CHAPTER ONE
INTRODUCTION

1.1 Background

The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic is one of the greatest challenges confronting humankind. The magnitude of the pandemic has exposed children to extensive adversity in a world affected by HIV and AIDS (UNICEF, 2007). HIV and AIDS can render children vulnerable in a multitude of ways, including placing them at increased risk of experiencing negative life effects, exposing them to increased poverty, losing their parents and other significant adults, dropping out of school and being excluded from social networks and processes (Richter, Foster & Sherr, 2006).

HIV and AIDS has devastated the lives of millions of children, and the anticipated extent of the mounting crisis is enormous. "In 2004, globally, more than 14 million children, under the age of 15 had lost their mother or father or both parents to AIDS" (Gulaid, 2004:43). This figure was projected to reach 25 million by 2010 (ICAD, 2001:01). Estimates reported that, about 55 percent of all orphans were of ages 12 to 17 years (UNAIDS, 2004).

Resilience has been identified as a psychological construct which is multifaceted in nature. 'The concept of resilience was a complex construct that involved interaction between adversity and an individual's internal and external protective factors as well as developed competencies that allowed one to overcome adversity". (Luthar & Zigler, 1991; Rutter, 1987; Masten,2001) argued that resilience in an individual required two judgments, first that an individual should be exposed to significant risk or adversity and secondly, the individual had achieved at least typical or normal developmental outcomes. Resilience is a continuum that varies with each developmental stage and could be expressed in behaviours at each stage that could be interpreted as positive or negative and has the ability to promote or impair health (Howard, 1996; Luthar & Zigler, 1991; Morsi, 1998; Werner, 1992).

Therefore, promoting resilience is critical as that contributes to the prevention of negative outcomes for youths challenged by significant stressors. In children, "resilience had to be understood as the capacity of a child to deal effectively with stress and pressure, to cope with everyday challenges, to rebound from disappointments, mistakes, trauma, and adversity, to develop clear and realistic goals, to solve problems, to interact comfortably with others, and to treat oneself and others with respect and dignity" (Brooks & Goldstein, 2006; 297).

1.2 Theoretical framework

The construct of 'resilience' broadly refers to the class of phenomena involving successful adaptation in the context of significant threats to development (Masten, 1994–).To study resilience, researchers have devised several methodologies and these included the retrospective, single sample or cross-sectional study (Zirmin,1986:339-349), short-term, transactional, longitudinal study (Luthar et al., 1993) and long-term prospective studies (Werner & Smith,1982).

Impediments to the availability of care givers not only during infancy, but also during childhood, adolescence and adulthood continue to play a prominent role in the quality of care available to the individual and in the emergence of psychopathology (Johnson, 1996, Klerman, Weissman, Rounsaville and Chevron, 1984; Mufson, Moreau,Weissman,& Klerman,1993).Contextual stressors such as financial strain, residential change and neighbourhood violence reduced caregivers capacities for providing available and responsive care (Cassidy,2008).The way in which children and caregivers adapted to these stressors so as to maintain an attachment bond was an important factor influencing developmental pathways.

The model of Genetics in explaining an individual's capacity to cope with any challenges, assumes that "Individual attributes such as temperament, cognitive abilities and the environment affect their resilience. Some would develop psychopathology, while others would not and this phenomenon explained why children in the same family had different developmental outcomes. According to this framework, gene-environment transactions were necessary to trigger psychopathology. Plomin (1994) examined the role of genetics in resilient children and reached a conclusion that genetics often times protected individuals from developing psychopathology and

increased resilience . Rutter, (1990), also emphasized the role of genetics by citing for example that children raised by depressed parents who manifested depression could not represent purely environmental outcomes in children but rather could have been mediated by genetics. The advocates of this model argued that resilience in some children could well be explained by means of interpreting genetic, biological, psychological and sociological factors. As children develop and interact with the environment, resilience formed and enabled children to handle future challenges.

The literature revealed various perspectives of studying resilience but this study used Bronfenbrenner's ecological model as the basis of its investigation. The major focus of this model was that a child's development was beyond an individual as the basis of analysis. He argued that a child's environment could not be reduced to a single immediate setting containing the subject but rather should include conditions outside any immediate setting that could have had profound influence on behavior and development within the setting (1979). Bronfenbrenner's ecological model therefore divided a child's environment into micro-, meso, exo-, and macro-systems as the basis of child development.

Microsystem according to Bronfenbrenner's theory (1979), are all the settings in which a child personally interacts and is influenced. Some last a long time throughout childhood such as the family, others come and go regularly such as a class or a Club. In the Microsystem, the child is affected directly where social relationships take place. A child builds cognitive or physical skills, experiences, personal successes, failures and a child is socialized through first-hand personal experience.

Mesosystem are connections between contexts such as relation of family experiences to school ,church, families and to peer experiences.

Exosystem involves links between a social setting in which an individual does not have an active role and the individual's immediate context. For example, a child's experience at home may be influenced by a mother's experiences at work.

Macrosystem include a child's socioeconomic status, poverty, its school, ethnicity and its experiences.

This study took Bronfenbrenner's ecological model and focused its investigations on the narratives and SES as agents of fostering resilience in orphaned children between 7-12 years. The study analyzed in depth how some orphans bounce back successfully better than others within the same ecological settings. In this regard, the focus of analysis was centered on the everyday environment (Home, neighbourhood, relationships with siblings, peers and caregivers).

1.3 Statement of the Problem

As the pandemic of HIV and AIDS increased in its spread across the globe, the number of children losing parents was also increasing. The pandemic had destroyed social fabric such that a lot of children had either been single orphaned or double orphaned. The family (Father, Mother and Children) was perceived to be a sanctuary and beacon of hope in times of adversities where everyone was heard and accepted and problems could be solved collectively. Families provided the basic framework for a child's development and had an enormous impact on a child's resilience (Mallmann, 2003). Death, illness, or other loss came as a surprise and children as well as adults were shocked, angered, in panic or denial, or sometimes felt guilt. Therefore, family separation through death especially between children and the primary caregivers (Parents) was a very traumatic event for young children. These children needed emotional support. They were directly affected by the death of their parents and they seldom knew how to talk about it. They did not understand what had happened. The memories of the dead parents tended to haunt them. Children were at risk of multiple adversities which extended over time. Goldman (1994) argued that, "Children could withdraw, detach, and depersonalize life to escape issues of grief so painful that not feeling and not talking were some of the ways to survive". Cassidy (2008), also argued that prolonged separation of children and adolescents from parents had dramatic effects on the emotional life of young children. However, resilience cushioned some families and children against adversity outcomes.

1.4 Aim of the Study

The aim of the study was to investigate how some Orphans who were between 7 and 11 years in Zambia were able to adapt successfully better than other Orphans of the same age groups.

1.5 Objectives of the Study

The objectives of the study were;

1. To investigate how the Socio-economic status (SES) of the adoptive homes influenced resilience.
2. To determine whether family narratives to orphans including, the content, context and tone of the narrator supported the development of resilience.

1.6 Hypotheses

It was hypothesized that,

i. Orphans from high socio-economic status (HSES) families would show better adjustments than orphans from low socioeconomic status (LSES).

ii. Quality family narratives mediated by content, context and the tone of the voice that responsible guardians used would be supportive of Orphans resilience.

1.7 Significance of the Study

Zambia was facing a challenge of coping with the increasing number of orphans and other vulnerable children. According to NAC, in 2004, it was estimated that the total number of orphans in Zambia was 1,147,614. The total number of orphans was expected to increase by about 16 percent to 1,328,000 in 2010. Of that, 45 percent were expected to be paternal, 42 percent maternal and 13 percent dual orphans. That number was alarming against the backdrop of inadequate child welfare facilities that the government was able to provide. Therefore, the importance and value of studying emotional and psychosocial adjustments in children is that no child is immune to pressure: even the best cared for children and/or children with both parents who may not face significant adversity or trauma experience pressures and challenges imposed on them by their environment. Arising from that uncertainty, there is an urgent need to investigate how some orphaned children manage to cope with emotional and psychosocial problems. The information derived out of the study was to be used by caregivers and professionals who are involved in childcare and/or education. The research also provided valuable information targeted at families with orphaned children and help government to come

up with programs that would enhance the strategies and approaches that specifically attend to the emotional and social needs of children.

