Health Transition Review, Supplement to Volume 7, 1997, 105-124

The psychological effect of orphanhood: a study of orphans in Rakai district *

James Sengendo and Janet Nambi

Faculty of Social Sciences, Makerere University, P.O. Box 7062, Kampala

Abstract

This paper examines the psychological effect of orphanhood in a case study of 193 children in Rakai district of Uganda. Studies on orphaned children have not examined the psychological impact. Adopting parents and schools have not provided the emotional support these children often need. Most adopting parents lack information on the problem and are therefore unable to offer emotional support; and school teachers do not know how to identify psychological and social problems and consequently fail to offer individual and group attention.

The concept of the locus of control is used to show the relationship between the environment and individuals' assessment of their ability to deal with it and to adjust behaviour. Most orphans risk powerful cumulative and often negative effects as a result of parents' death, thus becoming vulnerable and predisposed to physical and psychological risks.

The children were capable of distinguishing between their quality of life when their parents were alive and well, when they became sick, and when they eventually died. Most children lost hope when it became clear that their parents were sick, they also felt sad and helpless. When they were adopted, many of them felt angry and depressed. Children living with widowed fathers and those living on their own were significantly more depressed. These children were also more externally oriented than those who lived with their widowed mothers.

Teachers need to be retrained in diagnosing psycho-social problems and given skills to deal with them. Short courses should be organized for guardians and community development workers in problem identification and counselling.

Uganda is now faced with a huge problem of orphans resulting from the recent wars and AIDS; according to the 1991 census, there are one and a half million orphans. Death from AIDS and war robs many children of both parents; in the past, orphans were left with a surviving parent with whom they grew up, but the death of both parents in contemporary times leaves such orphans in the hands of aged grandparents or other relatives or simply on their own.

* An earlier version of this paper was written for World Vision, Kampala, which provided financial support for the research, and to which we wish to express our gratitude.

The term 'orphan' in Uganda is used to refer to a child who has lost either one or both parents. The death of both parents is usually the result of AIDS and consequently these orphans are most concentrated in areas most hit by AIDS, such as Rakai district. Once a child

loses a parent or both parents, such a child may be adopted by relatives from either of the parents' families. In most cases adopting parents live in different environments with which a child may not have been familiar. There are almost always associated physical and psychological problems: for example, the orphan may experience poverty for the first time.

Adopted orphans

Adopting families often have problems of their own, such as their own large families to care for, and therefore, severe economic strains. Hunter (1990) observed that sometimes the adopting parents are too young or too old to properly care for additional children. UNICEF (1990) noted pathetic situations, where grandparents who expected to be supported by their children suddenly had to care for their orphaned grandchildren. These grandparents were found to be less able to provide discipline and adequate socialization, and even to address the basic needs for food, clothing , shelter and health care (Hunter 1990). Bledsoe (1989) also observed that adopted or fostered children often receive worse treatment than the biological children in the same family. Nalwanga-Sebina and Sengendo (1987) found that the education, nutrition and health status of children adopted into impoverished families suffered from lack of resources necessary for their basic needs.

All these studies point out the disadvantages of the orphaned children, disadvantages to which there has been a response by some agencies such as UNICEF, World Vision and Save the Children Fund (UK), which have devised special intervention programs to enable children to cope with orphanhood. Many of the programs have assisted orphans with relief supplies such as food, clothing and bedding. Several agencies have school sponsorship programs through which many children, who otherwise would have been out of school, are receiving formal education as well as vocational training.

Emotional problems among orphans

However, in spite of these efforts, many of the orphaned children continue to experience emotional problems and little is being done in this area of emotional support. There are several reasons. First, there is a lack of adequate information on the nature and magnitude of the problem; secondly, there is a cultural belief that children do not have emotional problems and therefore there is a lack of attention from adults. Thirdly, since psychological problems are not always obvious, many adults in charge of orphans are not able to identify them. However, even where the problem may have been identified, there is a lack of knowledge of how to handle it appropriately. In many cases children are punished for showing their negative emotions, thereby adding to their pain. In schools, there is an obvious lack of appropriate training of teachers in identifying psychological and social problems and therefore offering individual or group attention. In recognition of these problems World Vision initiated and sponsored this study to investigate the nature and extent of emotional problems among its school sponsored orphans in Rakai district.

The problem as seen by the child psychologist

Children and bereavement

Like adults, children are grieved by the loss of their parents. However, unlike adults children often do not feel the full impact of the loss simply because they may not immediately understand the finality of death. This prevents them from going through the grieving process which is necessary to recover from the loss (Brodzinsky, Gormly and Ambron 1986). Children

therefore are at risk of growing up with unresolved negative emotions which are often expressed with anger and depression. Adults may also experience negative emotions in times of bereavement, but, unlike children, adults have the intellectual ability, life experience and emotional support that enables them to control their anger and depression (Brodzinsky et al. 1986).

