	4	5	6	7
6.ጓደኞቼ የእውነት እኔን ለመርዳት ይጥራሉ፡፡	1	2	3	4	5	6	7
7.ነገሮች ሲበላሹ በጓደኞቼ እተማመናለሁ፡፡	1	2	3	4	5	6	7
8.ስለ ችግሮቼ ከቤተሰቦቼ ጋር መነጋገር እችላለሁ፡፡	1	2	3	4	5	6	7
9.ደስታና ሀዘኔን የማካፍላቸው ጓደኞች አሉኝ፡፡	1	2	3	4	5	6	7
10.በህይወቴ ስለ እኔ ስሜቶች ግድ የሚለው አንድ ልዩ ሰው አለኝ፡፡	1	2	3	4	5	6	7
11.ቤተሰቦቼ ውሳኔ ስወስን ለመርዳት ፈቃደኛ ናቸው፡፡	1	2	3	4	5	6	7
12.ስለ ችግሮቼ ከጓደኞቼ ጋር ማውራት እችላለሁ፡፡	1	2	3	4	5	6	7

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university, and that all sources of material used for this thesis have been acknowledged.

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