1.8 Conceptual definitions

Resilience - The American Psychological Association (Comas-Diaz, Luthar, Maddi, O'Neil, Saakvitne, Tedeschi, 2004:1) defined resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress – such as family and relationship problems, serious health problems, or workplace and financial stressors. Masten & Coastsworth (cited in Middel, 2001) defined resilience as "manifested competence in the context of significant challenges to adaptation or development". More specifically, Grotberg (2003) referred to resilience as "the human capacity to deal with, overcome, learn from or even be transformed by the inevitable adversities of life". According to Staudiger, Marsiske & Bates (1993), the same term resilience refers both to "the maintenance of healthy development despite the presence of threat and the recovery from trauma". Other authors referred to resilience as "a pattern of positive adaptation in the context of the past or present adversity" (Wright & Masten, 2005); "a psychological quality that allows a person to cope with, and respond effectively to, life stressors" (Neill & Dias, 2001); or "that inbred, evolutionary ability to live and grow and love against all odds" (Seligman, cited in Brooks & Goldstein, 2003; xv).

Orphan - Is a socially constructed concept and varies among cultures and countries. Some refer to children who have lost one parent and others reserved the definition for those who had lost both Ng'andu Kasonde, S. (2007).

Emotional competence - refers to "a person's ability in expressing or releasing his /her inner feelings (emotions) Ng'andu Kasonde, S. (2007). It implies an emotional stability and emotional management.

Adjustment - refers to "Patterns of behaviour or performance which conformed to expected cultural standards or norms, e.g. being able to make friends, able to help others when in need, manifesting a reasonable amount of social compliance"(Ng'andu.K.S.,2007).

A child refers to "A young human being below the age of full physical development" (Soanes, C and Stevenson, A.2006).

Family narratives - refers to situations where parents tell stories to children and in turn children tell stories to parents and friends, siblings tell stories to each other (Taylor, Aspinwall, Giulian, & Dakof, 1993).

1.9 Operational Definitions of terms in the Study

Resilience - The capacity to bounce back successfully in any adversity.

Orphan - any child who was between 07 and 11 years who had lost both parents.

Care givers - anybody who was responsible for the daily care of orphans.

Emotional competence - the ability to copy with any challenges that would cause mental problems.

A child - any person between 7 and 11 years.

Adjustment - how well, accommodative, receptive or friendly an orphan was towards fellow peers, caregivers and the community.

Challenges - Annoying situations, reactions to things done or said to cause anger or upset, unpleasant situations, temptations etc.

Family narratives – Any stories and tales that were narrated to either children or caregivers.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter focuses on the literature of studies which were carried out by different researchers in different countries on coping strategies of orphans from a global point of view and the African perspective.

2.2 Global Context

Garmez (1993) identified three protective factors when children met with adversity;(1) the personal characteristics of the child,(2) the presence of a caring adult and/or a warm family (3) strong external support, such as belonging to a social group or community, school, or church etc. Masten, Best and Garmez (1990) also found that adults caring for children during or after major stressors was the most important and consistent protective factor, and that recovery seemed to be most difficult when acute psychosocial trauma included the loss of adequate care. The child's reaction to loss of parents appeared to be as important in determining risk or resilience as the loss itself. An unavailable mother and /or neglectful care subsequent to the loss of the father could leave the child desperately vulnerable and thus at risk for later depression and anxiety (Harris, et al, 1986). In that regard, care giving experiences prior and subsequent to loss appeared central to the development of antisocial personality disorders among adolescents.

Taylor et al. (1993) also suggested that resilient attitudes, thoughts and beliefs could be instilled in children through story telling. For example the researchers examined the effectiveness of positive and negative stories on coping in participants with cancer and college students' midterms. The researchers argued that knowing that others had both faced and overcome the problem was helpful, and reassuring-positive stories could be considered as a way of instilling hope, encouragement, and resilience. Worden (1996) suggested that the functioning level of the surviving parent/caregiver was the most powerful predictor of a child's adjustment to the death of a parent and/or parents. Children with a less well-functioning care giver showed more anxiety and depression, and sleep and health problems.

Rutter (1990) also argued that children of severe parental conflict and traumatic events appeared protected if the child had a good relationship with even one of the parents. Other studies had

shown that children raised in a family with alcoholism, chronic conditions, or AIDS fared far better when one or both parents provided an encouraging and positive atmosphere (Austin & McDermott, 1988; Levine, 1990:). Masten et al, (1990) found that under stress conditions, boys tend to show more disruptive or aggressive behaviour than girls. The findings highlighted that girls were more resilient than boys in childhood.

2.3 African Context

While the most consistent protective factor appeared to be the quality of caregiving children receive, the literature has also pointed out other characteristics that appear to protect children and improve resilience. Lothe (2003) conducted a study on resilience among eight surviving orphans of the catastrophic drought and famine of Ethiopia of ages between 18-23 years and found that the most important factor in fostering resilience in problems were, Hope, Religion, and Personal history and understanding of their roots. The results therefore cast doubts on whether resilience theory was sufficiently captured across different cultural settings.

Walsh (1998) defined family resilience as "The ability of any family to withstand and rebound from crisis and adversity". Resilient families were able to adjust to changing situations and had positive attitudes towards family challenges through communications, talking things through with each other and supporting each other in times of need. Although resilient children seemed to have grown up in households that promoted resiliency, an important question which still remained was, "Were entire families' resilient or just individual members?" In addressing the above question, Richters and Martinez (1993) conducted a study focusing on the relationships among a violent community, family home characteristics, and adaptational success or failure. The results indicated that a child's chance of adaptational success or failure was positively related to the stability and safety of his or her home.

In many cases, family dynamics promote more or less gradual, continuous change in a child's development; however, a single event such as a traumatic divorce or death of a parent can cause a fairly dramatic change in a child's behavior and emotional adjustment. The death of a parent, parents or other care givers for example is not a single event but rather an often lengthy process of multiple effects on some children. These children undergo a lot of stressful moments such that some tend to have capacity to resolve these traumatic events while others don't. In most cases,

orphaned children are also forced to deal with separation from brothers and sisters. Confused by loss of parent/parents coupled with separation from their siblings, some orphans sometimes act angrily or aggressively towards substitute care givers (Mallmann, 2003). These complex realities become even more intricate as they relate to various aspects of the children's lives.

Masten (2001) argued that stressors and changes occurring before, during, and after the death itself had different effects for different people. In other ways, faced with significant stressors or adversities, some children appeared to rise above their circumstances and attain outcomes associated with healthy development. For those that failed to pull through traumatic events, they resorted to all kinds of inappropriate behaviours such as substance abuse, theft, indulging in unprotected sex, petty crimes, juvenile delinquency etc.

In the early days in Africa, Zambia in particular, children who lost their parents were traditionally supported by the extended families. But nowadays with increased numbers of orphans, reduced numbers of responsible caregivers, slowly fading (Times of Zambia, 16 June 2009) extended families coupled with poverty, the extended families are no longer the safety nets that they once were although they remain the predominant source of care for orphans in most communities. Many of these children by and large are still under the care of grandparents, older siblings, and young siblings or just abandoned largely because they have no one to look after them, while others ended up being institutionalized. Although those institutions or facilities could have provided support in terms of basic needs, such as clothing, education, health, water, food and shelter, those forms of care alone could not have supported the development of the children's emotional and psychosocial competencies and consequently they could have led to poor developmental outcomes. Kaufman et al, (2004) argued that even high quality institutional care appeared to have deleterious effects on children's development. Ahnert, et al. (2006) in a meta-analysis also found that children's attachment to caregivers was observed to be less secure when group size and child-caregiver ratios were large.

Additionally, institutions or facilities in Zambia are mostly manned by few and unqualified personnel who rarely devote adequate time to each individual child for emotional or psychological support in times of need largely due to congestion. Inadequate staff-to-child ratio

result into poor quality of care. Children under those adverse circumstances develop strategies with all their caregivers that are adapted to increase the probability of protection and survival under challenging conditions and fail to pinpoint a specific primary caregiver. That is largely due to the fact that those institutions accommodate a lot of children who would individually require close contact with caregivers for emotional and psychological support but that did not materialize because of lack of qualified professionals in child development. Furthermore, due to an increased number of orphans arising from the epidemic, it was practically impossible to accommodate all in institutional homes and as such, the majority were left in communities. Consequently, some of those orphans failed to adjust in the face of adversities.

Kasonde-Ng'andu (2007) conducted a study in Zambia on, "Loss of parents, academic performance and psychosocial adjustment of 400 rural and 395 urban grade five pupils ". Alpha reliabilities of CBCL internalizing, externalizing and total problems on three groups of respondents were computed. The reliability estimates were consistently high across the three categories of informants (Teachers, caregivers and youths). The results were in line with the international standards for the CBCL scales.

