Psychosocial Profile of Institutionalized Children

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Abstract:

The aim of this study was to identify the psychosocial characteristics of institutionalized children and to profile the major problems of them in sheltered houses.

Sample:

This cross sectional descriptive study was carried out on a sample of 100 boys and 100 girls at Dar-Eltarbia in Giza for boys, and the Social Care Institution for Girls in Al-Agouza.

Tools:

Data collection tools included an interview questionnaire form and a child psycho social scale.

Results:

The results revealed that the duration of institutionalization ranged between 1.2 and 7 years, 19.5% had previous institutionalization, and 62.0% were satisfied with institution services; 3.5% were current smokers and 36.5% were ex-smokers; 3.0% were using addictive drugs; 99.0% reported aggressive behavior, and 43.5% committed aggression against themselves. The major psycho-social problems were delusions (50.5%), depression symptoms (46.0%), and anger (29.0%). Depression and aggression symptoms had relations with child age ($p < 0.001$), education ($p=0.01$), concerns about adolescence changes ($p < 0.001$), drug addiction ($p=0.002$), aggressive behavior ($p=0.002$), aggression against self ($p < 0.001$), and major life events ($p=0.001$), previous trial to escape from institution ($p=0.007$), satisfaction with services ($p=0.02$), and relations with others ($p=0.003$). Statistically significant positive moderate to weak correlations were revealed among the five types of psycho-social symptoms. It is concluded that institutionalized children have symptoms of major psycho-social problems in the form delusions, depression, and to less extent anger. Many factors related to child, parents, and institution influence these symptoms, and must be taken into account for prevention and management of such symptoms among

these children. The study recommends that these findings be forwarded to the institutions, and similar evaluations of psychosocial symptoms should be done in these institutions on admission and on periodic basis. Special considerations should be given to children with high risk for such problems. The institutional services need to be improved.

Keywords:

Institutionalization, anger, depression, children

Introduction:

Residents of social care institutions constitute a group of a society who are victims of condition they have nothing to do with. As a result of their lacking families who take care of them and direct them, they have problems and difficulties in their life, (Harman et al., 2000). Institutionalized children have behavioral and emotional problems at much higher rates than other children (DosReis et al., 2001; Clark et al., 2007). Those children are "Those who have or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (McPherson et al., 1998; Sawyer et al., 2007). Despite having a greater need for mental health services, these children face significant barriers to such care and often do not receive needed mental health services (Barber et al., 2001). Community-level contextual stressors, such as poverty, unemployment, crime, and lack of social support, have been associated with both an increased incidence of behavioral and emotional problems and inadequate mental health care (Harman et al., 2000; DosReis et al., 2001).

Foster institutions were first developed in 1936 in Egypt. They were known as asylums, and were affiliated to the Ministry of Interior, municipalities, or benevolence societies. They used to consist of large buildings divided into dormitories with long hallways like prisons. These institutions used to be only for homeless boys. In 1939, their affiliation was transferred to the Ministry of Social Affairs, and they started to accept children with no families to care for them, with the aim of raising and educating them (Atallah, 2008).

Institutionalized children are considered as highly deprived class of society. These children are left helpless, abandoned, neglected due to social, economic and personal reasons by the parents/ caregivers and they are deprived of one or more necessities of life. Early separation from parents, deprivation of parental care, love, affection, warmth, security, acceptance and discipline during childhood disrupts their normal socio-emotional development (Hunshal, and Gaonkar, 2008).

The results of the Hunshal and Gaonkar' (2008) study showed that majority of the institutional children had unsatisfactory social, emotional and educational adjustment and very few of them had good adjustment. This clearly indicates that institutional children have more social, emotional and educational problems which made them socially more aggressive, emotionally unstable and educationally not interested in studies and these characteristics were responsible for unsatisfactory adjustment of children. Similarly, the earlier studies conducted by Hiremani et al. (1994), Chaudhary and Bajaj (1995) and Chaudhary and Uppal (1996) also reported that institutional children were emotionally insecure, immature and unstable.

Institutional children may be protected from harm if they get an opportunity to develop stable emotional relationship with at least one important and consistent person in their lives who can provide support and protection. So the mechanical type of care must be replaced with personal concern by the staffs who are in charge of the children particularly the house mothers whom they consider as a

substitute parent. However a stable, reliable and understanding relationship does not depend primarily on words but on consistent response to child's feelings which gradually develops foundations of trust, confidence, and sense of security. This provides strong base from which they develop self identity, self respect, and a sense of confidence and work (Nelson et al., 2007).

