CHILD CARE AND ATTACHMENT IN INSTITUTIONAL CARE

BY

THOKOZILE PHIRI

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DECLARATION

I, Thokozile Phiri, hereby solemnly declare that this thesis is my own work. It has not been previously submitted to this or any other university for the award of an academic degree.

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APPROVAL

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Examiner 1: …… Signature: ……. Date: ……

Examiner 2: …… Signature: ……. Date: …….

Examiner 3: …… Signature: ……. Date: ……

Chairperson Board of Examiners:

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Supervisor: ……. Signature: …… Date: …….

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ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
HIV	:	Human Immuno-Deficiency Virus
ASCT	:	Attachment Story Completion Task
EASQ	:	Emotional Availability and Sensitivity Questionnaire
EAS	:	Emotional Availability Scale
PCIS	:	Parent/Caregiver Intervention Scale
BEIP	:	Bucharest Early Intervention Project
AQS	:	Attachment Q-Sort
MBQS	:	Maternal Behaviour Q-Sort
RAD	:	Reactive Attachment Disorder

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ABSTRACT

Attachment is an important aspect of every human being's life as it has a major role to play in human development especially in the social-emotional domain. There are several factors that influence the formation of secure attachment in infants and these include quality of care and caregiver sensitivity. The aim of this study was to examine child care and attachment in Zambian orphanages. The study was conducted at SOS Children's Villages (Societas Socialis) and a sample size of 35 infant-caregiver dyads were used, including both male and female participants. Research questions were: 1) What is the nature of child care in child care orphanages? 2) To what extent are caregivers in SOS Children's Village responsive and sensitive to children in their care? 3) What child attachment patterns exist in SOS Children's Village? 4) What is the relationship between caregiver sensitivity and child attachment? The tools for data collection were: the Emotional Attachment and Emotional Availability Scale Attachment Story Completion Task and the Daily Hassles Questionnaire. The key findings of this study revealed that the majority of the children were securely attached. The findings also showed that the majority of caregivers showed moderate sensitivity to children in their care. The findings of this study inspire the need for more research in this area of attachment and child care in the context of institutionalisation.

Keywords: Child attachment, Caregiver sensitivity, Child care, Attachment patterns.

CHAPTER ONE: INTRODUCTION

1.1 Overview

Worldwide, there are more than 163 million children who have lost at least one parent. Of these children, 18.5 million have lost both parents while about 17.8 million of them have lost one or both parents due to Human Immuno-Deficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) (Facts and Figures SOS, 2014). About 4.3 million orphans live in Sub-Saharan countries; this number has increased by over 50% since 1990. The circumstances of orphanhood are variable from one country to the other and there are many factors that have a major impact on mortality including war, famine, diseases such as malaria, and poverty (Bailey, 2012). Nearly 60% of the Zambian people live in poverty (World Bank, 2017). This poverty has led to the lack of proper nutrition in many families, decreased school enrolments, the absence of parental sensitivity to children due to the fact that parents are mostly busy outside the home working so that they can provide for their families and the erosion of the extended family. All these factors contribute largely to making children vulnerable to institutional care, but the real challenge presents itself when it comes to raising these orphans and providing them with proper care.

John Bowlby, founder of attachment theory, defines attachment as the lasting psychological connectedness between human beings (Bowlby, 1969). Furthermore, attachment refers to the nurturing bond that exists between child and caregiver both physical and emotional, it is formed during the early years of life and continues developing throughout the lifespan. Bowlby noted that, "the provision of mothering is as important to a child's development as proper diet and nutrition" (Kobak, 1999, p.23). This essentially means that mothering (which is associated with warmth and sensitivity) is important if a child is to develop properly. Children

form attachments with their caregivers for survival purposes. A child can either be securely or insecurely attached and the nature of attachment formed will influence a child's development. Attachment is the close emotional relationship between the child and the mother characterised by mutual affection and a desire to maintain proximity (Bowlby, 1962). Secure attachment is a classification of children who believe in the availability andresponsiveness of the caregiver. Insecure avoidant a classification of children who do not orient to their attachment figure while exploring the environment and appears independent of the attachment figure both emotionally and physically while insecure ambivalent is a classification of children who exhibit clingy and dependent behaviour while rejecting the attachment figure when they engage in interaction (Bowlby, 1962). Children can form attachments with their parents, siblings, other family members as well as caregivers who are not biologically related to them (Bowlby, 1980).

Ainsworth formulated the concept of maternal sensitivity to infant signals and its role in the development of infant-mother attachment patterns (Bretherton, 1992). Maternal/caregiver sensitivity is important for child attachment as the type of maternal/caregiver sensitivity either negative or positive, predicts the child's attachment pattern. Studies conducted in the field of attachment have shown that maternal sensitivity is significantly related to attachment security in middle class samples (de Wolff and van IJzendoorn, 1997; Thompson, 1998).

One effect of orphanhood is institutionalisation. Institutionalization refers to the state of being placed or kept in a residential institution (Oxford dictionary Online, 2018). Institutional care is understood to be any residential care where an institutional culture prevails (Mulheir, 2012*).* There are other factors that drive children into institutional care other than orphanhood for example domestic violence, sexual abuse, alcohol abuse and abandonment. However, due to the large number of orphans and the weakening of the extended family system, most children have

been left vulnerable with no one to take care of them thus organised responses to a child in need of care and protection is institutional care. Anecdotal evidence has shown that institutionalisation is a widespread phenomenon in Zambia. Children raised in institutions are at a dramatically increased risk for a variety of social and behavioural problems, including disturbances of attachment (Zeanah, 2000). Taken together with previous research on attachment and institutionalization, it is clear that attachment is a severely compromised developmental domain in young, institutionalized children. Literature shows that such is the case because of inconsistent parenting practices, poor quality of care (Chansa, 2009). The provision of quality care for young children in extreme conditions of social deprivation is important. This is so because, quality child care helps foster a positive child-caregiver relationship. According to Zeanah et al (2005), in the stark environments of institutions a positive relationship with a caregiver is possible, although unlikely. Positive relationships with caregivers in institutions are unlikely mainly because of the unrealistic ratios of infant to caregiver, so the emotional strain on the caregiver may be *too* much. Bowlby (1980) argued that early experiences provide a secure emotional base by influencing children's feelings of confidence, worth and interpersonal trust. According to attachment theory, children who experience responsive, supportive and consistent caregiving develop high self-worth, they are trusting and are comfortable about depending on others. On the contrary, unresponsive, abusive and inconsistent caregiving leads to negative self-worth and discomfort about the availability of others (Bowlby, 1969/1980; Schmitt et al., 2004). There have been several studies exploring child attachment in institutions and they have documented that there are numerous delays and disturbances in development among these children.

Further, early attachments have been proved to be important not only as an indicator of the parent-child relationship but also for their significant effects on other aspects of the child's

functioning especially in personality and socio-emotional development. Orphanage- reared children who have received adequate physical care without social and/or cognitive stimulation; and few opportunities to establish a relationship with a consistent caregiver, show striking delays in motor and cognitive growth over the period of institutionalization (Zeanah et al 2005). As indicated by Zeanah et al, many factors contribute to these delays in development, the quality of childcare could be added to the list of these factors. Despite the growing number of studies in attachment there is still need for more studies to be conducted especially in the Zambian context.

1.2 **Problem statement**

Children in institutional care have been reported to show developmental delays including delays in emotional development hence the need to explore how child care influences child attachment (Zeanah et al., 2005). According to Chansa (2009), one of the factors that lead to increased number of orphans in Zambia is loss of parents as a result of disease e.g. HIV and AIDS. Previously, the extended family system used to act as a buffer for orphans but subsequently the erosion of the extended family support and this has contributed to the increase in the rates of institutionalisation in Zambia. Despite the existence of institutional care in Zambia research examining the role of caregivers in socioemotional development (e.g. attachment) is limited in this context. When caregivers are sensitive, emotionally available and responsive to the children in their care, the likely outcome is that the children will develop a secure attachment. Conversely, when caregivers are insensitive, emotionally unavailable and unresponsive, the likely outcome is that the children will develop an insecure attachment. Bowlby (1962) stated that, “attachment is as important as nutrition to an infant”. But the large numbers of orphans and vulnerable children is overwhelming especially that most of the caregivers in institutions lack training on how to be sensitive and responsive to the children. This puts pressure on the

caregivers thereby compromising the quality of care. Anecdotal evidence shows that most orphanages in Zambia have a caregiver - child ratio of 1:15. While in a study by Vorria et al where the caregiver - child ratio was 1:4 and 1:6 it was found that caregiver - child ratio affected quality of care (Vorria et al, 2003). According to Zeanah (2000), children raised in institutions are at increased risk for various social and behavioural problems. Orphanage- reared children who have received adequate physical care without social and/or cognitive stimulation; and few opportunities to establish a relationship with a consistent caregiver, show striking delays in motor and cognitive growth over the period of institutionalization (Zeanah et al 2005). It is therefore, important to explore childcare in an institutional setup in order to understand the factors affecting attachment formation because this is the backbone of children's social and emotional development.

1.3 **Justification of the study**

This study is significant in that it will help to give a clearer picture of the attachment patterns, child care practices, caregiver sensitivity and the daily hassles experienced by caregivers in institutional care. In a context where child institutionalization is on the rise, an investigation/assessment of care practices and daily hassles that caregivers face is important in understanding the quality of child care. In addition, this assessment of the current child care practices may lead to improving these practices and in turn improving attachment security of the children raised in institutions. Further motivation of deciding to conduct a study on this topic was derived from the observation there is paucity of studies that have investigated child care and attachment in Zambia. Additionally, studying child care and attachment in the context of institutionalisation from a Zambian perspective will render an opportunity to test the *sensitivity* hypothesis of attachment theory- that attachment security is dependent on childrearing

antecedents, particularly parental sensitivity (van IJzendoorn & Sagi, 1999). It may also be beneficial to other scholars in that it will add to the already existing body of literature and it may encourage other researchers to conduct more research in this area of attachment. Additionally, it will also give the principal investigator more insight on the topic of study thereby igniting desire to conduct similar research in future.

1.4 **Aim**

The overall aim of this study was to investigate child care and attachment in SOS Children's Village.

1.5 **Objectives**

The objectives were to;

i. Explore child care in SOS Children's Village.
ii. Determine child attachment patterns in SOS Children's Village.
iii. Examine caregiver sensitivity in SOS Children's Village.
iv. Determine the relationship between caregiver sensitivity and child attachment patterns in SOS Children's Village.