Fiese, et al, (1999) and Taylor, et al. (1993) also argued that, researchers, educators and clinicians found some factors that had some benefits for children in promoting resilience and they called them Family narratives. Family narratives were situations where parents told stories to children and in turn children told stories to parents and friends, siblings told stories to each other. Similarly in Zambia, parents told stories to their children and parents listened to stories from their children. Depending on the types of stories, that helped to strengthen resilience. Family narratives involved participation of members, parental control during conversation, affirming and disaffirming comments, affect and tone, and interpersonal functioning. The information disclosed during narratives could be involved in resilience especially if the content of the stories incorporated the theme of resilience in children's daily lives. Fiese et al. (1999) asserted that narratives had been used to assess family functioning, interpersonal interactions and communication patterns. The telling of stories in and of itself, as well as the content of the stories told affected children's necessary adjustments. Furthermore family narratives go beyond the individual and deal with how the family made sense out of its world, expressed rules of interaction and created beliefs about relationships.

Goldman (1994) found that pre-and post-bereavement rituals were very important predictors of adjustments in orphans. Succession planning when a parent and/or parents were still alive reinforced adjustments in orphans once their parent/parents died. This involved identifying alternative care givers, encouraging parents to prepare memory boxes where they would keep sealed envelopes containing letters to be read after the parent's death, photos, recorded tapes with messages, birth certificates, a Will, parent's Identity cards and memoirs indicating how happy parents were when a child was born. Goldman (1994) . The children were growing up in a foreign country and they risked losing contact with their origins and as such the parents left their legacy of wise words, precious memories and standards to live. A memory book did not protect children from loss and separation, but it helped them to understand the past, knew that the parent(s) they had lost loved them, and to be stronger to face the future. By increasing communication in a safe environment, children were supported to develop increased understanding and resilience to the impact of death.

Mallmann (2003) argued that children who had been prepared for the death of their parents (either by the parent or by other caregivers) generally coped better with the death. Preparation for the death of a parent strengthened the child's ability to cope with adversities. The extent to which orphans felt included in such rituals and the way in which they were prepared for them reinforced adjustments once their parent/s died.

Studies have also shown that gender differences appeared to vary with the stages of the life cycle and the demands made on each gender in the context of the prevailing sex role. Masten et al (1990), examined gender and age differences in children as factors influencing resilience. They found that older children had stronger and longer lasting reactions to traumatic experiences than very young children. The reason behind that was that, older children were more aware of, and therefore more sensitive to, the implications of the traumatic experience and placed more emphasis on external factors, such as the reaction of others. With regard to gender differences, the results showed that under stress conditions, boys tended to show more disruptive or aggressive behaviour than girls, and girls more anxiety and depression than boys Masten et al (1990). Combining age and gender, the results showed that girls were more resilient than boys in childhood but boys were less vulnerable to long lasting effects of abuse in adolescence and adulthood.

Schools are institutions that set standards for and exert positive influence on children over the course of time across developmental stages and milestones (Elias et al in Goldstein and Brooks, 2006).This means that school going children are more likely to bounce back successfully than non school going children when they are faced with adversities.

The social economic status of the adopting family or the subsequent caregiver is also an important factor in children's adjustments. When a breadwinner dies it is more likely that the economic status of the family changes too. Orphans hardly go to school or have decent meals; others resort to all kinds of vices including prostitution, substance abuse, theft etc to mitigate poverty. Orphans are sometimes subjected to a lot of socioeconomic hurdles. (Times of Zambia 16 June 2009) reported that extended family unity is slowly fading away leaving thousands of children homeless and having to fend for themselves. Children who are orphaned face a lot of challenges such that some who are not capable of pulling through these hardships end up getting themselves in various mischiefs such as prostitution, depression, low self-esteem etc. Orphans face insurmountable behavioral problems which require professional advice in order to address these concerns.

Thus it appears that strengthening resilience is a very important aspect of child development in an environment where many communities are at 'pains' to take care of orphans. In the Zambian situation, it is estimated that about 64% Zambians are poor (living below US a day), Liche (2009). Some intervention programs designed to assist orphans have focused on improving the parent-child relationship (Egeland & Erikson, 1990; McCubbin, Thompson, Thompson, & Futrell 1999), some aimed to increase coping skills of minority children, others emphasizes life and social skills training. An example of skill training was the training of street kids and other vulnerable children by Zambia National Service under the auspices of the Ministry of Youth, Sport and Child Development. The present study was designed to examine how some orphans were able to adjust better than others.

CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter presents the research methods which were employed in this study. It constituted the following: research design, target population, sample size, sampling procedure, research instruments, data collection and data analysis.

3.2 Research Design

The study was a triangulation where both qualitative and quantitative approaches were used. The quantitative part of the study included a correlational design. Predictor variables were Family Socio-economic Statu (SES) of adopting families and the quality of family narratives that caregivers gave to their orphans. Dependent variables; were psychosocial and Emotional competences.

3.3 Target population

The target population comprised of all male double orphaned children between 07 to 12 years in Chaisa, Chipata and Garden compounds of Lusaka district in Lusaka province.

3.4.1 Sample size

Sixty-one (61) Orphans and their caregivers were drawn from low socio-economic status and forty-nine (49) from high socio-economic status in some selected compounds in Lusaka urban district. The sample of the study comprised 110 orphans drawn from Chaisa, Chipata and Garden compounds in Lusaka district and their 110 primary caregivers.

3.5 Sampling Procedure

In selecting the participants for the study, the information on orphans was first obtained from teachers and institutions like churches and SOS village. Snowball sampling to recruit orphans was used to select a purposive sample of male double orphans using information provided by the Catholic Church, schools and Social Society (SOS) village in Lusaka on the families keeping

orphans. Kombo and Tromp (2006) stated that the power of purposive sampling lies in selecting information related to the central issues under study.

3.6 Research instruments

The Child Behaviour Check List (CBCL) (Achenbach, 1991) (See Appendices 1 & 2) and a structured interview questionnaire about family narratives developed by Fiese, et al (1999) were used in the study.

3.7 Ethical considerations

Talking about deceased parents can be a very traumatic event to some children and would seem like opening up 'old wounds'. Some children would break into uncontrollable mourning. So in order to guard against such situations, children were asked if they would be comfortable to answer questions which would sometimes remind them of their deceased parents. But in case some orphans could not control their grief, they were allowed to express their grief and later allowed to continue.

The purposes of the study were explained and each participant (caregivers) were required to sign a consent form while orphans were asked to assent to the request. Both caregivers and orphans were informed that it was their right to withdraw at any time of the study if they felt not interested any more.

3.8 Pilot study

A pilot study was conducted on twenty (20) participants to determine whether or not the items in the instruments that is, CBCL and a check list of probe questions for the family narratives were understood clearly by the subjects.

The interviews were alternated flexibly between the orphans and caregivers depending on how the caregivers and the orphans responded. The other objective of the pilot study was to determine the best way of administering the measures during the study. Findings from the exercise showed that the instruments were useful to the main study.

3.9 Data Collection

The data were collected between November 2010 and December 2010.

Child Behaviour Check List (CBCL) was used to obtain information from the orphans and caregivers.

A Tape recorder was used to gather information pertaining to Family narratives using a pre structured interview questionnaire for the caregivers and the orphans. 110 orphans from Chaisa, Chipata and Garden compounds with their caregivers were asked to tell stories using a pre structured questionnaire and a tape recorder to elicit family narratives. Focus group discussions (FGDs) were used where orphans, caregivers, researcher and research assistants were present. Each session took on average of 10 to 15 minutes. Pre structured questions (See Appendix 3) were used interchangeably to both caregivers and orphans in order to elicit information.

3.10 Data Analysis

The Statistical Package for Social Sciences (SPSS) was used to analyze quantitative data from the questionnaires while qualitative data (family narratives) were subjected to rigorous assignment of scores to each narrative paying particular attention to their coherence and relationship beliefs. The family narratives elicited were subjected to qualitative analyses using Fiese et al (1999) scoring procedure. After each session, audio tapes were transcribed verbatim, and two coders (Researcher and Research assistant) firstly independently scored the narratives and thereafter jointly analysed each transcript and identified narratives that emerged during conversations and gave an average score. Frequencies, means and percentages were used in describing distributions of the single and summated variables. The product-moment correlation coefficient was calculated to assess the strength of relationships between variables, and ANOVA was used to assess the significance of differences in mean scores between groups.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the study aimed at investigating orphan's psychosocial adjustment following the death of their parents in Lusaka District of Lusaka Province. The hypotheses were that Social Economic Status (SES) of adoptive homes influenced resilience and that family narrative to orphans, including the content, context and tone of the caregivers supported the development of resilience. The findings are presented according to the objectives of the study.

4.2 Age of caregivers

Table 1 below shows the age and sex of the caregivers that took part in the study.

Table 1: Sex and age of caregivers

Age (in years)	Sex		Total
	Male	Female	
20 – 30	7	26	33
30 – 40	-	27	27
40 – 50	-	19	19
Above 50	6	25	31
Total	13 (11.8%)	97 (88.2%)	110 (100.0%)

The table above shows that 30%, (7 males and 26 females) were aged between 20 and 30 years, 25% (6 males and 25 females) were between 30 and 40 years, 17% (19 females) were between 40 and 50 years and 28% (6 males and 25 females) aged above 50 years.