Significance Of The Study:

Children who have been institutionalized for long periods suffer from increased fragility in psychological structure, becoming more vulnerable and more liable to social suffering than those living in their homes. Therefore efforts should be directed to substitute family care for these young people and help them to adjust to the society so they become good and effective members. Institutional social care is one choice in providing care for children and young people deprived from family care, so efforts should be paid to improve this type of care, in order to help residents to avoid psychosocial problems and face life's issues So it becomes necessary to know whether institutionalized children who are devoid of family life with the emotional warmth grow up normally and how well they are able to cope with himself and adjust to the demands of the environment/society around them. Therefore the study with the aim to know the level of adjustment of institutionalized children was taken up.

Aim Of The Study:

1. To identify psychosocial characteristics of institutionalized children in sheltered houses.
2. To profile the major problems of institutionalized children in sheltered houses.

Subjects And Methods:

The aim of this study was to identify the psychosocial characteristics of institutionalized children and to profile the major problems of them in sheltered houses. The research hypothesis was that children who have been institutionalized for long periods suffer from increased fragility in psychological structure, becoming more vulnerable and more liable to social suffering than those living in their homes. The methodology used in carrying out the study is described under four designs, namely technical, operational, administrative, and statistical designs.

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Technical Design

- Research Design :An exploratory cross-sectional descriptive research design was adopted to fulfill the purpose of the study. It helps the researcher to describe and document aspects of a situation as it naturally occurs. As well, this design helps to establish a database for future research.
- Study Setting :The study was carried out at Dar-Eltarbia in Giza for boys, and the Social Care Institution for Girls in Al-Agouza, Cairo.

Subjects And Sample:

All the children in both settings were eligible for inclusion in the study sample according to the following criteria:

- Inclusion Criteria:
  1. Age 6-12 Years.
  2. Enrolled in the institution during the study period.
  3. Spent at least one year in the institution.
- Exclusion Criteria: None.

All eligible children who fulfilled the criteria were included in the study. Their number was 100 boys and 100 girls.

Tools:

Two different tools were used for data collection, namely an interview questionnaire form and a child psycho-social scale.

1. Interview questionnaire form: This tool was designed by the researcher based on review of related literature. It included the following parts:
   a. Socio-demographic data of the child such as age, sex, school attendance and educational attainment
   b. Details about child institutionalization: duration of stay, causes of admission, previous admissions, trials to escape
   c. Child assessment of institutional services.
   d. Child health status: history of any diseases or disabilities, concerns about health and adolescence changes, as well as risky behaviors as smoking and drug abuse.
   e. Child aggressive behavior and violence towards self or others.
   f. Child exposure to major life events and the relations with others inside and outside the institution. The child was considered as having good relations if his relation with 60% or more of the items was checked as good.
2. Child psychosocial disorders scale: This tool was adopted and modified from Kaufman et al (1997). It includes assessment of five psycho-social disorders as follows:
   a. Depression Symptoms: 16 Items
   b. Anger Symptoms: 16 Items
   c. Anxiety Symptoms: 18 Items
   d. Hallucinations: 11 Items
   e. Delusions: 10 Items.

   Each item was to be checked either present or absent. The scale was to be filled independently by the researcher and the supervisor.

   Scoring: The item checked present was scored "1" and the absent "0" The scores of the symptoms of each disorder were summed up and converted into a percent score. The child whose score reached 60% or higher was considered as having the symptoms of the disorder. This was done separately for the researcher's and caregiver's assessment forms. Then, the assessments of the researcher and caregiver for each child were compared. The child was considered as having the symptoms of the disorders if both agreed, and not having the symptoms of the disorders if both disagreed. In case of differences in the two evaluations, the child was considered as probably having the symptoms of the disorders.

The reliability of the psycho-social disorders scale was assessed through the internal consistency method. The tool reliability proved to be very good, with Cronbach alpha coefficient 0.86.

Also, the developed tools were reviewed by experts in nursing and medical pediatrics, psychiatry, as well as experts in socio-behavioral sciences. Validation was through majority agreement.

Operational Design:

- Pilot Study: A pilot study was conducted on 27 children (8 boys and 19 girls) to judge the feasibility of conducting the study. It also served to check the clarity and applicability of the study tools and test their ability to elicit the desired information. As well, the tools were tested for appropriateness, content, wording and order. The pilot also helped to measure the time needed for filling out the forms, According to the results of the pilot, necessary changes were done and the tools finalized. The pilot study sample was not included in the main study sample.
- Fieldwork: Once official permission was granted from the research committee, and from the directors of the selected institutions to proceed with the study, the researcher initiated data collection. Children and their caregivers who met the eligibility criteria were identified. The

researcher met with each potential subject, and informed him/her about the purpose and the nature of the study and its procedures. The researcher explained to caregivers how to fill out the forms. Then, the assessment by the researcher was done by individually interviewing each child. The time required filling in the questionnaire varied from one child to the other depending on educational status, past experience, and psychological and social status; the average time was between 50 and 70 minutes. The researcher visited the institutions three times every week during day time, 9 am to 2 pm. This was done alternatively in the two institutions, i.e. Sunday, Monday, and Tuesday in Dar El Tarbia, and Saturday, Wednesday, Thursday in the Institution of Social Care in Agouza. Data collection was carried out over a period of three months, with close observation for children from July 2009 to December 2009.

