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Elizabeth Acampora

Impact of Institutional Care on a Child's Mental Health in Vietnam

Social Work Honors Project

Currently, there are an estimated 150 million children worldwide who are considered orphans, 34.5 million of whom have only lost their mother and 101 million of whom have only lost their father (UNICEF, 2015). Although society generally only considers a child who has lost both of their parents to be an orphan, children who have lost only one parent, still have two living parents, or are impoverished, can also be considered orphans depending on their circumstances. Children who have one or two living parents who are not mentally, physically, or financially able to parent, are also defined as orphans (UNICEF, 2015). Thus, a majority of orphans still have a living parent but one who is unable to care for them. For those who reside in an orphanage as a result of this, there can be negative impacts on their mental and emotional health.

Children who are not able to find a home at an orphanage will often resort to living on the street. According to UNESCO (2015), there are approximately 150 million street children worldwide. A street child is defined as a child who lives or works on the street, but still may have living parents. These children may have run away from home due to abuse or may be orphans (UNESCO, 2015). Regardless of their situation, it is almost impossible for street children to have all their basic needs met and they rarely have an opportunity to receive education, making them extremely vulnerable to all types of abuse and mental illnesses (UNESCO, 2015).

For those children who eventually come to live in an orphanage, some of whom were just abandoned at the doorstep, they are forced to cope with the loss of one or both of their parents, causing a disruption in their attachment bond with their parents (Bowlby, 1988). When there is a major disruption in a child's early relationships, specifically before the age of 5, the brain development of the child is negatively impacted (Rogers, 2013). This halt in the child's brain development can also occur when a young child is maltreated or receives insufficient care, which is often the case at most orphanages (Rogers, 2013). As a child is growing, they rely on the care

and comfort of their caregiver (who in most cases is their parent), to feel safe and secure in their living environment. A child often looks to their parent for guidance and mimics their behavior in order to develop their own personality and behavioral patterns (Bowlby, 1988). Both Bowlby and Mary Ainsworth identify specific attachment bonds that children can develop, which can either have a beneficial or detrimental effect on the child's emotional development (Rogers, 2013). The secure attachment, identified by both Bowlby and Ainsworth, is represented when a child freely explores new situations knowing they have a safe adult or caregiver to return to if they ever feel the need (Rogers, 2013).

For children who do not display or develop a secure attachment, they may then develop an insecure attachment, which can be either anxious resistant, anxious avoidant or disorganized (Rogers, 2013). An anxious resistant attachment, similar to Ainsworth's insecure resistant, is when a child is unsure whether their parent will be there when they become scared and need reassurance. These children thus fear separation from their caregiver, worried that if they become separated, they will never be reunified again (Rogers, 2013). For children who have this type of attachment, they often become very anxious when they are separated from their parent and do not feel comfortable exploring new surroundings. Thus, as they develop, these children obtain a very limited view of the world around them, due to their lack of experiences (Rogers, 2013).

Children who have no faith that their parent will be available for reassurance, experience an anxious avoidant attachment and are forced to become emotionally self-sustained. When a child no longer has their parent(s) to observe and mimic, they are unable to form that essential secure attachment bond (Rogers, 2013). Children with an insecure disorganized attachment bond, which often results from maltreatment, are often fearful and confused around a caregiver, thus resisting any offered assistance (Rogers, 2013). This deeply affects the child's ability to properly develop

their emotional and personality regulation. In a study conducted in Italy, out of 399 children living in institutions, only 18% had a secure attachment bond, while 28% had an insecure attachment bond and 54% had a disorganized or unidentifiable bond (Lionetti, Pastore, & Barone, 2015). Thus, children who live in institutional care are at risk of forming insecure attachment patterns, negatively impacting their emotional development.

Unfortunately, because of how many children and how few caregivers there are at orphanages, the amount of interaction, and thus influence, the caregivers have on the children is minimal. As a result, when children come from an abusive household where they had no healthy attachment bonds and then receive minimal individualized attention at the orphanage, their chances of ever forming a healthy attachment bond are nearly eliminated. When a child's brain development is affected, their emotional development is also greatly impacted. Often, when a child has a disruptive or traumatic experience like those previously stated, they form an insecure attachment bond with their caregivers.

In addition to being fearful around caregivers because of their inability to trust and rely on those around them, when a child initially enters an orphanage, they are often traumatized by their past experiences, especially the specific events or situations that caused them to end up in an orphanage. For some of these orphans, not only were they separated from their parents, they were also neglected or abused. Included in adverse childhood experiences (ACEs), actions such as physical, emotional, and sexual abuse, neglect, and violence within the family, can have a negative effect on the child's development (Ong et al., 2015). Children who are abuse survivors are often traumatized and suffer from severe stress, which affects the child's neurobiology by stunting the development of their hippocampus and corpus callosum (Ong et al., 2015). Studies have shown that the hippocampus is smaller in individuals who have been diagnosed with depression, which

is a result of severe stress reducing the production of the brain-derived neurotrophic factor (BDNF), stopping the growth of the hippocampus prematurely (Masi & Brovedani, 2011). This irreversible damage continues to affect a child's emotional and personal development. Even as the child ages, their brain continues to develop improperly, permanently affected by the lack of development earlier in their life. This improper emotional and brain development increases the child's chances of later developing a mental illness (Masi & Brovedani, 2011).

Children who have previously spent any portion of their lives living or working on the street are at an increased risk of having experienced potentially traumatic events (PTEs) and suffering from Post-Traumatic Stress Disorder (PTSD) (Atwoli et al., 2014). Street children are also very likely to be bullied, which often has a severely negative effect on their self-esteem, as was found in a study conducted with street children in Kenya (Atwoli et al., 2014). Thus, these children are at a high risk of developing mental illnesses, such as depression and anxiety. As stated previously, children who have been maltreated or neglected by their parents or have lost one or both of their parents, are also at a high risk of developing a mental illness, such as depression or anxiety (Nguyen, Dedding, Pham, & Bunders, 2013; Nguyen, Dunne, & Le, 2009).

The World Health Organization defines depression as having symptoms such as experiencing a constant depressed mood, no longer showing interest in activities in which one used to frequently participate, low self-esteem, and fatigue (Um-e-kalsoom & Waheed, 2011). Although anxiety symptoms can be very similar to depressive symptoms, the experience of hyperarousal and heightened feelings of stress and fear are specific to anxiety (Tran, Tran, & Fisher, 2013). In Vietnam, specifically, depression and anxiety are most common among women who live in rural communities and have young children (Tran et al., 2013). In a study completed in the Ha Nam Province located in northern Vietnam, 12% of the 221 women interviewed were diagnosed with

depression and 11% were diagnosed with an anxiety disorder (Tran et al., 2013). Going untreated, these mental illnesses only worsen. This can become a major problem, especially for children when they age out of the orphan care system.