4.3 Occupation of caregivers and sex

Caregivers were asked to indicate the type of occupation they were engaged in. Table 2 below shows their responses.

Table 2: Occupation of caregivers and sex

Occupation	Sex		Total
	Male	Female	
Civil Servant	-	14	14
Business	13	26	39
None	-	57	57
Total	13 (11.8%)	97 (88.2%)	110 (100.0%)

The table shows that 52%, (57 women) who were participants were unemployed, 36% (13 males and 26 females) were involved in business activities and 13% (14 females) worked in formal employment as civil servants.

4.4 Relationship of caregiver to the orphan

Caregivers were asked to say how they were related to the orphan. Table 3 below shows their reactions.

Table 3: Caregiver's relationship to the orphan

Relationship	Sex		Total
	Male	Female	
Nephew	6	60	66
Grandson	-	37	37
Any other	7	-	7
Total	13 (11.8%)	97 (88.2%)	110 (100.0%)

As can be seen in table 3, 37/97 representing 38% of the female caregivers interviewed the orphans were related to them as grandchildren, and 60/97 representing 58% as a nephew. For 6/13 representing 46% of the male caregivers the orphans were related to them as a nephew while for 7/13 representing 54% were related by some other family relationship.

4.5 Background characteristics of the orphans

4.5.1 Age of Orphans

As regards the age range of orphans in the study, 56 (50.9%) were aged between 10 and 11 years, 33 (30.0%) were aged between 9 and 10 years and 21 (19.1%) represented the age between 7 and 8 years old.

4.6 Average expenditure of caregivers on food per month

Further, the study sought to find out how much the respondents spent on average on food per month. Table 4 below shows their responses.

Table 4: Average expenditure of caregivers on food per month

Average expenditure per month	Sex		Total
	Male	Female	
Less than K900,000.00	6	55	61 (55.5%)
Between K900,000.00 and K1,200,000.00	7	28	35 (31.9%)
More than K1,200,000.00	-	14	14 (12.6%)
Total	13	97	110 (100.0%)

The table above shows that most of the caregivers (55%), (6 males and 55 females) spent less than K900, 000.00 while 32%, (7 males and 28 females) spent between K900, 000.00 and K1, 200,000.00 per month, and 13% (14 females) spent more than K1, 200,000.00 per month .

4.7 CBCL Behaviour checklist

A Clinical research study (Achenbach, T. M. 1991), data were analyzed using CBCL, The international average T-score for total problems, externalizing problems, and internalizing problems were computed, T scores less than 60 were considered in the normal range, 60-63 represented borderline scores, and scores greater than 63 were in the clinical range. The instrument was completed by caregivers and orphans themselves independently to assess orphans' adjustment to psychosocial challenges following the death of their parents. Findings based on problems scores are presented below.

Table 5: Correlations between CBCL scales for caregivers and orphans

		CBCL internalizing problems (Orphan)	CBCL internalizing problems (Caregiver)	CBCL externalizing problems (Orphan)	CBCL externalizing problems (Caregiver)	CBCL total problems (Orphan)	CBCL total problems (Caregiver)
CBCL internalizing problems (Orphan)	Pearson Correlation Sig. (2-tailed)	1 .					
CBCL internalizing problems (caregiver)		-.040	1				
CBCL externalizing problems (Orphan)	Pearson Correlation	**.907****	-.049	1 .			
CBCL externalizing problems (Caregiver)	Pearson Correlation	-.006	**.686****	-.010	1		
CBCL total problems (Orphan)	Pearson Correlation	**.974****	-.046	**.979****	-.008	1	
CBCL total problems (Caregiver)	Pearson Correlation	-.022	**.892****	-.029	**.941****	-.026	1

**.Correlation is significant at the 0.01 level (2-tailed)

The table above shows that there is a significant relationship between internalizing and externalizing problems as reported by both the caregivers and orphans themselves.

Table 6: Employment status of caregivers and CBCL internalizing, externalizing and total problems scores

Occupation of parent/guardian	Descriptive statistics	Internalizing	Externalizing	Total problems
Civil servant	Mean	3.5	12.0	19.6
	N	14	14	12
	Std. Deviation	.5	4.7	11.1
Business persons	Mean	2.4	2.9	5.0
	N	39	39	14
	Std. Deviation	2.8	3.0	2.1
Unemployed	Mean	3.3	6.5	18.0
	N	57	57	43
	Std. Deviation	2.1	4.1	12.4
Total	Mean	3.0	5.0	14.8
	N	110	110	57
	Std. Deviation	2.3	4.1	12.2

4.8 Occupation of parent/caregivers

Findings of the study showed that orphans from caregivers who were civil servants exhibited more externalizing problems (mean = 12.0) than those that were in business and unemployed who scored means of 2.8 and 6.5 respectively. From the above data it seems that employment status of the care giver had an effect on the adjustment of the orphaned children.

Table. 7 ANOVA for Occupation of caregivers

		Sum of Squares	df	Mean Square	F	Sig.
INTERNALIZING	Between Groups	17.440	2	8.720	.139	.870
	Within Groups	6692.523	107	62.547		
	Total	6709.964	109			
EXTERNALIZING	Between Groups	14.737	2	7.369	.449	.639
	Within Groups	1754.181	107	16.394		
	Total	1768.918	109			

ANOVA were performed on the descriptive means differences among the occupation groups of caregivers. The results indicated that F (2) = .139 where p>.870 for internalizing problems and F (2) = .445 where p>.639. Therefore, even if the descriptive means group differences existed among the groups, these differences were not statistically significant for both internalizing and externalizing problems.

Table 8: Average expenditure on food per month and CBCL internalizing, externalizing and total problem scores reported by caregivers

Average expenditure on food on each orphan per month	Descriptive	Internalizing	Externalizing	Total
Less than K900,000=00 per month	Mean	**3.17**	**5.74**	**17.00**
	N	61	61	61
	Std. Deviation	2.50	4.31	13.39
Between K900,000=00 and K1,200,000=00 per month	Mean	**2.60**	**3.80**	**11.00**
	N	35	35	21
	Std. Deviation	2.37	3.36	8.85
More than K1,200,000=00 per month	Mean	**3.50**	**4.50**	**12.00**
	N	14	14	14
	Std. Deviation	.52	4.67	5.18
Total	Mean	3.03	4.96	14.79
	N	110	110	110
	Std. Deviation	2.30	4.14	12.19

4.9 Whether the social economic status of adoptive homes influenced resilience

Average expenditure on food per month

Income and expenditure of an individual was one aspect of an individual's socio-economic status. The study sought to find out how much the respondents spent on food per month. That aspect was important so as to measure whether there was association between expenditure on food and the CBCL problem scores. Table 8 shows that orphans from families of low average expenditure on food per month scored higher on external behaviour problems (Mean = 5.7) and internal problems (mean = 3.2) followed by the orphans from caregivers whose income was more than K900, 000.00 per month. An interesting situation to note here was that orphans from

caregivers whose expenditure was more than K1,200,000,00 scored higher on internalizing behaviour problems (mean = 3.5) and external problems (mean = 4.5) than those from the middle expenditure (mean = 3.5). There were more behaviour problems by orphans who came from low expenditure compared to those from the medium and high expenditure groups.

Table 9 ANOVA for average expenditure on food per month as a factor that influenced resilience

		Sum of Squares	df	Mean Square	F	Sig.
EXTERNALIZING	Between Groups	.447	2	.223	.014	.987
	Within Groups	1768.471	107	16.528		
	Total	1768.918	109			
INTERNALIZING	Between Groups	141.221	2	70.610	1.150	.320
	Within Groups	6568.743	107	61.390		
	Total	6709.964	109			

Externalizing problems

ANOVA were performed on the three groups of average expenditure on food per month to clarify group differences. Analyses of data showed that even if there were differences in descriptive means among the three groups of average expenditure, these differences were not statistically significant. The results indicated that $F(2) = 0.014$, where $p > .987$ for externalizing problems.

Internalizing problems

Similarly when the means for internalizing problems were subjected to statistical analyses by ANOVA, where $F(2) = 1.150$, $p > .320$, the results also showed non statistical significance for internalizing problems among the three groups of SES.

Therefore, even if there were descriptive means differences among the average expenditure of the adopting families, the differences were not statistically significant to affect the orphans' exhibiting externalizing and internalizing problems.

4.10 Correlations between CBCL subscales and SES - care givers

To find out whether the socio-economic status of adoptive homes had an effect on resilience, the correlation was calculated between CBCL externalizing and total problems and SES. The results are shown in Table 10 below. The table shows that there is positive correlation between average expenditure of caregivers on food per month and CBCL externalizing problems, $r = .350$, $p < .01$; and CBCL total problems, $r = .368$, $p < .01$ as calculated. An association was also found between CBCL total problems and CBCL externalizing problems, $r = .941$, $p < .01$.