Administrative Design:

Oral consent along with written permission were obtained from the responsible authorities in the Ministry of Social Affairs, the General Management of Social Defense, and the Initialization Children in Giza. Prior to the initial interview, each child and caregiver were fully informed about the purpose of the study. The researcher emphasized that participation in the study was entirely voluntary and anonymity of the child was assured through coding the data. They were informed about their right to refuse or withdraw at any time. The study maneuvers could not cause any harmful effect to participants.

Statistical Design:

Data entry and statistical analysis were done using SPSS 14.0 statistical software package. Categorical variables were compared using chi-square test. In larger than 2×2 cross-tables, no test could be applied whenever the expected value in 10% or more of the cells was less than 5. Pearson correlation analysis was used for assessment of the inter-relationships among quantitative variables, and Spearman rank correlation for ranked ones. Statistical significance was considered at p-value <0.05.

Results:

Table 1 presents the Socio-demographic characteristics of institutionalized children. They had equal sex distribution, and their age ranged between 6 and 12 years with mean 10.9 years. Less than half of the sample age was 10-11 years. Slightly ore than half of them (57.5%) were currently enrolled in schools and less than two-thirds were able to both read and write (65%). Their birth order was mostly second (41.5%).

Table 2 demonstrates that about three-fifth of the study children were satisfied with various aspects, with the lowest satisfaction being with food and sports, 57.0% each. Their satisfaction with their supervisors and the institution administration was mostly average or good. In total, 62.0% of the children were satisfied with the institution.

Table 3 describes the smoking habits of the study children. It indicates that only 3.5% were current smokers and 36.5% were ex-smokers. The mean age at starting smoking was 7.7±1.3 years. All current smokers started smoking before institutionalization, and 90.4% of ex-smokers quit smoking after being admitted.

Concerning addiction, table 4 demonstrates that 3.0% of the study children were using addictive drugs, while 12.5% sometimes used them. The corresponding figures for addiction in the family were quite close to these figures. The most common drugs used were bango (67.7%) and hashish (48.4%). One child reported using cocaine (3.2%).

Table 5 presents the history of aggression

among study children. Almost all of them (99.0%) reported quarreling, while 8% reported fire-setting. The most commonly used tools for aggression were nails (90.0%) and stones (60.0%), whereas knives and chemicals were the least reported, 6.5% and 5.0% respectively. More than two-fifth of the children (43.5%) had committed aggression against themselves.

As table 6 shows, the relations of children with their families had the highest percentage of poor responses (17.8%), while the relations with their peers in the institution had the lowest percentage (5.5%). On the other hand, the highest percentages of good relations were with friends outside the institution (61.6%), whereas the lowest percentage of good relations was with the family.

Table 7 shows that the majority of the children in the study sample had forced migration as the most common major life event (97.0%). Other reported major events were the death of a significant other and scary situation, 56.0% each. Meanwhile, 9.5% reported having been exposed to sexual assault. On average, each child had almost three major life events.

Table 8 illustrates the major psycho-social problems among children in the study sample. It indicates that about half of them had delusions (50.5%), and depression symptoms (46.0%). Anger was the least frequent problem (29.0%).

The correlations between the scores of aggression and various psycho-social symptoms among children are displayed in Table 9. It shows that only the crowding index and the institutionalization years had no statistically significant correlations with aggression or any of the five psycho-social symptoms. The strongest correlations were between depression and age (r=0.365), and between hallucinations and the number of institutionalization (r=-0.368).