1.6 **Research Questions**

i. What is the nature of child care in SOS Children's Village?
ii. What child attachment patterns exist in SOS Children's Village?
iii. To what extent are caregivers in SOS Children's Village responsive and sensitive to children in their care?
iv. What is the relationship between caregiver sensitivity and child attachment patterns?

1.7 Delimitation

The study was conducted in Lusaka district and only confined to SOS Children's Village. SOS Children's Village being a child care institution which adopts a family-based approach in the rearing of orphaned and vulnerable children. Furthermore, the study included participants such as children and caregivers from SOS Children's Village.

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview

This chapter contains research and literature regarding institutionalisation and attachment. It includes a background of the attachment theory, the theory on which this study is based. Children reared in orphanages are privileged to be provided with the basic needs of life. But along with this privilege comes a multitude of challenges, these include stigmatization, inadequate attention from their caregivers who are in most cases emotionally unavailable because their roles are quite demanding. Regarding infant care and attachment in an orphanage setting, it appears that the challenges of institutionalisation have serious impacts on the proper development of children reared in orphanages.

2.2 Theoretical review

John Bowlby and Mary Ainsworth are the major proponents of attachment theory. As the founding father, Bowlby (1982) believed that the behavioural system of an attachment relationship was an adaptation fixed in place through the process of natural selection, and as such, evidence of the secure-base relationship should be observable in any human socio-cultural setting. Bowlby and Ainsworth's theory of attachment holds the assumption that the attachment figure is a secure base for the infant's exploration and is a haven of safety for the infant in times of stress (Ainsworth, 1967; Bowlby, 1988; Ainsworth, Bell & Stayton, 1974), and in whichever way attachment relationships may be classified, they always imply the secure base phenomenon (Ainsworth, Blehar, Waters & Wall, 1978; Zimmermann, 2005).

Ainsworth was greatly influenced by Bowlby's work and her contributions to attachment theory were great especially her pioneering work which includes her Uganda (1969) and

Baltimore (1970) studies, where she embarked on observational projects (Bretherton, 1992). Ainsworth's innovative methodology did not only make it possible to test some of Bowlby's ideas empirically but also helped expand the theory itself and is responsible for some of the contemporary directions it has taken today. She also contributed to attachment theory by proposing the concept of the attachment figure as a secure-base from which an infant can explore the world. In addition, she formulated the concept of maternal sensitivity to infant signals and its role in the development of infant-mother attachment patterns (Bretherton, 1992).

The securely attached infant is confident in a caregiver's availability, responsiveness and power to serve as a secure-base in support of ordinary exploration and, when necessary, as a haven of safety in retreat. Securely attached infants are more able, compared to insecurely attached children, to use one or more caregivers as a secure base from which to explore and as a haven of safety. Studies conducted in the field of attachment have shown that maternal sensitivity is significantly related to attachment security in middle class samples (de Wolff and van IJzendoorn, 1997; Thompson, 1998). According to Bowlby, "responsiveness to crying and readiness to interact socially are amongst the most relevant variables" (p. 315) in determining who will serve as an attachment figure (Cassidy, 2008). Indeed, it makes a lot of sense to recognize that parents that display higher levels of sensitive responsiveness to their children elicit optimal levels of secure-base behaviours from the children. A child that senses that a parent sensitively reads and accurately responds to him or her is most likely to use that parent as a secure-base and haven of safety (Mooya, 2012). This means that the caregiver who invests a lot emotionally, in interacting with the infant will most definitely serve as an attachment figure.

According to Bowlby (1982), attachment theory is applicable to the human species, not just members of a single culture, propounding on what has come to be known as the *universality*

hypothesis of attachment. The *universality* hypothesis of attachment predicts that attachment bonds will be established in any given culture and proof of the secure-base relationship will be observed in any given society. The theory has grown and expanded to show that the association between the quality of early care (i.e. sensitivity) and infant attachment security holds across a variety of situations, contexts and cultures, pointing to what has come to be known as the *sensitivity* hypothesis of attachment theory- that attachment security is dependent on childrearing antecedents, particularly parental sensitivity (van IJzendoorn & Sagi, 1999).

2.3 Empirical review

Maternal/caregiver sensitivity is an important condition for the development of secure child-mother/caregiver attachment and consequently an important predictor of proper child development. According to attachment theory, the relationship between the quality of early care and child attachment security holds firm, not only within the culture most studied (i.e. the West) but also across a wide range of cultures (Bretherton, 1985). Research has shown that the secure-base phenomenon is universal to children from different cultures and socio-economic contexts.

In a meta-analysis of 66 studies (*N*=4176), on parental antecedents of attachment security, addressing the question of whether maternal sensitivity is associated with infant attachment security and the strength of the relationship (de Wolff & van IJzendoorn, 1997), it was found that maternal sensitivity is significantly, if moderately, related to attachment security in middle-class, non-clinical samples. The combined effect size for the association between maternal sensitivity and attachment was r (1664) = .22 (K=30, *N*=1666). However, when they adopted a more strict definition of the predictor variable and included only studies that measured sensitivity using Ainsworth's original rating scale, the effect size increased to r (835) = .24 (K=16, N=837). Moreover, de Wolff and van IJzendoorn (1997) have estimated that 862 studies

yielding null findings would be needed to reverse the conclusion that the two variables are significantly related.

Posada, Carbonell, Alzate, & Plata (2004) conducted a study among a middle to middle-low class sample of 30 infant-mother dyads (14 boys, 16 girls) in Bogota, Colombia. All the children in this study were healthy and came from a nonclinical sample. Mothers were the primary caregivers. The study aimed at studying the association between maternal behaviour and the organization of infants' secure base behaviour as assessed by the Attachment Q-Sort (AQS). A Pearson correlation index indicated that the constructs of maternal caregiving/sensitivity and the security score for the infants were positively and significantly related (r= .61, p< .001). Results interestingly showed that the higher the overall quality of care score a mother obtained, the higher her infant's security score. In addition, maternal sensitivity, measured using the Maternal Behaviour Q-Sort (MBQS) and child security were found to be significantly associated (r= .42, p= .01). In Posada and colleagues' quest to investigate the cross-cultural generality of the sensitivity-security link, the evidence supports the notion that maternal sensitivity and infants' use of the caregiver as a secure-base is not just a construct exclusively relevant to middle-class samples from the Western countries, but is applicable to infant-mother dyads in other populations as well (Mooya, 2012).

In addition, the child to-caregiver ratio (3–7:1) in the institutions that participated in the study by Dobrova-Krol and colleagues was similar to the institution in Greece (4–6:1) (Vorria et al., 2003) and more favourable than in Romanian institutions, (10–12:1) (Smyke, Dumitrescu, & Zeanah, 2002). The percentage of securely attached children in that study was comparable to the results of the Greek study (28% vs. 24%, respectively), and 10% higher than in the Romanian sample. Apparently, a more favourable child-to-caregiver ratio may have an enriching effect on

the attachment formation in institutional care (Dobrova-Krol, Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2010). The child-to-caregiver ratios in Romanian institutions are similar to the ones in Zambia and this according to Dobrova-Krol and colleagues is a significant factor in predicting the quality of caregiving which in turn predicts the attachment security.

A European team conducted a research among institutionalised orphans in Kinshasa (Democratic Republic of Congo) (Muadi et al., 2012). The research compared and contrasted attachment quality between two groups of children living in an institution and children living with their family, all aged between four and seven years. The age of the children allowed them to use a specific method: The Attachment Story Completion Task (ASCT). The children were asked to complete stories that are supposed to assess children's internal working model of attachment; they also used a doll to enact some scenes. The results showed a significant difference in the rate of attachment between the two groups, with the institutionalized children being less securely attached. Maudi et al also report that orphans in Kinshasa have achieved higher rates of attachment than other children in other populations such as Romanian children; they conclude that the children might be more resilient in this population.

Further, studies have shown that even if children are adopted, having spent the first years in an orphanage can have negative consequences for many years to come (Judge, 2003; Nelson et al., 2007). Researchers found that four-year-old orphans who had spent two years in an institution were less secure and less able to understand emotions than non-orphans (Vorria et al., 2003). Similarly, Smyke et al (2002) conducted a study in a Romanian institution, with three groups: (a) a 'typical' unit; (b) a pilot unit with fewer adults caring for each child, giving greater stability in care; and (c) a control group of never institutionalised children. They found significantly higher rates of Reactive Attachment Disorder (RAD) in children in the typical unit

than in the other two groups. Notably, children described as 'their favourite' by a caregiver had lower rates of attachment disorders (Smyke et al., 2002). Put together, these studies (Judge, 2003; Nelson et al, 2007; Smyke et al, 2002; Vorria et al 2003) support the notion that caregiver-infant interactions play a major role in socio-emotional development.

A review of eight papers reporting seven studies of children living in institutions show a distribution of attachment styles. Results show wide differences between studies, the mean rate of secure attachment was 26 % (median = 25.9, range0–47 %), avoidant 23 % (median = 24.8, range 2.5–55.5 %), ambivalent 11.8 % (median= 10.6, range 0–26 %) and disorganised 43.6 % (median = 48.6, range 5.3–65.8 %).The high rates of disorganised attachment in children living in institutions may be a response to conditions that hinder the construction of an organised attachment (Bakermans-Kranenburg, Dobrova-Krol, & Van Ijzendoorn, 2011). As suggested by some authors, the disorganisation in attachment patterns in these settings may not reflect the same processes as in family settings (where parental abuse or a caregiver's unresolved status due to loss or trauma may be the key). In institutions, disorganised attachment may just reflect the lack of opportunity for the formation of an organised attachment due to the limited resources, such as single caregiver for many children, the shift system and staff changes (Bakermans-Kranenburg et al., 2011). The findings from these studies point out the fact that the availability of the caregiver both emotionally and physically, predict attachment style.

On the other hand, the Howes and Segal (1993) study found higher rates of attachment security compared to other studies. Notably, the institution in this study appeared to be of good quality and stability of caregiving (good child: caregiver ratio, low staff turn-over, small size), which may explain the higher secure attachment. This is consistent with results shown in the main intervention study, conducted by St. Petersburg-USA intervention project (2008). It also

reflects the fact that institutions can vary widely in their quality of care and that these variations can have a strong impact on emotional development and attachment.

