Mental health problems among orphanage children in the Gaza Strip

**Lamia Thabet, Abdel Aziz Mousa Thabet, Sajida Abdul Hussein and Panos Vostanis** report on a study that aimed to establish the level of emotional problems among 115 children aged 9–16 years (average 13.4), who were living in two orphanages in the Gaza Strip. The children’s age of admission to the orphanage (average 8.8 years) was higher than in traditional orphanages in other countries. This was related to the reasons for admission, following their father’s death, and the inability of their remaining family to care for them. However, children retained substantial contact with their family of origin by visiting during school holidays (88.6%) or being visited at the unit (97.4%). Using previous standardised mental health measures completed by the children and their main carers, children demonstrated high rates of anxiety, depressive and post-traumatic stress reactions. These mental health problems were strongly inter-related but were not found to be associated with social/care variables. Potential implications of the findings for orphanages and other residential units in developing countries are discussed. These should take into consideration the socio-cultural characteristics of each country and limited local resources; involve non-governmental organisations and local communities; tackle wider stigmatising attitudes; and instil a child-centred philosophy within these settings.

**Introduction**

The negative effects of institutional rearing are well documented. Poor caregiving, lack of stimulation and the absence of a consistent caregiver have been implicated in the negative outcomes among institutionalised children (Rutter, Kreppner and O’Connor, 2001). As fostering and adoption are not as yet available or even accepted in some countries, orphanages are still being used as child placements following disasters, war situations and other causes of parent loss or absence (Aboud et al, 1991; Johnson et al, 1992). Although such settings can provide a secure and positive alternative to abusive and unsafe family or community environments, they cannot provide individualised and family nurturing (McKenzie, 1998). Instead, evidence, predominantly from studies with infants and young children, indicates the risk of attachment disorders and developmental delays (in the physical, behavioural, social and cognitive domains) (Suman, 1986; Vorria et al, 2003; Johnson, Browne and Hamilton-Giachritsis, 2006). These are largely accounted for by the absence of individual nurturing relationships with primary caregivers (Daunhauer, Bolton and Cermak, 2005). Findings are similar to those from research with children in public care who have been raised in a range of institutions (Browne et al, 2006). Additional risk factors operate for children orphaned by HIV/AIDS (Freeman, 2004; Masmas et al, 2004).

Age of admission to the institution and length of stay are important factors involved (Leite and Schmid, 2004). In a study with war orphans in Eritrea, Wolff and Fesseha (1998, 2005) found that organisational and staff attitudes within the orphanage affected children’s emotional well-being. Children who lived in a setting where the entire staff participated in decisions and self-reliance was encouraged through interaction with staff showed significantly lower emotional distress than those living in an environment with fixed rules and schedules and impersonal staff–child interactions. In Iraqi Kurdistan, children in orphanages reported more mental health problems, particularly post-traumatic stress reactions, than children in foster care (Ahmad and Mohamad, 1996). Mental health problems continued to increase within the orphanage sample, unlike for children in foster care (Ahmad et al, 2005). Even among internationally adopted children, those who had previously lived in orphanages were more likely to have develop-
mental and mental health problems, at least in the short/medium-term, than those previously in foster care (Miller, Comfort and Tirella, 2005).

Some of these findings are difficult to compare, as circumstances leading to admission to an orphanage vary between countries. For example, in Palestinian society children are admitted at a relatively later age, following the death of one or both parents, and retain some contact with their surviving family of origin. This was the rationale for this study in two orphanages in the Gaza Strip. The aim was to establish the rates of mental health (predominantly emotional) problems, and their potential association with factors related to their care history.

Methods

Setting and participants
The two orphanages (Al-Karama and El-Amal) were based in Gaza City and had a total of 115 resident children between nine and 16 years. Both orphanages follow the same care system and are sponsored by government, local donations and non-statutory (local and international) organisations. In particular, these two are supported by the Al Salah Association, a non-governmental agency in aid of marginalised and deprived families. The charity runs schools, sponsors children who have lost their parents and provides additional benefits. Large families who find it difficult to cope after the loss of one parent (usually the father) may approach orphanages for one or two of their children to be admitted. Children can retain contact with the remaining parent and relatives, and return home during school holidays. They can also be visited at the orphanage to retain links with their natural extended family.

