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A Comparison of Mental Health Problems and Coping Strategies in Orphans and Non-Orphans

Sameera Shafiq
Department of Psychology
University of Gujrat
&
Maria Farooq Kiani
Department of Psychology
University of Gujrat

Abstract

The present research aims to compare the levels of mental health problems such as depression, anxiety, and stress between orphans and non-orphans and to explore the differential use of coping strategies between the two groups. The research has been conducted in three phases. Phase I dealt with the forward-backward Urdu translation process of the English version of the Ways of Coping Questionnaire (WAYS). Phase II comprised a pilot study and checked the adequacy of the WAYS for administration on the sample of 20 orphans and 20 non-orphans selected from different areas of Jhelum by using a purposive sampling technique. Phase III comprised the main study of the research where the Urdu version of Depression, Anxiety, Stress Scales (DASS-42) and WAYS are administered to 100 non-institutionalized orphans and 100 non-orphans between age range 15 years to 25 years. The results of the research showed that they have also used different coping strategies with less frequency as compared to non-orphans. Double orphans have significantly high levels of stress, anxiety, and depression than single orphans. Moreover, double orphans significantly differ in the use of coping strategies in comparison to single orphans. Implications are discussed in light of the findings of the research.

Keywords: *Anxiety, Assessment of Coping Skills, Depression, Healthy Adolescents, Orphans, Stress.*

UNICEF (2017) has estimated in the world there are approximately one hundred and forty million orphans in 2015. Those who have lost both parents are known as Double Orphans and those having one parent surviving (mother or father) are called Single Orphans. According to UNICEF (as cited in The Nations, 2018), in Pakistan approximately four point two million individuals are orphans. The present study has focused on mental health problems of adolescents who are either single orphans or double orphans in the age group of 15 years to 25 years due to poor socio-economic conditions and low availability of employment opportunities in Pakistan. They are non-institutionalized, neither married nor financially earning members of the families in which they lived. Mental health refers to the individual's wellness or well-being in which he or she can recognize one's innate potential to cope with daily life hassles and to be a productive member of the community at large (World Health Organization, 2014). Mental health problems refer to matters that are harmful to one's state of psychological health and need to be dealt with effectively either to channel emotional states healthily or overcome them. In the present study, mental health problems include negative emotional states of depression, anxiety, and stress. A lot of research has been conducted on orphans whose parents have died due to Acquired Immune Deficiency Syndrome (AIDS).

Correspondence concerning this article should be addressed to:
Sameera Shafiq
Department of Psychology University of Gujrat
E-Mail: sameerashafiq@yahoo.com

The study of orphans with death caused other than AIDS has been seen as a neglected area. Therefore, the present study has focused on orphans whose parents have died either due to disease (other than AIDS) or accident.

Several studies showed that orphans have suffered from high levels of psychological problems. They have shown emotional and behavioral adjustment problems in addition to depression, anxiety, and post-traumatic stress disorder. These conditions worsened over a long period (Cluver, Gardner, & Operario, 2007, 2008; Cluver, Orkin, Gardner, & Boyes, 2012). Orphans whose parents died at early age suffered from prolonged grief disorder (Schaal, Dusingizemungu, Jacob, Neuner, & Elbert, 2012). They have exhibited both internalizing and externalizing problems (Cluver, & Gardner, 2007) along with the manifestation of depression, anxiety, and developmental disorders (Fawzy, & Fouad, 2010). In Longitudinal Research conducted in 2005 (with a sample size of 1,025) and 2009 (with a sample size of 723), Boyes, and Cluver (2013) found that young orphans reported a high level of stigma, depression, and anxiety than youth who were not orphans. Schaal, Jacob, Dusingizemungu, and Elbert (2010) posited that stress due to prolonged grief disorder accounted for 8% of two hundred and six double- or single- orphans. This has diminished the well-being of orphans psychologically (Cluver, & Gardner, 2007).