Due to the trauma and severe stress that abuse survivors may experience and the instability of their living environment, children who live in institutions experience more psychiatric symptoms than those living at home (Norman & Bathori-Tartsi, 2010). In a study conducted in the Ukraine, children ages 10 to 14 who lived in institutional care had a higher chance of being diagnosed with Attention Deficit and Hyperactivity Disorder, and also displayed more social, emotional, and behavioral difficulties than children living at home (Norman & Bathori-Tartsi, 2010). Social difficulties included interrupting and distracting other children, behavioral difficulties included restlessness, impulsivity, inability to finish tasks and being easily distracted and emotional difficulties included the inability to pay attention and easily forgetting what they were recently taught (Norman & Bathori-Tartsi, 2010).

This significant change in a child's behavior may be a result of the loss they experienced when they first arrived at the orphanage. This major disruption in their life may cause the child to experience constant sadness and anxiety and to withdraw from those around them (Ong et al., 2015; Um-E-Kalsoom & Waheed, 2011). When a child is placed in an orphanage, they may experience separation anxiety and withdraw themselves from those around them similar to those behaviors demonstrated by children with an insecure attachment pattern (Bowlby, 1988; Rogers, 2013). Furthermore, experiencing this loss will also cause the child to feel extremely lonely and as if they have nobody with whom they can talk or relate, causing them to internalize their problems (Um-E-Kalsoom & Waheed, 2011). When a child moves to an orphanage, an unknown and frightening environment they share with other orphaned children, there are only a few

caregivers to look after them, greatly decreasing the individualized care they receive (Um-E-Kalsoom & Waheed, 2011). This abrupt transition alters the way in which the child's personality and mental health develop, largely influenced by their inability to develop a healthy and secure attachment bond (Bowlby, 1988). As stated by Bowlby and Ainsworth, a secure attachment bond is an essential part of a child's healthy emotional development (Bowlby, 1988; Rogers, 2013). However, having a caring and constantly present caregiver is required for a child to be able to form that secure attachment bond. Due to the large populations at the orphanages, although the caregivers often provide as much care as they can, they are unable to provide individualized attention since they have to divide their time among dozens of children.

In addition to the transition to life in an orphanage and the lack of a constant caregiver, many of the children have a history of abuse, which multiple studies have shown also negatively impacts the children's ability to form a secure attachment bond. Children in Vietnam may experience abuse because of the constant economic difficulties that many parents face due to the ongoing economic and social development taking place (Nguyen, et al., 2009). Furthermore, many of the children who live in the orphanages in Vietnam come from backgrounds of abuse, increasing their risk of poor emotional and attachment bond development.

In 2006, a study conducted in Hanoi, Vietnam with 2,591 students between the ages of 12 to 18 years old found that emotional abuse had the highest impact on the child's mental health; sexual abuse, physical abuse and neglect also negatively impacted a child's mental health (Nguyen et al., 2009). For males, emotional abuse and neglect were the highest predictors for anxiety, whereas emotional and physical abuse were the highest predictors for anxiety in women (Nguyen et al., 2009). Furthermore, it was also found that approximately 20% of these children did not

discuss any mental health problems they were having, leaving them to cope with the illness alone (Nguyen et al., 2009).

Although Vietnamese children in orphanages have not been assessed for mental health, Vietnamese children in the community have. Children who attend school in Vietnam are at risk for being highly pressured by their parents, caregivers, and teachers to perform well in school (Nguyen, Dedding, Pham, & Bunders, 2013). When children do not receive an acceptable grade on their exam according to their parents' or teachers' standards, one child stated that their parents are "very sad, angry and dissatisfied" making them "feel very sad too" (Nguyen, Dedding, Pham, & Bunders, 2013, p.7). Children are also likely to take on a course load greater than they can handle especially when seeking the approval of their caregivers (Nguyen, Dedding, Pham, & Bunders, 2013).

Out of the 1,144 Vietnamese high school students who participated in the study conducted by Nguyen, Dedding, Pham, Wright, and Bunders (2013), approximately 41% experienced depressive symptoms, 23% experienced anxiety symptoms and 25% had serious suicidal thoughts. Without receiving proper treatment, students who continue to experience depressive and anxiety symptoms are without the proper resources to develop helpful coping skills, increasing their chances of highly considering or attempting suicide. Although this study shows that a majority of high school students suffer from a mental illness and that the awareness of this is increasing, there are minimal organized treatment options available for these students (Nguyen, Dedding, Pham, & Bunders, 2013). Furthermore, Vietnamese orphanages that give children the opportunity to attend school, experience dual risks of developing a mental illness. Not only are they at an increased risk from being maltreated or abandoned by their parents, but they also are at an increased risk due to the high educational expectations of Vietnamese children.

For children who develop a mental illness as a result of any of the above reasons, the risk of suicide becomes a concern. In Vietnam, suicide is one of the top 10 causes of death for all ages (Tuan, Dalman, Thiem, Nghi & Allebeck, 2009). The risk is particularly high for young adults as over half of the reported attempted suicides (50.8%) were made by individuals between the ages of 15 to 24 (Tuan et al., 2009). In 90% of the reported cases of suicide, the individual had been previously diagnosed with at least one mental illness (Tuan et al., 2009). In a study conducted in 2010, it was found that out of every 100,000 people, approximately 10 attempted suicide every year (Nguyen et al., 2010). Although this rate is lower than other countries, such as in Canada where the rate is between 357-534 per 100,000 people per year, this is still a problem that needs to be addressed, especially since about 92% of all individuals who committed suicide and had a diagnosed mental illness, were not receiving any treatment at the time of their death (Nguyen et al., 2010; Tuan et al., 2009).

Although studies have indicated a high presence of mental illness in Vietnam, there is still a strong negative stigma attached to it. In a study comparing Australian nurse students' and Vietnamese nurse students' response to a case study describing an individual displaying depressive symptoms, the Vietnamese nurse students identified the stated depressive symptoms as signs of weakness and immaturity (Niemi, Malqvist, Giang, Allebeck, & Falkenberg, 2013). Due to this stigma, individuals are less likely to discuss their depressive symptoms, if they are experiencing them, especially the psychological symptoms since those are much more indicative of a mental illness (Niemi et al., 2013). A common idiom used in Vietnam, "neurasthenia," which translates to a "nervous breakdown," is less stigmatized than depression since it is seen as the result of a specific traumatic event rather than an ongoing psychological disorder (Niemi et al., 2013, p.9). As a result, it is seen as more socially acceptable to seek treatment if an individual is experiencing

"neurasthenia" as opposed to depression or anxiety, since there is less of a stigma associated with this condition (Niemi et al., 2013, p.3).