Permission of the Ministry of Social Welfare and the Al Salah Association to approach the orphanage managers was granted and the study was approved by the local Helsinki research ethics committee. When both unit managers agreed, orphanage staff were approached and informed of the aims of the study. These were subsequently explained to the children and consent was sought from both the key worker and the child. Data collection was undertaken by the first author, who holds a BA degree in nursing and had acquired training to carry out this research. Children were interviewed at the institutions and potentially difficult questionnaire items were explained to them. Arrangements were made for children to access counselling and mental health support, if needed, and to opt out of the study at any stage. The caregivers also completed one of the questionnaires. The data were collected over a two-month period. Although socio-demographic data are presented on all 115 children, three did not take part, leaving a sample of 112 children who completed the mental health measures.

Measures

Children’s Post-traumatic Stress Reaction Index (CPTSD-RI)
This standardised 20-item self-report measure was designed to assess post-traumatic stress reactions of children aged 6–16 years following exposure to a broad range of traumatic events (Pynoos, Frederick and Nader, 1987). It includes three subscales – Intrusion (7 items), Avoidance (5 items) and Arousal (5 items) – and three additional items. The scale has been found valid in detecting the likelihood of Post-traumatic Stress Disorder (PTSD). Items are rated on a 0–4 scale, and the range of total CPTSD-RI scores is between 0 and 80. Scores are classified as ‘mild PTSD reaction’ (total score 12–24), ‘moderate’ (25–39), ‘severe’ (40–59), and ‘very severe reaction’ (above 60). The CPTSD-RI used in this study was based on DSM-IIIR criteria, rather than another PTSD instrument based on DSM-IV criteria, as the CPTSD-RI had already been validated in the Arab culture (Thabet and Vostanis, 1999).

Child Depression Inventory (CDI)
The CDI is a standardised self-report questionnaire of depressive symptomatology (Kovacs, 1985). This has been developed for children and young people aged 6–17 years. The CDI includes 27 items, each scored on a 0–2 scale (from
‘not a problem’ to ‘severe’), for the previous two weeks. The total score ranges between 0 and 54, and a score of 19 has been found to indicate the likelihood of a depressive disorder. The CDI has been adapted for use with Arab children (Gharib, 1985).

Revised Children’s Manifest Anxiety Scale (RCMAS)
The RCMAS is a standardised 37-item self-report questionnaire for children aged 6–19 years (Reynolds, 1980). It measures the presence or absence of anxiety-related symptoms (‘yes/no’ answers) in 28 anxiety items and nine lie items. A cut-off total score of 18 has been found to predict the presence of anxiety disorder in an Arab population (Thabet and Vostanis, 1998).

Strengths and Difficulties Questionnaire (SDQ)
The SDQ is a widely used measure of behavioural and emotional problems (Goodman, 2001). It includes 25 items, of which 14 describe perceived difficulties, ten perceived strengths and one is neutral. The SDQ consists of the subscales of Hyperactivity, Emotional, Conduct and Peer problems, as well as a pro-social subscale. The SDQ has previously been used with Palestinian children (Thabet, Stretch and Vostanis, 2000). A cut-off score of 17 or higher has been shown to predict mental health problems likely to require assessment and intervention.

Statistical analysis
Descriptive statistics and frequencies were used to present the pattern of data for the whole sample. Categorical variables were compared by chi-square test. Continuous scores were compared by t-test if normally distributed, and by Mann-Whitney non-parametric test if not. The association between questionnaire scores (not normally distributed) was examined by Spearman rank correlation test.

Results
Socio-demographic variables
The children’s mean age was 13.4 years (range 9–16). There were 64 girls (55.7%) and 51 boys (44.3%). Their area of origin was city (51.3%), village (9.6%) or refugee camp (39.1%). They had a mean number of five siblings (range 1–13). Children had entered the orphanage at a mean age of 8.8 years (SD 2.5, range 2–16). Before entering the orphanage, they had lived with their birth family for a mean 8.7 years (SD 2.4, range 2–14).

All children had lost their fathers. The reasons for paternal loss were: death from sudden cause (55.7%), chronic disease (13.0%), road traffic accident (6.1%), killed by occupation forces (20.9%) and imprisonment (1.7%). Some children (15.6%) had also lost their mother due to death from sudden cause (8.7%), chronic disease (4.3%), road traffic accident (0.9%) or killed by the occupation (1.7%). In almost half the families (47.0%), mothers had not been living with their husband prior to his death because of separation or divorce, but had maintained some level of contact with the children following their admission to the orphanage.