Musisi, Kinyanda, Nakasujja, and Nakigudde (2007) posited that orphans showed a significantly greater frequency of emotional and behavioral problems as compared to non-orphans which in turn was associated with their poor academic performance, low confidence, and low self-esteem. Their social performance was shoddier as compared to non-orphans. Atwine, Cantor-Graae, and Bajunirwe have conducted research in 2005 for the assessment of psychological distress in orphans and nonorphans of eleven years to fifteen years of age. They have administered the Beck Youth Inventories of Emotional and Social Impairment on one hundred and twenty-three orphans. They have compared these orphans with

one hundred and ten non-orphans. Results showed that orphans compared to non-orphans showed high levels of anxiety, depression, and anger. Therefore, it is concluded that tangible support in terms of material goods is not enough for orphans. Rather they also need emotional and social support for better functioning and well-being. Lassi, Mahmud, Syed, and Janjua (2011) found that in institutionalized orphans, foster mothers' depression and the child's nutritional status were significant predictors of behavioral problems. Koumi et al., 2012 found behavioral problems in 64.5% of orphans residing in an orphanage.

According to Chouhan, and Sharma (2017) negative emotional conditions such as stress, anxiety, and depression are comorbid with each other and are experienced as a reaction to facing the threatening situations one encounters in life. These states are not always harmful rather in the optimal amount they sometimes equip one to cope well with dangerous situations. Therefore, negative situations that people encounter in their lives cause them to feel sad moods and emptiness which in turn motivate them to come out of those bad times. However, if the frequency and intensity of sad mood, emptiness, and hopelessness persisted more than the usual duration of coping, it would affect their work and social spheres. At this point, the available coping resources of an individual exceed the demands of the situation (Lazarus & Folkman, 1986). Mental health problems are operationalized in terms of depression, anxiety, and stress reactions measure through the scores of a standardized scale namely, the Depression, Anxiety, and Stress Scale-42 (DASS-42, Lovibond, & Lovibond, 1995). Whereas the coping strategies used to handle these mental health problems is operationally defined by the scores obtained on the Ways of Coping Questionnaire (WAYS, Folkman & Lazarus, 1988). The WAYS assess the coping process unlike different inventories measuring the coping styles or dispositions.

Earlier researches showed that mood and symptom levels were related to coping responses. Depressed persons used coping strategies differently as compared to non-depressed individuals (Billings, & Moos, 1981; Coyne, Aldwin, & Lazarus, 1981). A few studies have focused on the exploration of coping strategies in orphans *(see* Chase, Wood, & Aggleton, 2006; Daniel, & Mathias, 2012; Van der Brug, 2012). 487 adolescents and 630 adults showed empirically a strong relationship between psychopathology and the use of coping strategies. Cognitive coping strategies such as self-blame, rumination, catastrophizing, and positive reappraisal were shown to be significant in reporting depression, and anxiety (Garnefski, Legerstee, Kraaij, Kommer, & Teerds, 2002). Regression analyses of another study by McCracken, and Gross (1993) indicated that anxiety defined as cognitive, motoric, and physiological response types along with stress accounted for significant differences in coping strategy scores.

Mahmoud, Staten, Hall, and Lennie (2012) studied five hundred and eight students who are between the age group 18 years to 24 years. They measured depression, anxiety, and stress through the Depression, Anxiety, Stress Scale-21 (DASS-21) and coping strategies with Brief COPE Inventory. They found that multiple regression analysis of maladaptive coping strategies was the predictor of depression, anxiety, and stress in adolescents. Similarly, Dumont and Provost (1999) researched two hundred and ninety-seven adolescents (studying in 8th and 11th grades) and found by discriminant function analysis that adolescents used coping strategies differently to depression, stress due to daily hassles, and adjustment indices. Results of a study showed that high levels of anxiety were related to emotion-focused coping and avoidance coping strategies (Ntoumanis, & Biddle, 2000). The objectives of the present study are:

To assess levels of depression, anxiety, and stress between orphans and non-orphans.

1. To explore the differences in the mental health problems of orphans and non-orphans.
2. To examine the differences in the coping strategies of orphans and non-orphans.
3. To examine the differences in the mental health and coping strategies in various types of an orphanage.