There is also a large religious factor supporting the stigma held regarding mental illness in Vietnam and why individuals do not openly express any psychological symptoms. The Confucian belief is that one should live in a collectivistic society in which the main focus is on the success of the whole group, rather than the success of the individual (Niemi et al., 2013). It is seen as greatly inappropriate for an individual to express their own personal emotions and troubles because that would indicate they are focusing on their own well-being, which is never supposed to take precedence. Receiving psychotherapy to improve one's own well-being is considered inappropriate behavior in a collectivistic society (Niemi et al., 2013). In the Vietnamese culture, it is expected that individuals will only engage in an activity if it will benefit those around them and not in ones that will only benefit themselves (Niemi et al., 2013). However, seeking help for the alleviation of physical pain and symptoms is seen as more acceptable. Thus, unlike in the United States, where discussions of mental illness focus on psychological symptoms, in Vietnam, there is a focus on physical symptoms, such as headaches, insomnia, dizziness and other aches and pains (Niemi et al., 2013).

Due to the negative stigma attached to the reporting of psychological symptoms, Vietnamese scales used to detect mental illnesses were specifically designed to primarily focus on the physical symptoms. Some of the most commonly used scales are the Vietnamese Depression Scale (VDS), the Phan Vietnamese Psychiatric Scale (PVPS) and the Depression Anxiety and Stress Scales (DASS) (Niemi et al, 2013; Phan, Steel & Silove, 2004; Tran et al., 2013). In a study comparing the Composite International Diagnostic Interview, which does not contain specific Vietnamese idioms and expressions, to the PVPS, it was found that the PVPS detected four times

more mental illness cases (Niemi et al., 2013). A major beneficial part of the PVPS is its somatic scale, which includes questions about physical symptoms, making it much more meaningful to the participants since they are seen as the most frequently reported and important symptoms (Niemi et al., 2013). Of the 26-item depression subscale of the PVPS, 14 of those questions are regarding somatic symptoms that individuals may be experiencing, which clearly illustrates the strong focus on the physical aspects of mental illnesses (Phan et al., 2004).

Although Vietnam's National Community Mental Health Care project was launched in 2001 to improve the distribution of medications for mental illnesses and the Vietnamese government is eager to improve mental health services, no such improvements have been made, specifically in regards to treatment for depression (Murphy et al., 2015). When this project was launched, the original focus was on schizophrenia and epilepsy, which has been implemented, but has yet to be fully implemented for more common mental illnesses, specifically depression (Niemi, Thanh, Tuan, & Falkenberg, 2010).

The presence of psychologists, psychiatrists and other trained professionals in the mental health field is very low in Vietnam (Murphy et al., 2015; Niemi et al., 2013). In a country with a population of over 90 million people, there is only 1 psychiatrist and .03 psychologists for every 100,000 people, compared to 13.7 psychiatrists and 31.1 psychologists for every 100,000 people in the United States (Niemi et al., 2010). Even though these professionals receive training specifically in the mental health field, psychiatrists are trained for three years, psychiatric doctors only receive one year of training and general practitioners receive just one month of training (Niemi et al., 2010). As a result, some of these professionals who individuals trust to provide them with the proper treatment have a very limited mental health knowledge base (Niemi et al., 2010).

Out of the 64 provinces in Vietnam, only 27 have a separate psychiatric hospital available for individuals (Niemi et al., 2013). Although this does give individuals suffering with mental illnesses the chance to receive treatment, the only form of treatment that is frequently used is medication (Niemi et al., 2013). There is no family education to provide information to any concerned families nor any psychotherapy to be offered in conjunction with the medication (Niemi et al., 2010). However, the only medications completely covered by the Vietnamese government are those which are used to treat schizophrenia and epilepsy (Murphy et al., 2015). For all other medications, individuals have to be willing, and able, to spend about 33% of their daily income, if they receive the minimum wage, in order to be able to control their mental illness (Niemi et al., 2013).

Since the physical, or somatic, symptoms are the ones that are often reported and used to define a mental illness, the main focus of all the forms of treatment available is to help manage or eliminate the somatic symptoms, such as severe headaches, insomnia and dizziness (Niemi et al., 2013). Using traditional Vietnamese medicine and herbal remedies is the most common form of treatment available, since these are used to cure any physical discomforts or pains, not just those associated with mental illnesses (Niemi et al., 2013).

These types of treatments, although they may be accessible for Vietnamese adults, may not be as easily accessible for children. However, since children learn a majority of their behavior by observing and mimicking their mother, they are also at the risk of developing a mental illness similar to that of their mother (Tran et al., 2013). In addition, as noted, there are several other risk factors that also increase a child's chances of developing a mental illness, including being a victim of maltreatment, being pressured to do well in school, losing a parent or both and being neglected

as a child (Atwoli et al., 2014; Nguyen, Dedding, Pham, & Bunders, 2013; Nguyen, Dedding, Pham, Wright & Bunders, 2013; Nguyen et al., 2009; Um-e-kalsoom & Waheed, 2011).

Brittany's Hope

Among other organizations, Brittany's Hope is a non-profit agency that supports three centers in Vietnam which provide for orphaned children. In honor of the loss of her first adopted daughter, Brittany, Candace Abel founded Brittany's Hope, a non-profit organization that is both involved in providing international adoption grants for families adopting children with special needs and providing orphan care worldwide (Brittany's Hope, 2015a). Although Brittany's Hope currently supports centers in Vietnam, Ethiopia and Kenya, the organization began with centers in Vietnam (Brittany's Hope, 2015b). As discussed previously, many of the children who reside at these centers have one or both parents who are still alive but do not have the mental, physical, or financial ability to raise or care for their children.

Three of the major centers in Vietnam that are supported by Brittany's Hope are the House of Love, the Ben Tre Child Protection Center and Ha Tinh Village. The House of Love, located in Southern Vietnam in Cam Ranh currently cares for 97 children. Located in the Mekong Delta, the Ben Tre Child Protection Center, which was originally founded to serve street children, but has now expanded to serve all children in need, currently cares for 73 children. Ha Tinh Village, located in Northern Vietnam, currently cares for 63 children (Brittany's Hope, 2015b). Although Brittany's Hope and the centers' caregivers ensure that the children receive all basic needs, through a developed sponsorship program, individuals in the United States are able to financially and socially support a specific child through a monthly payment and various forms of communication, such as letters and Skype conversations. Due to constant communication, these children form extremely strong bonds with their sponsor parents, allowing them to receive that individualized

attention that they often lack at the center. This sponsorship program started in 2005 at the House of Love, in 2013 at Ha Tinh Village and in 2015 at the Ben Tre Child Protection Center.