Unfortunately, adults do not seem to appreciate that children are also adversely affected by bereavement even though they may not have an adult's understanding of death. Little attention is therefore given to children's emotions. Children are not given the required support and encouragement to express their emotions nor are they guided to deal with them. For example, children are not always talked to, nor listened to, and therefore their emotions are not understood. When they have no appetite for food or when they have no strength for house chores, or lack the strength to attend school, or when they become inattentive in class, they are simply punished.

Children and social change

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

It is feared that many children may find it difficult to adapt to the new changes. Minde (1988) makes it clear that it is not the social change itself that may cause psychological problems, rather it is the failure of the individual to adapt to social change. Like bereavement, social change and the resultant need to adapt to it create stress. According to Minde (1988), this stress may be shown in symptoms of confusion, anxiety, depression, and behavioural disorders such as disobedience. The same symptoms may cause learning problems. Children who are frustrated, fearful, and depressed may fail to concentrate in class and therefore perform badly. Failure by the school and the home systems to recognize these symptoms and address them will aggravate the child's psychological problems.

Adverse circumstances and locus of control

The concept of 'locus of control' refers to the relationship between the environment and the individual's assessment of his or her ability to deal with it and to adjust behaviour accordingly. Locus of control has two dimensions: the external and internal. The external locus of control assumes that a person's life is controlled by external factors, such as luck, fate and nature. Externally oriented individuals ('externals') do not see themselves as responsible for what happens to their lives but merely accept what happens. From this perspective, a person is helpless and is at the mercy of the environment.

The internal locus of control assumes the ability to predict environmental events and be able to respond appropriately. Internally oriented individuals ('internals') feel they have the ability to control events and the resultant behaviour. Therefore, they are in control of their own fate. 'It is this perception of the ability "to do something" that gives rise to the concept of perceived control' (Lefcourt 1976:5).

Locus of control in relation to orphans

As noted above, most orphans are at risk of being confronted by powerful cumulative and often negative social changes in their lives over which they have no personal control. Experiences in continuously adverse circumstances do not make life appear to be subject to control through one's own efforts (Lefcourt 1976). Perceived lack of control produces a feeling of helplessness and loss of hope, and diminishes an individual's will power (Richter 1959; Overmier and Seligman 1967; Lefcourt 1976).

Death of parents makes children vulnerable and predisposes them to physical and psychological risks over which they have no control. The feeling of helplessness is very costly in terms of psychological well-being and may be reflected in lack of concern, involvement and vitality in social and school activities. Emotionally, it is indicated by sadness and depression.

The effects of death and bereavement are not always negative. Positive effects are possible as when a child moves from a poor family to an economically better-off one. Children who are fostered may be motivated to use all their power to prove their worth to their new families and to win their support. Children who are forced to live on their own may behave more responsibly and more maturely out of the sheer need to survive.

Locus of control, adjustment and depression

Locus of control is important for effective coping behaviour in the case of stress. When faced with stress, internals tend to adopt a problem-solving strategy while the externals tend to react emotionally, for example by being angry (Sarason and Sarason 1989:441). Consequently, internals are able to leave their disappointments behind them and live happily.

Externals, on the other hand, continue to carry their burdens into their future and hence are often depressed. Our theoretical expectation is that depression is positively correlated with external locus of control and negatively correlated with internal locus of control. This means that those who scored high on the depression scale also scored high on the locus of control scale. Likewise, those who scored low on depression, also scored low on the locus of control scale.

Psychological well-being (mental health)

According to Warr (1987), mental health has five major components: affective well-being (happiness), competence, internal locus of control, aspiration and integrated functioning or adjustment. These five components are interrelated. Therefore, internal locus of control should positively correlate with adjustment; children who feel in control of their environment would potentially have a better capacity to adjust. Similarly, adjustment should negatively correlate with depression: children who experience increased adjustment to their environment would concomitantly be less depressed.

Methods used in the study

Several methods of investigation were used for this study.

Documentary review

Given the complexity of the subject matter, we found it useful to make a thorough literature search in order to develop a relevant conceptual framework. Thus we benefited from academic articles, professional reports and other forms of literature which have been written for similar situations.

Sampling

Purposive sampling was used in this investigation. In theory, our study population was composed of all AIDS-orphaned children in Rakai district, but, given the interests of the sponsors of this study, and the resources available, the population was reduced to those orphans (6-20 years) under the education sponsorship of World Vision. A combination of purposive sampling techniques was used to identify specific categories of orphaned children sponsored by this organization. Having identified categories with the help of the Parish Community Development Workers, we used a simple random sampling technique to select the orphans from the five main categories as indicated in Table 1. In addition, 24 children from intact families were selected for comparative purposes.

