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Orphanage caregivers' perceptions of children's emotional needs

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ABSTRACT

Problems in orphan care are endemic in sub-Saharan Africa where 80% of all children orphaned by AIDS live. Institutions are often the only level of care available for infant orphans, but such care may increase children's risk for psychological, emotional and developmental problems. This study explores Ghanaian institutional caregivers' views of children's emotional and relational needs with the aim of understanding these caregivers' capacities to provide effective care for orphans. Qualitative data was gathered from 92 staff at eight Ghanaian orphanages. Results indicate that while caregivers describe a basic understanding of children's emotional and interpersonal needs, they detail a lack of training and support necessary to fully attend to these needs. Specifically, training for caregivers regarding children's basic attachment needs and the particular emotional needs of orphaned children is critical. The present study suggests the need for training and interventions to strengthen orphanage caregivers' capacity to provide effective orphan care.

1. Introduction

Approximately 12% of Sub-Saharan Africa's children are orphans (UNICEF, 2007). Of these 53.1 million children, nearly six million were orphaned in 2010 alone (UNICEF, 2006). Orphaned and abandoned children face significantly increased risk of poor health and psychological distress (Ribeira, Brown, & Akuamoa-Boateng, 2009; UNICEF, 2006). Additionally, research suggests that infant institutionalization increases the risk for emotional and developmental problems, including attachment disorders, delays in learning, and cognitive functioning (Makame, Ani, & Grantham-McGregor, 2002; Sigal, Rossignol, Perry, & Ouimet, 2003).

An orphan is defined as a child who has lost one or both parents (World Bank, 2004). Orphans and vulnerable children (OVC) is a term designated by the World Bank (2004) to describe groups of children that experience negative outcomes—such as losing access to educational opportunities or experiencing morbidity and malnutrition—at higher rates than their peers. While many children in Africa are vulnerable to negative risk factors, OVC are the most critically vulnerable, facing greater risk than their peers through early death, poor health, educational deprivation, abuse, neglect, exploitation and limited access to basic social amenities (World Bank, 2004). The World Bank (2004) estimates that nearly 20% of Sub-Saharan Africa's children are OVC. OVC who are without parental care are often placed in institutions where they receive less stimulation, less individual attention, and fewer opportunities than required for optimal emotional and social development (UNICEF, 2007).

The aim of the present study was to identify orphanage caregiver perceptions' of children's emotional needs. Orphanage caregivers are in a unique position to significantly impact OVC's emotional and relational development.

2. Institutionalized children's emotional development

Children's early experiences have long-term consequences for personality functioning, intellectual processes and social relationships (Richter, 2004). Moreover, children reared in deficient institutional environments show a range of developmental delays (Crockenberg et al., 2008). If they have adequate food supplies and access to basic material necessities, what is it about the institutional setting for children that so affects their development? Researchers suggest that institutionalized children who are exposed to social and emotional neglect exhibit psychosocial dwarfism and physical growth deficiencies (Johnson et al., 2010). These deficits are likely associated with children's emotional adjustment and attachment relationships, which depend considerably on the quality of their early attachment relationships (McLaughlin, Zeanah, Fox, & Nelson, 2012; Muhamedrahimov, Palmov, Nikiforova, Groark, & McCall, 2004; Smyke et al., 2014).

John Bowlby, attachment theory's founder, asserted that healthy attachment relationships with primary caregivers serve as the bedrock for children's developing relational patterns. More recent research suggests links between children's early attachment relationships and later developmental trajectories, including their capacity for affect regulation, sociability, adjustment, and psychopathology (Fonagy, Gergely, Jurist, & Target, 2002; McGoron et al., 2012). These relationships

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require stability and consistency, as well as responsive, trustworthy and developmentally appropriate caregiving behaviors (Crockenberg et al., 2008; Groark, Muhamedrahimov, Palmov, Nikiforova, & McCall, 2005).

Infants appear biologically driven to form attachment relationships regardless of their culture (Fox & Hane, 2008). Proximity to a caregiver and having attachment needs met provides the child with a sense of security (Ainsworth, 1978; Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982, 1973, 1978, 1980, 1988). The infant then comes to trust and use this caregiver as a secure base from which to explore the social and physical world (Bowlby, 1973, 1988; Crockenberg et al., 2008). Separation from primary caregivers and others with whom the child has attachment bonds can be a source of distress for children (Masi, Mucci, & Millepiedi, 2001). Separation threatens the development and maintenance of emotional connections and healthy attachment relationships (Bowlby, 1973, 1988; McLaughlin et al., 2012). Distress, symptoms of anxiety, depression and psychopathology often accompany an infant's separation (McLaughlin et al., 2012). Without a warm, responsive caregiver and with a lack of sustained interactions and positive attunement between an infant and his caregiver, the infant's development will be negatively affected. Healthy attachment experiences encourage infants' development of cognitive skills, appropriate social and emotional development, and mental health (Veríssimo, Santos, Fernandes, Shin, & Vaughn, 2014).