Rationale

Wild (2001) has recommended that there is a dire need to design a study that would compare adjustment issues across multiple domains of orphans, who have faced parental death due to causes other than AIDS with the non-orphans of the same community. Except for Majeed, Khan, and Khan (2014) who have conducted research and found no significant differences in the emotional stability of institutionalized orphans (*n=80*), non-institutionalized orphans (*n=80*), and non-orphans (*n=80*), the majority of the studies (Doku, 2009; Govender, Reardon, Quinlan, & George, 2014; Khanum, Iqbal, & Qureshi, 1995; Makame, Ani, & Grantham- McGregor, 2002; Nyamukapa et al., 2010; Wolff, Tesfai, Egasso, & Aradomt,1995) have indicated a difference in the mental health of orphans and non-orphans which in turn lead to the differential usage of the coping strategies. The present study has focused on the comparison of the levels of depression, anxiety, and stress between orphans, and non-orphans. Further, the differences in their use of coping strategies have also been investigated as mentioned worth exploring by Baguma, Kyomugisha, and Kimeze (2004). The implications of the findings are useful to counselors, psychologists, and clinical psychologists, to provide their services to this segment of the population on a humanitarian basis. Intervention based on the enhancement of the coping strategies of orphans can help them handle the daily hassles of life in a better way.

Hypotheses

Based on the literature review, the hypotheses of the present study derived are given below:

1. Depression, anxiety, and stress will be significantly higher in orphans than in non-orphans.
2. There will be significant differences in the use of coping strategies of orphans and non-orphans.
3. There will be significant differences in the mental health of orphans for maternal, paternal, and double types.
4. There will be significant differences in the mental health of orphans for maternal, paternal, and double types after controlling the confounding variable of age.
5. There will be significant differences in the coping strategies of orphans for maternal, paternal, and double types after controlling for the confounding variable of age.

Method

The present study was conducted in three phases

Phase I

Phase I undertook the translation of the Ways of Coping Questionnaire (WAYS, Folkman, & Lazarus, 1988) in Urdu for utilization with orphans and non-orphans between the age range of 15 to 25 years. Permission was sorted from the copyright owner of the instrument namely Mind Garden. The process of translation is comprised of the following steps.

Step 1. The WAYS were translated by the six bilingual experts in Urdu (2 psychologists, and four Linguistic experts). The best translation was elected through a committee approach.

Phase II

It comprises the pilot study to assess the language of the Urdu-translated version of WAYS.

Participants

Twenty orphans (5 males and 15 females) between the age range of 15 years to 25 years (*M= 21.1, SD= 2.9*) were selected purposively from different areas of Jhelum. Their education ranged from primary to master. Twenty non-orphans (7 males and 13 females) between the age range of 15 to 25 years (*M=21.6, SD= 1. 2*) were selected purposively from different areas of Jhelum. Their education ranged from intermediate to master.

Procedure

WAYS Urdu version was administered to 40 individuals (20 orphans and 20 non-orphans). The questionnaire was assessed for its level of comprehension. Minor changes were made only in difficult words and they were adjusted to simple understandable Urdu.

Phase III

It comprises of the main study to assess the relationship among depression, anxiety, stress, and coping strategies.

Participants

100 orphans (49% males and 51% females) between the age range 15 years to 25 years (*M=19.8, SD=3.1*) with the educational background of matric to masters were purposively selected from Jhelum. The inclusion criteria focused on unemployed adolescents between the age range of 15 to 25 years either with the death of a mother, a father, or both, and a control group with both father and mother alive. The exclusion criteria focused on the elimination of adolescents with a physical disability, illiteracy, and death of mother, father, or both due to AIDS, previous history with any psychiatric disorder, and who are employed. They were approached by snowball sampling technique in which one known orphan was contacted and the rest of the orphans were selected by the reference of the known orphan. The permission was taken from the guardians (close relatives with whom the orphans were living). The non-orphans adolescents were selected by purposive sampling technique from the neighborhood of the orphan.