Table (1) Socio-demographic characteristics of children in the study sample (n=200)

		Frequency	Percent
Age (Years)	<10	79	39.5
	10-11	94	47.0
	12+	27	13.5
	Range	6-12	
	Mean±SD	10.9±1.4	
Sex	Male	100	50.0
	Female	100	50.0
Education	None	15	7.5
	Entered School And Quit	70	35.0
	Currently Enrolled In School	115	57.5
Currently enrolled in school (n=115)	1	27	23.3
	2	35	30.2
	3	24	20.7
	4	14	12.1
	5	6	5.2
	6	7	6.0
	1st Preparatory	2	1.7
	Literacy Class	1	0.9
Can@	Read	118	59.0
	Write	111	55.5
	Both	130	65.0
Birth Order	1st	60	30.0
	2nd	83	41.5
	3rd +	57	28.5

Table (2) Satisfaction with institution services and relations as reported by children in the study sample (n=200)

		Frequency	Percent
Satisfied With	Lodging	124	62.0
	Recreation	124	62.0
	Social	124	62.0
	Spiritual	124	62.0
	Health	122	61.0
	Education	122	61.0
	Cultural	121	60.5
	Food	114	57.0
	Sports	114	57.0
Treatment By Supervisors	Poor	36	18.0
	Average	89	44.5
	Good	75	37.5
Treatment By Administration	Poor	36	18.0
	Average	90	45.0
	Good	74	37.0

		Frequency	Percent
Total Evaluation	Good	124	62.0
	Poor	76	38.0

Table (3) History of smoking among children in the study sample (n=200)

		Frequency	Percent
Smoking	None	120	60.0
	Ex-Smoker	73	36.5
	Current Smoker	7	3.5
Current smokers (n=7)			
No. of cigarettes	Range	4- 80	
	Mean±Sd	21.4±26.4	
Duration in (Years)	Range	<1-4	
	Mean±Sd	2.5±1.5	
Age at start (years)	Range	6-10	
	Mean±Sd	7.7±1.3	
Start	Before Admission	7	100.0
	After Admission	0	0.0
Ex-smokers (n=7)			
No. of cigarettes	Range	1-60	
	Mean±Sd	17.0±14.7	
Duration in Years	Range	<1-4	
	Mean±Sd	1.2±1.1	
Age at start (Years)	Range	6-10	
	Mean±Sd	7.5±1.1	
Stopped before (Months)	Range	<1-9	
	Mean±Sd	2.5±1.5	
Stopped	Before Admission	7	9.6
	After Admission	66	90.4

Table (4) History of addiction among children and parents in the study sample (n=200)

		Frequency	Percent
Addiction	No	169	84.5
	Sometimes	25	12.5
	Yes	6	3.0
Drugs used (n=21)[@]	Bango	21	67.7
	Hashish	15	48.4
	Tablets	9	29.0
	Antitussives	3	9.7
	Kollah	2	6.5
	Cocaine	1	3.2
Addiction In Family	No	175	87.5
	Sometimes	21	10.5
	Yes	4	2.0

Table (5) History of aggression among children in the study sample (n=200)

		Frequency	Percent
Aggressive Acts	Quarrelling	198	99.0
	Destruction	48	24.0
	Fire Setting	16	8.0
Total aggressive act	1	139	69.5
	2- 3	61	30.5
Tools used	Nails	180	90.0
	Stones	120	60.0
	Glass	85	42.5
	Razor Blades	67	33.5
	Knives	13	6.5
	Chemicals	10	5.0
Aggression Against Self		87	43.5

Table (6) Institutional relations as reported by children in the study sample (n=200)

Relations With	Poor		Acceptable		Good	
	No.	%	No.	%	No.	%
Family	33	17.8	83	44.9	69	37.3
Friends outside	12	6.5	59	31.9	114	61.6
Peers in institution	11	5.5	81	40.5	108	54.0
Supervisors	16	8.0	82	41.0	102	51.0
Workers	16	8.5	84	44.4	89	47.1
Administration	16	8.0	85	42.5	99	49.5

Table (7) History of major life events and relations among children in the study sample (n=200)

		Frequency	Percent
Major Life Events	Forced Emigration	194	97.0
	Death of significant other	113	56.5
	Scary situation	113	56.5
	Illness or accident with hospitalization	93	46.5
	Fire	21	10.5
	Sexual assault	19	9.5
Total number of events	1-2	64	32.0
	3-6	136	68.0
	Range	1-6	
	Mean±Sd	2.8±0.8	

Table (8) Major psychosocial problems among children in the study sample (n=200)

Symptoms of	No		Probable		Yes	
	No.	%	No.	%	No.	%
Depression	31	15.5	77	38.5	92	46.0
Anger	76	38.0	66	33.0	58	29.0
Anxiety	45	22.5	89	44.5	66	33.0
Hallucinations	30	15.0	111	55.5	59	29.5
Delusions	18	9.0	81	40.5	101	50.5

Table(9) Correlation among various scores of psycho-social symptoms and various socio-demographic and institutionalization characteristics