A majority of these children were abandoned by their parents at the gates of the center, many of whom were born with disabilities. In Vietnam, because of their strong Confucian beliefs, if a family has a child with any type of disability, it is viewed as a punishment for the family because they have done something wrong in the past to deserve it. Thus, the family often abandons them to disassociate themselves. These centers provide meals, clothing and shelter for many children, but because there are only about 20 caregivers at each center, the children do not receive as much individualized attention as they would if they lived at home with their families. The caregivers only have the time to be able to feed, bathe and teach the children, but due to their lack of understanding and training in mental health as well as their time constraints, there is little to no time to identify or treat a child's mental health issues.

Once children complete their education and leave the center, the support they received ends and the children become entirely responsible for their personal well-being. Since many of these children do not have a family to go home to, they can face many difficulties, especially if they are unable to initially find a job that provides enough income to afford food, clothing, and shelter. Furthermore, for individuals who already had been suffering from a mental illness, this precarious lifestyle can greatly impact the progression of their mental illness. As stated before, over half of the reported suicide attempts in Vietnam were made by individuals between the ages of 15 to 24 years old, which is the age range when individuals begin to age out of the orphan care system (Tuan et al., 2009). Thus, for individuals who have an untreated mental illness when they are forced to become self-sustaining are at a very high risk of attempting, or committing suicide, which is a problem that needs to be addressed.

Overall, when children are developing, they rely on their parents to serve as a model, but when this model is removed or maltreats the child, their personality and mental health development can be greatly damaged and stunted. These children are then put at a higher risk of developing a mental illness, specifically depression and anxiety. An individual's culture has a major influence on the factors that can cause the development of a mental illness, but there are some generalizations that can be made for children that are in similar situations but in different countries and cultures. Thus, in some of the studies previously discussed, although they were conducted in Pakistan, Kenya and Cambodia, the observations made regarding the impact of living in institutional care on a child's mental health can be seen as strong predictors of the influence that institutional care in Vietnam may have on a child's mental health. However, this is a major limitation since generalizations cannot be made between two different countries. The other major limitation was that many of the studies discussed were one of the first of their kind to be conducted. Thus, further research has to be performed since these were just initial exploratory studies. Furthermore, although the discussed studies had been conducted within the past 10 years, Vietnam has been developing at a fast rate so the stated status of the country's mental health system is constantly changing and developing.

To date, no study has assessed the mental health of children in orphanages in Vietnam. Therefore, in order to further understand the impact institutional care can have on a child's chances of developing depression or anxiety, a study was conducted at the three previously discussed centers in Vietnam. The ultimate purpose of this study was to discover the prevalence of depression and anxiety at the Ben Tre Child Protection Center, the House of Love and Ha Tinh Village. By understanding the presence of depression and anxiety and the influence of living in an institution on a child's mental health, orphanages will be able to make appropriate changes in their care of

the children to better serve their emotional needs and help them have a healthy emotional development, regardless of their previous traumatic experiences. The purpose of this study is thus to discover the prevalence of depression and anxiety at the Ben Tre Child Protection Center, the House of Love and Ha Tinh Village in Vietnam and to determine if this varies by child demographics.

Methodology:

In order to measure the prevalence of depression and anxiety among the children at the Ben Tre Child Protection Center, the House of Love, and Ha Tinh Village in Vietnam, a survey was conducted. These three centers are supported through the non-profit organization, Brittany's Hope. It was a descriptive study since no research has ever been performed in this specific area.

To complete the study, consent forms were provided to each of the directors at the three centers by Brittany's Hope in-country staff member, who translated them into Vietnamese prior to distribution. The children over the age of 18 who wished to participate completed an informed consent form, children between the ages of 12 and 17 completed a child assent form and children between the ages of 10 and 12 provided verbal consent, conducted by center caregivers. Since the intended goal was to have the children physically complete the survey and questionnaire individually, only children over the age of 10 were eligible to participate. By having the children complete the survey on their own, it was hoped that they would provide truthful answers, allowing for more valid results.

The children who completed the consent or assent forms were then given the Phan Vietnamese Psychiatric Scale (PVPS) to complete with a demographic questionnaire attached. Although the children's names remained anonymous, in order to connect the reported symptoms with specific demographics, the children were asked to complete a short questionnaire along with

the PVPS. This questionnaire asked the children to state their age, sex, length of stay at the center and whether they had one, two or no living parents. Brittany's Hope's staff member provided copies of the PVPS and the demographic questionnaire to the directors of the centers who then were responsible for administering them to the children. For their privacy, the children were given the opportunity to complete the PVPS and demographic survey in a room separate from the other children at the center. After completion of both the PVPS and the demographic questionnaire, the completed forms were collected by the director of each center and were sent via mail to the staff member, who then sent them back to Brittany's Hope. All copies of these forms were returned to Brittany's Hope so they can remain together and protected.

Using convenience sampling, the sample pool for this study was children from all three centers, adding up to a total of 119 participants. Since the children completed the survey on their own, only children over the age of 10 were eligible to participate. The age range was from 10 to 32 years old, with the average being 15 years old, and there were 69 (58%) female participants and 50 (42%) male participants (See Table 1). From the House of Love (HOL), there were 40 (33.6%) participants, from the Ben Tre Child Protection Center (BTO), there were 46 (38.7%) participants and from Ha Tinh Village (HTV), there were 33 (27.7%) participants (See Table 1). Ranging from .75 to 14 years, the average time the children had been living at their respective center was 6 years (See Table 2). Out of these participants, 46 (38.7%) children only had a living mother, 19 (16%) only had a living father, 24 (20.2%) had two living parents, 25 (21%) had lost both of their parents and 5 (4.2%) children did not know where their parents were (See Table 1).

The PVPS contains 53 questions, including a 26-item depression subscale, a 13-item anxiety subscale, and a 14-item somatization subscale. Using a 3-point Likert scale, the participants selected either (1) "never occurred," (2) "occasionally occurred," or (3) "frequently

occurred," to correspond with every statement (Phan et al., 2004). If the children did not feel comfortable completing any of the questions, they were able to skip them. Since this scale revolves around a highly sensitive topic, the answers and identity of the children remained anonymous.

In order to report on the scores the children received on the PVPS, the average of the responses the children provided were used. The mean of the children's scores on the 26-item depression subscale, which includes both the "Affective" and the "Psycho-Vegative," were found and then compared to the average score of an individual who had been diagnosed with depression by a psychiatrist (Phan et al., 2004). This procedure was done with the children's mean scores on both the 13-item anxiety subscale and the 14-item somatization subscale. If a child scored higher than the mean score received by an individual with an official diagnosis, it was concluded that the child suffered from either depression and/or anxiety. For individuals who had been diagnosed by a psychiatrist as suffering from depression, they received a score of 1.95 or above on the depression subscale. For those diagnosed with anxiety, they received a 1.60 or above and for somatization, they received a 1.95 or above (Phan et al., 2004).