11% were double orphans where as 89% were single orphans (47 % lost their father, and 42% lost their mother). The major cause of death was illnesses such as heart attack, cancer, hepatitis, and so on (70%), 23% died in accidents, 5% suffered from various types of injuries (such as the head, and leg), and 2% fell from a roof. 100 non-orphans (45% males and 55% females) between the age range 15 years to 25 years (*M=20.7, SD=3.1*) with matric to masters were purposively selected from Jhelum.

Measures

Two standardized scales were used in the present study

1. **Depression, Anxiety, and Stress Scales (DASS-42, Lovibond & Lovibond, 1995).**

DASS-42 was developed by Lovibond and Lovibond in 1995. The Urdu translation of DASS-42 was carried out by Farooqi and Habib in 2010. DASS comprised 42 items designed to measure depression, anxiety, and stress, in the sample of orphans and non-orphans. Each category has 14 items in it making 0 the lowest score and 42 the highest score for that category. The scoring categories range from 0 (which did not apply to me at all) to 3 (which applied to me very much). The Cronbach's alpha reliability of the Depression scale is 0.89, the Anxiety scale is 0.82 and the Stress scale is 0.89, with 0.96 on the total scale in the present sample of the study.

2. **Ways of Coping Questionnaire (WAYS, Folkman & Lazarus, 1988).** WAYS developed by Folkman and Lazarus (1988), comprised 66 items designed to measure the coping process with eight subscales. The subscales of WAYS are Confronting Coping, Distancing, Self-Controlling, Seeking Social Support, Accepting Responsibility, Escape Avoidance, Planful Problem-Solving, and Positive Reappraisal. It is a Likert scale with four response categories ranging from 0 (not used) to 3 (used a great deal). The score for each subscale is calculated by adding the scores of each item for that category. A high score indicates the usage of the coping category to deal with stressful encounters. The Cronbach's Alpha reliability coefficient of WAYS (Urdu) in this study is 0.94.

Procedure

Urdu versions of DASS and WAYS were administered on 100 non-institutionalized orphans selected by snowball sampling technique and 100 non-orphans selected by purposive sampling technique residing in their relatives' houses situated in Jhelum. They were briefed about the purpose of the study and verbal informed consent was sorted out not only by them but also by their guardians. It approximately took 15 to 20 minutes to fill out the questionnaires. Permission from the guardians (close relatives with whom the orphan was staying) was sorted for double orphans between the age range of 15 to 18 years. However, in the case of maternal and paternal orphans, permission was sorted from the father and mother respectively. Parents of non-orphan adolescents were contacted for granting permission to their children between the ages of 15 and to 18 participate in the study. The participants were briefed about the purpose of the study and verbal informed consent was sorted out. No element of deception was present in the study for research participants. They were told that they can withdraw from the study at any time they want to. However, they were briefed that they cannot gain any financial help participation of their involvement in the research.

Results

The results of the present study are given as below:

Table 1

Psychometric Properties for WAYS Scale and Subscales (N=200)

Subscales/Scale	M	SD	Range	Cronbach's α
Confrontive Coping	9.37	2.45	3.00-17.00	.60
Distancing	9.68	3.00	3.00-17.00	.69
Self-controlling	10.85	3.20	3.00-19.00	.65
Seeking social support	9.33	3.05	1.00-17.00	.60
Accepting responsibility	6.43	1.98	1.00-11.00	.50
Escape avoidance	10.99	2.98	4.00-21.00	.75
Planful problem-solving	9.36	2.92	3.00-16.00	.68
Positive reappraisal	10.98	3.32	5.00-19.00	.70
WAYS	77.01	18.30	47.00-126.00	.94

Note. M=Mean, SD=Standard Deviation

Table 1 shows that the values of Cronbach's Alpha are acceptable as the lowest is 0.50 to 0.94 highest value. According to Sharma (2016) the value of a reliability coefficient below 0.50 is unacceptable and above 0.90 is excellent.