Most children visited their family of origin during school holidays: 68 per cent visited their mother, 10.4 per cent their grandparents and 10.4 per cent visited other relatives. While at the orphanage, 80 per cent of the children were visited by their mother or siblings, 15.7 per cent by relatives and two children (1.7%) were visited by friends.

Rates of reported likely mental health problems
It is important to stress that the measures of mental health problems are not diagnostic tools, even though they are standardised and widely used for different types of presentations. The established cut-off scores indicate the likelihood of mental health problems that may require clinical assessment and intervention. These cut-off scores may also vary across cultures. Therefore, the frequencies presented below are tentative rather than diagnostic. Subsequent analysis examined the continuous scores of those mental health measures in relation to other variables.

Of the 112 children who completed the questionnaires, 49 per cent reported CDI
Table 1
Most frequently reported mental health symptoms (questionnaire items) among Palestinian children in orphanages (N = 112)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Item</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
<td>Children’s Post-Traumatic</td>
<td>I feel scared, upset, or sad that I don’t really want to know how I feel</td>
<td>77.4%</td>
</tr>
<tr>
<td>Stress Reaction Index</td>
<td>I get scared, afraid or upset when I think about [event]</td>
<td>77.4%</td>
</tr>
<tr>
<td>(score ‘sometimes’ or ‘often’)</td>
<td>When something reminds me, or makes me think about [event], I get tense or upset</td>
<td>61.6%</td>
</tr>
<tr>
<td>Child Depression Inventory</td>
<td>I think about bad things that happened to me</td>
<td>79.1%</td>
</tr>
<tr>
<td>(score ‘sometimes’ or ‘yes’)</td>
<td>I stay sleepless every night</td>
<td>69.6%</td>
</tr>
<tr>
<td></td>
<td>I must push myself all the time to complete my school duties</td>
<td>68.7%</td>
</tr>
<tr>
<td>Revised Children’s Manifest</td>
<td>I get nervous when things do not go the right way for me</td>
<td>83.5%</td>
</tr>
<tr>
<td>Anxiety Scale</td>
<td>I often worry about something bad happening to me</td>
<td>67.0%</td>
</tr>
<tr>
<td>(score ‘yes’)</td>
<td>I worry about what is going to happen</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

(depression) scores above the clinical cut-off, 28.5 per cent above the RCMAS (anxiety) cut-off, and 39.3 per cent scored within the severe spectrum of the CPTSD-RI (post-traumatic stress) range. According to the carers’ rating on the SDQ, 49 children (43.7%) were within the likely clinical range.

The most commonly self-reported questionnaire items (symptoms) are presented in Table 1. As the three questionnaires (CDI, RCMAS and CPTSD-RI) have different rating scales, the items experienced ‘sometimes’ and ‘often’ were combined. The most frequent presentations included anxiety-related cognitions, insomnia, constricted affect and distress caused by reminders of past traumatic events.

Socio-demographic variables and mental health problems
There were no significant gender differences on any of the mental health measures (Mann-Whitney non-parametric test). Male residents were significantly older than females (t-test: t = 1.94, df = 113, p = 0.05), but they did not differ on age of entry to the orphanage. Children’s chronological age, age of entry to the orphanage and previous period of living with their family of origin were not associated with any mental health questionnaires scores (Spearman rank correlation).

Relationship between different types of mental health problems
All types of mental health issues (questionnaire continuous scores) were significantly associated with one another (Spearman rank correlation). Total depression (CDI) scores were significantly correlated with total PTSD (CPTSD-RI) scores (r = 0.34, p<0.001), anxiety (RCMAS) scores (r = 0.59, p<0.001) and overall mental health problems (SDQ total scores) (r = 0.26, p = 0.005). Total anxiety (RCMAS) scores were significantly correlated with PTSD (r = 0.54, p<0.001) and total SDQ scores (r = 0.41, p<0.001).

Discussion
Despite the expansion of fostering and adoption, predominantly in western societies (including intercountry adoption),
residential units, usually known as orphanages, are widespread in non-western developing countries. Their establishment appears to vary and to be determined by social, economic and cultural circumstances rather than as a strategic choice within limited welfare systems. In addition to the common reasons for fostering and adoption across the world, namely family breakdown, parents’ inability to cope and forms of abuse and neglect, other extensive causes of parental loss include war and political conflict in many regions, and HIV/AIDS, mainly in African countries. The absence of state response amid severe economic deprivation can be partly compensated by strong social and extended family networks and communities. These can thus take an informal kinship or fostering role and ensure continuity and safety for affected children (Masmas et al., 2004). There are also increasing examples and models of foster placements in developing countries (Gunston, 1995; George, van Oudenhoven and Wazir, 2003).