Studies involving attachment in institution-based care show deficiencies in caregiver stability and consistency, as well as in caregiver responsiveness and emotional availability (Crockenberg et al., 2008; Johnson et al., 2010; Muhamedrahimov et al., 2004). Due to insufficient child–caregiver ratios and inconsistent caregiver shift rotations, children in institutional settings typically encounter repeated separations from caregivers (Johnson et al., 2010; Muhamedrahimov et al., 2004). Negative effects of separations on children include symptoms such as agitation, depression, altered cardiac activity, and sleep interruptions (Perry, Sigal, Boucher, Paré, 2006).

Research conducted in Romanian orphanages suggests that social interaction with caregivers may be a primary factor influencing cognitive and physical development (Groark et al., 2005; Johnson et al., 2010). In one study, orphanage caregivers, prior to being trained to provide warm, responsive caregiving, displayed high levels of anxiety and communicated little with the children in their care (Groark et al., 2005). Further, the children responded to their orphanage caregivers with indiscriminate friendliness, lack of eye contact, aggression and impulsive behaviors. After training and staffing rearrangement interventions, however, caregivers became more responsive and children's interpersonal skills improved along with their physical growth, cognition, language, and motor development (Groark et al., 2005).

Some orphanage studies have found that while the material needs of orphans were met, orphans experienced deprivation in terms of emotional need fulfillment, including interpersonal interactions with staff (Freidus, 2010; Sanou, Turgeon-O'brien, Ouedraogo, & Desrosiers, 2008). These studies' longitudinal data support the idea that establishing higher quality child–caregiver interactions with appropriate training in emotional engagement and contingent caregiving leads to promising outcomes in children's growth and development (Groark et al., 2005; Johnson et al., 2010).

Close emotional ties between staff and orphaned children living in residential institutions may serve as an effective psychological buffer against OVC's adverse life events and circumstances (McGoron et al., 2012). Moreover, training orphanage staff to provide warm, responsive and consistent caregiving can improve children's social interaction and physical development (Eapen, 2009; Muhamedrahimov et al., 2004; Taneja et al., 2002). This research demonstrates the importance in evaluating gaps in caregivers' perceptions of children's emotional needs.

3. Institutionalized care for orphans and vulnerable children in Ghana

In 2007, 1,100,000 of the world's orphaned children lived in Ghana (UNICEF, 2006). This figure represents 4.7% of Ghana's total population and 10.4% of Ghana's children and adolescents under the age of 18. Approximately 21.3% of Ghana's orphans live in the Ashanti region (Ansah-Koi, 2006). In this region, institutional care is often the only care available to orphans (Sanou et al., 2008).

Over the last two decades, the number of orphanages in Ghana has increased from ten to more than 140 (Save the Children, 2009). According to the Government of Ghana (2008), there are more than 148 children's institutions currently operating throughout Ghana without license to do so. Founded and run by individuals, private institutions and non-governmental organizations, these facilities emerged to address the high demand for OVC care in urban areas (Deters & Baja, 2008).

The Government of Ghana (2008) recognizes that the use of residential care in sub-Saharan Africa is "an inappropriate and unsustainable phenomenon to respond to the orphan crisis" (p. 14). Yet, because the country's financial capacity and organizational resources remain insufficient to support a foster or familial care system, a majority of Ghana's OVC remain in institutional care. In these institutions, staff and administrators continue to struggle with limited resources to feed, clothe and educate the children in their care (Castillo, Sarver, Bettmann, Mortensen, & Akuoko, 2012).

A vast body of research exists regarding the detrimental effects of institutionalized care for OVC in general, and throughout Sub-Saharan Africa in particular (Ansah-Koi, 2006; Ribeira et al., 2009; Sanou et al., 2008; UNICEF, 2003). Still, few studies focus on the institutional care of Ghanaian OVCs. Further, no research explores Ghanaian orphanage caregivers' and staff perceptions of children's needs. Given this paucity of literature, the present study sought to answer the question: What is the understanding of children's emotional and relational needs among childcare staff and administrators at institutions for OVC operating in the Ashanti region in Ghana? Clarifying this understanding may help such organizations to better perceive and enhance staff capacities to meet orphaned children's developmental needs.

4. Method

4.1. Sample

Participants included 92 Ghanaian employees from eight residential institutions for children in the Ashanti region of Ghana. See Table 1 for participant demographics. All participants interviewed took part in overseeing and caring for the children, thus their inclusion in the study. Participants included 54 caregivers (utilizing the role "childcare officer," "childcare assistant," or "mother"), cooks, guards, administrators, and office staff. Some orphanage staff were not specifically trained or designated to be caregivers, but still played a significant role in providing direct childcare. Male participants ($n = 12$) constituted nine of the 10 administrators, two of the four foster parents and one of the four cooks interviewed. Inquiries were made at seven of the eight institutions ($n = 81$) surrounding whether staff had received training on caring for children (see Table 2).

One of the eight institutions was called a "children's home," the term used in Ghana to define "homes for children in need of care and protection" (Government of Ghana, 2008, p. 14). Another was called a "babies home," a children's home designated for children from zero to five. The Ashanti Regional Office of the Department of Social Welfare (DSW) oversees the operations of all eight establishments. Six of the residential institutions' financial resources come from private and external donors including religious organizations, while two of the institutions receive government support in addition to private donations.