Table 10: Correlations between CBCL subscales scores and average expenditure on food per month reported by caregivers.

		CBCL Externalizing problems	CBCL total problems	Average expenditure on food per month
CBCL Externalizing problems	Pearson Correlation	1		
CBCL total problems	Pearson Correlation	**.941****	1 .	
Average expenditure on food per month	Pearson Correlation	**.350****	**.368****	1 .
	N	109	109	110

**.Correlation is significant at the 0.01 level (2-tailed)

4.11 Correlations between CBCL subscales as reported by the orphans and number of meals taken per day as a measure of SES

Table 11 presents correlations among CBCL subscales as reported by the orphans and number of meals taken per day as a measure of SES. A positive association was found between CBCL total problems and CBCL internalizing and externalizing problems, $r = .974$, $p <.01$ and $r = .979$, $p < .01$ respectively. An association between CBCL internalizing problems and CBCL externalizing problems was also found, $r = .907$, $p < .01$. However, the calculations showed that there was no significant association between number of meals taken per day as a measure of SES and other CBCL subscales.

Table 11: Correlations between CBCL subscales and how many meals taken per day as reported by orphans as a measure of SES

		CBCL internalizing problems	CBCL externalizing problems	CBCL total problems	Number of meals taken per day
CBCL internalizing problems	Pearson Correlation	1 .			
CBCL Externalizing problems	Pearson Correlation	**.907****	1 .		
CBCL total problems	Pearson Correlation	**.974****	**.979****	1 .	
Number of meals taken per day	Pearson Correlation	.014	.005	.010	1
	N	110	110	110	110

**.Correlation is significant at the 0.01 level (2-tailed)

4.12 Correlations between CBCL internal subscales: Withdrawal; Anxiety; Somatic and SES

The findings of the study showed that there is a correlation between withdrawal and anxiety, r = .47, p < .01; withdrawal and somatic problems, r = .72, p <. 01 as calculated for the orphans. Caregivers also showed positive correlation between withdrawal and anxiety, r = .53, p < .01. The caregivers showed positive correlation between average expenditure on food per month and withdrawal, r = .24, r < .01. A positive correlation was also reported on SES and caregivers ratings of somatic problems, r = .45, p < .01.

Table 12: Correlations between CBCL internal subscales: Withdrawal; Anxiety; Somatic and average expenditure on food per month (SES)

		CBCL withdrawal (Orphan)	CBCL withdrawal (Caregiver)	CBCL anxiety (Orphan)	CBCL anxiety (Caregiver)	CBCL somatic (Orphan)	CBCL somatic (Caregiver)	SES
CBCL withdrawal (Orphan)	Pearson Correlation	1						
CBCL withdrawal (Caregiver)	Pearson Correlation	.054	1 .					
CBCL anxiety (Orphan)	Pearson Correlation	**.474****	-.014	1				
CBCL anxiety (Caregiver)	Pearson Correlation	.020	**.535****	-.005	1			
CBCL somatic (Orphan)	Pearson Correlation	**.727****	-.014	**.439****	.024	1		
CBCL somatic (caregiver)	Pearson Correlation	-.079	-.084	-.094	.133	-.002	1	
SES	Pearson Correlation	.003	**.245***	.027	-.087	-.015	**.449****	1 .

4.13 Correlation between CBCL externalizing subscales: Aggression; delinquency; and SES

The table below shows that there is internal consistency with externalizing problems as shown by caregivers and orphans ratings. The table shows that there is an association between delinquency and aggression, $r = .726$, $p < .01$ as reported by orphan ratings. The caregivers also reported a positive association between delinquency and aggression, $r = .247$, $p < .01$. The rest of the results are shown in the table below.

Table 13: Correlation between CBCL externalizing subscales: Aggression; delinquency; and SES

		CBCL aggression (Orphan)	CBCL aggression (caregiver)	CBCL delinquency (Orphan)	CBCL delinquency (caregiver)	SES
CBCL aggression (Orphan)	Pearson Correlation	1				
CBCL aggression (Caregiver)	Pearson Correlation	-.026	1 .			
CBCL delinquency (Orphan)	Pearson Correlation	**.726****	.043	1 .		
CBCL delinquency (Caregiver)	Pearson Correlation	-.019	**.247****	-.020	1	
SES	Pearson Correlation	-.004	.037	.020	**.734****	1

4.14 Family narratives

It was anticipated that family narratives to orphans, including the content, context and tone of the caregivers would support the development of resilience. According to Fiese, et, al (1999) high score of family narratives indicate high quality family narratives. Orphans who exhibited resilience were expected to score low T-score on the CBCL (Achenbach, T. M. 1991). As regards whether family narratives to orphans including content, context and tone of the narrator supported the development of resilience, the results of the study were as shown in table 14 below.

Table 14: Correlations – Care giver narratives

		Internal consistency	Organization	Congruence and content	Relationship beliefs	Interviewer intimacy	Tone of voice
Internal consistency	Pearson Correlation	1					
Organization	Pearson Correlation	**.448****	1				
Congruence and content	Pearson Correlation	**.458****	**.539****	1			
Relationship beliefs	Pearson Correlation	**.395****	.556**	**.482****	1		
Interviewer intimacy	Pearson Correlation	**.211***	**.482****	**.343****	**.521****	1	
Tone of voice	Pearson Correlation	.322**	.487**	.159	**.244***	**.559****	1 .
	N	.110	110	110	110	110	110

*.Correlation is significant at the 0.05 level (2-tailed) **.Correlation is significant at the 0.01 level (2-tailed)

The table above shows the results on family narratives as reported by caregivers. The table shows that there is very high association between organization and internal consistency, $r = .45$, $p<.01$. There is also a relationship between interviewer intimacy and internal consistency, $r = .21$, $p < .01$; organization, $r = .48$, $p < .01$; congruence and content, $r = .34$, $p <.01$; and relationship beliefs, $r = .52$, $p < .01$. The table also indicates that a relationship between tone of voice and internal consistence, organization, relationship beliefs and interviewer intimacy.

Orphans were also asked to rate the family narratives. Table 15 below shows their responses. Internal consistency covaries correlates with none of the other scales except tone of voice, $r = .47$, $p < .01$. However, there were positive correlations between interviewer intimacy and organization, $r = .51$, $p < .01$; interviewer intimacy with congruence and content, $r = .26$, $p < .01$; and intimacy with relationship beliefs, $r = .36$, $p < .01$. The table also shows that tone of voice correlates significantly but negatively with organization, $r = -.28$, $p < .01$; with congruence and content, $r = -.39$, $p < .01$; with relationship beliefs, $r = -.46$, $p < .01$; with interviewer intimacy, $r = -.40$, $p < .01$.

Table 15: Correlations – Orphans narratives

		Internal consistency	Organization	Congruence and content	Relationship beliefs	Interviewer intimacy	Tone of voice
Internal consistency	Pearson Correlation	1					
Organization	Pearson Correlation	-.019	1				
Congruence and content	Pearson Correlation	.100	**.431****	1			
Relationship beliefs	Pearson Correlation	-.235	**.738****	**.647****	1		
Interviewer intimacy	Pearson Correlation	-.074	**.517****	**.269****	**.363****	1	
Tone of voice	Pearson Correlation	**.477****	**-.287****	-.396**	**-.469****	**-.480****	1
	N	.110	110	110	110	110	110

*.Correlation is significant at the 0.05 level (2-tailed)

**.Correlation is significant at the 0.01 level (2-tailed)

Correlation tests were calculated on the subscales of family narratives for both orphans and caregivers to test whether there were associations between and within subscales of the quality of the narratives. The findings revealed that there were indeed associations between and within subscales of quality of family narratives for orphans. However, more interestingly the internal consistence subscale correlated with none of all the subscales except with the tone of voice subscale. The other issue was that tone of voice on the other hand correlated significantly negatively with the other four subscales except the internal consistence.

Caregivers subscales of family narratives were also correlated and the findings revealed that there were positive correlations between and within the family narratives subscales.

4.15 Qualitative findings

Despite the short and difficult to code family narratives collected due to low level of familiarity with the families, most of the children interviewed produced only very short narratives of a few words, with the result that detailed analysis of their content was not possible and even tone of voice was difficult to code with confidence. The number of eligible orphans for coding was forty-six (46) whose scores were between twenty and thirty (20-30).The average number of

words spoken in the family narratives by orphans were ten (10). This was in line with Labov's (1969) arguments on verbal capacity effect.