However, residential settings still care for a substantial number of children who cannot be looked after by extended or other types of families. Reasons may include: multiple physical and learning disabilities; early abandonment; risk of abuse; street children; societal attitudes to fostering or disability; disruption of social and community ties through displacement of populations and violence across communities; and the devastating consequences of HIV/AIDS (Tuhaise, 1994; St Petersburg and USA Orphanage Research Team, 2005). When residential placements are inevitable, these are provided by state or, increasingly, by non-governmental (national or international) organisations. Both the characteristics of the children and their carers will vary accordingly. Old orphanages in eastern Europe are faced with multiple challenges of state and care philosophy, staff training and lack of funding, although there have been incidents of promising change through international collaboration (Daunhauer, Bolton and Cermak, 2005; Browne et al., 2006). In contrast, settings such as SOS villages, which have been set up with an underpinning theoretical (attachment) and organisational framework, and are supported by international charities, have embedded these aspects in their care approach, and have demonstrated more positive results in relation to children’s holistic development, adjustment and later reintegration (Dumaret, 1988).

The Palestinian children described in this study have different characteristics and needs to those reported in previous research, as do the residential settings in which they are cared for. Therefore, they may require different future supports and interventions that make allowances for those specific issues. Their age of entry to orphanages (average around nine years) is substantially higher than in other countries, where children are often admitted as infants or in early childhood. Despite the lack of detailed data and information on family circumstances, the findings indicate a combination of acute and longstanding reasons for admission to an orphanage. The acute precipitant in all cases was the father’s death, with a small number of children having lost both parents. In the majority of families, the surviving mothers had either not been previously living with the children or were unable to look after them. The causes of the fathers’ deaths also reflect the ongoing war, conflict and occupation, responsible for 20 per cent. As we have found in a number of previous studies, children’s exposure to war trauma from an early age predicts emotional problems – predominantly post-traumatic stress but also anxiety and depression (Thabet, Abed and Vostanis, 2002; Thabet, Karim and Vostanis, 2006). Therefore, orphaned children are likely to have been affected by both direct exposure to trauma and family loss. A third factor was more difficult to establish from the available data, namely the extent to which there were mediating parenting difficulties.

1 SOS Children is an international charity for children orphaned and abandoned through war, famine, disease or poverty. Children live in group (foster) homes, with a foster mother being responsible for the children’s care in each home within the village.
which might explain the surviving mothers’ inability to look after their children. The large family size, which is representative of the general population, and severe economic adversity are other potentially accentuating factors. Finally, an interesting and potentially important factor is the children’s pattern of visits by and to members of their family. This could well suggest different reasons for their being accommodated and may reflect socio-cultural aspects of Palestine.

The high rates of mental health problems, predominantly those of emotional nature, are not surprising per se. They appear consistent with findings from studies with other groups of neglected, traumatised and institutionalised children, although the mechanisms may differ. The most widely studied factor has been institutional privation and its impact on children’s social, cognitive and emotional development (Rutter, Kreppner and O’Connor, 2001; Johnson, Browne and Hamilton-Giachritsis, 2006). Children admitted to orphanages in later life share more characteristics with looked after children in western residential settings (Meltzer et al., 2003). As in this study, mental health problems can be the outcome of exposure to trauma and family adversity, which can be compounded by the lack of secure attachment caregiving and stimulation within the orphanages (Leite and Schmid, 2004; Ahmad et al., 2005).

Overall, the main questions arising from this descriptive study relate to the potential impact of family factors, as in all other populations of children in public care, as well as the specific circumstances in the Gaza Strip and the local political conflict. Although this design could not adequately address these issues, there is indirect evidence to speculate that both these mechanisms are involved and thus place children at higher risk than other populations. Also, the findings suggest that interventions should target both family relationships and circumstances, and direct exposure to external trauma.

Unlike other studies with children in public care (eg Meltzer et al., 2003), we did not establish a clear link between care-related factors and child mental health problems. This could be due to the heterogeneity of this relatively small group of children, as different factors may have had differential effects related to different reasons for being in care. Alternatively, the reason may be the relatively limited quality of data on children’s histories (as discussed below). In addition to the need for more detailed information and evidence in future studies, social care interventions should primarily focus on issues of abuse, neglect and attachment difficulties, as in any other culture, if such events have been identified. One difference in this group and society is that at least a proportion of Palestinian children retain contact with their families, and many return to live with them or other relatives at a later stage. An objective of their care programme is for them to receive education and employment, to live independently and to sustain their own family.