	Pearson Correlation Coefficient					
	Scores of					
	Aggression	Depression	Anger	Anxiety	Hallucination	Delusion
Age	0.230**	0.365**	0.322**	0.064	-0.158*	0.030
Education@	-0.107	-0.233**	-0.264**	-0.258**	0.070	-0.080
No. Of Siblings	0.072	0.043	0.182**	0.063	0.109	0.058
No. of step-siblings	0.169*	0.150*	0.148*	-0.015	-0.023	0.095
Birth Order	-0.043	-0.148*	-0.073	-0.043	0.044	-0.077
Institutionalization Yrs	-0.032	0.043	0.012	0.090	0.020	0.063
No. Of Institutionalization	-0.253	-0.207	-0.212	0.044	-0.368*	-0.139
Perception Of Health@	-0.068	0.052	-0.103	0.048	0.061	0.089
No. Of Event	0.304**	0.257**	0.306**	0.157*	0.073	0.117
Relations With Others	-0.232**	-0.328**	-0.462**	-0.169*	-0.283**	-0.137

@Spearman Rank Correlation,
*Statistically significant at $p<0.05$, **Statistically significant at $p<0.01$

Discussion:

Young children who are institutionalized usually have a variety of risk factors that precede their placement. The outcomes at particular points in development are the result of ongoing interactions between child's characteristics including genetic factors and early experiences, and the environmental characteristics. Hence, children with any history of institutional rearing may have more psycho-social disorders (Zeanah et al., 2009).

Children in out-of-home care are considered a population at high risk for adverse outcomes across all domains of functioning. Rates of emotional and behavioral problems in this population have ranged from 30 to 80 percent (Burns et al., 2004; McMillen et al., 2005) and have been attributed to histories of abuse and neglect, backgrounds of general family dysfunction, parental substance abuse and poverty as well as the potential trauma associated with removal from home (Landsverk et al., 2002).

The aim of the present study was to explore the psychosocial characteristics of institutionalized children and to profile the major problems of the in sheltered houses. The study was carried out on 200 institutionalized children of equal sex distribution, and age between 6 and 12 years. About one third of these children quit schooling, mostly in grade 3. This high quit rate indicates that these children could not respond to the demands of the school environment. In congruence with this, Brendgen et al. (2001) and Snyder et al. (2005) indicated that foster children are at particularly high risk for difficulties in schooling. They lack basic social skills and fail to develop successful peer relations during school entry, and are

at greater risk for conduct problems, peer rejection, and academic failure throughout childhood and adolescence.

According to the present study findings, the most frequently reported reasons for institutionalization were begging and theft, in addition to other crimes that reached murder and rape at such young age. They are mostly related to child leaving home or runaway. On the other hand, about one third of the children reported admission according to parents' will. This is expected in disorganized families with stepparents, where the child is not welcomed at home.

In line with these foregoing present study findings, Witherup (2008) clarified that leaving home and running away is a severe form of problem behavior exhibited by children that increases the likelihood of drug use and abuse, committing crimes, engaging in prostitution, contracting sexually transmitted diseases, attempting suicide, joining street gangs, skipping school, and dropping out of school. Given these serious risks of runaways, several government reports and research studies estimated high incidence of running away (U.S. Bureau of the Census, 2000; Hammer et al., 2002)

About three-fifth of the present study children expressed their satisfaction with most aspects of institution services. The highest levels of dissatisfaction were with food and sports. This reflects a good level of care as judged by the children. The dissatisfaction with food and sports services might be related to resources and finance. Usually the dissatisfaction with institutional care comes form the features that characterize such care as: regimented daily schedules, high ratios of children to caregivers, non-individualized care, lack of psychological investment by caregivers, and rotating caregiver shifts, which all contribute to an adverse care giving and social environment (Zeanah et al., 2006).

Also, only a small minority of the present study children considered their relations with supervisors as poor. This relationship between the supervisor and the child is crucial in child development, as the supervisor is considered as the foster parent of the child. Hence, a supportive relationship between caring adults and children in care is crucial (Shirk and Stangler, 2004). Children with histories of maltreatment may close themselves off to relationships, or may be less open to them (Britner and Kramer-Rickaby, 2005).

Moreover, many of the present study children are at the start of adolescence, with the associated physical and psychological changes that need support and guidance form caregivers. In this respect, Steele and Buchi (2008) mentioned that children in the institutional care system have special health care needs unique to the circumstances that lead to their out-of-home placement. This can make caring for these children more complicated, time consuming, and costly. To develop systems of care that can reduce these difficulties, it is critical that child welfare agencies and policy makers have accurate information regarding the needs of these children at high risk at the time of entry into the foster care system.