Table 1

Demographics	Number of Participants	% of Total Participants
Sex		
Male	50	42
Female	69	58
Center		
Ben Tre Child Protection Center (BTO)	46	38.7
House of Love (HOL)	40	33.6
Ha Tinh Village (HTV)	33	27.7
Number of Living Parents		
Only Mother	46	38.7
Only Father	19	16
Both Mother and Father	24	20.2
None	25	21
Unknown	5	4.2
Age		
10-12 Years Old	27	22.7
13-14 Years Old	30	25.2
15-17 Years Old	44	36.9
18+ Years Old	18	15.1

Table 2

Time Living at Center (Years)	Number of Participants
.75	1
1	5
2	4
3	8
4	29
5	15
6	12
7	7
8	8
9	13
10	7
11	1
12	4
13	2
14	2
Total	118

Results:

Using a one-Way ANOVA test, a significant difference ($F_{(2,98)}$=9.401, p=.000) was found between the three centers for the scores the children received overall, as well as on the Depressive Psycho-Vegative (DP) subscale ($F_{(2,110)}$=12.806, p=.000), the Somatic Symptoms (SS) subscale ($F_{(2,116)}$=15.313, p=.000) and the Depressive Affective (DA) subscale ($F_{(2,111)}$=7.682, p=.001). However, there was no significant difference on the Anxiety (A) subscale.

Using a post-hoc Scheffé test, it was found that on the DA subscale, there was a significant difference between the scores of the children at the HOL and the other two centers. When comparing scores received by the children on the DP and SS subscales, there was a significant difference found between those at BTO and the other two centers. For overall scores on the PVPS, there was only a significant difference found between the children at the HOL and BTO.

When the children's scores were tested to see if they differed by demographic, no statistically significant results were found. This included comparisons made of the scores against age, sex, time living at the center and number of living parents.

To measure the presence of clinical levels of depression, anxiety and somatic symptoms among the participants, the average of the children's scores were found for each subscale. These average scores were then compared to that of an individual who had received an official diagnosis from a psychiatrist. For depression, the average needed to be considered depressed was 1.95, and only 1 participant met that requirement, with a mean score of 2.00. For anxiety, the average score that was obtained by an individual who had been diagnosed with anxiety by a psychiatrist was 1.60. Fifteen of the participants received a 1.60 or above, indicating that they suffered from anxiety. For somatization, the score needed was 1.90, with only 2 participants receiving a score of 1.90 or above.

Discussion:

In this study, the prevalence of depression and anxiety, as well as the influence child demographics may have, among three orphanages in Vietnam was studied. However, contrary to information gathered from studies completed with Vietnamese school children indicating that all types of abuse and neglect increased a child's chances of developing depression or anxiety, it was found that among the children in the study, there is a very low presence of depression and/or

anxiety. Since many of the children who live at one of the three studied centers have experienced a type of abuse or neglect and also attend school, thus having dual risk, it was predicted that the presence would be even higher at the three centers. However, with only 1 child (.8%) receiving a score on the PVPS indicating depression, 15 children (12.6%) receiving a score on the PVPS indicating anxiety, and 2 (1.7%) receiving scores indicating somatization, the rates were much lower than the rates found among Vietnamese school children in a study conducted by Nguyen et al. (2013): 41% experienced depressive symptoms and 23% experienced anxiety symptoms.

Although the overall rates and scores received by the children were low, due to the higher focus on physical symptoms, it was expected that children would have scored higher on the somatic symptoms scale, rather than the anxiety scale, but this was not found. However, this may be explained by the high occurrence of separation anxiety that children experience.

When comparing the children's scores to their demographics, no statistically significant results were found indicating that a child's demographics play no role in determining whether they will develop a mental illness, specifically depression and/or anxiety. For children who had been receiving services at one of the three centers for a longer period of time, a difference in their development of mental illness was expected to be lower than that of children who had only been receiving services at these centers for a short period of time. This was predicted as children who have been living at the center for a longer period of time have been receiving proper resources and care, and thus have been living in a stable environment, for a longer period of time. Furthermore, children who have been living at the center for a higher number of years are also more socially adapted, feeling included socially, decreasing their feelings of loneliness and isolation which are symptoms of depression, and thus minimizing their risk of developing a mental illness (Um-e-

kalsoom & Waheed, 2011). However, the results noted otherwise indicating that this demographic has no predictive factor in terms of a child's mental health.

Although the predicted results were not found, the overall mental health of the children at these centers was better than predicted. The presence of Brittany's Hope and their sponsorship program could play a role in helping to combat the negative impact of institutional care on a child's mental health and providing a positive impact instead. Through Brittany's Hope, individuals in the U.S. are given the opportunity to sponsor a child, which involves making a $35 monthly payment helping to provide food, clothing, education and medical care to their sponsored child. Through this program, the sponsors and children have the opportunity to write letters to one another and send gifts around the holidays or when Brittany's Hope staff makes a visit to the center once a year.

Despite the fact that the sponsor is not physically located at the center, the sponsorship program allows the child to receive individualized attention from an individual who shows their genuine care and concern for the child's well-being. As stated, attachment theory focuses on attachment bonds that can be formed during an individual's childhood (Rogers, 2013). For many children who come to live at an orphanage and have been victims of abuse or neglect, they are at risk of developing an insecure disorganized attachment bond which can be very hard to reverse, especially if the child never has a dedicated caregiver in their life (Rogers, 2013). Although the caregivers at the centers genuinely care about the well-being of the children, due to the disproportionate ratio between caregivers and children, the caregivers are unable to provide the individualized care children need to reverse these unhealthy attachment bonds and develop a healthier and more secure one.

Since the existence of the sponsorship program most likely improves a child's mental health, it was predicted that the children at the Ben Tre Child Protection Center, where the sponsorship program was established in 2015, would receive higher scores compared to the children at the House of Love, where the sponsorship program was established in 2005 (Brittany's Hope, 2015b). However, it was found that the scores received by children at the House of Love on all four subscales as well as overall were all higher than those received by the children at the Ben Tre Child Protection Center. The sponsorship program and the overall involvement of Brittany's Hope at all three centers have allowed for the children's physical needs to be met due to the installation and improvement of high quality facilities and services at all three centers, such as healthier cooking and eating environments, as well as clean and comfortable living and bathing centers. Living at these high quality centers, the children are able to have access to clean water, proper nutrition and medical care, increasing their overall physical well-being. This has a positive impact on an individual's mental well-being since it minimizes their chances of experiencing the physical symptoms of mental illnesses and thus decreases their chances of developing one.

Limitations:

Since this study was a descriptive study and one of the first of its kind within Vietnam, there were several limitations present that limited the extent to which this study was able to accurately determine the prevalence of mental illnesses in Vietnamese orphanages. With no control group present due to the lack of accessibility to an orphanage not receiving funding or support from Brittany's Hope, there was no outside group to which the results from the three studied centers could be compared. Furthermore, since all three centers that were studied are supported by Brittany's Hope, it was difficult to assume the results would be similar at other orphanages since many of them do not receive as much funding and thus cannot provide as much support as those

supported by Brittany's Hope. Having a lack of access to proper resources may negatively impact a child's mental health but that aspect could not be studied during this research study due to a lack of accessibility.