Caregiver sensitivity has been shown to be a significant factor mediating the quality of attachment both in institutionalised and fostered children. In a study carried out with 76 foster care children, foster mothers' maternal sensitivity (measured with Maternal Behaviour Q-Sort) was a direct predictor of security in attachment (Ponciano, 2010). In accordance with this, in a sample of children placed in a shelter with alternative caregivers, it was observed that more children formed secure attachments with the more sensitive and less detached caregivers (measured with Arnett Scale of Teacher Sensitivity; Howes and Segal 1993). The only study that found a non-significant relationship between sensitivity of the caregiver (measured with Parent/Caregiver Interaction Scale (PCIS)) and attachment classification (secure disorganised) was characterised by a sample of institutional caregivers all of whom had low levels of sensitivity, defined by quality of interactions and appropriateness (Vorria et al., 2003).

One of the most important early studies in this regard was Tizard's study of young children placed in residential nurseries in London in the 1960s (Tizard & Hodges, 1978; Tizard & Rees, 1975). She identified a group of 65 children placed in these nurseries at birth or soon thereafter. Between the ages of 2 and 4 years, 24 of the children were adopted, 15 of the children were returned to their birth families, and another 26 remained institutionalized. When the 26 still institutionalized children were assessed at age 4 years, 8 (30.8%) of them were emotionally withdrawn and unresponsive, displaying unusual social behaviours and no evidence of discriminated attachments. Another 10 (38.4%) children were indiscriminate, approaching and seeking attention from relative strangers as readily as from familiar caregivers. The remaining 8 (30.8%) children had managed to develop a preferred attachment to a caregiver at the nursery

(Tizard & Rees, 1975). This study indicates that the majority of children who remained in the residential nurseries had difficulties regulating their emotions and they did not develop social skills. This in turn affected their ability to interact with their peers, caregivers and other people.

Zeanah, Smyke, Koga, Carlson, & Bucharest Early Intervention Project Core Group (2005) studied the quality of caregiving related to classifications of attachment and/or to signs of Reactive Attachment Disorder (RAD). Two groups of children participated in this study and each was drawn from children participating in the Bucharest Early Intervention Project (BEIP) (Zeanah et al., 2005), an investigation of foster Attachment in Institutionalized Children 1017 care as an alternative intervention for young children in institutions. The first group was 136 children (Institutionalized Group) who had spent on average 90% of their lives in institutions in Bucharest, Romania. The second was a group of 72 Romanian children who had never been institutionalized and who were recruited from pediatric clinics affiliated with the Institute of Maternal and Child Health in Bucharest. Within the Institutionalized Group, analysis of variance (ANOVA) was used with attachment status (organised vs. disorganised vs. unclassified) as the grouping variable to examine quality of caregiving. Scores of children who fell in the Organised and Disorganised groups (M=515.43, SD=53.16; M=514.41, SD=53.59, respectively) were not different from one another but were greater than those of children in the Unclassified group (M=511.54, SD=52.55), $F(1, 92)55.107$, $p<.01$. Post hoc Tukey's testing indicated that the quality of caregiving received by the children in the Unclassified group was poorer than that received by the Organised group (p=.006) and by the Disorganised group (p=.024).This study demonstrated that the quality of the caregiving that the child received in the institutional setting was significantly related both to the continuous rating of attachment and to the child's organization of attachment. Impressively, these results held even when other variables, such as

cognitive level, perceived competence, and quantitative interaction ratings, were controlled for (Zeanah et.al, 2005). This is evidence that the quality of caregiving has a great impact on infant attachment styles.

Review of literature above has shown how attachment is influenced by caregiver sensitivity, emotional availability and responsiveness thereby leading to child developmental delays. Most research has also documented the caregiver inconsistencies that characterise many child care institutions and they have contributed largely to the attachment patterns of these children. The present study looks at attachment, caregiver sensitivity, responsiveness, emotional availability and childcare in an institution that mimics a traditional family set-up.

CHAPTER THREE: METHODOLOGY

3.1 Overview

This chapter presents a narrative on the methodology that was employed in the study.

3.2 Research approach and design

This study used the descriptive correlational cross-sectional design. This was so because it was effective in collecting the data needed to answer the research question of the study. It used the descriptive correlational cross-sectional design because it's aim was to investigate and explore variables in the natural setting and even though it used retrospective data collection measures, it was done at one specific time and relationships were assessed.

3.3 Study Site

Most the studies that have investigated child care and attachment styles in orphanages have looked at orphanages that do not have a family unit arrangement thus SOS Children's Village being only institution (at the time of the study) in Lusaka that has a child care system mimicking the traditional family unit was selected as a study site. SOS stands for *Societas Socialis*-which means "a just and fair society" in Latin. It was started in 1949 by Hermann Gmeiner in Austria after the Second World War, his ambition was to create a socially responsible society that cared for children. Hermann named it SOS Children's Villages, the SOS emphasizes that a responsible and just society takes care of children who have no one else and are calling for help because they are in urgent need. Their mission is to provide loving homes, stable relationships and a future for children with no one else. SOS Children's Villages is an independent, non-governmental, social development organisation that provides care and support

for children and disadvantaged families in 135 countries and territories and that advocates the concerns, rights and needs of children (SOS Children's Villages, 2017).

Over 81,000 children and young people live SOS families and youth programs; most of them in one of the 572 SOS Children's Villages. SOS Children's Villages also provides families with material, psychological and social support: Nearly 505,000 people participate in one of the 574 SOS family strengthening programs. Approximately 284,000 children, young people and adults attend SOS schools, SOS kindergartens, SOS vocational training centres or SOS social centres. More than 759,000 single health services were delivered at 71 SOS medical centres in 2017. In times of crisis and disaster, SOS Children's Villages helps through emergency relief programs (SOS Children's Villages International, 2017). SOS Children's Villages was selected as site for this study because it has a child care system mimicking the traditional family unit.

3.4 Sample

The focus of the study was to examine child care and attachment among children in SOS, therefore the study sample included 37 child-caregiver dyads drawn from SOS Children's Village. However, two of the children were excluded from the sample because they were not responsive when asked to participate in the study. They could not continue with the measures when asked to respond, thereby bringing the sample size to 35 child-caregiver dyads, 11=female, 14=male and 14=caregivers. Children's age M=8.46, SD=1.29 and caregiver's age M=50.31, SD=4.96. Table 1 below shows the demographic characteristics of the participants.

Table 1: Demographic characteristics

Variable	*n (%)*	*M*	*SD*
Age of child	35	8.46	1.29
Age of child when first came to SOS (in months)	33*	38.88	19.14
Age of caregiver	12	50.08	4.96
Level of education of mother			
▪ Secondary level	(74.3)		
▪ Tertiary level	(25.7)		
Gender of child			
▪ Female	(32)		
▪ Male	(68)		
Children with biological siblings in the home	(29)		

Notes: * *n* of participants who responded to question

3.5 Sampling procedure

The study used purposive sampling. The participants were selected based on the characteristics in the population of interest. The following criteria were used:

a) Inclusion criteria:

   i. The children must be permanent residents of the orphanage

   ii. The children must be aged 6-10 years

   iii. They must have stayed at the orphanage for at least 6months

b) Exclusion criteria:

   i. The children are not permanent residents of the orphanage

ii. The children are not aged 6-10 years

iii. They have stayed in the orphanage for less than 6 months

3.6 Measures

Caregiver and *child emotional availability and sensitivity* were assessed using the *Emotional Attachment and Emotional Availability Questionnaire* (EAS; Biringen et al., 1993; Stams et al., 2002). This questionnaire not only contains scales for parental behaviour (parental responsiveness, sensitivity and emotional availability), but also scales for child behaviour (e.g., child responsiveness, sensitivity and emotional availability). Both *caregiver and child emotional availability and sensitivity* were assessed on a scale of 1-never, 2-almost never, 3-sometimes, 4-almost always, and 5-always. A score of 1-never meant that the activity did not happen, 2-almost never meant that it happened rarely, 3-sometimes meant that it happened sometimes, 4-almost always meant that it happened often and 5-always meant that it happened always.

Caregiver stress was assessed using the *Daily Hassles Questionnaire* (DHQ; Crnic & Greenberg, 1990). This tool contains scales for caregivers/parents to rate the frequency of daily tasks that involve child care and then rate the intensity of the bother that came from doing those tasks. For example; “cleaning messes of toys or food”, “kids won’t listen/do what they are asked without being nagged”. The Daily Hassles Questionnaire measured caregiver stress on two domains, namely (1) frequency and (2) Intensity. The former had a Cronbach’s Alpha of $\alpha = .7$ while the latter had a Cronbach’s Alpha of $\alpha = .8$.

Caregiver stress was assessed on two scales (1) frequency of *caregiver stress* was rated as follows: 1-rarely, 2-sometimes, 3-a lot, and 4-constantly. Scores of 1 (rarely) and 2 (sometimes) meant that the caregivers did not experience frequent stress doing these tasks while scores of 3 (a lot) and 4 (constantly) meant that these tasks frequently stressed the caregiver. (2)

Intensity of *caregiver stress* was rated on a scale of 1 to 5 (1 being the lowest amount of stress and 5 being the highest). Scores of 1 and 2 meant that the amount of stress the caregiver experienced while doing these tasks was low, a score of 3 meant it was moderate while scores of 4 and 5 meant that the amount of stress the caregiver experienced doing these tasks was high. In some cases, caregivers would score high on the frequency but low on the intensity of the daily hassles and vice versa. These data were entered in SPSS for analysis.

Child attachment representation was measured using the *Attachment Story Completion Task* (ASCT; Verschueren & Marcoen, 1994a; based on Cassidy, 1986, and Bretherton et al., 1990). Each child was asked to complete four attachment related story beginnings using a doll family. The topics of the stories were the following: *favourite toy being stolen by an unfamiliar child, giving a present to the attachment figure*; *saying "I'm sorry*"; and *crying because the child has quarreled with another child at school*. Each of the four stories was classified into one of four groups and was rated on a five-point scale for attachment security. If the child completed the story with little hesitation, then the story would be classified as "secure" and receive a score of 4 or 5. If the child was reluctant to complete the story, the story would receive the classification "insecure" and score 1 or 2. If the child did not show a clearly secure or clearly insecure story, the classification of "secure/insecure" and a score of 3 was given.