The specific impact of the local political conflict and military occupation on children in the general Palestinian population has been well established by a number of studies (eg Thabet, Abed and Vostanis, 2002; Thabet, Karim and Vostanis, 2006). High levels of emotional problems, in particular post-traumatic stress reactions, are attributed to direct exposure to traumatic events of war, such as raids and shelling, and indirect exposure through adults’ reactions and the media. Children in orphanages are no exception to this exposure; in addition, 20 per cent of these children’s fathers had been killed during the conflict. Therefore, one could speculate that this group has a cumulative risk, which probably explains the particularly high rates of detected mental health problems. The occupation is also responsible for the extremely high socio-economic adversity in one of the most heavily populated areas of the world. Extreme poverty could be partially implicated in some families struggling to look after all their children. In turn, this has been shown to mediate the development of mental health problems in the Gaza Strip (Thabet and Vostanis, 1998).

The main level of support for children in orphanages is provided by teachers and social workers. They have training and
experience in working with deprived families, and some have received training from the Gaza Community Mental Health Centre in detecting emotional problems and working therapeutically with the children. Although there are no formalised organisational links, children have access to local child health services, as well as to non-governmental organisations providing therapeutic support.

A number of limitations in this study constrain the interpretation of the findings. Although no association was established between care-related variables and mental health issues, available data were fairly crude and did not allow a more detailed understanding of what appear to be complex and possibly heterogeneous circumstances. The same applies for the establishment of the potentially protective effect of contact with the family of origin, depending on the quality of attachment relationships, family attitudes and contact arrangements. The high rates of post-traumatic stress reactions may have been at least partly related to exposure to war trauma, which was not taken into consideration in this study. Although the measures have been previously used in studies of Palestinian children, there may well have been a cultural bias, particularly in the use of cut-off scores. Finally, it is important that future studies explore the characteristics of the institutional and care regimes and the staff involved, to provide evidence for the planning of interventions.

Although not directly within the remit of this study, a number of service implications can be considered. These have to address different levels, ie quality of institutional care, work with families and direct interventions with children. Despite the limited available evidence, there are some interesting and encouraging models emerging from descriptive or evaluation studies, aspects of which could be applied to residential units in developing countries. One has to consider their strained resources throughout these recommendations. This situation makes it necessary to maximise community and other types of support as far as possible and to anticipate that fostering schemes are likely to evolve and increase throughout the world in the near future (Morah et al, 1998; George et al, 2003).

Admission criteria to residential units should be clear and consistent, and all attempts should be made to re-unify the child with his or her family if there is no risk involved and rehabilitation is viable with continuing support. Previous research has shown that it is possible for orphanages to create humane social environments (Wolff and Fesseha, 1998; Groark et al, 2005; Sparkling et al, 2005). However, sound understanding of local and cultural issues and strategic agreement on the direction of the unit are required before external agencies (eg international charities) undertake staff training and begin to tackle longstanding institutional difficulties (Devi, 2004; Hardman, 2004). Although family contact may not be possible or appropriate for many units and children, in this study the circumstances appeared to vary, and many children were visited by or spent brief periods with their family of origin or extended family. A number of factors are important in planning and monitoring such arrangements, not least putting the child’s needs first and establishing their expectations and the impact of such contact.

It is important that related socio-cultural attitudes are addressed in parallel, such as potential stigmatisation of children living in institutions, or relatives’ reluctance to be actively involved in their care. The term ‘orphanage’ is itself a misnomer as most children actually had a living parent, implying that broader attitudes and stigma need to be tackled at a population level. Addressing looked after children’s emotional and other mental health needs requires a co-ordinated interagency approach by welfare and health agencies across all societies, and this is difficult to achieve. Developing integrated therapeutic approaches and accessing mental health services in countries of very limited resources has to be realistic and targeted and has to maximise the potential of non-governmental organisations. Only a small number of children with severe mental health difficulties who have not responded to other interventions should be referred to
mental health services. The high rates of such established difficulties indicate that a consultative model may be effective for orphanages and similar residential units. Despite the lack of services in developing countries, some innovative therapeutic interventions such as structured play or play therapy (Taneja et al, 2005) and creative therapies (Robb, 2002) have been applied in orphanages. It is hoped that emerging practice or service examples, together with related evidence, will draw generalisable lessons that can be shared across different societies.

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