Table 1
Categories of children covered by the study

	N	%
Orphans living with fathers only	14	7.3
Orphans living with mothers only	39	20.2
Orphans living with grandparents	44	22.8
Orphans living with other relatives	23	11.9
Orphans living on their own (child-headed families)	49	25.3
Children in intact families	24	12.4
Total	193	99.9

We interviewed each of these children in depth, using an interview guide. In addition, we interviewed guardians where possible, and teachers in order to assess school performance and link it with the observations from the home situation.

Focus-group discussions were held with teachers, some orphans and Parish Counselling and Development Committee members. In-depth discussions were held on the emotions and behaviour of the orphaned children and the precipitating factors for such behaviour.

Depression scales

Depression scales were designed to measure the different levels of depression a child could have had: 25 questions were designed for this purpose (see Appendix). During the analysis, the individual scores were added and the mean score was calculated from the data. Evidence shows that 49.2 per cent of the children were depressed and 50.8 per cent were not depressed. Younger children who were too depressed to respond to the questionnaire were asked to draw pictures of their choice.

Data analysis

Data analysis consisted of several stages. First data were coded for purposes of facilitating computer entries; frequency distribution of key variables was calculated, followed by correlation analysis of variables relevant to this study.

A T-test was carried out for the purpose of establishing whether there was any statistical difference in means among selected pairs of categories of children. Initially, a Statistical (null) Hypothesis to be tested was stated as:

> Ho: All means are the same i.e. there is no difference between the means of different groups of orphans.

Against this null hypothesis, an alternative hypothesis was developed, namely:

Ha: Not all means among groups of orphans are the same.

SPSSpc+ was used to compute and test for difference in variances and means of selected pairs of independent categories. For the test on means, the value of test statistics and the p-value were provided.

Locus of control

The theoretical justification for using the concept of locus of control in this study has been given in the earlier part of this paper. Twenty questions were developed and asked of children. These questions were based on the Nowicki-Strickland model (1973) in which a scale of 40 questions was developed to assess the locus of control. Lefcourt describes the Scale as 'a paper and pencil measure, consisting of 40 questions which are answered either yes or no by placing a mark next to the question. The higher the score the more external the orientation' (Lefcourt 1976:169).

Emotional changes in children resulting from changing family circumstances

Children's feelings when parents were alive and well

In order to assess the emotional change in children after their parents had died, we found it necessary to inquire about the feelings and thoughts of these children when their parents were alive. Most orphans reported that they used to feel nice, happy and relaxed. Of those who could remember, 79 per cent said they were happy because they were going to school and 21 per cent because they used to eat well. Children's perceptions of their conditions by age are shown in Table 2.

Table 2
Children's perception of their conditions when parents were alive and well, by age (%)

Age	Schooling/ H/H chores	Eating well	Too young	No response	NA	Don't remember
6-9	24	29	35	6	6	-
10-14	40	12	31	3	14	2
15-19	57	7	18	3	14	3
Total	44	12	26	3	13	2

Schooling and household chores are the central activities of young people. From Table 2, it can be noted that the older children, most of whom might have started school, reported schooling as their main activity at the time when parents were alive. The younger ones, who normally have less responsibility and more time for play, remembered eating well most.

Children's life when parents began getting sick

When parents fall sick, the life of children is affected. The most important activity of childhood is schooling. Table 3 shows the effect of parents' sickness on the school life of children, by their age.

Table 3
Children's perception of their condition when parents became sick, by age (%)

Age	Undisrupted schooling	Schooling and caring	Left school to care	Dropped out of school	Too young to tell	Others
6-9	24	-	-	11	41	24
10-14	29	4	4	7	41	27
15-19	26	16	9	12	16	21
Total	28	7	5	9	27	24

Table 3 shows that all age groups were likely to drop out of school when parents became sick; however, the older children's school life was more disrupted. Among the 15-19 year olds, 16 per cent had to combine both schooling and care-giving and nine per cent had to leave school to care for the sick parents. The disruption becomes even worse when parents die, as shown in Table 4.

Table 4
Children's perception of their condition when parents died (%)

Age	Undisrupted schooling	Lost school time	Left school	Too young to tell	Others
6-9	18	18	6	41	18
10-14	19	24	5	32	20
15-19	19	16	29	19	17
Total	19	21	12	29	19

Like Table 3, Table 4 shows that there is more disruption among the older children, although all children reported about the same percentage of school loss. More of the 15-19-year-olds than the younger groups dropped out of school.

School disruption was further examined in relation to the current family categories. The results are shown in Table 5.

It is expected that, when parents are alive, most children attend school. School attendance among children in this sample before their parents died was within the range of national statistics in which the combined primary and secondary enrolment rate is given as 51 per cent (UNDP 1993:143). At the death of the parent or parents many orphans (24%) lost school time. The least affected were those who lost a mother and remained with a widowed father; 14 per cent of the sample dropped out of school and only 21 per cent continued with schooling without disruption.