Thereafter, each child would receive an overall attachment classification, either secure, insecure, based on the classification for the four stories. A global attachment security score was given by summing the scores on the four stories. Coders, who were blind to all other information of the child, coded the stories from verbatim transcripts and narratives made from the voice recording session. Each story was coded independently, without knowing any information about

the other stories of the child. This was done in such a manner to ensure that the coding was not affected by coder biasness.

3.7 Data collection

Self-report measures were used to collect quantitative data. The participants (both caregiver and child) completed the *Emotional Attachment and Emotional Availability Questionnaire* and then the children completed stories in the *Attachment Story Completion Task*. The latter procedure took place in the child's bedroom and it was recorded with a voice recorder. The caregivers also responded to the daily hassles questionnaire. *Caregiver sensitivity* was classified as either low, moderate or high.

After a brief encounter with the caregiver and child, the researcher asked the caregiver to leave the room and given a questionnaire to fill out. The researcher then spoke to the child for a short while (two-five minutes) and when the child seemed comfortable, the administration of the story task began. It began with a warm up story about going shopping to ensure that the child understood the procedure. Four attachment-related story beginnings were then narrated for the children by the researcher.

The story beginnings introduced the following themes:

1. Crying after quarrel with friend at school.
2. Saying I'm sorry.
3. Favourite toy stolen by unfamiliar child.
4. Giving a present to attachment figure.

After presenting each of these stories, the researcher asked the participant to "tell me what happens next." Prompts such as ("and then what happens", "what did mummy/teacher

do?") This first type of prompts focused on the story issue and was used only if the subject failed to do so. The second type focused on clarification and used if the subject talked about unspecified agents ("who said sorry?"); the third type of prompt was to elicit more elaboration ("anything else?"), unless the child indicated by speech or action that the story was finished.

3.8 Data analysis

The data were checked for normality to ensure that the correct types, either parametric or non-parametric, of tests were chosen. Data were analysed using both quantitative and qualitative methods. The quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS v 21). Descriptive statistics (e.g. means, standard deviations etc.) were used to report participants' demographic characteristics like age, gender etc. To explore the relationship between different variables such as emotional availability (*caregiver sensitivity*) and *child attachment*, correlation analyses were used. Frequencies were used to report *caregiver stress* and *caregiver sensitivity.*

Detailed verbal transcripts were made from the audio story completions. The transcripts were subsequently analysed in two ways. A content analysis was undertaken to examine the children's ability to understand the story issues. Each child's stories were given a global score in order to classify the children's story presentations as either secure or insecure attachment patterns. These classifications were based on structure and content of the stories. Fluency, coherence in the story presentations indicative of a secure attachment relationship. The classifications took into account the child's global performance (language, confidence, voice tone).

Separate criteria were used for each story. In the "crying after quarrel with friend at school" story, responses were classified as secure if the quarrel was resolved properly and the

teacher was not extreme in disciplining the children. In the "saying I'm sorry" story, responses were classified as secure if the broken pieces of glass were collected and thrown away and maternal discipline or anger were not violent or extreme. In the "favourite toy stolen by unfamiliar child" story, responses that involved going in search of the toy and confrontation (although not violent confrontation) were classified as secure. Finally, a positive ending to the story "giving present to attachment figure" was classified as secure. Additionally, to receive a secure score, responses had to be with little hesitation and not more than one prompt for the story issue.

Two types of criteria were used for scoring insecure responses: (1) avoidance of the story issue, and (2) incoherent or odd responses these were based on the criteria used by Bretherton et al (1990). Story responses were coded as avoidant if the subject responded only after several prompts or gave no response. Some participants avoided the story issue despite responding, this was viewed as insecure avoidant because such behaviour was attributed to defensiveness concerning attachment issues. Incoherent responses by the participant and giving responses that did not make sense within the story were regarded as insecure ambivalent.

Participants who fluently and appropriately resolved the story issues were classified as secure if this occurred for all four stories. However, if the children displayed strong defensive, avoidant or odd responses over three stories their classification was insecure avoidant. Those whose responses were odd and incoherent were classified as insecure ambivalent. Furthermore, in cases where it was difficult to classify either secure or insecure, the classification was secure/insecure.

3.9 Ethical considerations

The participants were briefed about the study and its importance. The participants were well informed about the possible benefits and risks that would arise from the study. They were also briefed about the procedures that would be performed and then the participants were asked if they wished to participate in the study. Once they had agreed, they were provided with a consent form which they were required to sign. All the participants were not coerced in any way into taking part in the study, if they chose not to and if they decided to discontinue participation during the course of the study, they did so without having to explain why and without facing any negative consequences. The children gave assent to participate in the study (see Appendix A).

Confidentiality was observed, the identities of all the participants in this study were not disclosed under any circumstances therefore, each participant was assigned a code to label their data. The information collected was only used for scientific purposes and only shared with the research team working on this study. It was anticipated that the procedures that were used in the study would not cause any physical or mental harm to the participants. However, the participants were exposed to minimal stress no more than they encounter in their day to day activities. In events where this stress rose above the minimal level during a procedure, it was immediately stopped so that the participant relaxes before returning to the procedure. Because of the nature of the procedures of this study, ethical clearance was sort from the University of Zambia ethics board and the management at SOS Children's village Lusaka. At the end of the procedures, the participants were thanked for their contribution to the study, their most valuable time and their cooperation.

3.10 Limitations

i. Due to the sensitive nature of the study and the participants, it was difficult to use certain data collecting tools such as video camera, so the study relied on self-report.

ii. The study only included one orphanage in the sample compelling us to make generalisations (across orphanages) with caution. This was, however, mainly due to the fact that SOS is quite a unique child care institution and it was the only one that fit the criteria of the current study.

CHAPTER FOUR: RESULTS

4.1 Overview

This chapter contains the findings of the study. The results are presented according to the objectives.

4.2 Nature of child care in SOS Children's Village

The first objective of this study was to *explore child care in SOS children's village Lusaka*. On order to *explore child care,* interviews were conducted with orphanage administrators and caregivers. This was coupled with unstructured observations within the orphanage setting by the researcher.

Child care in SOS children's villages is characterised by the family arrangement, where the child is raised in a *family home* with a caregiver and siblings. Apart from having a family, the *family home* exists in a community which is called a village and within that village other systems exist like a school and health facility. Children are cared for by a caregiver, also called the SOS-mother who live with them in the *family home*. Each family home comprises a maximum number of ten children both male and female under the care of a mother. The number of children in a family home ranged from 9 to 12 per *family home*. The children go to school within the SOS village and after school, they play with their friends. If they fall ill, they receive medical attention from the health care clinic which is also within SOS village.

The mothers are responsible for the children's well-being (that is ensuring that they eat, go to school on time, are healthy), cleaning the house and general management of the house. In addition, the caregivers participate in other official duties which include writing child reports and

attending training workshops. Other caregivers go to school. Sometimes, the caregivers play with the children and help with homework. In the same way, the children help with house chores. They are also involved in gardening activities and they let the children participate in the maintenance of the gardens. A salient feature of child care is caregiver stress. To assess caregiver stress, descriptive statistics were computed. Figures 1 and 2 below, show the frequency and amount of stress the caregivers experienced frequency, as reported by the caregivers.