One respondent a grandmother when asked about her orphan she had to say the following; *Dalitso amakonda kukamba ati, ine ambuye nizazipaya* meaning grandmother one day I will kill myself.The grandmother narrated that the child had exhibited suicidal behaviour on more than one occasion without any special reason. Below were some of her CBCL items which she responded as **very true (2)** or **often true (1)** about her orphan;

Table 16 Some CBCL items of the caregiver

CBCL	Attributes/characteristics	Scores
01	Acts too young for his age	Very true
03	Bragging/boasting	Often true
07	Can't sit s till,restless,hyperactive	Very true
16	Cruelty, bullying meaningless to others	Often true
18	Attempts suicide	Very true
22	Disobedient at home	Often true
28	Breaks rules at home/elsewhere	Very true
43	Lying / cheating	Often true
61	Poor school	Very true
69	Secretive, keeps things to self	Often true
74	Showing off/clowning	Very true
85	Strange ideas	Very true
91	Talks about killing self	Very true
95	Temper tantrums/hot temper	Often true

When the child was asked anything important about his grandmother, this was what he narrated;

Palibe meaning nothing.

Another respondent, an Auntie, on the other hand narrated positively about her nephew on how she felt proud about him. When asked to narrate about her nephew this was what she had to say,

Ine nimagulitsa pa ka Ntemba, so kambili kambili nika mutuma kugula vogulisa, amagula popanda mabvuto kukakhala chenji amagulilapo vina osapanda kumuoza meaning I sell

and buy goods on a small makeshift stall and every time I send him, he always buys and when there is extra money he would rather buy anything worth that money than taking back the money.

She also narrated that,

Kusukulu achita bwino, analeka kutukana na kuchita dewo nanzake meaning at school he is doing fine and he stopped using abusive language and fights with friends.

When the child was asked anything about her auntie, he echoed the following;

Ba Auntie nibakonda chifukwa banigulila vonse vamene nifuna.Bamaniuza ati ukapunzira wuzankala wolemela meaning I like my auntie because she gives me anything that I ask for and she always encourages me to go school if I wanted to get rich.

Another respondent, an Uncle, narrated that he was very proud of his nephew because he had changed remarkably since he came to stay with him. He expressed the following sentiments about his nephew;

Uyu mwana wachinja kwambiri.Pamene anabwera anili kuchita dewo na kutukana kwambiri koma masiku ano analeka meaning the child had changed from bad to good.Previously he used to fight and use abusive language which has since stopped.

When the child was asked anything about the parent, he narrated the following;

Ine ba Uncle nibakonda chifukwa baniuza kuti nikapunzila ninzankhala wolemela meaning I love my uncle because he tells me that when I get educated I will be rich so I should concentrate at school.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study which sought to investigate how some Orphans in Zambia are able to adapt successfully better than others in the wake of adversities. The discussion is presented according to the hypotheses of the study.

5.2 *Hypothesis one*

"Orphans from high socioeconomic status (HSES) families would show better adjustments than orphans from low socioeconomic status (LSES)". In order to ascertain the socio-economic status of adoptive homes, it was decided to consider the average expenditure on food per month in these households and occupation of the caregivers.

According to the descriptive means differences the study revealed that families who lived on an average expenditure of less than K900, 000 on food per month had orphans who exhibited more withdrawal, thought problem, attention, and delinquency and aggression behavior problems compared to those whose expenditure was of more than K1.200, 000 on food.

However, when the findings were subjected to ANOVA the results were not statistically significant. The results did not support our hypothesis. This could have been due to the difficulties in measuring socio-economic status in the compounds. The procedure of measuring socio-economic status may not have been capturing the real SES thereby distorting the outcome. The socio-economic status focused on the average expenditure on food in a single month of May 2010, Phiri (2010) rather than average expenditure per annum. Furthermore, people in high density areas were living under very difficult economic environment so they might not have been giving the true information.

In the case of orphans' self-ratings, there was no correlation with socioeconomic status. The differences in the self- ratings between caregivers and orphans could have been attributed to the fact that they seemed to perceive the same child differently, maybe because the caregiver only observed a child's behavior in a limited subset of the many contexts experienced by the child.

5.3 *Hypothesis two*

"Quality family narratives mediated by content, context and the tone of the voice that responsible guardians used would be supportive of Orphans resilience". Fiese, et al, (1999) and Taylor, Aspinwall, Giulian, & Dakof, 1993) argued that, researchers, educators and clinicians found some factors that had some benefits to children in promoting resilience and they called them Family narratives. Family narratives were situations where parents told stories to children and in turn children told stories to parents and friends, siblings told stories to each other. The findings of the present study, however, did not support our hypothesis. Fiese, et al, (1999) and Taylor, Aspinwall, Giulian, & Dakof, (1993) on family narratives. The family narratives did not support the hypothesis which predicted that it would strengthen resilience in orphans.

The tone of voice subscale of family narratives of orphans correlated significantly negatively on average of .30 with the other four subscales except for the internal consistence. This finding is consistent with Labov (1969) verbal capacity effect on monographs and linguistic argument on children. He argued that children who are interviewed for the first time in new social contexts tended to remain shy and unable to converse but when a close friend was introduced the same child competed for conversation. This effect could have explained the poor quality of family narratives exhibited in orphans and consequently did not support our hypothesis. The time which was spent for family narratives discussions was also too little to expect a child to open up to strangers for any discourse.

The researcher had predicted that families that shared their daily activities together in more coherent manners, through collaborative narrative interaction in which family members request, provide quality information, would strengthen emotional regulation.

Miller, (1994), argued that from the moment of birth, children are surrounded by stories, stories they tell about themselves, stories others tell about them, and the stories of others. (Fiese et al., 1995; & Norris et al., 2004) alluded also that even in the first year of life, well before infants can participate in these narrative interactions, they are hearing about the triumphs and failures of past family members as they trickle down the family stories told over and over to entertain, to soothe and to teach. These stories that they hear from their families contain information depending on the contents, strengthen their ability to overcome adversities. However, the results did not agree

with the previous theoretical assumption. The reason could be that the qualities of family narratives were poorly collected due to short period of family familiarization and less time to elicit family narratives. Unlike the Anthropologists who spend relatively long time such as two or more years to study family activities, in the case of this report, time limit contributed to poor quality family narratives. This explanation supported Labov's (1969) findings on the difficulties of eliciting narratives from children and argued that children on first contact with strangers may not articulate well in conversing but once a child gets familiarized with the stranger, the child even competes to converse.

The other factor could be that families are under economic hardships and people may not be willing to talk to strangers easily.

5.4 Statistically Significant Findings

As regards to CBCL rating score of caregivers on orphans from different occupation on behavioral problems, orphans from unemployed caregivers exhibited more withdrawal, thought, attention, delinquency and aggression behavior problems compared to those from businessmen and the civil servants. According to Achenbach, Mc Conaughty & Howell (1987) on meta-analyses, correlations among multiple informants between the subject (Orphans) and people who know them such as parents, teachers and/or any other person should have an average correlation of .22 for it to be reliable and valid. The average correlation as rated by caregivers whose expenditure were below K900, 000 on orphans' internalizing problems was .32 and .35 correlation on externalizing problems. The CBCL scores calculated for caregivers on orphans are thus consistent with the international findings on the validity and reliability of multiple ratings.

5.5 Limitations

On the quality of family narratives elicited from orphans, the information elicited was weak due to low level of familiarity of the researchers to the families. The verbal capacity of children/orphans could have affected the quality of family narratives of orphans thereby exhibiting weak quality of family narratives by the researcher. According to Labov (1969), children on first contact with a stranger may not articulate in storytelling. In his study, he concluded that when a close friend was brought in, the same child actively competed for conversation.

Since visits in the present study were conducted only once, the verbal capacity effect could explain why the qualities of family narratives were poor especially for the children. The short time in eliciting family narratives contributed to the poor family narratives. However, the findings could be used as a building block to conduct more research on family narratives.

The results of this study could not be generalized due to the purposive methodology which was employed to recruit participants but it gave an insight for future researchers to explore further.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter concludes the study and also makes some recommendations based on the findings of the study.

6.2 Conclusion

This study focused on a sample of orphans living in high density communities where they lacked the necessary facilities and infrastructure to enhance their livelihood. These material constraints appeared to the author to leave little room for quality social interactions among orphans and their caregivers. Caregivers had less time to interact with their orphans through family narratives as most of the time they were busy looking for basic needs such as food for their families. Parents had less time to pass on stories through family interactions to their children.

The study showed that orphans under the care of caregivers whose average expenditure was low on food, faced a lot of externalizing problems compared to those orphans whose caregivers had middle and high average expenditure on food per month. The findings raised the issues of interventions by interested parties to map out strategies that would help alleviate the situation through provision of necessary assistance to these children.