Table 5
Effect of parents' death on children's schooling (%)

	In school while parents alive	Continued schooling	Lost school time	Left school	Too young/ No response
Widowed father	57	43	7	21	21
Widowed mother	59	31	23	13	31
Grandparents	39	7	27	7	52
Other relatives	39	17	26	17	39
Child-headed	55	22	25	18	35
All orphans	50	21	24	14	37

In this study children with the highest chances of continuing their education were those who had lost a mother (43%) or father (31%), and remained with a surviving parent. Those fostered by grandparents before or after the death of parents had the least chance (7%) of undisrupted education. It may be noted that children living with their grandparents and other relatives were less likely to go to school even when their biological parents were still alive.

Beginning of sickness

The experiences of children were assessed right from the period when their parents started falling sick. The intention of this stage was to examine whether or not their feelings and thoughts changed significantly between the period when the parents were alive and well and the period when the parents became sick. Table 6 shows the results.

Table 6
Thoughts at beginning of parents' sickness

	No.	%
Would recover	31	18
Would not recover	70	41
Too young to bother	55	33
No response/not applicable [a]	13	8

[a] Not applicable: child was not living with parent during sickness.

Table 7
Children's feelings at the onset of parents' sickness

	No.	%
Sad but hopeful	31	18
Sad and hopeless	65	39
Desperate	4	2
Nothing	7	4
Too young to tell	50	30
No response/Not applicable	12	7
	169	100

Many children lost hope when their parents fell sick. Of those who had had some opinion about their parents' prospects only 31 per cent had some hope of their recovery; the majority were demoralized at the onset of the sickness. Of those who were demoralized from the beginning, 89 per cent had AIDS-infected parents. Of the children whose parents finally died of AIDS 79 per cent knew from the beginning that they would not recover.

When parents got sick, many children felt sad, some became desperate; only a few said that they did not feel anything. Of those who were affected only 31 per cent were hopeful that the parents would recover. The rest lost hope at the initial stages of parents' sickness; most of these had AIDS-infected parents.

The following is part of a focus-group discussion with four orphans living alone (Child-Headed Family), aged 8 - 15 years, at Bisanje

Q. How did you feel when your parent started getting sick?

A. I did not think of his death.
Felt nothing.

Thought he would recover.
I did not feel disturbed.

Q. What were your thoughts when he became very sick?
Felt very bad, I feared.
My thoughts were all disturbed.
I got very frightened.
I did not want people to come home.
Did not know what to do. I knew he was going to die.

Many children in the study were aware of the AIDS epidemic. They knew the symptoms of an AIDS-infected person and for many, it was from these symptoms that they discovered that their parents had AIDS and were destined to die.

AIDS is a long-lasting terminal illness that debilitates the victim to the point of complete dependence. We therefore found it necessary to enquire into the orphans' thoughts and feelings at the time when their parents were seriously sick. Tables 7 and 8 show the results.

Table 8
Children's thoughts when parents were very sick.

	No.	%
Sad	6	4
Sad and worried	15	9
Scared parent would die	82	49
Nothing	6	4
Too young to understand	47	28
No response/not applicable	13	8

From Table 8 it can be noted that when parents were seriously sick, children became very sad and worried or scared of the impending death. Of those who expressed their thoughts, most were worried or scared of the looming death of their parents. Other feelings recorded in response to a similar questionnaire were of fear and hopelessness. Only two children were 'sad but determined to face the future'.

At the time of parents' death

As shown in Table 9, at the death of parents half of the children reported that they felt sad; 22 per cent were too young to recall what their feelings were then. Of those who expressed their emotions, three felt 'determination to face the future'.

Table 9
Children's reactions at parents' death

	No.	%
Sad and scared	19	11
Very sad and helpless	84	50
Cried	19	11
Sad but determined to face future	3	2
Too young to tell	37	22
No response	7	4

The four orphans in the child-headed family at Bisanje responded as follows:

Q. When your father died, did you feel angry about it?

A. Yes, for about one month.
I did not want to eat during that period.
Then it kind of stopped.
The presence of grandparents helped to comfort us, but when they went, the fears started again.
We would eat at 6 p.m and lock ourselves in the house.
Then we got used after about three months.
Fear feelings still come back when you think of him, though dead.
Occasionally you get reminded of his voice.
What he used to say over certain things.
Occasionally you dream talking to him or see him.
What he used to say over certain things.
Wake up in great fear.
Dreams still come though not very often (Focus-group discussion).