Heavily relying on the cooperation of Brittany's Hope's in-country staff to assist in the completion of this study, a large portion of this research was completed indirectly. As the researcher was unable to be present during the completion of the study, there was no way to determine whether the children completed the surveys on their own, or if they had assistance from the caregivers. For many of the children, this was the first time they were seeing questions of this detail regarding their mental health, which could have made it very difficult for them to provide honest and accurate answers. Whether they are aware of the negative stigma or not, they are most likely familiar with the lack of discussion regarding an individual's mental health and thus do not consider their own on a regular basis, making this survey difficult to complete. If a caregiver was present during the administration of the survey or was assisting the child in completing it, it is highly probable that the responses would be inaccurate as many children seek to please their caregiver, which, to them, would include not experiencing depressive and/or anxious symptoms. Thus, it is possible that these children did not provide truthful answers as a way to prove themselves and please their caregivers.

Lastly, this study was completed during the Lunar New Year holiday, celebration of which is very similar to Christmas. All children at these three centers receive gifts and many receive letters from their U.S. sponsors which can help to increase their overall happiness. For this holiday, the children receive a two week break from school, relieving them of the stress and pressure they may often experience as a result of their school work. Oftentimes, children are able to go home to visit their families and friends which can have a positive impact on their mental health as well.

Thus, completing this study during such a celebratory time of the year in Vietnam could have decreased the accuracy of the results received on the survey.

Conclusion:

Overall, although expected differences were not found, the mental health of children at the House of Love, the Ben Tre Child Protection Center and Ha Tinh Village is much better than expected, which is positive. However, these results cannot accurately be translated to other orphanages throughout Vietnam since the amount of resources and support children at those centers receive may vary drastically from that provided by Brittany's Hope at the three studied centers. Since this translation cannot be complete, further research must be conducted where an outside control group is present to allow the prevalence of mental illnesses in Vietnam to be more accurately recorded.

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Appendix A

Phan Et Al. : The Phan Vietnamese Psychiatric Scale

PHAN VIETNAMESE PSYCHIATRIC SCALE

Sau đây là những câu hỏi về triệu chứng của bệnh tâm thần mà người ta có thể mắc phải. Tôi muốn hỏi anh "trong 4 tuần qua anh" có bị một trong những triệu chứng này không. Cho mỗi triệu chứng, làm ơn chọn một trong ba trạng thái dưới đây:

1 = không hề xảy ra
2 = thỉnh thoảng xảy ra
3 = thường xuyên xảy ra

The following questions are about symptoms of mental illness. I would like to ask you whether you experienced any of the following symptoms *in the last 4 weeks.* For each item, please **choose one of the following options** that you consider most appropriate:

1 = Never occurred
2 = Occasionally occurred
3 = Frequently occurred

PHẦN MỘT Depression (affective)	Không hề xảy ra Never occurred	Thỉnh thoảng xảy ra Occasionally occurred	Thường xuyên xảy ra Frequently occurred
1. Cảm thấy cô đơn, trống vắng hay quạnh quẻ? Did you feel lonely or empty?			
2. Cảm thấy buồn bã, rầu rĩ quá độ (thái quá, lung lắm)? Did you feel extremely sad or depressed?			
3. Mặt mũi nhợt nhạt, mắt có quầng thâm, thần sắc trông ủ dột, sầu thảm? Did you become pale or have dark rings under your eyes, or feel really low in spirits or downhearted?			
4. Cảm thấy tuyệt vọng? Did you feel hopeless?			

5. Cảm thấy cuộc sống không còn có ý nghĩa? Did you feel your life had become meaningless?			
6. Cảm thấy không có niềm tin vào tương lai? Did you feel that there was no hope in the future?			
7. Cảm thấy muốn lìa bỏ cuộc sống này? Did you feel like ending your life?			
8. Cảm thấy ngủ không yên giấc? Did you have difficulty sleeping?			
9. Cảm thấy bất bình với cuộc sống? Did you feel unsatisfied with life?			
10. Có cảm giác nhục nhã, hổ thẹn về bản thân mà không duyên cớ? Did you feel disgraceful or ashamed of yourself without any reason?			
11. Tự chê trách hành động và tư tưởng của chính mình một cách khắt khe, phi lý? Did you criticize yourself and your own behavior harshly or unreasonably?			
12. Tâm thần bất định không thể chú tâm vào công việc gì? Were you unable to keep your mind on something due to mental disturbances?			
13. Không còn ham thích gặp mặt hay hội họp với ai? Did you lose interest in meeting with people or attending social gatherings?			
14. Cảm thấy kém tự tin vào bản than? Did you have very little confidence in yourself?			
15. Cảm thấy giá trị bản than bị sụt giảm? Did you feel worthless?			
PHẦN MỘT Depression (psycho-vegative)			

1. Chỉ có thể chú tâm vào công việc hay cuộc trò chuyện trong một thời gian rất ngắn? Were you only able to concentrate on something or a conversation for a very brief moment?			
2. Cảm giác lú lẫn, đờ đẫn? Did you feel confused or in a daze?			
3. Cảm giác như hồn phách thất lạc, ngẩn ngơ? Did you feel preoccupied or lost?			
4. Cảm thấy chậm chạp, ủe oải? Did you feel slow of sluggish?			
5. Suy nghĩ lộn xộn, kém sang suốt? Did you feel your thoughts had become mixed or unclear?			
6. Ngủ liên miên mà vẫn thấy mệt mỏi khi thức dậy? Did you feel fatigued after plenty of sleep?			
7. Giam mình trong nhà hay trong phòng ngủ suốt cả ngày? Did you lock or confine yourself within your house or bedroom all day?			
8. Nói trước quên sau, thần trĩ lãng đãng? Did you feel forgetful or absent-minded?			
9. Khóc lóc không duyên cớ? Did you cry without any reason?			
10. Đãng trí, không thể nhớ được những gì mình vừa làm (không nhớ được mình đã đặt để những vật tuỳ than hang ngày ở đâu như chìa khoá, khắn tay, mũ…) Did you feel absent-minded or were not be able to remember what you had just done (for example, you could not remember where your personal belongings such as keys, handkerchief, hat, etc were?)			
11. Không muốn rời giường ngủ? Did you feel like not getting out of bed?			