Other studies have reported that family narratives also seemed to play a significant role on the way orphans perceived their environment. Fiese, et al, (1999) and Taylor, Aspinwall, Giulian, & Dakof, 1993). However, the findings of the present study did not support our hypothesis as expected. The explanations could be mitigated by Labov's (1969) arguments. It is therefore important for future researchers to consider verbal capacity effect when eliciting family narratives as argued by Labov (1969). Families should find time to interact with their children where they can sit and share knowledge through quality stories.

6.3 Recommendations

Based on the findings of the study, the researcher recommends that;

- Families should be encouraged to spend more time with their children in order to foster interactions.
- Caregivers looking after orphans should ensure that they narrate positive stories that should have good contents in order to strengthen resilience among children.

6.4 Future research

Future research on family narratives should spend enough time on family visits in order to elicit quality family narratives.

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APPENDICES

Appendix I: Questionnaire on Psychosocial and Emotional Competences for Orphans.

1. What is your Sex?
   a) Male
   b) Female
2. How old are you?
   a) 07-08 years
   b) O8-09 years
   c) 09-10 years
   d) 10-11 years
3. Where do you live?
   a) Matero
   b) Lilanda
   c) Chaisa
   d) Kabwata
   e) Chilenje
   f) Kamwala
4. Do you go to school?
   a) Yes
   b) No
5. Are your parents able to pay for your school requirements?
   a) Yes
   b) No
6. Who looks after you?
   a) Elder brother
   b) Elder sister
   c) Aunt
   d) Grandmother
   e) Grandfather
   f) Any other (Specify) . . . .

7. How many meals do you have per day?

a) Once
b) Twice
c) Thrice
d) Sometimes

8. Below is a list of items that describe children and youths. Please circle the 2 if the item is very true or often true. Circle the 1 if the item is somewhat or sometimes true. If the item is not true, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to you.0 = Not True (as far as you know) 1 = somewhat or Sometimes True 2 = Very True or Often True.
(Child Behaviour Check List (CBCL) was adapted from Sophie Kasonde Ng'andu (2007), in her Thesis "Loss of parents, academic performance and psychosocial adjustment).

1. I act too young for my age 0 1 2
2. I drink alcohol without my 0 1 2 parents' approval (Describe) 0 1 2
3. I argue a lot 0 1 2
4. I fail to finish things I start 0 1 2
5. There is very little I enjoy 0 1 2
6. Bowl movement outside toilet 0 1 2
7. I brag 0 1 2
8. I have trouble concentrating/paying attention 0 1 2
9. I can't mind of certain things(Describe) 0 1 2
10. I have trouble sitting still 0 1 2
11. I'm too dependent on adults 0 1 2
12. I feel lonely 0 1 2
13. I feel confused 0 1 2
14. I cry a lot 0 1 2
15. I'm pretty hone 0 1 2
16. I'm mean to others 0 1 2
17. I dream a lot 0 1 2
18. I deliberately try to hurt/kill myself 0 1 2
19. I try to get a lot of attention 0 1 2
20. I destroy my own things 0 1 2
21. I destroy things belong to others 0 1 2
22. I disobey my care givers 0 1 2
23. I disobey at school & in the community 0 1 2
24. I don't eat as well as I do 0 1 2
25. I don't along with other children 0 1 2
26. I don't feel guilty after doing something I shouldn't 0 1 2
27. I'm jealous of others 0 1 2
28. I break rules at home, school or elsewhere 0 1 2
29. I'm afraid of certain animals, situations or place other school (Describe) 0 1 2
30. I'm afraid to of going to school 0 1 2
31. I Fear going to school 0 1 2
32. I Fear I might think or do something bad 0 1 2
33. I Feel I have to be perfect 0 1 2
34. I Feel or complain that no one loves me 0 1 2
35. I Feel others are out to get me 0 1 2
35. I feel worthless or inferior 0 1 2
36. I accidently get hurt a lot 0 1 2
37. I get in many fights 0 1 2
38. I get teased a lot 0 1 2
39. I hang around with kids 0 1 2
40. I hear sounds /voices that are other people think aren't there (Describe) 0 1 2

41. I act without stopping to think 0 1 2
42. I would rather be alone than with others 0 1 2
43. I lie or cheat a lot 0 1 2
44. I bit my finger nails 0 1 2
45. I'm nervous or tense 0 1 2
46. Parts of my body twitch or make nervous movement (Describe) 0 1 2
47. I have nightmares 0 1 2
48. I'm not liked by other peers 0 1 2
49. I can do certain things better than others 0 1 2
50. I'm too fearful or anxious 0 1 2
51. I feel dizzy or light headed 0 1 2
52. I feel too guilty 0 1 2
53. I eat too much 0 1 2
54. I feel overtired without good reasons 0 1 2
55. I'm over weight 0 1 2
56.
    a) Physical problems without known medical cause; Aches/pain(Not stomach/headache 0 1 2
    b) Physical problems without known medical cause; Headache 0 1 2
    c) Physical problems without known medical cause;Nausea,Feel sick 0 1 2
    d) Physical problems without known medical cause; Eye problems (Not if corrected by glasses (Describe) 0 1 2
    e) Physical problems without known medical cause; Rashes/Skin problems 0 1 2
    f) Physical problems without known medical cause; Stomach-aches 0 1 2
    g) Physical problems without known medical cause;Vomiting,throwing up 0 1 2
    h) Physical problems without known medical cause; Other (Describe) 0 1 2
57. I physically attack people 0 1 2
58. I prick my skin/other parts of the body 0 1 2
59. I can be pretty friendly 0 1 2
60. I like to try new things 0 1 2
61. My school work is poor 0 1 2
62. I'm poorly coordinated/clumsy 0 1 2
63. I would rather be with other kids than kids of my own age 0 1 2
64. I would rather be with younger kids than kids of my own age 0 1 2
65. I refuse to talk 0 1 2
66. Repeats certain acts over and over; compulsions 0 1 2
67. I run away from home 0 1 2
68. I scream a lot 0 1 2
69. I'm secretive/keeps things to myself 0 1 2
70. I see things that other people think aren't there (Describe) 0 1 2
71. I'm self-conscious/easily embarrassed 0 1 2
72. I set fires 0 1 2
73. I can work well with my hands 0 1 2
74. I show off/down 0 1 2
75. I'm too shy or timid 0 1 2
76. I sleep less than most kids 0 1 2
77. I sleep more than most kids during day and/or night

(Describe) . . . .
. . . . 0 1 2

78. I'm inattentive/easily distracted 0 1 2

79. I have speech problem (Describe) . . . .
. . . .
. . . . 0 1 2

80. I stand up for my rights 0 1 2

81. I steal at home 0 1 2

82. I steal from places other than home 0 1 2

83. I store up too many things I need (Describe) . . . .
. . . .
. . . . 0 1 2

84. I do things that other people think are strange (Describe) .
. . . .
. . . . 0 1 2

85. I have thoughts that other people would think are strange (Describe) . . . .
. . . .
. . . . 0 1 2

86. I'm stubborn 0 1 2

87. My moods /feelings change suddenly 0 1 2

88. I enjoy being with people 0 1 2

89. I'm suspicious 0 1 2

90. I swear or use dirty language 0 1 2

91. I think about killing myself 0 1 2

92. I like to make others laugh 0 1 2

93. I talk too much 0 1 2

94. I tease others 0 1 2

95. I have a hot temper 0 1 2

96. I think about sex too much 0 1 2

97. I threaten to hurt people 0 1 2

98. I like to help others 0 1 2

99. I smoke, chews or sniff tobacco 0 1 2

100. I have trouble sleeping (Describe) . . . .
. . . .
. . . . .0 1 2

101. I cut classes or skip school 0 1 2

102. I don't have much energy 0 1 2

103. I'm unhappy, sad or depressed 0 1 2

104. I'm louder than others 0 1 2

105. I use drugs for non medical purposes (Describe) . . . .
. . . . 0 1 2

106. He/she likes to be fair to others 0 1 2

107. He/she enjoys a good joke 0 1 2

108. He/she likes to take life easy 0 1 2

109. He/she tries to help other people when He/she can 0 1 2

110. I wish I were of the opposite sex 0 1 2

111. I keep from getting involved with others 0 1 2

112. I worry a lot 0 1 2

Please write down anything else that describes your feelings, behaviour, or interests.

. . . .
. . . .
. . . .
. . . . 0 1 2

Appendix II: Questionnaire on Psychosocial and Emotional Competences for Caregivers

1. What is your Sex?
   a) Male
   b) Female
2. How old are you?
   a) 20-30years
   b) 30-40years
   c) 40-50years
   d) 50 and above
3. Where do you live?
   a) Matero
   b) Lilanda
   c) Chaisa
   d) Kabwata
   e) Chilenje
   f) Kamwala
4. What do you do for a leaving?
   a) Civil servant
   b) Businessman
   c) Non of the above
   d) If any (specify)………………………
5. What is the size of your family?
   a) 3-5
   b) 6-8
   c) 9 and above
6. How many orphans are under your daily care?
   a) 1

b) 2

c) Above 3

7. What was the relationship with the deceased parent/s?

a) Sister

b) Brother

c) Aunt

d) Son

e) Daughter

f) If any (Specify)……………………….