Table 2

Levels of Depression in Orphans (n=100) and Non-orphans (n=100)

Levels of Depression	Orphans		Non orphans	
	F	%	f	%
Normal	1	1%	48	48%
Mild	2	2%	18	18%

Moderate	29	29%	30	30%
Severe	51	51%	4	4%
Extremely Severe	17	17%	-	-

Note: f= frequency; %= percentage

Table 2 shows that in the severe and extremely severe levels of depression, 68% of orphans lie compared to 4% of non-orphans.

Table 3

Levels of Anxiety in Orphans (n=100) and Non-orphans (n=100)

Levels of Anxiety	Orphans		Non orphans	
	f	%	f	%
Normal	-	-	33	33%
Mild	-	-	9	9%
Moderate	2	2%	29	29%
Severe	17	17%	22	22%
Extremely Severe	81	81%	7	7%

Note: f= frequency; %= percentage

Table 3 shows that in the severe and extremely severe levels of anxiety, 98% of orphans lie compared to 29% of non-orphans.

Table 4

Levels of Stress in Orphans (n=100) and Non-orphans (n=100)

Levels of Stress	Orphans		Non orphans	
	f	%	f	%
Normal	5	5%	62	62%
Mild	14	14%	22	22%
Moderate	54	54%	15	15%
Severe	26	26%	1	1%
Extremely Severe	1	1%	-	-

Note: f= frequency; %= percentage

Table 4 shows that in the severe and extremely severe levels of depression, 27% of orphans lie compared to 1% of non-orphans.

Table 5

Mean, Standard Deviation, Independent t-test, and Cohen's d for Difference in Mental Health Problems of Orphans (n=100) and Non-orphans (n=100)

Variables	Orphans		Non-orphans		*t(198)*	*p*	*Cohen's d*
	M	*SD*	*M*	*SD*			
Depression	22.6	4.8	10.7	5.0	16.8	<.001	2.42
Anxiety	23.1	4.3	11.1	5.6	16.7	<.001	2.40
Stress	22.7	4.8	11.8	6.3	13.6	<.001	1.94

Note: M= Mean; SD=Standard Deviation, t=Independent t-test; p= level of significance.

Table 5 shows significant differences in the scores for depression, anxiety, and stress between orphans and non-orphans. Orphans exhibit high scores in depression (*M=22.6*), anxiety (*M=23.1*), and stress (*M=22.7*) as compared to non-orphans. The mean value of depression indicates that orphans suffered from severe levels of depression as compared to mild levels of depression in non-orphans. The mean value of anxiety indicates that orphans suffered from an extremely severe level of depression as compared to a moderate level of anxiety in non-orphans. The mean value of stress indicates the orphans suffered from a moderate level of stress as compared to the normal level of stress in non-orphans.

Table 6

Mean, Standard Deviation, Independent t-test, and Cohen's d for Differences in the Use of Coping Strategies of Orphans (n=100) and Non-orphans (n=100)

Variables	Orphans (n=100)		Non-orphans (n=100)		*t(198)*	*p*	*Cohen's d*
	M	*SD*	*M*	*SD*			
Confrontive Coping	8.36	1.8	10.38	2.5	-6.37	<.001	0.92
Distancing	8.16	2.1	11.21	2.9	-8.32	<.001	1.20
Self-Controlling	9.30	2.1	12.64	3.2	-8.67	<.001	1.23
Seeking Social Support	7.62	1.9	11.04	2.9	-9.52	<.001	1.39
Accepting Responsibility	5.74	1.5	7.12	2.1	-5.22	<.001	0.75
Escape-Avoidance	10.09	2.2	11.89	3.3	-4.46	<.001	0.63
Planful Problem-Solving	7.99	2.1	10.74	2.9	-7.51	<.001	1.08
Positive Reappraisal	8.86	2.0	13.11	2.9	-11.75	<.001	1.70

Note: M= Mean; SD=Standard Deviation, t=Independent t-test; p= level of significance.

Table 6 shows significant differences in the scores of the usage of coping strategies between orphans and non-orphans. Orphans make less frequent use of these coping strategies such as confronting coping (*M=8.36*), distancing (*M=8.16*), self-controlling (*M= 9.30*), seeking social support (*M=7.62*), accepting responsibility (*M=5.74*), escape avoidance (*M=10.09*), planful problem-solving (*M=7.99*), and positive reappraisal (*M=8.86*) compared to non-orphans.