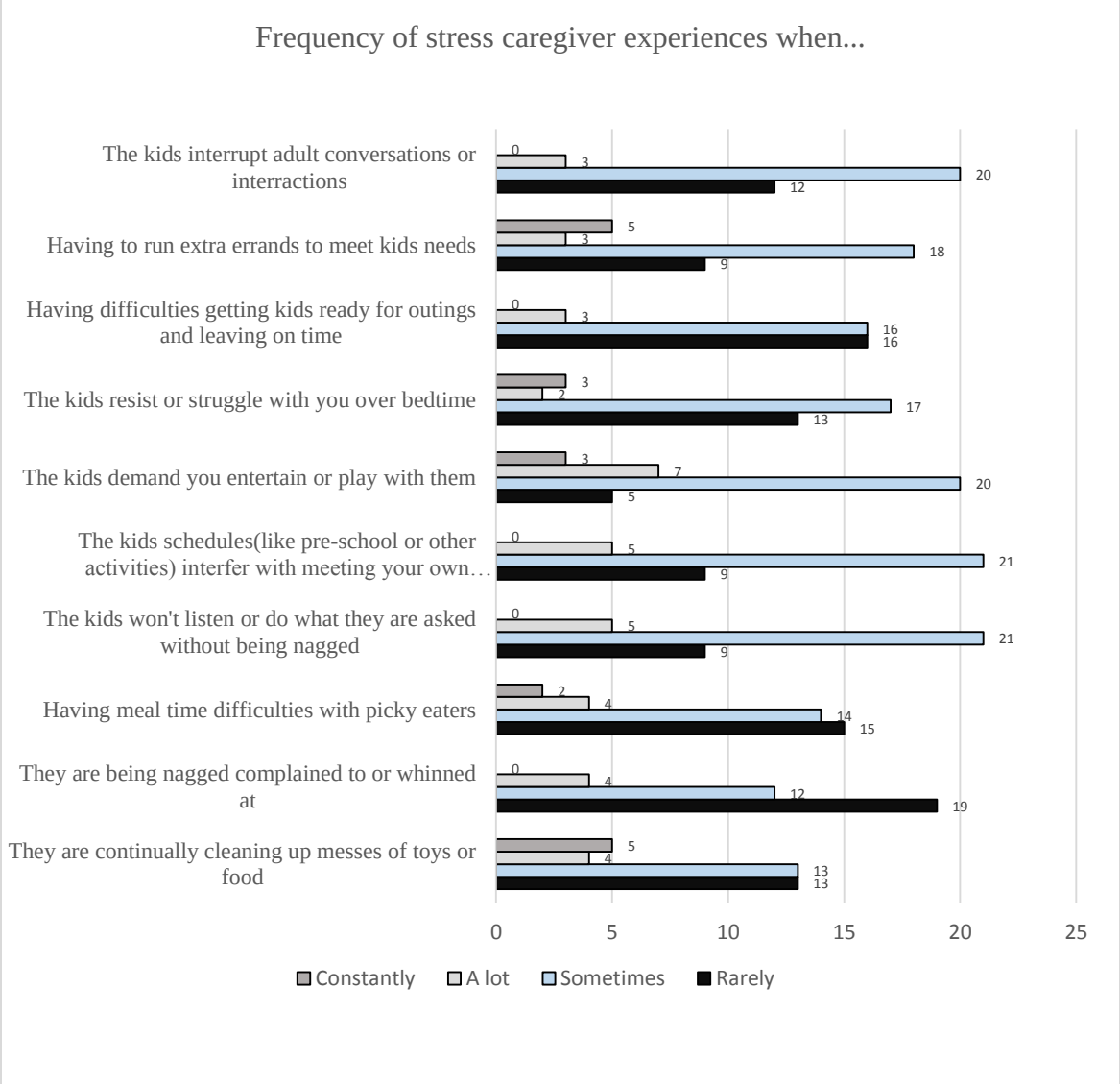

Figure 1: Frequency of caregiver stress

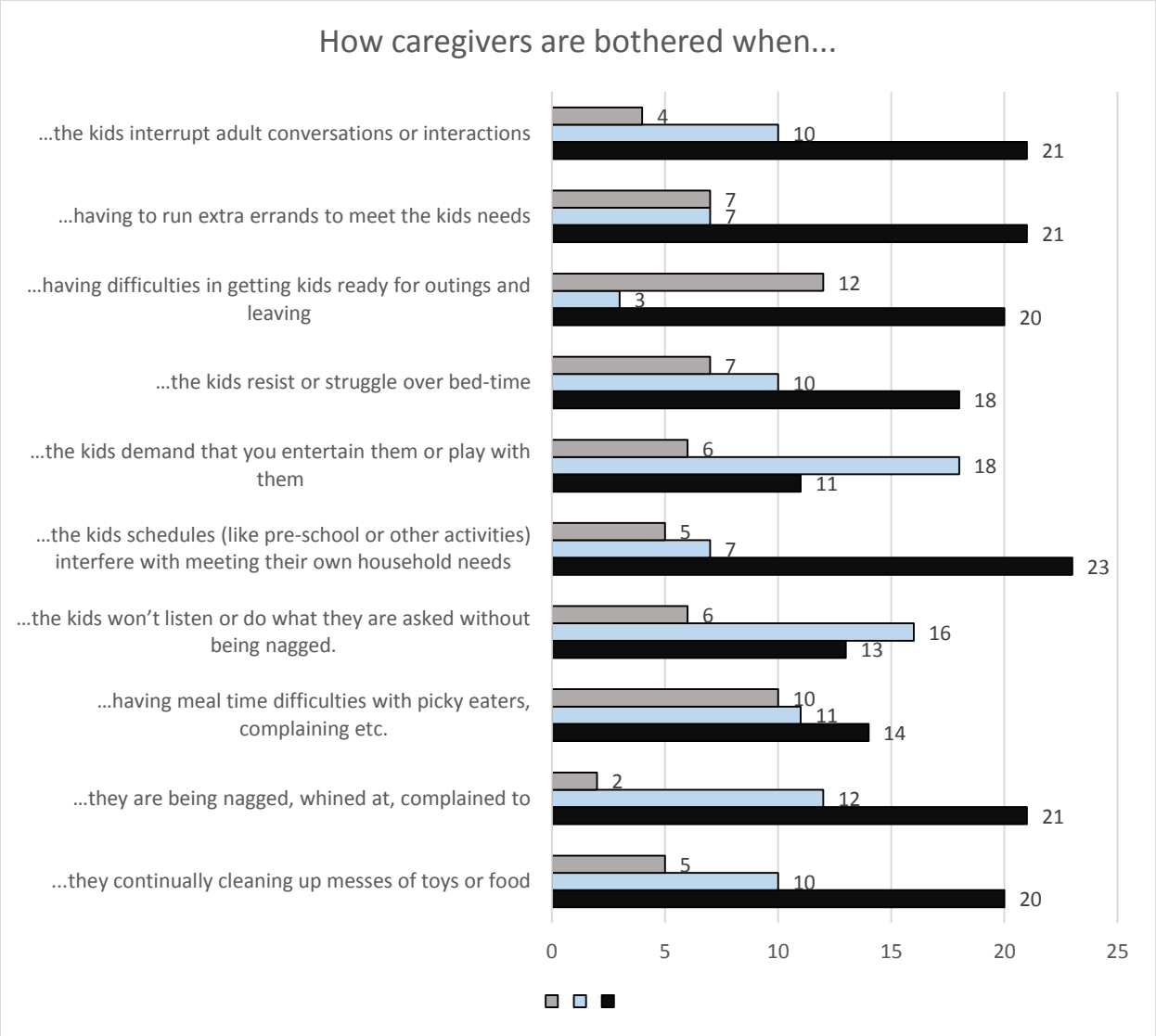

Figure 2: Intensity of caregiver stress

As can be noted from the Figures 1 and 2, the stressors most experienced by caregivers were having to run extra errands to run children's needs and continually cleaning up messes of toys and food. The stressor that most bothered mothers was when children demanded them (mothers) to entertain or play with them while the one that last bothered them was children resisting/struggling with them over bed time.

4.3 Child attachment patterns

The second objective of this study was to *determine child attachment patterns in SOS children's villages*. To determine the attachment patterns, children were classified as either securely attached; secure/insecure(*ly*) attached; and insecure(*ly*) attached.

The results show the attachment patterns that exist in SOS children's villages. As indicated in Figure 3, 34.3% of the children displayed *secure* attachment to their caregivers; 54.3% of the children displayed *secure/insecure* attachment to their caregivers; and 11.4% of the children displayed *insecure* attachment patterns. These findings showed that the majority of the children were *secure/insecure(ly)* attached to their caregivers.

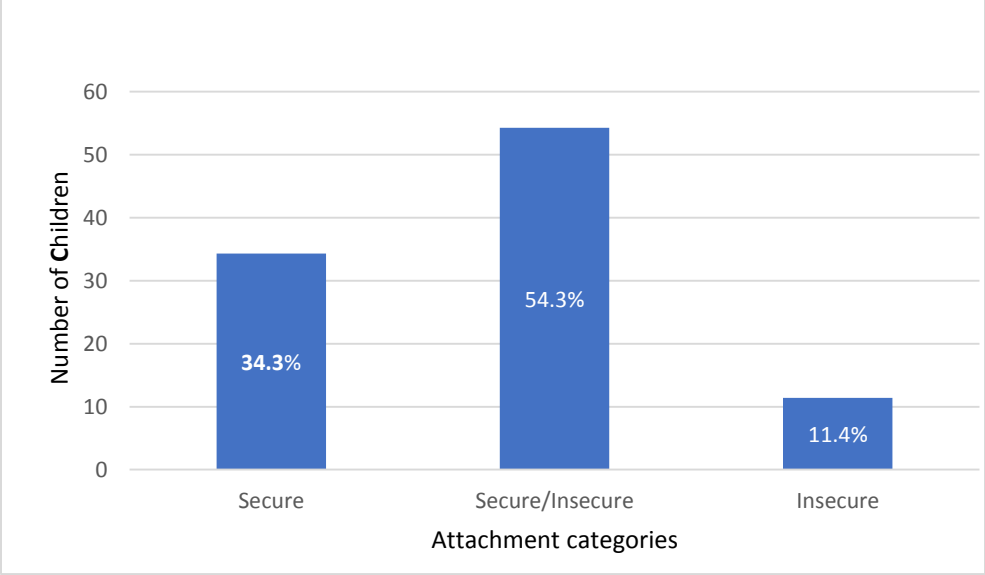

Figure 3: Attachment classifications

Further attachment was categorized as either *secure* or *insecure*. When this was done, the results showed that 57.1% of the children were *securely* attached to their caregivers and 42.9% of the children were classified as having *insecure* attachment patterns, as shown in Figure

4 below.

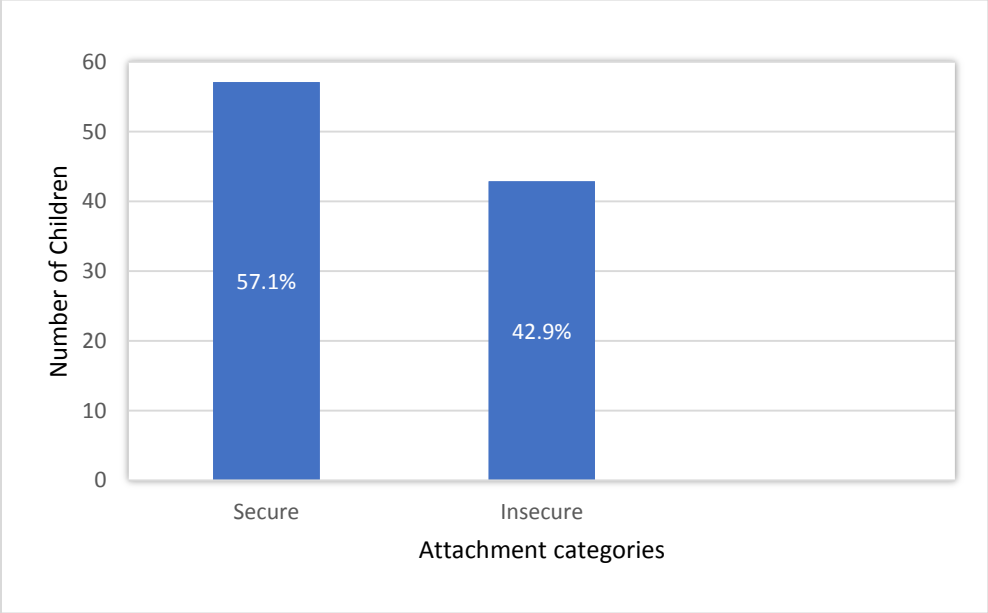

Figure 4: Attachment classification (secure/insecure)

4.4 Caregiver sensitivity

The third objective of this study was to *examine caregiver sensitivity in SOS Children's Village.* The results showed that the majority of caregivers were moderately sensitive to children in their care as can be seen in figure 4 below, 74% of the caregivers were moderately sensitive while 26% of them were highly sensitive. Caregivers who experienced stress often, reported lower levels of sensitivity. Caregivers who experienced hassles more frequently than their counterparts exhibited lower sensitivity, as measured using the daily hassles questionnaire.