PHẦN HAI Anxiety			
1. Tự dưng cảm thấy lo sợ, hãi hùng đến cứng người mà không hiểu duyên cớ? Did you suddenly become so scared that you couldn't move for no obvious reason?			
2. Đột nhiên cảm thấy bị kích động dữ dội, tay chân bủn rủn, cảm giác muốn ngất xỉu? Did your limbs suddenly become weak, or did you feel like you were about to faint?			
3. Đột nhiên cảm thấy bị kích động mạnh đến nỗi run rẩy cả thân mình và tay chân? Did you suddenly feel so hysterical that your body and limbs began to shake and tremble?			
4. Đột nhiên sợ sệt đến nỗi cảm thấy nóng và lạnh (ớn lạnh/lạnh nhột) dọc theo xương sống không duyên cớ? Did you suddenly become so frightened that you felt a chilling sensation running down your spine for no obvious reason?			
5. Đột nhiên cảm thấy bị kích động mạnh đến nỗi lạnh toát tay chân, không có nguyên nhân? Did you suddenly feel so hysterical that your limbs became extremely cold for no obvious reason?			
6. Đột nhiên thân thể thoát mồ hôi mà không có nguyên do? Did you suddenly begin to sweat for no reason?			
7. Tự nhiên tay chân rân ran, tê cứng? Did your limbs suddenly tingle and become numb?			
8. Đột nhiên tay trở nên lung bùng, không nghe được tiếng động bên ngoài mà có tiếng u u (vo vo) bên trong? Did your ears suddenly become blocked and as a result you experienced buzzing sounds in your ears?			
9. Tự dưng thấy cổ họng bị nghẹn lại? Did your throat suddenly feel choked?			
10. Đột nhiên cảm thấy bị ngộp thở? Did you suddenly feel suffocated?			

11. Bất thình lình cảm thấy hồi hộp, tim đập thình thịch và rất nhanh? Did you suddenly have palpitations, and a pounding and racing heart?			
12. Tự nhiên cảm thấy đau thắt ngực như nghẹn tim? Did you suddenly have severe chest pain as if your heart was squeezed?			
13. Cảm thấy như đang ở trong tình trạng nguy biến mà không ai cứu giúp? Did you feel as if you were in danger but no one was around to help?			
PHẦN BỐN Somatic symptoms			
1. Bị chóng mặt hay choáng váng, xây xẩm mà không tìm ra bệnh? Did you have dizzy spells without any obvious illness?			
2. Bị buồn ói, nhờn nhợn như muốn ói (mửa) mà không tìm ra bệnh? Did you feel nauseous or sick in the stomach without any obvious illness?			
3. Đi tiểu tiện khó, bất thường mà không tìm ra bệnh? Did you have difficulty urinating without any obvious illness?			
4. Bị đau thắt lung như đau thận mà không tìm ra bệnh? Did you have pain in your lower back as if having kidney problems without any obvious illness?			
5. Ăn không tiêu, ợ chua hay ợ hơi mà không tìm ra bệnh? Did you have indigestion, sour belching or burp without any obvious illness?			
6. Có triệu chứng suy (yếu) tim, tâm lực hao mòn mà không tìm ra bệnh? Did you feel you had symptoms of a heart problem as if you were losing energy without any obvious illness?			

7. Cảm thấy tứ chi rã rời, đau nhức mà không tìm ra bệnh? Did you have tired and aching limbs without any illness?			
8. Bị đau (nhức) đầu, đôi khi đau chịu không nổi mà không tìm ra bệnh? Did you have headaches, sometimes unbearable, without any obvious illness?			
9. Bị nặng mắt, nhức mắt, nhìn thấy đom đóm mắt? Did you have tired eyes, sore eyes or see flashing lights?			
10. Cảm thấy bải hoải, kém khí lực (thể lực)? Did you feel worn out or low in energy?			
11. Cảm thấy kém sinh khí? Did you feel low in energy?			
12. Cảm thấy bị đau khớp xương? Have you had painful joints?			
13. Càng ngày càng cảm thấy/tỏ ra như thể không có hơi sức để làm việc? Did you feel increasingly tired day after day as if you have to energy to function?			
14. Mặt phừng phừng, nóng hừng hực mà không có bệnh Did you have hot flushes over the face without any obvious illness?			

Appendix B

Demographic Survey

Please attach this survey to your completed Phan Vietnamese Psychiatric Scale.

Title of Research: Impact of Institutional Care on a Child's Mental Health in Vietnam
IRB# 831622-1

Principal Investigator: Elizabeth Acampora, senior social work student at Elizabethtown College

I identify as (Please select the one that best fits you):

Male: ____
Female: ____

I am _____ years old.

I have been living at this center for _____ years.

My parents (Please select the one that best fits you):

Only my mother is alive: _____
Only my father is alive: _____
Both my parents are alive: _____
Both of my parents have passed away: _____
I do not know where my parents are: _____

Appendix C

[NAME OF CENTER] Site Consent

Title of Research: Impact of Institutional Care on a Child's Mental Health in Vietnam
IRB# 831622-1

Investigator: Elizabeth Acampora, senior social work student at Elizabethtown College

Purpose of Research:
The purpose of this study is to identify the prevalence of mental health illnesses, specifically depression and anxiety, in children living under institutional care in Vietnam.

Procedures:
Our center will be provided with copies of the Phan Vietnamese Psychiatric Scale (PVPS) and a demographic survey to distribute to the children who have agreed to participate in the study, if we decide to partake in this study. The PVPS has 53 questions, all of which only require the child to select one of the three given statements that they feel best describe them. The questions will ask the children about any physical and mental symptoms that they may currently be experiencing. The demographic survey will ask the children to identify their sex, age, length of stay at the center, and about their parents. We agree to be available to explain any portions of the questionnaire that the children may not understand, all of which will be provided in our native language. The completion of this study should only take approximately 30 minutes to 1 hour but the children may take as many breaks as they need throughout the duration of the study. The children will also have a quiet and separate location within the center to complete the survey.

Risks and Discomforts
Since this scale asks the children about their mental health, it may cause them to feel uncomfortable or to experience some of the stated symptoms. If, at any point during the completion of this survey, a child feels uncomfortable, they have the right to withdraw from the study and to have all their information disregarded and destroyed. We will also be available to provide any support the children may need.

Benefits
By participating in this survey, we understand that the information collected may allow us to have a better understanding of the prevalence of depression and anxiety at our center. This may provide us with the information we need to provide more appropriate emotional support if needed. We understand that we may also obtain a better understanding of the symptoms of depression and anxiety that we should look for in the children at our center.

Confidentiality
We understand that all information gathered in this study will remain anonymous and that no specific identifying information will be collected to make it possible for the children to be identified. The information and data collected in this study will be secured, only allowing the researchers identified in this consent form to have access to the data. The results of this research study will be compiled into a paper and will also be presented in a professional setting, as well as to the staff at Brittany's Hope and to our staff.

Withdrawal without Prejudice

We understand that participation in this study is completely voluntary and there are no penalties if we decide we do not wish to participate. If at any point during this study, we no longer wish to participate, we may withdraw from this study and all completed study materials from the children at our center will be destroyed and disregarded.