Table 7

One Way ANOVA Post Hoc Comparison Table for Mental Health of Maternal Orphans (n=34), Paternal Orphans (n=35) and Both (n=31).

	Maternal Orphans (1)		Paternal Orphans (2)		Double Orphans (3)		F Ratio	p	η^2	Post Hoc Bonferroni
	M	SD	M	SD	M	SD				
Stress	22.1	4.1	21.22	5.2	25.1	4.3	6.6	.002	.12	3>1,2
Anxiety	20.8	3.7	20.71	4.4	23.6	3.5	5.8	.004	.11	3>1,2
Depression	20.7	4.2	21.62	5.3	24.5	4.5	5.6	.005	.10	3>1,2

Table 7 shows One Way ANOVA Post Hoc Bonferroni significant differences in the levels of mental health of orphans with maternal, paternal, or both categories. Orphans whose parents have died showed a high level of stress (*M= 25.161, SD=4.04*), anxiety (*M=23.612, SD=3.51*), and depression (*M=24.516, SD=4.57*) as compared to maternal and paternal orphans.

Table 8

One Way MANCOVA for Mental Health of Maternal Orphans (n=34), Paternal Orphans (n=35) and Double Orphans (n=31) after Controlling the Age.

Effect		Value	F	Sig.	Partial Eta Squared
Orphan Categories	Pillai's Trace	.18	3.10	.006	.089
	Wilks' Lambda	.83	3.09	.006	.090
	Hotelling's Trace	.20	3.09	.007	.091
	Roy's Largest Root	.15	4.63	.005	.128

Table 8 shows statistically significant differences with One Way MANCOVA between orphanage categories (maternal orphans, paternal orphans, and both) on mental health (stress, anxiety, and depression) after controlling for age, F (2, 96)=3.09, p<.001, Wilk's ƛ=.82, partial η^2= .10.

Table 9

One Way MANCOVA for Coping Strategies of Maternal Orphans (n=34), Paternal Orphans (n=35) and Double Orphans (n=31) after Controlling the Age.

Effect		Value	F	Sig.	Partial Eta Squared
Orphan Categories	Pillai's Trace	.293	1.93	.020	.146
	Wilks' Lambda	.73	1.91	.022	.147
	Hotelling's Trace	.35	1.89	.024	.147
	Roy's Largest Root	.19	2.09	.044	.157

Table 9 shows statistically significant differences with One Way MANCOVA between orphanage categories (maternal orphans, paternal orphans, and both) on the coping strategies after controlling for age, F (7, 89)=1.91, p<.001, Wilk's ƛ=.72, partial η^2= .15.

Discussion

The main objective of the present study was to comparatively investigate the levels of depression, anxiety, and stress between orphans and non-orphans. The findings of Tables 1, 2, and 3 show that 68% of orphans have experienced severe and extremely severe depression compared to 4% of non-orphans. In anxiety, 98% of orphans are in the categories of severe to extremely severe anxiety scores compared with 29% of non-orphans. The reason 29% of non-orphans suffer from this high range of anxiety is attributable to their adolescence period as this is a crucial stage in one's development where one has to make choices regarding career and marriage settlements. Only 1% of non-orphans were in the categories of severe and extremely severe stress compared to 27% of orphans. These findings are consistent with previous research in which depression, anxiety, and emotional distress were highly reported among orphans compared with non-orphans (Batool, & Shehzadi, 2017; Kaufman, Zeng, Wang, & Zhang, 2013; Um-e-Kalsoom, & Waheed, 2010; Wolff, & Fesseha, 1999).