Smoking is a major problem among institutionalized children and youth. According to the current study, only 3.5% of the children reported being current smokers, while more than one-third of them were ex-smokers. Smokers started at a very young age, almost eight years, and quitting smoking was mostly after institutionalization. The low percentage of current smoking may be related to under-reporting due to fear of the child to report being smoker. In fact, most of the ex-smokers may be considered to be actually current smokers. The findings are much lower than those reported in an

institution-based survey in Turkey (Erguder et al., 2009), where 29.3% were current cigarette smokers. The authors explained that institutionalized children seem to be more prone to start and continue smoking compared to non-institutionalized ones.

The rate of use of addictive drugs among the present study children was close to the rate of current smoking; but more than one-tenth reported occasional use, with close figures for addition in the family. The problem of under-reporting may also play some role here as in smoking. The rates are also much lower than those found in the study by Steele and Buchi (2008) were one third of the institutionalized children had a personal or family history of drug or alcohol use.

Furthermore, and in agreement with the present study findings, Milne et al. (2009) demonstrated that family history of drug addiction was associated with child drug dependence, recurrent course for drug dependence, and worse impairment for drug dependence. Also, Pilowsky and Wu (2006) demonstrated that children in institutional care had a higher prevalence of substance use disorders, and were about five times more likely to have a past year diagnosis of drug dependence. This was attributed to childhood maltreatment as a frequent antecedent of substance abuse.

Concerning aggressive behavior, almost all the current study children reported quarreling. The aggressive behavior reached fire-setting in about one-tenth of them. More than two-fifth of the children reported having committed aggression against themselves. The high prevalence of aggressive behavior is in agreement with Heflinger et al. (2000) who mentioned that such conduct problems are more elevated among children in institutional care. The most common of these problems are the aggressive and delinquent ones. Similar findings were also reported in Canada (Stein et al., 2004). Moreover, follow-up studies of adults who had been in institutional care as children found that a high proportion had criminal records in adulthood (Fanshel et al., 2000).

The relations of children in the study sample were poorest with their families and best with peers in the institution and friends outside the institution. The relations with supervisors were also mostly acceptable or good. The findings reflect the aversion of these children to their families who were the cause of their institutionalization, and the more closeness to their new families in terms of supervisors and peers. In agreement with these findings, Wulczyn and Zimmerman (2005) indicated that institutionalization does not only involve separation from parents but can also involve disruption or loss of the sibling relationship. This is reflected in child welfare policy and practice, which have increasingly emphasized preserving and maintaining sibling relationships of institutionalized children whenever possible (Shlonsky et al., 2005). Peer relationships may include step-siblings and half-siblings as well as other sibling relationships that do not involve biological relationships but hold psychological or social importance (Herrick and Piccus, 2005; James et al., 2008).

Major life events are of significant influence on children. The present study findings indicated that for the majority of the children forced migration was major life event, in addition to other events as death of a significant, scary situations, and sexual assault. Such events, if not manipulated properly would lead to major psycho-social problems in children. In this regard, Smyke et al. (2007) clarified that psycho-social problems result from the lack of a consistent, responsive caregiver. This behavior has also been observed in children adopted from high-quality institutions that provided adequate nutrition and general stimulation but not consistent caregivers, but

less in an institution designed to increase caregiver consistency (Bruce et al., 2009).

According to the present study findings, a number of major psycho-social symptoms were identified among children. The most common were delusions and depression symptoms, while anger was the least common, although it affected about one-third of them. The findings are in agreement with the report of the St. Petersburg-USA Orphanage Research Team (2008) which demonstrated a variety of atypical behaviors, including shift from early passivity to later aggressive behavior, over-activity and distractibility, and inability to form deep or genuine attachments among institutionalized children.

On the same line, with respect to depression, epidemiological research suggests that disruptive experiences during childhood, particularly those involving separation from parents in conjunction with inadequate substitute care, impart a heightened vulnerability that interacts with subsequent life stress to produce disorder (Steele et al., 2009). Also, Zeanah et al. (2009) reported that children who lived in an institution were significantly more likely to meet criteria for any psychiatric disorder, as well as both externalizing and internalizing disorders.

Furthermore, it was found that children involved in institutional care were more likely to have significant higher rates of anxiety, depression, somatic complaints, and mood symptoms than those without such care (Pilowsky and Wu, 2006). Also, Heflinger et al. (2000) found that 23% and 19% of the institutionalized children had symptoms in the clinical range of the externalizing and internalizing scale, respectively.