A word must be said about children who do not provide responses. According to Freud's psychoanalytic theory, these are children who have bottled up this bad experience and pushed it into the unconscious to be forgotten. Because they have not allowed themselves to deal with this experience, it still remains painful for them to talk about it. These children need to be helped to accept the bad experience of their parents' death so that they feel free to discuss it. It is only if they can look back to the life of the deceased, and talk or even joke about it, that the bereaved can be said to have overcome grief. Inability to discuss the deceased is an indication that the grieving process has not been completed.

The psychological effect of orphanhood

Loss of loved ones, particularly during childhood, brings with it depressive thoughts and feelings among which are sadness, anger and guilt. These are normal feelings at the time of bereavement. However, with the passage of time, and as the individual accepts the loss, the negative emotions are expected to disappear.

In this study, children were asked whether they were angry about their parents' death and whether they blamed their parents for their death. The results are shown in Tables 10 and 11.

Table 10
Expression of anger (%)

	Angry	Not angry	Don't know
Widowed father	43	14	43
Widowed mother	48	28	23
Grandparents	57	9	34
Other relatives	65	4	31
Child-headed	47	16	37
All	52	15	33

Table 10 shows that many orphans were still angry about their parents' death. Those staying with relatives were the most likely to be angry followed by those living with grandparents. Children were least likely to be angry if they stayed with a surviving parent or

on their own. Most of those who were angry reported that this anger was felt especially when they found themselves beset with problems, or when they feared the situation in which they found themselves. The children's anger is understandable because children depend entirely on their parents for their maintenance, survival and education. When parents die it is difficult to find adequate substitutes. Orphans were classified as depressed and non-depressed as shown in Table 11.

The negative emotions of anger, worry and self-hatred were weighing down these orphans. Children whose minds are occupied by the negative emotions, children who cannot sleep and who are tired all the time, cannot be expected to concentrate on their studies and fully benefit from school. There is therefore an urgent need to help these children deal with their grief.

Q. Did you continue going to school after your father's death?

A. Yes, we continued for some time.
You don't think of him at school.
You are not very bothered at school, but when you return home, then you get reminded of him.
You feel as if he is telling you do this or that.
Feelings of loss are greatest when time to go home comes.

Q. Did the teacher understand your feelings when you lost your father?

A. No, even when hungry, nobody gives you anything to eat.
If lost in thought in class he would cane you for being inattentive in class.

Q. What should teachers do?

A. He should be interested in what I am thinking about and then punish if need be, but not to just beat us because we don't seem to understand what he is teaching (Focus group discussion, child-headed family).

Table 11
A comparison of depressed and non-depressed children on selected items of the depression index (%)

	No		Sometimes		Yes	
	Depressed	Non-depressed	Depressed	Non-depressed	Depressed	Non-depressed
I am sad all the time	16	84	48	52	76	24
I do everything wrong	37	63	56	44	77	23
I am sure terrible things will happen to me	14	86	44	56	71	29
I hate myself	32	68	75	25	71	29
I feel like crying every day	29	71	75	25	87	13
I have trouble sleeping at night	31	69	59	41	71	29

I am tired all the time	25	75	58	42	81	19
I feel lonely all the time	60	40	67	33	33	67

Orphans and non-orphans

In a study like this one, where it is not possible to control factors such as the death of parents, we can only examine the effects by comparing those who have been affected and those who have not been exposed to the factor. In this study we therefore found it necessary to compare orphans and non-orphans on several factors as shown in Table 12.

Table 12
A comparison of orphans and non-orphans on several factors

	Orphans	Non-orphans	Mean
Expected lifespan	51	67	52
Locus of control score	7	7	7
Depression Mean Score	19	12	18
Adjustment Score	13	11	13
Want marriage (%)	60	83	63
Want children (%)	62	92	65
At school or in job by year 2000 (%)	82	100	84
Dead by year 2000 (%)	4	0	4

From Table 12 it is apparent that non-orphans were more optimistic about the future than the orphans. For example non-orphans expected to live longer than orphans. All non-orphans thought they would be at school or working by the year 2000 compared to only 82 per cent of orphans. More non-orphans than orphans expected to marry or have children.

Orphans had a higher average score of depression (19) than the non-orphans. The Children's Depression Index which was used in this study has a cut-off score of 18 points for the depressed and the non-depressed; that is, all those who score 18 points or below are classified as non-depressed and those scoring 19 points and above are classified as depressed. Since the average depression score for orphans was found to be 19, all orphans were therefore in the depressed range, according to this scale, while non-orphans were not. Depression can, therefore, be said to be one of the major effects of orphanhood. Noting that depression is positively correlated with the external locus of control, we conclude that loss of parents is a major factor affecting the psychological well-being of a child to warrant special attention in terms of service design and delivery. The specific effects of depression will be discussed in subsequent sections of this paper.