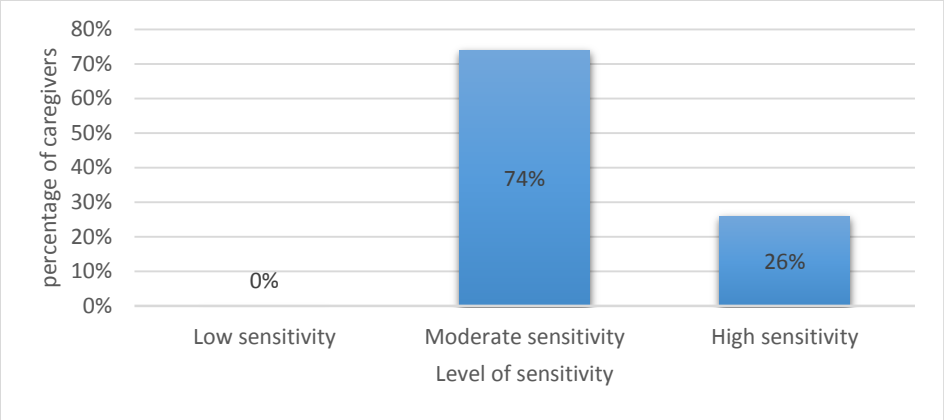

Figure 5: Level of caregiver sensitivity

4.5 Caregiver sensitivity and child attachment

The fourth objective of this study was to *determine the relationship between 'caregiver sensitivity' and 'child attachment pattern'*. To test this, a Pearson correlation was conducted. As can be seen from Table 2 below, there was no relationship between *caregiver sensitivity* and *child attachment style*, $r = -.06$, $p > .05$.

Table 2: Correlation matrix – sensitivity and attachment

		1	2	3	4	5	6
1	Caregiver sensitivity	-					
2	Caregiver's age	.03	-				
3	Caregiver stress *frequency**	-.51**	-.33*	-			
4	Caregiver stress *intensity**	-.37*	-.47**	.88**	-		
5	Child sensitivity/responsiveness	.30*	.08	-.17	-.15	-	
6	Child attachment style	-.06	.01	.06	.08	-.06	-

Notes: *p< .05, **p< .01

CHAPTER FIVE: DISCUSSION

5.1 Overview

This chapter presents the detailed discussion of the study findings. In the present study, child care and attachment to caregiver were both assessed. This provided the opportunity to address several important theoretical issues in attachment research (especially in the Zambian context), more specifically of attachment styles among children raised in institutional care. The main aim of this study was to investigate childcare and attachment in the orphanage. The findings were that the SOS Children's village mimics the traditional family unit; the majority of children were securely attached; the caregivers were moderately sensitive to the children in their care; there was no relationship between maternal sensitivity and child attachment pattern; and the frequency of daily hassles significantly predicted maternal sensitivity.

5.2 Nature of child care in SOS Children's Village

The first objective was to *explore child care in the SOS Children's Villages orphanage*. Anecdotal evidence shows that the nature of child care in other orphanages does not put into consideration the *traditional family setup*. This *traditional family setup*, existent in most orphanages, has been associated with negative child outcomes e.g. slow language acquisition and reduced social, emotional and cognitive abilities (Sonuga-Barke et al, 2017). Some of the factors associated with the *traditional family setup* include *high caregiver turnover*, high child-caregiver ratio etc. SOS villages has acted to buffer the effects of the *traditional family setup* in the institutional context by ensuring that they have stable and consistent caregivers (the mother). In addition, they have limited the number of children in the home to 10, mimicking the family setup common in most Zambian family settings which have an average of 6 family members. In the

SOS Children's village, the influence that the family unit has on the holistic development of the child is viewed as important. The family unit is characterised by emotional support from other family members i.e. mother and siblings, learning to resolve conflicts, and parental care. These domains of care are linked to the holistic child development for example for a child's language domain to develop, that child needs to interact with other people who talk to that child and then he/she will develop. Children develop physically depending on the type of nutrition, health care they get and these all fall under parental care. In addition, children develop emotionally by interacting with others beginning with their family members and they develop cognitively too by resolving conflicts with others. Although the family setup in SOS has no fathers, they have SOS-mothers, aunts and siblings, mimicking the traditional family setup in most Zambian contexts where children experience multiple caregivers while the mother still remains the primary caregiver (Mooya, 2016). Children in SOS are not exposed to a lot of caregivers but have one permanent caregiver so in a way there is a certain level of consistency in this type of child care institution. Unfortunately, it is not the perfect family because the caregivers tend to go on "leave" (meaning they leave their "SOS homes" to go to their personal homes and then a substitute caregiver is put in charge of their orphanage home). It would be interesting to study how such an arrangement affects attachment in children. Because there are questions of whether children may get attached to the substitute caregiver in the absence of the permanent caregiver. Especially if the permanent caregiver is away for a long period of time. Additionally, it was found that sometimes caregivers had difficulties separating their personal home issues from their work in the orphanage, hence, in some instances if the caregiver has personal family problems, this will directly affect her emotional state. This will result in compromising the way she relates to the children. In addition to the personal problems, the caregivers in the orphanage deal with a

lot of administrative work which usually puts them under pressure. For example the administrators of the orphanage would expect the caregivers to do some administrative work (for example: writing child reports) and give them a tight timeline in which to complete the task without taking into account that they have a number of children to care for; it is such frustrations that compromise the quality of care and caregiver-child interactions. Further, the responses to the daily hassles questionnaire which measured *caregiver stress* showed that the majority of caregivers were usually carrying out daily tasks as opposed to entertaining or playing with the children. Although they acknowledged that their interaction with the children was important for the socio-emotional development of the children they did not actively engage in interactions with the children especially play. This suggests that they were often stressed and preoccupied with the proper running of their homes hence unable to invest enough time into their relationships with the children.

The quality of care, including caregivers' availability, sensitivity, acceptance, and a sense of belonging, is related to children's emotional and social outcomes. Sensitive care also implies a relationship between infant and caregiver that is stable over time. The most serious problem in many institutions is that the infant/caregiver ratio is too high thereby presenting a challenge for the caregivers to take good care of the children. In Metera, for instance, the infant/caregiver ratio ranged from 4:1 to 6:1, which does not offer sufficient opportunities for one-to-one interaction and reciprocal communication (Vorria et al., 2003).

The findings of this study also showed the different daily hassles that caregivers were faced with in SOS Children's Village. Many of them reported that they spent most of their time (frequency) performing these daily hassles. This was because they had many things to do daily. They also reported how much bothered they were by performing these daily hassles and the

majority of them reported that they were not bothered. This means that the majority where not bothered by the daily hassles they had to perform but the amount of time they spent performing these daily activities affected them.

5.3 Child attachment patterns

The second objective was *to explore child attachment patterns in SOS Children's Villages*. It was hypothesized that *the majority of the children will be insecurely attached*. When attachment was assessed on a three-point scale (*secure; secure/insecure insecure*), it was found that the majority of the children were *secure/insecure*. When attachment was further assessed on a two-point scale (*secure; insecure*), the results showed that the majority of the children were securely attached. These results contrasted with other studies conducted with institutionalised children. In the Zeanah et al. study none of the institutionalized children was found to be securely attached (Zeanah et al., 2005). This difference in findings may have mainly been because of the difference in the childcare present in the SOS Children's Village. This difference being the closeness of how children are taken care of in the orphanage to how they are taken care of a biological family setting. However, the findings of the present study are similar to the findings of a study conducted by Vorria and colleagues where it was found that in spite of insufficient sensitive care in residential settings, one in five of the Greek infants was securely attached with their caregiver (Vorria et al., 2003). It is speculated that this was because of the consistency of caregiving that exists in SOS Children's Village. Furthermore, it is because the children live with their siblings and this is in line with Mooya (2016) who found that children form attachments to their siblings. According to the National Conditions and Guidelines for alternative care in Zambia, sibling groups should be kept together and in SOS Children's Village, biological siblings are raised by the same caregiver as opposed to separating them, they are taken

under the care of the same SOS-mother (SOS Children's Villages Zambia, 2014). Although the results were contrary to what was hypothesized, the percentage of children with insecure attachment (when attachment was assessed on a two-point scale) was relatively high. Securely attached children reported to having both good and bad times with their caregivers and they described themselves in a more positive light but still possessed a capacity to acknowledge normal imperfections, a combination that reflects the confidence to explore and reveal both strong and weak points of the self and other (Cassidy, 1988). The importance of the relationship with the caregiver was acknowledged in their completion of the story stems, and interaction with her was described as clear, direct, positive, and supportive; more often than in the stories of the other children, the child protagonist was accepted and valued, and affection was expressed. Just as these children could tolerate imperfections in themselves, so the relationships described in the stories could tolerate stress.

In theory, such capacity for confident exploration of both the self and the relationship follows from the "secure base" of an accepting and accessible attachment figure and is in line with a large body of attachment research (e.g., Arend, Gove, & Sroufe, 1979; Cassidy, 1986; Main et al., 1985; Main & Weston, 1981; Sroufe, 1983; Waters, Wippman, & Sroufe, 1979). The organization of children classified as insecure/avoidant centers on avoidance of the relationship. The findings of the current study concur with a growing body research on attachment connecting avoidance to a dismissal of the importance of attachment relationships (Main & Kaplan, 1985; Main, 1990; Main & Goldwyn, 1984) and to a defensive idealization of the self or the attachment figure (Main & Goldwyn, 1984; Main, George & Kaplan, 1985). Both Bowlby (1973, 1980) and Ainsworth et al. (1978), have theorized that avoidance serves the function of preventing the processing of information that would trigger attachment behaviour and that it can thus be viewed

as a defensive mechanism. Dismissal of the importance of the relationship with mother in the doll stories can be viewed as an instance of the child's excluding from conscious processing input that tends to activate attachment behaviour: Admitting that nurturing and responsive relationships are important, when faced with the lack of such a relationship might arouse extremely painful emotions or prompt either anger or clinginess, which might increase the risk of alienating the attachment figure (Main & Weston, 1981).

This insecure attachment might have been because the caregivers were not readily available to the children therefore, they were unable to form lasting and trusting relationships with them. However, these inconsistencies in *caregiver sensitivity* were in most cases due to the other duties and tasks that the caregivers were engaged in. Noting that caregiver sensitivity is part of parenting, this finding is in line with the findings from a study by Chansa, who found that, orphanage children are often exposed to inconsistent and inadequate parenting hence, they experience difficulty in forming healthy attachments (Chansa, 2009). From the results of this study, the type of parenting and care that the children generally receive is not the same as in normal families and this affects attachment formation and child outcomes. Unlike in the orphanage, in a normal family unit, parents do not go on leave from their parenting duties that is caring for their children, cooking, cleaning, and helping their children with school work.