Regarding the high prevalence of symptoms of delusions and hallucinations among children in the present study, it has been claimed that behavioral dysfunction during childhood and adolescence can foreshadow the development of psychopathology in adulthood. Thus, several population-based prospective studies have documented social, behavioral, and emotional antecedents in children who later develop schizophrenia and related disorders (Welham et al., 2008). Meanwhile, Scott et al. (2009) found that psychopathology during childhood and adolescence was associated with high levels of delusional-like experiences. For some young adults, psychotic-like experiences were associated with increased psychopathology from at least age 5.

Moreover, in recent years there has been increasing interest in the idea that features of psychosis can be conceptualized along a continuum (Scott et al., 2006), and sub clinical psychotic-like experiences are much more prevalent than clinically defined psychotic disorders (van Os et al., 2009). There is evidence to suggest that psychotic-like experiences are associated with an increased risk of developing mood disorders and substance use disorders as well as psychotic disorders. From this perspective, delusional-like experiences and hallucinations have been viewed as "intermediate phenotypes" that may be of importance either in predicting later psychosis or as a phenomenological feature that may share etiological or pathogenic mechanisms with full clinical syndromes (Welham et al., 2008).

The present study revealed statistically significant positive correlations among various psycho-social symptoms in children, except for the correlations between anxiety and anger and anxiety and hallucinations. The findings are quite plausible since most these symptoms are mutually enforcing each other. In agreement with this, several investigators have documented associations between depression and outward anger expression (Rudnicki et al., 2001; Richmond et al., 2001; Koh et al., 2005). Collectively, available evidence suggest that

aggressive, outward violent behavior is associated with an increased risk of symptoms of depression (Kitamura and Hasui, 2006; Moussavi et al., 2007).

The current study has also shown that the strongest correlation was between anger and depression. The finding is in line with Goodwin (2006) in a study on health behavior survey of American school-aged children. It was demonstrated that outward anger expression was associated with an almost 3-fold increased risk of feelings of depression. Similar positive associations between anger expression and symptoms of depression have been reported among Japanese students (Kitamura and Hasui, 2006). Also, in Ethiopia, moderate and high anger-out expression scores were associated with a 2.18-fold and 3.38-fold increased risk of having depressive symptoms respectively (Terasaki et al., 2009).

The correlations between the scores of aggression and various psycho-social symptoms among children demonstrated statistically significant weak correlation with all factors except the institutionalization years. It was also noticed that age, relations with others, and the number of major life events were the most influential. In agreement with this, Gudlaugsdottir et al. (2004) documented associations between aggressive behavior and negative life events. As regards age, Miller et al. (2005) reported that children institutionalized at younger age had less problems, and better development. The negative correlation between good relations and aggressive and psycho-social symptoms is also in congruence with Rubin et al. (2007) who emphasized the importance of good care and relationships, which influence the wellbeing for children in out-of-home care.

Conclusion:

Based on the main study findings, it is concluded that institutionalized children have symptoms of major psycho-social problems in the form delusions, depression, and to less extent anger. Almost all of them have aggressive behaviors. Overall, children were satisfied with the institution services. The main factors associated with the psycho-social symptoms are child age and education, drug addiction, aggressive behavior, major life events, satisfaction with institutional services, and relations with others. These factors are more influential on depression and anger symptoms, and must be taken into consideration for prevention and management of psychosocial symptoms among institutionalized children.

Recommendations:

Based on the study findings, the following recommendations are suggested:

1. The findings of the study must be forwarded to the institutions both under study and similar ones.
2. Special considerations should be given to children with high risk for such problems, as those with no or low educational attainment, major life events, and with previous history of institutionalization.
3. The institutional services need to be improved, especially cultural and sportive activities, which can be considered as part of the corrective program of the institution. More care should be given to health services, especially adolescence health services, as a large part of these children are in this stage with all its physical and psychological changes that need special management from the side of the institution.
4. Smoking and drug abuse is a major problem in these institutions, and the figures detected in the present study may under-estimate the magnitude of the problem; therefore, more care should be given for prevention and control of these bad habits.

5. The high tendency to aggressive behavior among these children should not be taken as a normal behavior of these children given their psychosocial background, and must be addressed by specialized psychologists.
6. Further follow up studies are proposed to investigate the predictive value of early detection of psychosocial symptoms in early diagnosis of actual psychosocial problems among institutionalized children mainly for addiction.

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الملخص

المنظور النفسى والاجتماعى لأطفال المؤسسات الاجتماعية

إن أطفال المؤسسات الاجتماعية معرضون لخطر متزايد من المشاكل المادية والتنموية والسلوكية والعاطفية. وهم أكثر عرضة للمشاكل النفسية الاجتماعية مقارنة بالأطفال الآخرين. وهذه المشاكل يمكن أن تؤدى إلى تأخير أو خلل وظيفى بين هؤلاء الأطفال. وعلاوة على ذلك، فقد وجد ارتباط بين المشاكل ووجود تلك المشاكل فى مرحلة الطفولة والاضطرابات النفسية لدى البالغين. لذلك، من المهم تقييم حجم هذه المشاكل بين أطفال المؤسسات والتعرف على العوامل ذات الصلة.