The first hypothesis of the present study states that depression, anxiety, and stress will be significantly higher in orphans than in non-orphans. The results of table 4 confirm the acceptance of the hypothesis as significant differences were found in the experience of depression, anxiety, and stress between orphans, and non-orphans. These findings are in line with the findings of other researchers (Cluver, & Gardner, 2006; Getachew, Ambaw, Abebe, & Kasahun, 2011; Kumakech, Cantor-Graae, Maling, & Bajunirwe, 2009; Schaal, Dusingizemungu, Jacob, & Elbert, 2011; Schaal, Dusingizemungu, Jacob, Neuner & Elbert, 2012). Orphans experience a high level of depression, anxiety, and stress compared to non-orphans because they worry about financial stability and resources, their educational attainment, and career paths. Females particularly remain conscious about their marriages and how the expenditures would be fulfilled.

The second hypothesis of the study states that there will be significant differences in the use of coping strategies of orphans and non-orphans. The findings of table 5 confirmed the hypothesis as orphans make less use of different coping strategies than non-orphans counterparts. The orphans have made significantly less use of confronting coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem-solving, and positive reappraisal because they were forced to live with other relatives who tried to avoid them or gave them minimal support. They were taunted and were austerely dealt with in matters of money expenditures. They were having no choice and will of their own. They were bound to obey others and please them to gain their support. The majority of research has indicated a relationship between different psychiatric disorders and less effective use of coping strategies (Asarnow, Carlson, & Guthrie, 1987; Dumont, & Provost, 1999; Sinyor, et al., 1986).

The third hypothesis of the study stated, "There will be significant differences in the mental health of orphans for maternal, paternal, and double types of the orphanage". The findings revealed significant differences in mental health among the types of the orphanage. Double orphans showed high levels of depression, anxiety, and stress as compared to single orphans. The health status of single orphans or double orphans was investigated by Lindblade, Odhiambo, Rosen, and DeCock (2003) in Kenya and found no significant differences for the types of orphanages and health indicators. Perhaps the reason for the inconsistency of the finding of the previous research with the results of the present study is attributable to the age of the sample selected. Lindblade et al., (2003) have studied orphan children below six years of age. However, the present study has focused on orphan adolescents with Mage=19.8). Guardians felt highly responsible for the health of children below age six as compared to when they reached adolescence.

Combining the fourth and fifth hypotheses of the present study, there will be significant differences in the types of the orphanage and level of mental health, and subsequent use of coping strategies in orphan adolescents. The results of the current research showed significant differences among the types of orphanages with double orphans experiencing high mental health problems and low use of coping strategies as compared to single orphan adolescents. These findings are consistent with the results of the previous research. Ruiz-Casares, Thombs, and Rousseau (2009) found double orphans to be more depressed than single orphans with a mean age of 14.9 years in Namibia. Significant differences in coping skills of double orphan adolescents whose parents died due to AIDS (Louw, Mokhosi, and Van den Berg, 2012; Germann, 2005).

Implications

In Pakistan, special policies and rules are not available for orphans to take care of them at the governmental level in terms of financial aspects after the death of their parents, especially their fathers. The orphanage is present to cater to the needs of the children without parents but space is not accessible for a high number. Therefore, the government should take steps to launch programs that are designed to financially support orphans particularly ones without fathers. Moreover, new orphanages with better physical conditions should be constructed to help those who have lost both parents. It is implied that free counseling services must be delivered to this segment of the population for the elevation of psychological problems and enhancement of skills to deal with them effectively.

Limitations and Future Recommendations

The limitations of the present research have focused on a small sample size of orphans and a comparable group of non-orphans, selected from Jhelum. The causal relationship between mental health problems and the use of coping strategies has not been found between orphans and non-orphans. It has been suggested that for future research a design based on the large

sample size of orphans selected from the orphanage and a comparable group of non-orphans can enhance the generalizability of the research. Moreover, a quasi-experimental design can give a clear picture of causal attributing variables in the precipitation of mental health problems.

Conclusion

Conclusively it has been empirically found that orphans experienced a high level of mental health problems as compared to non-orphans. Further, they have made less use of different coping strategies than non-orphans to deal with their daily life problems. Moreover, the level of depression, anxiety, and stress experienced by double orphans is higher than maternal and paternal orphans. Further, after controlling for confounding variables for age, the types of the orphanage (maternal, paternal, and double) were found to show significant differences in mental health and the use of coping strategies in adolescents.

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