5.4 Caregiver sensitivity

The third objective of this study was *to examine caregiver sensitivity in orphanages*. Caring for children whether in an orphanage or family setting is a process that requires a sensitive and responsive caregiver who is capable of emotional engagement and participation in contingent collaborative communication (responsive communication) both verbal and non-verbal levels (Chansa, 2009). In the present study, it was found that the majority of the caregivers were

moderately sensitive and this finding was because the majority of caregivers were more concerned about getting things done (cleaning the house, buying groceries, writing reports) and ensuring that the children had food, clothes, school materials, but when asked whether they played with the children, the majority of them responded *NO*. One reason for this was that each house within the orphanage had a routine, and playing with the children was not part of the routine. Another contributing factor to this is that in Zambia, traditionally, parents or adults *never* play with children.

Additionally, because of the high caregiver-child ratio, it was difficult for the caregiver to pick up on each child's non-verbal cues such as body language, facial expressions and attend to the needs of each child at that moment, so these needs were not met and this was interpreted negatively by the children as they did not understand their caregiver's pressure. In turn, they too became less emotionally available, responsive and sensitive. In this study, the majority of caregivers did not pay attention to the children's non-verbal cues and this further strained their emotional relationship. The caregivers were moderately sensitive and responsive to the children's emotional needs due to the overwhelming amount of duties they had to perform in addition to caring for several children (Vorria et al., 2003).

5.5 Caregiver sensitivity and child attachment

The fourth objective of this study was to determine the relationship between *caregiver sensitivity* and *child attachment patterns.* The results showed that there was no relationship between *caregiver sensitivity* and *child attachment pattern*. The findings of the present study contradict previous research supporting the notion that parents or caregivers who are less sensitive are associated with insecure child-parent or child-caregiver attachment relationships which in turn decrease the optimal conditions for the children's socio-emotional development

(Main, Kaplan & Cassidy, 1985). Studies have also shown that insecure attachment is presumed to be a result of frightening parental behaviour (Hesse & Main, 2006; Main & Hesse, 1990). Furthermore, the relationship between attachment representation and sensitive parenting may be influenced by the possible moderating effect of child characteristics, and/or the positive attachment relationships formed with other people (Verschueren & Marcoen, 1999; Stevenson-Hinde & Verschueren, 2002). Therefore, in the present study this finding was because of the influence from the moderating effect of the children's relationships among themselves and other significant others. In other words, the children in SOS Children's Village were securely attached because of the nurturing relationships they had formed with other children, or other significant others aside from their primary caregivers.

CHAPTER SIX: CONCLUSION

6.1 Overview

This chapter contains the conclusions, limitations and recommendations of the study.

6.2 Conclusion

There is no doubt that studying child care and institutionalisation is important. The present study has clearly highlighted the childcare practices that exist in the orphanage as well as the attachment patterns that exist in the orphanage. It has brought to light the daily hassles that caregivers in the orphanage experience and that the frequency of these daily hassles may affect caregiver sensitivity. The strength of this study is that it has shown how childcare practices influence child attachment patterns. This has contributed towards the literature on attachment especially in Zambia where it is currently understudied.

6.3 Recommendations

The following recommendations can be made;

i. Future research could compare the developmental outcomes of children in an orphanage setup like SOS with those in the old orphanage set up (the ones with multiple caregivers).

ii. Lastly but not least, the stakeholders should help reduce the number of children per caregiver by building more houses for the children. When the child to mother ratio is reduced, it will be less stressful for caregivers and may result in better child-caregiver attachment relationships.

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APPENDICES

APPENDIX A: Informed Consent Form
"Child Care and Attachment in Institutional Care."

THE UNIVERSITY OF ZAMBIA

DIRECTORATE OF RESEARCH ND GRADUATE STUDIES

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Telephone:	+260-211-290258/293937	P. O. Box 32379
Fax:	+260-211-290258/293937	Lusaka, Zambia
E-mail	drgs@unza.zm	

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Informed Consent Form for Caregivers in SOS Children's Villages Lusaka who are being invited to participate in a research titled "Child Care and Attachment in Institutional Care."

Name of Principal Investigator: Thokozile Phiri

Name of Organization: University of Zambia

Study Title: Child Care and Attachment Styles in Institutional Foster Care.

Contact information: +260978658402

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

I am Thokozile Phiri, studying for the qualification of Master of Arts degree in Child and Adolescent Psychology at the University of Zambia. I am doing research on the type of child care that exists in SOS Children's Villages and its influence on child attachment patterns. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me.

Purpose of the research

The relationships we form with people are important even as children and the type of care that children get may influence how they relate with others. I believe that you can help by telling me what you know about child care in institutional foster care and about child care practices in general. We want to learn what type of care children in SOS get and also how you relate with them as well as how they view you. This information may serve as a pathway to bringing help in this area of child care.

Type of Research Intervention

This research will involve your participation in answering a self-administered questionnaire which will take about 30 minutes to 1 hour. But of course, if you do not understand any part in the questionnaire, you are free to ask me for clarity.

Participant Selection

You are being invited to take part in this research because I feel that your experience as an SOS-mother/caregiver can contribute much to our understanding and knowledge of the child care practices here and generally.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate nothing will change. You may change your mind later and stop participating even if you agreed earlier.

Procedures

I am asking you to help me learn more about child care practices in institutional foster care. I am inviting you to take part in this research project. If you accept, you will be asked to answer some questions about child care practices and also how you interact with the children in your care.

You may answer the questionnaire yourself, or it can be read to you and you can say out loud the answer you want me to write down. If you do not wish to answer any of the questions included in the questionnaire, you may skip them and move on to the next question. I will bring the questionnaire to you and you may either fill it out as I wait or I could live it with you, and collect it another time. The information recorded is confidential, your name is not being included on the forms, only a number will identify you, and no one else except my academic supervisor and I, will have access to your survey.

Duration

The research takes place over a period of one month in total. During that time, I will visit you more than once depending on the number of children in your care qualify and agree to participate in the research.

Risks

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation is likely to help us find out more about how to maintain or improve child care practices here as well as in other foster care institutions. Doing so may also help us find ways of helping children's social and emotional development.

Reimbursements

You will not be provided any incentive to take part in the research.

Confidentiality

The research being done in SOS Children's Villages may draw attention and if you participate you may be asked questions by other people in the community. I will not be sharing information about you to anyone outside of the research team. The information that I collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researcher will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except my academic supervisor.

Sharing the Results

Nothing that you tell me today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that I get from this research will be shared with you through administers of SOS Children's Villages Lusaka, and it will also be made widely available to the public. The results will be published so that other interested people may learn from the research.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the research at any time that you wish without your job being affected or anything bad happening to you.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me: Thokozile Phiri on +260978658402 or email: pthokozile8@gmail.com. This proposal has been reviewed and approved by the Humanities and Social Sciences Research Ethics Committee, University of Zambia.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I have been invited to participate in research about child care and attachment styles in institutional foster care.

(This section is mandatory)

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

If illiterate [1]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of participant**

Signature of witness _____

Date _____

Statement by the researcher/person taking consent

[1] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. Confidentiality will be exercised

2. The participant's rights will be respected

3. Voluntary participation

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Appendix B: Assent Form

THE UNIVERSITY OF ZAMBIA

DIRECTORATE OF RESEARCH ND GRADUATE STUDIES

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Telephone:	+260-211-290258/293937	P. O. Box 32379
Fax:	+260-211-290258/293937	Lusaka, Zambia
E-mail	drgs@unza.zm	

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Informed Assent Form for children between the ages of 6 -10 years who are permanent residents in SOS Children's Villages Lusaka and who are being invited to participate in this research on Child Care and Attachment in Institutional care.

Name of Principal Investigator: Thokozile Phiri
Name of Organization: University of Zambia
Study Title: Child Care and Attachment in Institutional Care.
Contact information: +260978658402

This Informed Assent Form has two parts:

- **Information Sheet (gives you information about the study)**
- **Certificate of Assent (this is where you sign if you agree to participate)**

You will be given a copy of the full Informed Assent Form

Part I: Information Sheet
Introduction

My name is Thokozile Phiri and my job is to research on the type of child care that exists here in SOS and how it influences the way you relate with your mother, friends and other people. I want to know how the care you get affects your relationships with others and I think that this research could help tell me that.

I am going to give you information and invite you to be part of a research study. You can choose whether or not you want to participate. I have discussed this research with your parent(s)/guardian and they know that I am also asking you for your agreement. If you are going to participate in the research, your parent(s)/guardian also have to agree. But if you do not wish to take part in the research, you do not have to, even if your parents have agreed.

You may discuss anything in this form with your parents or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not after you have talked it over. You do not have to decide immediately.

There may be some words you don't understand or things that you want me to explain more about because you are interested or concerned. Please ask me to stop at any time and I will take time to explain.

Purpose: Why are you doing this research?
I want to find ways to improve the care you get so that you can develop healthy and meaningful relationships with your parent(s)/guardian(s), siblings, friends and others. In order to find these ways, it is better to first know the existing types of care.

Choice of participants: Why are you asking me?
I need this information from children who are your age - between 6 and 1o years old - who live in SOS Children's Villages which is a foster care institution. I am only getting this information from children who live in this particular foster care institution.

Participation is voluntary: Do I have to do this?
You don't have to be in this research if you don't want to be. It's up to you. If you decide not to be in the research, it is okay, and nothing changes. This is still your home; everything stays the same as before. Even if you say "yes" now, you can change your mind later and it's still okay.

I have checked with the child and they understand that participation is voluntary __(initial)

Procedures: What is going to happen to me?

I am going to ask you some questions about yourself and how you relate with your parent(s)/guardian(s) and what things you do together. Then I will start four stories which I am going to ask you to complete in your own ways. The stories will be short and once you are done with each story please let me know by saying, "The end".

I have checked with the child and they understand the procedures _____(initial))

Risks: Is this bad or dangerous for me?
There is no harm that will come to you by participating in this research. But you might feel uncomfortable to answer some questions, in which case you are free to let me know

I have checked with the child and they understand the risks and discomforts ____(initial)

Benefits: Is there anything good that happens to me?
Nothing really good might happen to you. The vaccine may not stop you from getting malaria. But this research might help in finding ways to improve the care you get and that could help other children who are in foster care institutions.

I have checked with the child and they understand the benefits_____ (initial)

Reimbursements: Do I get anything for being in the research?
You will not get any gifts or money. Because you live quite far from the clinic, we will give your parents enough money to pay for the trip here and (whatever other expense is reasonable).