8. How old is your orphan?

a) 07-08 years

b) 08-09 years

c) 09-10 years

d) 10-12 years

9. What is your relationship with the orphan?

a) Nephew

b) Niece

c) Grandson

d) Granddaughter

e) Any other (Specify) . . . .

10. How many meals do you have in a day?

a) Once

b) Twice

c) Thrice

11. How much do you spend on average on food per month?

a) Less than K900, 000.

b) About K900, 000 but cannot afford nonfood basic needs.

c) Spends more than K1, 200,000=00 and can afford non food basic needs such as health, shelter and education.

12. How many school going children do you have?

a) 1

b) 2

c) 3

d) 4

e) None

13. Are you are able to pay for their school requirements?

a) Yes

b) No

14. Are you able to pay health scheme and buy medicine if one of your family members gets sick?

a) Yes

b) No

15. Below is a list of items that describe children and youths. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = somewhat or Sometimes True 2 = Very True or Often True

1. Acts too young for his/her age 0 1 2
2. Drinks alcohol without parents' approval (Describe):_____________________________ _________________________________ _____ _________________________________0 1 2
3. Argues a lot 0 1 2
4. Fails to finish things he/she starts 0 1 2
5. There is very little he/she enjoys 0 1 2
6. Bowel movements outside toilet 0 1 2
7. Bragging, boasting 0 1 2
8. Can't concentrate, can't pay attention for long 0 1 2
9. Can't get his/her mind off certain thoughts; obsessions (Describe):_____________________________ _______________________________________ _________________________________0 1 2
10. Can't sit still, restless, or hyperactive 0 1 2
11. Clings to adults or too dependent 0 1 2
12. Complains of loneliness 0 1 2

13. Confused or seems to be in a fog 0 1 2
14. Cries a lot 0 1 2
15. Cruel to animals 0 1 2
16. Cruelty, bullying, or meanness to others 0 1 2
17. Daydreams or gets lost in his/her thoughts 0 1 2
18. Deliberately harms self or attempts suicide 0 1 2
19. Demands a lot of attention 0 1 2
20. Destroys his/her own things 0 1 2
21. Destroys things belonging to his/her family or others 0 1 2
22. Disobedient at home 0 1 2
23. Disobedient at school 0 1 2
24. Doesn't eat well 0 1 2
25. Doesn't get along with other kids 0 1 2
26. Doesn't seem to feel guilty after Misbehaving 0 1 2
27. Easily jealous 0 1 2
28. Breaks rules at home, school, or elsewhere 0 1 2
29. Fears certain animals, situations, or places, other than school (describe):
____
____
________________________________ 0 1 2
30. Fears going to school 0 1 2
31. Fears he/she might think or do something bad 0 1 2
32. Feels he/she has to be perfect 0 1 2
33. Feels or complains that no one loves him/her 0 1 2
34. Feels others are out to get him/her 0 1 2
35. Feels worthless or inferior 0 1 2
36. Gets hurt a lot, accident-prone 0 1 2
37. Gets in many fights 0 1 2
38. Gets teased a lot 0 1 2
39. Hangs around with others who get in Trouble 0 1 2
g. Vomiting, throwing up 0 1 2
h. Other describes):_______________________ 0 1 2

40. Hears sound or voices that aren't there (Describe):
____
____
____
_________________________________0 1 2
41. Impulsive or acts without thinking 01 2
42. Would rather be alone than with others 0 1 2
43. Lying or cheating 0 1 2
44. Bites fingernails 0 1 2
45. Nervous, highstrung, or tense 01 2
46. Nervous movements or twitching (Describe)____________________________
____
____
_________________________________0 1 2
47. Nightmares 0 1 2
48. Not liked by other kids 0 1 2
49. Constipated, doesn't move bowels 0 1 2
50. Too fearful or anxious 0 1 2
51. Feels dizzy or lightheaded 0 1 2
52. Feels too guilty 0 1 2
53. Overeating 0 1 2
54. Overtired without good reason 0 1 2
55. Overweight 0 1 2
56. Physical problems without known Medical cause: 0 1 2
a. Aches or pains (not stomach or headaches) 0 1 2
b. Headaches 0 1 2
c. Nausea, feels sick 0 1 2
d. Problems with eyes (not if corrected by glasses) (Describe):
____
________________________________ 0 1 2
e. Rashes or other skin problems 0 1 2
f. Stomachaches 0 1 2

57. Physically attacks people 0 1 2
58. Picks nose, skin, or other parts of body body

(Describe):

____

_______________________________0 1 2

59. Plays with own sex parts in public 0 1 2

60. Plays with own sex parts too much 0 1 2

61. Poor school work 0 1 2

62. Poorly coordinated or clumsy 0 1 2

63. Prefers being with older kids 0 1 2

64. Prefers being with younger kids 0 1 2

65. Refuses to talk 0 1 2

66. Repeats certain acts over and over; compulsions 0 1 2

(Describe):

____

____

____

_______________________________0 1 2

67. Runs away from home 0 1 2

68. Screams a lot 0 1 2

69. Secretive, keeps things to self 0 1 2

70. Sees things that aren't there (describe):

____

____

____

_______________________________0 1 2

71. Self-conscious or easily embarrassed 0 1 2

72. Sets fires 0 1 2

73. Sexual problems

(Describe):

____

_______________________________0 1 2

74. Showing off or clowning 0 1 2

75. Too shy or timid 0 1 2

76. Sleeps less than most kids 0 1 2

77. Sleeps more than most kids during day and/or night 0 1 2

(Describe):

____

____

____

_________________________________0 1 2

78. Inattentive or easily distracted 0 1 2

79. Speech problem 0 1 2

(Describe):

____

_____

____

____

80. Stares blankly 0 1 2

81. Steals at home 0 1 2

82. Steals outside the home 0 1 2

83. Stores up too many things he/she doesn't need

(Describe):

____

_________________________________0 1 2

84. Strange behavior (describe):

____

____

_________________________________0 1 2

85. Strange ideas

(describe)____________________________

_________________________________0 1 2

86. Stubborn, sullen, or irritable 0 1 2

87. Sudden changes in mood or feelings 012

88. Sulks a lot 0 1 2

89. Suspicious 0 1 2

90. Swearing or obscene language 0 1 2

91. Talks about killing self 0 1 2

92. Talks or walks in sleep (describe):

____

____

____

_______________________________0 1 2

93. Talks too much 0 1 2

94. Teases a lot 0 1 2

95. Temper tantrums or hot temper 0 1 2

96. Thinks about sex too much 0 1 2

97. Threatens people 0 1 2

98. Thumb-sucking 0 1 2

99. Smokes, chews, or sniffs tobacco 0 1 2

100. Trouble sleeping

(describe):____________________________

____

____
_________________________________0 1 2
101. Truancy, skips school 0 1 2
102. Underactive, slow moving, or lacks energy 0 1 2
103. Unhappy, sad, or depressed 0 1 2
104. Unusually loud 0 1 2
105. Uses drugs for nonmedical purposes (don't include alcohol or tobacco) 0 1 2
(Describe): ___________________________
____
____
____
____
106. Vandalism 0 1 2
107. Wets self during the day 0 1 2
108. Wets the bed 0 1 2
109. Whining 0 1 2
110. Wishes to be of opposite sex 0 1 2
111. Withdrawn, doesn't get involved with others 0 1 2
112. Worries 0 1 2

Please write in any problems your child has that was not listed above:

____
_________________________________0 1 2
____
_________________________________ 0 1 2
____
_________________________________0 1 2

(Achenbach, T. M. (1991). Manual for Child Behavior Checklist/ 4-18 and 1991 Profile. Burlington, VT: University of Vermont, Dept. of Psychiatry).

Appendix III: Pre Structured Questions on the Family Narratives for both Caregivers and Orphans.

1) Can you tell me about an incident when you met the child during his / her parents life time.

2) Sometimes orphans can present challenges to families in dealing with school work, how is this child (Orphan) doing at school?

3) Can you tell me something he (Orphan) did at home that seems important to you? (Caregiver)

4) Can you think about a specific time when (Orphan's name) behavior was worrisome and how did you overcome it?

5) Can you tell me about an incident that made you feel proud about (Orphan's name).

6) How do you describe (Orphan's name) behavior both at home and at school?

7) Can you tell me something that your current parents did at home that seems important to you? (Orphan)

8) Can you remember any story that your parent told you and how was it about? (Orphan)

9) Can you tell me something that your current parents did at home that seems important to you? (Orphan)

10) ETC.