Surprisingly, on the adjustment score (Table 12), orphans scored higher than non-orphans, which seems to indicate that they were better adjusted than non-orphans. This unexpected result may be explained in terms of the people we asked to assess the adjustment of the orphans (who were all beneficiaries of World Vision assistance) and the official image of the organization in which we were perceived. We were travelling in a World Vision vehicle and being guided and introduced by the Parish Community Development Workers who are employees of World Vision; this gave the impression that we were officials of World Vision. Possibly parents or guardians thought that if they revealed the negative side of their children, they would risk being disqualified from the World Vision assistance. The teachers themselves who teach in the World Vision-assisted schools might have been suspicious of our presence and investigations since they also benefit from the school sponsorship program. From this

point of view, it was more advantageous for them to present a good image of the orphans under their care.

Self-reports of children as illustrated by the depression mean scores and the locus of control scale, in addition to our own physical observation of the orphans, were indicative of high levels of maladjustment. On the depression scale for example, children in this category reported that they were sad all the time, they hated themselves, they worried about everything, they had no appetite and could not sleep. Our findings were in agreement with those of Sarason and Sarason (1989:441) that depressed children

> had more physical complaints, were more likely to be overactive, had lower self-esteem, and were more likely to be involved in fights and refuse to go to school. Depressed children also appeared miserable, unhappy, tearful, or distressed.

Such children therefore, cannot be said to be well-adjusted.

Given that there is a high level of maladjustment, it may be argued further, that the coping abilities of orphaned children need to be studied in greater detail with a view to understanding the effect of stress on their lives.

Q. How have the people in the community helped you?

A. They treated us well.
If sick, they take you to hospital.
Sometimes they give us food and salt.
They visit us, sometimes.
We have not been neglected.
At school, fellow children treat us well, they play with us, lend us pens and books.

Q. Who helps most?

A. World Vision who pays our school fees.
But sometimes the fees paid by World Vision are not enough.
The school now wants us to pay Shs. 450 for church fee and Shs. 100 for the Education week, totalling 550/-. We don't have it (Focus group discussion, child-headed family).

Depression scores

Depression among children that occurs as a result of the parents' death is best understood in terms of emotional loss. As Brodzinsky et al. (1986:571) point out, early experiences with death are not completely forgotten, even if the family remains remarkably silent about them. It is argued that children lack the cognitive ability and life experiences that would enable them to reject their anger on rational grounds. Furthermore, among adolescents, it is also known that loss of a parent makes them feel cheated out of knowing the parent as one adult knows another. They feel deprived of the opportunity to share the first achievements with the parent. In fact, their development may be more directly affected. Among adopted children, research indicates that adopted young people experience a special case of identity loss. Having come to understand the implications of being relinquished, many adopted teenagers and young adults experience a sense of incompleteness and bewilderment about their identity (Brodzinsky et al. 1986:572).

From this conceptual background, we found it necessary to examine and compare depression scores of different categories of children to see if the differences were significant. In Table 13, Mean Depression Scores are compared among different categories of children. Also given is the p-value which is used to show the observed significance level. As used in this study, the p-value gives the smallest level at which the null hypothesis has been rejected below the significance level of I=.05.

Table 13 shows that young children (10-14 years) living with their widowed fathers are significantly more depressed than older children (15-19 years), living with widowed fathers, with mean depression scores of 22.9 and 17.8 respectively. This could be explained in terms of bereavement and ability to deal with it. Young children are said not to understand the finality of death and therefore to be unable to deal effectively with grief (Vargo and Black 1984; Speece and Brent 1984; Brodzinsky et al. 1986). With the weight of the loss on their minds, they are likely to remain depressed.

It may also be noted from Table 13 that orphans who have lost a father, those whose father or mother had died of AIDS and those staying with their widowed fathers, grandparents or other relatives, or on their own, had average depression scores in the depressed range (above a mean score of 18.0), compared to, for instance, children living with both parents, whose mean score was 6.3. Children whose father was alive were less depressed (mean score 14.6) than those whose father was dead irrespective of whether the father died of AIDS or not. This depression could result from the felt loss of a deceased parent or the loss of the support that children normally enjoy from their fathers.

Children whose mothers died of AIDS were found to be significantly more depressed than those from intact families. Again this can be explained in terms of loss of psycho-social support that mothers normally provide.