هدف البحث

هدف هذه الدراسة هو التعرف على الخصائص النفسية والاجتماعية للأطفال فى المؤسسات الاجتماعية والتعرف على المشاكل الرئيسية لديهم.

نوع البحث:

استكشافى مقطعى وصفى.

عينة البحث:

شملت الدراسة جميع الأطفال المؤهلين فى مؤسسة دار التربية للبنين فى الجيزة، ومؤسسة الرعاية الاجتماعية للبنات فى حى العجوزة وتضمنت ١٠٠ من البنين و١٠٠ من البنات، تم تنفيذ العمل الميدانى من يوليو ٢٠٠٩ إلى ديسمبر ٢٠٠٩.

أدوات جمع البيانات:

تم استخدام الأدوات التالية:

١. استمارة مقابلة للتعرف على الخصائص الديموجرافية والاجتماعية للطفل وظروف دخول المؤسسة.
٢. مقياس نفسى اجتماعى للطفل.

النتائج

أسفرت نتائج الدراسة عما يلي:

١. تراوحت أعمار الأطفال ما بين ٦ سنوات و١٢ سنة، و٥٧,٥% منهم مسجلون حاليا فى المدارس
٢. كان السبب الأكثر شيوعا لعدم دخول المدرسة أو التسرب منها هو التفكك الأسرى (٨١,٢%) والفقر (٣٠,٦%).
٣. إجمالا تبين أن ٦٢,٠% من الأطفال كانوا راضين عن خدمات المؤسسة، واعتبر ٣٥,٥% منهم أن حالتهم الصحية ضعيفة.
٤. أيضا تبين أن ٣,٥% من الأطفال كانوا من المدخنين الحاليين و٣٦,٥% من المدخنين السابقين، و٣,٠% منهم كانوا يستخدمون المواد المسببة للإدمان بصفة مستمرة، فى حين أن ١٢,٥% منهم كانوا يستخدمونها فى بعض الأحيان.
٥. جميع الأطفال تقريبا (٩٩,٠%) كان لديهم سلوك عدواني، و٤٣,٥% منهم كان لديهم سلوكا عدوانيا ضد الذات.
٦. كانت الهجرة الاضطرارية من أحداث الحياة الكبرى الأكثر شيوعا (٩٧,٠%)، وكانت أهم المشاكل النفسية الاجتماعية هى أعراض الأوهام (٥٠,٥%)، والاكتئاب (٤٦,٠%)، فى حين كان الغضب بشكل متكرر هو الأقل (٢٩,٠%).
٧. أعراض الاكتئاب والغضب كانت لها علاقة ذات دلالة إحصائية مع سن الطفل، والتعليم، والمخاوف بشأن تغيرات المراهقة، وإدمان المخدرات للطفل أو الأسرة، والسلوك العدواني، والعدوان ضد الذات، وأحداث الحياة الكبرى، والمحاولة السابقة للهروب من المؤسسة، والرضا عن الخدمات، والعلاقات مع الآخرين.
٨. كشفت الدراسة عن وجود ارتباط إيجابى ذى دلالة إحصائية بين أنواع الأعراض النفسية الاجتماعية الخمس.

توصيات البحث:

١. توصى الدراسة بأن تحال هذه النتائج إلى المؤسسات، مع عمل تقييمات مماثلة فى هذه المؤسسات عند القبول وبشكل دوري.
٢. ينبغى إعطاء اعتبارات خاصة للأطفال ذوى المخاطر العالية لمثل هذه المشاكل مثل غير المتعلمين والأسر المفككة، والذين عانوا من أحداث الحياة الكبرى، وذوى التاريخ السابق لدخول المؤسسة.
٣. أيضا إن الخدمات المؤسسية تحتاج إلى تحسين، مع المزيد من الخدمات الصحية والتركيز على المراهقة، ومشاكل التدخين وتعاطى المخدرات.
٤. يقترح المزيد من الدراسات للمتابعة وللتحقق من القيمة التنبؤية للكشف المبكر عن الأعراض النفسية الاجتماعية فى التشخيص المبكر لهذه المشاكل وخاصة فيما يتعلق بالإدمان (الحشيش-بانجو- كوكايين) بين أطفال المؤسسات الاجتماعية.

Childhood Studies
دراسات الطفولة