Payment for Research Related Injuries

Elizabethtown College has made no provision for monetary compensation in the event of any psychological discomfort or the intensity or development of a mental illness among any of the children at our center. We agree to be available for support if the children feel they need any additional support or care. We understand that the cost of any further assistance is the responsibility of the center.

Contacts and Questions

If we have any questions concerning the research project, we may contact Elizabeth Acampora by email: acamporae@etown.edu, by phone: (631) 624-5553, contact Brittany's Hope in-country staff, Le Thi Thu Hong, via email at hong@brittanyshope.org, or contact Dr. Susan Mapp at mapps@etown.edu. If we have any questions about our participant rights involved in this research, we understand we have the right to contact the Elizabethtown College Institutional Review Board Submission Coordinator, Sharron Farish at (717)361-1133 or via email at farishs@etown.edu.

Statement of Consent:

- ☐ I am in the position of authority to approve this study
- ☐ I have read the above information. I have asked questions and received answers. My organization is willing to participate in this study.
- ☐ A copy of this consent form has been provided to me.

Name of Center

Site Representative Name (Printed) Date

Signature of Site Representative Date

Researcher Signature Date

Appendix D

Script for Verbal Child Assent (Children 10-12 years of age)

Title of Research: Impact of Institutional Care on a Child's Mental Health in Vietnam
IRB#: 831622-1

Principal Investigator: Elizabeth Acampora, a social work student at Elizabethtown College
Email: acamporae@etown.edu,
Phone Number: (631) 624-5553

Caregiver:

"A student from Elizabethtown College in the United States is interested in learning more about your mental health through a research study. If you want to participate, you will be given a survey, called the Phan Vietnamese Psychiatric Scale, which will ask you about how you have been feeling over the past four weeks. You will also be asked how old you are, how long you have been living here and some other simple questions. Nothing that you provide to Elizabeth will be shown to anybody else. If you become upset and do not want to answer any more questions, you can stop without any punishment. The information that you do provide will not change the care you receive here. But, it may help your caregivers give you more support if you need or want it. Please tell me if you would like to participate in this study."

Appendix E

Child Assent to Participate in Research Study at [NAME OF CENTER]

Title of Research: Impact of Institutional Care on a Child's Mental Health in Vietnam
IRB# 831622-1

My name is Elizabeth Acampora and I am from Elizabethtown College in the United States of America.

I am asking if you would like to participate in a study so I can learn more about your mental health.

If you decide you would like to participate, you will be given a survey called the Phan Vietnamese Psychiatric Scale that will ask you questions about how you have been feeling over the past four weeks.

You will also be given another short survey to fill out so I can learn some basic information about you but none of the information you provide will be shared with anybody else except for me, the researcher.

If you become upset by any of the questions, I will be in contact with one of the caregivers at [NAME OF CENTER] to make sure you get the support you need.

If you do become upset by some of the questions or do not want to answer them, you can stop the study at any time without any punishment.

Your caregiver has given permission for you to complete this study but you can still say "no" if you do not want to participate.

The information you provide will not change your care at [NAME OF CENTER].

The information that you do provide may help your caregivers understand your emotions and mental health better. This may help your caregivers provide you with more support if you are interested.

By signing below, you agree to voluntarily participate in the research study. You and your caregivers will be given a copy of this signed form after you sign it.

Child's Name (Printed) Date

Child's Name (Signature) Date

Researcher Signature Date

Appendix F

Informed Consent- Participant's

Consent Form

Title of Research: Impact of Institutional Care on a Child's Mental Health in Vietnam

IRB# 831622-1

Principal Investigator: Elizabeth Acampora, senior social work student at Elizabethtown College

Purpose of this study:
The purpose of this study is to identify the prevalence of mental health illnesses, specifically depression and anxiety, in people receiving institutional care in Vietnam.

Procedures:
The director of the center will give me a copy of the Phan Vietnamese Psychiatric Scale and a demographic survey for me to complete, if I decide I wish to partake in this study. The PVPS has 53 questions, for each I am only required to select one of the three given statements that I feel best describe me. The questions will ask me about any physical and mental symptoms that I may be experiencing at this current time. The demographic survey will ask me questions about my sex, age, length of stay at the center, and about my parents. My director will be available to explain any portions of the questionnaire I do not understand, all of which will be provided to me in Vietnamese. The completion of this study should only take approximately 30 minutes to 1 hour but I may take as many breaks as I need throughout the duration of the study.

Risks and Discomforts
Since this scale asks about my mental health, it may cause me to feel uncomfortable or to experience some of the stated symptoms. If, at any point during my completion of this survey, I feel uncomfortable, I have the right to withdraw from the study and to have all my information disregarded and destroyed.

Benefits
By participating in this survey, I understand that my information may allow my caregivers to have a better understanding of my mental health and may be able to provide me with more appropriate emotional support if needed. I also understand that my caregivers may become more aware of the symptoms of depression and anxiety and be able to better identify them in either myself or my peers.

Confidentiality
My name will not be collected and no one will be able to identify my answers as belonging to me. I understand that all information gathered in this study will remain anonymous and that no specific identifying information will be collected to make it possible for me to be identified as a participant. The information and data collected in this study will be secured, only allowing the researchers identified in this consent form to have access to the data. All the information from this study will be compiled into a paper and will also be presented in a professional setting, as well as to the staff at Brittany's Hope and my caregivers.

Withdrawal without Prejudice

I understand that my participation in this study is completely voluntary and there are no penalties if I decide I do not wish to participate. If I become uncomfortable at any point during the study, I have the right to withdraw from the study with no penalties and any completed study materials will be destroyed.

Payment for Research Related Injuries

Elizabethtown College has made no provision for monetary compensation in the event of any psychological discomfort or the intensity or development of a mental illness. The caregivers at the centers are available for support if I feel I need any additional support or care. I understand that the cost of any further assistance is my responsibility.

Contacts and Questions

If I have any questions concerning the research project, I may contact Elizabeth Acampora by email: acamporae@etown.edu, by phone: (631) 624-5553, contact Brittany's Hope in-country staff, Le Thi Thu Hong, via email at hong@brittanyshope.org, or contact Dr. Susan Mapp at mapps@etown.edu. If I have any questions about my participant rights involved in this research I understand my right to contact the Elizabethtown College Institutional Review Board Submission Coordinator, Sharron Farish at (717)361-1133 or via email at farishs@etown.edu.

Statement of Consent:

- ☐ I am 18 years of age or older.
- ☐ I have read the above information. I have asked questions and received answers. My organization is willing to participate in this study.
- ☐ A copy of this consent form has been provided to me.

Participant's Name (Printed)	Date
Participant's Name (Signature)	Date
Researcher Signature	Date