Table 13
Mean Depression Scores

Category		Mean		P
Depression scores by age groups				
10-14 years				
Living with widowed father		22.9		.044
Living with widowed mother		17.3		
Child-headed	21.3		.007	
Intact family		4.4		
15-19 years				
Living with widowed father		17.8		.001
Living with widowed mother		14.2		
Living with grandparents	19.3		.001	
Living with other relatives		20.9		
Child-headed	20.4		.001	
Intact families		10.0		
Father alive	14.6		.005	
Father dead		20.4		
Father died of AIDS	21.7		.026	
Father alive		14.6		
Father died of other	17.2		.020	
Father alive		14.6		
Depression scores by type of family (all ages combined)				
Widowed father		20.8		.048

Widowed mother		16.9	
Widowed father	20.8		.034
Grandparents		19.3	
Widowed mother	16.9		.015
Other relatives		20.7	
Widowed mother	16.9		.038
Intact family		6.3	
Grandparents	19.3		.008
Other relatives		20.6	
Grandparents	19.3		.023
Intact family		6.3	
Other relatives	20.7		.017
Child-headed		20.9	
Child-headed	20.9		.044
Intact family		6.3	
Mother died of AIDS	21.7		.026
Intact family		14.8	
Mother did not die of AIDs	17.2		.020
Intact family		14.8	

Children living with widowed fathers were significantly more depressed than those living with widowed mothers. The explanation for this difference is the generally poor capacity of fathers to offer love and care to the children compared to mothers. This difficulty is even more pronounced by the fathers' inability to participate actively in domestic affairs before or after the death of the wives. It is possible that this difficulty could lead to disorganization of the entire family and hence higher depression levels of the affected orphans.

Contrary to the general belief that children living with their grandparents or other relatives are less depressed, this study found reasonable degrees of depression among these children. From Table 13, it may be noted that orphans living with their grandparents had a mean depression score of 19.3 and those living with other relatives scored 20.9, both of which were above the accepted depression mean level of 18.0. It is well known that grand parents tend to pamper their grandchildren but at the same time grandparents face the problems of general poverty including scarcity of food. The same conditions may prevail among other relatives as well. It is possible that lack of essential facilities is the factor that is leading to high levels of depression in this group of children whether they were living with grandparents or with other relatives.

Orphans living with widowed mothers were significantly more depressed than children who had both parents, as were orphans living with grandparents, those living on their own (child-headed families), and those whose mother or father died of AIDS. This is expected because the loss of the father-breadwinner is very often accompanied by abject poverty. However, children living with widowed mothers were significantly less depressed than those living with other relatives,probably because of the loss of emotional support of both parents and the harsh treatment that such orphans have to endure in their new environments.

Average locus of control scores

The concept of locus of control has so far been discussed not in figures but in its behavioural form to provide the reader with a picture of the psychological situation of the orphans and the challenges it poses. Here we present selected statistical evidence as analysed from the data

gathered in the study. The intent is to clarify with figures some of the behavioural observations.

Table 14 provides the mean locus of control scores for pairs of categories of children that were compared and the differences found significant. For all other possible combinations that are not indicated in the table, the differences were not significant at $I < 0.05$.

Table 14
Mean locus of control among various groups

Category	Mean	P
Widowed mother	6.4	.048
Child-headed	7.2	
Grandparents	6.6	.013
Child-headed	7.2	
Cause of father's death not AIDS	7.2	.002
Cause not known	7.0	
Cause of father's death not AIDS	7.2	.045
Too young to tell	5.9	
Cause of mother's death not AIDS	17.2	.020
Intact family	14.8	

Children who headed their families were more externally oriented than those who lived with widowed mothers. Similarly, the child-headed families were more external than orphans living with grandparents. This is expected since being left all alone in the world is more depressing than being left in the hands of a mother or a grandparent. There is a need for increased intervention through therapeutic programs for children living without adult care.

Orphans with the surviving relatives have something from their past to cling to, while those without any surviving relative are left at the mercy of the environment. Hence the higher degree of externality among the child-headed families.

Conclusions and selected recommendations

It has been shown that being an orphan, particularly as a result of AIDS, has major psychological effects on the children left behind. For this reason, the programs which are ordinarily designed for children's welfare should significantly make a distinction between AIDS orphans and other types of orphans. A number of proposals to benefit AIDS orphans follow.

Training workshops and seminars on psycho-social problems

Evidence shows that many children are a little too old for the school classes they are in. Coupled with the fact that many of them are depressed, this implies that a good proportion of them are not benefiting from the existing design of educational programs.

While it is important to use existing educational facilities, schools in particular, it is more cost-effective for the government and non-government organizations to find resources for workshops or seminars and similar short courses to retrain some school teachers in diagnosing psycho-social problems and in the process offer them skills to deal with such problems.

Workshops and seminars for community development workers and guardians

Community development workers and guardians were routinely exposed to signals of emotional problems, only they did not perceive them as such. This constraining factor limited their knowledge and understanding of the emotional problems of children. We recommend short courses and periodic workshops and seminars be organized for guardians and community development workers to train them in problem identification and counselling.

Need for child psychologists or school social workers

Many of the children who lost parents to AIDS were aware of the symptoms of AIDS and how a person who has it suffers. Orphans are aware of the seven major symptoms, fever, diarrhoea, vomiting, weight loss, hair loss, swellings or boils on the body, skin rash. These severe symptoms seen to have left a scar on their minds that needs to be addressed. In this study, we found orphans who are still angry and depressed as a result of the death of their parents from AIDS, even when such deaths occurred several years ago.