Confidentiality: Is everybody going to know about this?
I will not tell other people that you are in this research and all the information you will give will not be shared with anyone who does not work in the research study. After the research is over, your parent(s) will be told the results.

Information about you that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except my academic supervisor.

Sharing the Findings: Will you tell me the results?
When we are finished the research, I will share the results with your parent and I will tell her what we learnt. I will also give you a paper with the results written down. Afterwards, we will be telling more people, scientists and others, about the research and what we found. I will do this by writing and sharing reports and by going to meetings with people who are interested in the work I do.)

Right to Refuse or Withdraw: Can I choose not to be in the research? Can I change my mind?
You do not have to be in this research. No one will be mad or disappointed with you if you say no. It's your choice. You can think about it and tell me later if you want. You can say "yes" now and change your mind later and it will still be okay.

Who to Contact: Who can I talk to or ask questions to?
You can ask me questions now or later. I have written a number and address where you can reach me. If you want to talk to someone else that you know like your teacher or parent or auntie, that's okay too.

If you choose to be part of this research I will also give you a copy of this paper to keep for yourself. You can ask your parents to look after it if you want.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

PART 2: Certificate of Assent
I understand the research is about finding out the type of child care that exists in SOS Children's Villages Lusaka and how it affects my relationships with the people close to me and others. I understand that I will have to answer some questions and give information about myself.

I have read this information (Or had the information read to me) I have had my questions answered and know that I can ask questions later if I have them.

I agree to take part in the research.

OR

I do not wish to take part in the research, and I have <u>not</u> signed the assent below. _____ (initialed by child/minor)

<u>Only if child assents:</u>

Print name of child _____

Signature of child: _____

Date: _____

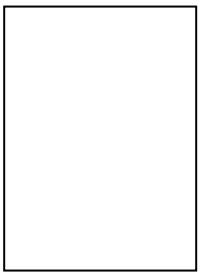
If illiterate:
A literate witness must sign (if possible, this person should be selected by the participant, not be a parent, and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I have witnessed the accurate reading of the assent form to the child, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness (not a parent) _____ AND Thumb print of participant

Signature of witness _____

Date _____



I have accurately read or witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

Print name of researcher_____

Signature of researcher_____

Date_____

Statement by the researcher/person taking consent
I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the child understands that the following will be done:
1. The child will be asked some questions
2. The child will be asked to complete some stories
3. The child's rights will be respected.
I confirm that the child was given an opportunity to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this assent form has been provided to the participant.

Print Name of Researcher/person taking the assent_____

Signature of Researcher /person taking the assent _____

Date _____
Copy provided to the participant _____ (initialed by researcher/assistant)

Parent/Guardian has signed an informed consent ___Yes ___No____ (initialed by researcher/assistant)

Appendix C: Constructs and measures

Domain	Constructs	Measures
Caregiver	Sensitivity	Emotional Availability Scale
	Responsiveness	
	Non-intrusiveness	
Child	Responsiveness	Emotional Availability Scale
	Involvement	
	Attachment	Attachment Story Completion Task
Child care	Caregiver stress	Daily Hassles Questionnaire

Appendix D: Emotional Availability Scale-Caregiver

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY.

Dear Participant, I am a Postgraduate student on the Child & Adolescent Psychology program at the University of Zambia, Great East Road Campus carrying out a research on child care and attachment. This survey is designed to get feedback on Child Care and Attachment in Zambian Orphanages.

Kindly be informed that you have been chosen in a sample of respondents to take part in the study by providing answers to a set of questions. Please, do answer the questions as honestly as possible. Be assured that the information that you will give in the questionnaire will not be revealed to anyone. Therefore, it will be treated with utmost confidentiality. This is why you are not required to indicate your name. Furthermore, this study is purely for academic purposes. It is a requirement for the partial fulfilment of the award of the Master of Arts Degree at the University of Zambia.

Thank you very much for your cooperation.

Yours faithfully,

Researcher

Questions about the family/child

#	Item				
1	Mother's age (years)				
2	Religion				
3	Mother's level of education	1. No education			
		2. Primary level			
		3. Secondary level			
		4. College/university level.			
4	Child's age (years)				
5	Number of children in family home				
6	Does child have biological siblings in family home?	Yes		No	
7	If yes, how many?				
8	Is child generally healthy?	Yes		No	
9	How old was the child when he/she came to				

	SOS Children's Village?				
10	Ages of the other children in family home.	1.		2.	
		3.		4.	
		5.		6.	
		7.		8.	
		9.		10	
11	Does the focus child help take care of younger siblings?				

SECTION 1

This part of the questionnaire is designed to assess the way you relate with your child. You will be asked to answer questions about your child. Please indicate your answer by crossing (X) below the answer of your choice.

No.	ITEM	NEVER	ALMOST NEVER	SOMETIMES	ALMOST ALWAYS	ALWAYS
1.	My child is upset a lot.					
2.	My child doesn't talk to me (…or babble and vocalize, if that is what is appropriate for your child's					

	level).					
3.	I wish my child smiled more and seemed happier.					
4.	My child listens to me (or appears to) when I talk to him or her.					
5.	My child seems happy when with others.					
6.	My child has lots of fun with me.					
7.	My child has a few friends.					
8.	My child seems sad to me.					
9.	Others (e.g., teachers, my friends) have commented on my child not seeming happy.					
10.	My child and I do a lot together.					
11.	My child listens to me when I discipline him or her.					
12.	My child tries to talk to me when he or she has something on his or her mind.					
13.	When I try to talk to my child he or she seems disinterested in my joining in.					
14.	My child likes to be on his or her					

	own and is a bit of a loner.					
15.	I feel I don't have a lot of control and my child is the one with control around here.					
16.	I don't feel I know this child.					
17.	When my child seems not to want to play with me, I feel hurt.					
18.	My child cries a lot and seems to get frustrated easily.					
19.	I listen to my child when he or she tries to explain things to me.					
20.	I try to see things from my child's perspective.					
21.	When things go wrong, I get frustrated easily.					
22.	I am usually in a good mood around my child.					
23.	When things go wrong, I tend to be flexible.					
24.	When I see that my child isn't getting it right, I jump in to correct him or her.					
25.	It's difficult for me to separate					

	from my child (for school, sleepovers).					
26.	I shadow my child's every step as if it could be his or her last and worry.					
27.	My child seems to need a lot of assurances of my caring and attention and seems to use distress to get attention.					

SECTION 2

The statements below describe a lot of events that routinely occur in families with young children. These events sometimes make life difficult. Please read each item and cross (X) how often it happens to you (rarely, sometimes, a lot, or constantly) and then cross (X) how much of a 'hassle' you feel that it has been for you **FOR THE PAST 6 MONTHS**. If you have more than one child, these events can include any or all of your children.

Sn	**Event**	**How often it happens**				**How much it bothers you (low to high)**				
		Rarely	**Sometimes**	**A lot**	**constantly**	**1**	**2**	**3**	**4**	**5**

1	Continually cleaning up messes of toys or food									
2	Being nagged, whined at, complained to									
3	Meal-time difficulties with picky eaters, complaining etc.									
4	The kids won't listen or do what they are asked without being nagged.									
5	The kids schedules (like pre-school or other activities) interfere with meeting your own household needs									
6	The kids demand that you entertain them or play with them									
7	The kids resist or struggle with you over bed-time									
8	Difficulties in getting kids ready for outings and leaving on									

9	Having to run extra errands to meet the kids needs									
10	The kids interrupt adult conversations or interactions									

*******Thank you very much for your participation and time********

Appendix E: Emotional Availability Scale-Children

SECTION 1

Please tick (X) the answer of your choice.

Sn.	**Item**	**Never**	**Almost never**	**Sometimes**	**Almost always**	**Always**
1.	My mother is upset a lot.					
2.	My mother doesn't talk to me much.					
3.	I wish my mother smiled more and seemed happier.					
4.	My mother listens to me when I talk to her.					
5.	My mother seems genuinely happy when with me and with others.					
6.	My mother has a lot of fun with me.					
7.	My mother has few friends.					
8.	My mother seems sad to me.					
9.	Others have commented on my mother not seeming happy.					
10.	My mother listens to me when I					

	disagree with her.					
11.	My mother tries to talk to me when she has something on her mind					
12.	When I try to talk to my mother about important matters, she seems disinterested.					
13.	My mother likes to be on her own and does not include me in important events or decisions.					
14.	I feel I don't have a lot of control, and my mother is the one with control around here.					
15.	I don't feel like I know my mother.					
16.	When my mother seems not to want to be with me, I feel hurt.					
17.	My mother gets angry easily and seems to get frustrated easily.					
18.	I listen to my mother when she tries to explain things to me.					
19.	I try to see things from my mother's					

	perspective.					
20.	When things go wrong, I get angry and frustrated easily.					
21.	I am usually in a good mood around my mother.					
22.	When things go wrong, I tend to be flexible.					
23.	It’s difficult for me to separate from my mother and I always want to be with her.					
24.	I shadow my mother's every step.					

Appendix F: Attachment Story Completion Task

This part is designed to assess the way in which you mentally represent important people in your life. You will be asked to complete four short stories.

1. "Crying after quarrel with friend at school."

Lusungu lent her pencil to her friend who didn't have a pencil in class. When it was time to knock off from school, her friend refused to give back the pencil to Bwalya and so they started quarrelling. Her friend said some bad things to her, and Bwalya started crying…. (What happens next?)

2. "Saying I'm sorry"

Kaluwe was rushing to go and watch magic bar. So, as he was running to the kitchen to go and put the glass cup, he dropped it accidentally and it broke. He knew that his mother wasn't going to be pleased with him. Kaluwe collected the broken glass on a dust pan and went to tell his mother. He said, "Mummy, I'm sorry. I have broken a cup." …. (What happens next?)

3. "Favourite toy stolen by unfamiliar child"

Mbawemi loves to play with his water gun, it is his favourite toy. Today, when he got home from school, he found his water gun missing. He had left it outside when he was going to school in the morning. Mbawemi asked his friends in the neighbourhood if any of them knew where his water gun was. One of them said that he had seen it with a child from across the road who they all didn't know… (What happens next?)

4. "Giving a present to attachment to figure"

Today is Mother's Day and Thumbiko has planned to do something special for her mother. She has been saving money to buy a present for her mother. When her mother returned home from work, Thumbiko gave her mother a present wrapped in pink wrapping paper and a flower she had plucked from their flower bed… (What happens next?).