Orphans need special child guidance and counselling programs. This is a specialized service which demands adequate training on the part of the counsellors. We, therefore, recommend that World Vision should consider the possibility of recruiting a qualified school social worker or child psychologist at the district level. The task here is to offer early warning of psychological conditions that may prevent a child from benefiting from school services; and to offer referral services for the cases the Community Development Workers are not able to handle. The officer so employed will have the skills to diagnose psycho-social problems and to offer psychotherapy to children in need.

In the medium term, therefore, efforts should be made to encourage the Ministry of Education and Sports to recruit a cadre of child psychologists and school social workers to work in schools and offer child guidance services.

Effect of bereavement on orphans' education

The effect of a parent's death on children's education has been found to be severe. Children lose school time even before parents die, many drop out of school. A higher proportion were too young to understand this negative experience which unfolds more and more as they grow older thus plunging them into deeper levels of depression. It is therefore vital that the level of child guidance should be higher than that which is currently being offered by the community development workers.

Depression and locus of control

A high percentage of children were depressed and externally oriented, that is, children who were depressed also showed signs of unresolved grief. Children who had lived in urban areas but were transferred to rural areas after the death of their parents, were particularly more depressed and less well adjusted to rural conditions. Their foster-parents were very often impoverished, which in itself made the children feel more depressed. This evidence strengthens our earlier recommendation for professional counselling as an intervention to facilitate emotional healing.

References

Bledsoe, C. 1989. The cultural meaning of AIDS and condoms for stable heterosexual relations in Africa: recent evidence from the local print media. Paper presented at the IUSSP Seminar on Population Policy in Sub-saharan Africa: Drawing on International Experience, Kinshasa, 27 Feb-2 March.

Brodzinsky, D. M., A.V. Gormly and S.R. Ambron. 1986. *Lifespan Human Development* (3rd ed.). New York: CBS College Publishing.

Hunter, Susan S. 1990. Orphans as a window on the AIDS epidemic in Sub-Saharan Africa: initial results and implications of a study in Uganda. *Social Science and Medicine*, 31, 6:681-690.

Lefcourt, Herbert M. 1976. *Locus of Control: Current Trends in Theory and Research*. Hillsdale: Lawrence Erlbaum Associates.

Minde, K. 1988. The effects of social change on the behaviour and academic performance of school age children. Unpublished paper.

Nalwanga-Sebina and J. Sengendo. 1987. Orphaned and disabled children in Luwero and Kabale Districts and in Ugandan child care institutions: a comparative profile to the general child population. Kampala: Makerere University.

Overmier, J.B. and M.E.P. Seligman.1967. Effects of inescapable shock upon subsequent escape and avoidance responding. *Journal of Comparative and Physiological Psychology* 63:23-33.

Richter, C.P.1959. The phenomenon of unexplained sudden death in animals and man. In *The Meaning of Death*, ed. H. Feifel. New York: McGraw-Hill.

Sarason, L. and B.R. Sarason. 1989. *Abnormal Psychology*. Sixth Edition. New York: Prentice-Hall.

Speece, Mark W. and Sandor Brent. 1984. Children's understanding of death: a review of three components of a death concept. *Child Development* 55:1671-1686.

UNDP. 1993. *Human Development Report.* New York: Oxford University Press.

UNICEF. 1990. *Children and AIDS: An Impending Calamity.* Paris.

Vargo, Marc E. and F.W.Black. 1984. Attribution of control and fear of death among first year medical students. *Journal of Clinical Psychology* 40:1525-1528.

Warr, Peter. 1987. *Work, Unemployment and Mental Health*. Oxford: Clarendon Press.

Appendix

Depression Assessment

For each of the following statements choose and tick one of the three alternatives, **No, Sometimes** and **Yes** that best describes you. Make sure that for each statement, you provide an answer.

	No	Sometimes	Yes
1. I am sad all the time			
2. Nothing will ever work out for me			
3. I do everything wrong			
4. I am bad all the time			
5. I am sure that terrible things will happen to me			
6. I hate myself			
7. All bad things are my fault			
8. Nothing is fun at all			
9. I feel like crying every day			
10. Things bother me all the time			
11. I do not want to be with people at all			
12. I cannot make up my mind about things			
13. I look ugly			
14. I have to push myself all the time to do my school work			
15. I have trouble sleeping at night			
16. I am tired all the time			
17. Most days I do not feel like eating			
18. I worry about aches and pains all the time			
19. I feel lonely all the time			
20. I never have fun at school			
21. I do not have many friends			
22. I do very badly in subjects I used to be good in			
23. I can never be as good as others			
24. I never do what I am told			
25. I get into fights all the time			