

Psychiatric and Emotional Disorders in a Sample of Egyptian Orphanage Resident Children

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This study aimed to investigate some psychiatric and emotional problems in an orphanage in Cairo. 74 Egyptian orphanage resident children were studied, age ranged between 9 - 12 years. They were equally distributed as regards gender. School children were matched as a control group for age, sex, and educational level. The sample and the control group were subjected to phobia scale for children, Children's Depression Inventory (C.D.I.), and psychiatric diagnosis using DSM IV.

The results revealed that the orphans scored significantly higher than the control group in phobic scale. Orphans scored higher in CDI but without statistically significant difference from the control group.

The most prevalent diagnosis in the whole sample was enuresis followed by conduct disorder, separation anxiety disorder, and sleep disorder.

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INTRODUCTION

Illegitimate children are likely to be parentally deprived, because they are brought into the world without proper fathers. They arouse our interest because of these circumstances, for they appear as the helpless victims of a powerful social and familial convection (Laslett 1977). Permanent separation of young children from both parents at an early age exposes them to increase risk for major psychiatric illnesses in later life. Chapin (1915), he also emphasized that the unit of civilization is the family which offers the healthiest environment. The most susceptible member of the family to all external condition is the infant. The best conditions for the infant require a home and a mother. Children who cope better with stress appear to have come from families where parental roles are clearly defined, where parents display concern for their children's edu-

cation and where they accord their children greater self direction in everyday tasks (Gibson 1989).

Orphanages recently have experienced an upsurge of interest as an alternative to the current bad system of foster care and to the priority we give to preserving the biological family unit, no matter how abusive, inadequate, partial, or otherwise dysfunctional that unit may be (Wiener 1998). In Egypt, the recent years have seen an increase of interest in building orphanages as a reflection of a religious attitude in caring over orphans. (El-Ray 1999). Orphan concerns included feeling different from other children, stress, stigmatization, exploitation, schooling, lack of visits and neglect of support responsibilities by relatives (Foster and Makufa 1997).

Infants and young children placed in orphanages showed progressive developmental deterioration, by the second year of life, most institutionalized children functioned in the retarded range on standard tests. These impairments result from a lack of sensory and social stimu-

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lation, with long hours spent supine in cribs without toys or interpersonal contact (Tizard and Joseph 1970, and Juffer et al. 1997) In the short term, orphanage puts young children at increased risk of serious infections, and delayed language development. In the long term, institutionalization in early childhood increases the likelihood that impoverished children will grow into psychiatric ally impaired and economically unproductive adults (Frank et al. 1996).

The relatively high incidence of nocturnal enuresis among the orphans relative to younger children in western industrialized countries, may be related to their grief or anxiety. The more aggressive behavior of orphans may have been an expression of their anger or depression (Wolff et al. 1995) Enuresis was associated with increased risk for learning disability, impaired intellectual functioning, and impaired school achievement in children (Biederman et al. 1995).

Extended institutional care is always harmful and should therefore be avoided if any other options are available (Wolff and, Fesseha 1998) Extended family networks are the primary resource for orphans, though some relatives exploit orphans or fail to fulfill their responsibilities. Interventions are suggested which support community coping mechanisms by strengthening the capacities of families to care for orphans (Foster, and Makufa 1997).

Orphans who lived in a setting where the entire staff participated in decisions affecting the children, and where the children were encouraged to become self-reliant through personal interactions with staff members, showed significantly fewer behavioral symptoms of emotional distress than orphans who lived in a setting where the director made decisions, and daily routines were deter-

mined by explicit rules and schedules (Wolff and Fesseha 1998).

Orphanages has been replaced by foster care that represented a substitute family giving temporary but stable and caring setting before adoption or return to the family. This is applied to children or youth who have lost parents or have been removed from their homes because of abandonment, neglect, abuse, or parental inadequacy (El-Ray 1999) Fostered children are apt to be nutritionally disadvantaged and have reduced access to modern medicine when they are sick (Bledsoe et al. 1988) They also suffer a substantial number of social or emotional problems. (Verhulst and Versluis-den Bieman 1995, Versluis-den Bieman and Verhulst 1995).

Adopted children with genetic risk for antisocial behavior receiving negative parenting are more liable to externalizing behavior (delinquency, aggression, and inattention) and to internalizing behavior (depression, anxiety, withdrawal, and somatic problems) (O'Connor et al. 1998) Adopted children are more likely to develop conduct disorders, problems with drug abuse, and antisocial personality traits. It is unclear whether these problems result from the process of adoption or whether parents who give up children for adoption are more likely to pass along a genetic predisposition for these behaviors (Eley, et al. 1998, Kaplan and Sadock 1998, and Plomin et al. 1998).

In fact, in Egypt orphanage harbors either true orphans or foundling abandoned by mothers after illegitimate pregnancies (EL-Ray 1999) Assessment of these problems is very important. Psychiatric, emotional, behavioral, and cognitive abnormalities are expected among orphans. This will put sincere effort to help these poor children.

Aim of the work

1) To study the psychiatric disorders among some Egyptian orphanage resident children.

2) To study some of the depressive and anxiety related disorders among them.

SUBJECT AND METHODS

The sample 74 Egyptian orphanage - resident children were studied. They were equally distributed as regards gender. Age ranged from 9 -12 years.

The orphanage is well equipped located in Maadi, one of the prestigious areas in Cairo. It is supported financially by the Ministry of Social Affairs and founded by wealthy individuals. The orphanage is directed by volunteers who worked hard to give their best care to manage the orphans' educational, emotional, physical and to a lesser extent the psychological needs.

The orphans are accommodated till the age of marriage which is supported by the committee. If marriage does not happen they are allowed to spend their whole life in the orphanage. They are allowed to enter one of the governorate schools and to complete their education at the university. If the process of education is not completed for any reason, the orphans are allowed to learn any manual skills.

Control group 74 school children were matched for age, sex and educational level.

The aim of the study was explained to the children (the orphans and the control group) and their right to choose whether to participate or not was clearly emphasized.

The orphans and the control group were subjected to the following.

1) Diagnosis using DSM-IV (1994), to detect any psychiatric disorder, by interview

2) Phobia scale for children. (EL-Taieb 1988).

A 20 item scale to be answered by yes or no. A score > 9 is considered high (phobic) To analyze the data collected further, we subgroup the questions according to the phobia they probed. As a result we obtained the following phobias:

Darkness: 7, 8, 9, 10, 12, 15 and 20

Animals : 14, 16, 17 and 19

Claustrophobia : 1, 3 and 4

Heights : 5, and 6

Social : 11 and 13

Fear of disease : 2

Fear of insects : 13

(3) The Children's Depression Inventory (CDI) (Gharieb, 1988).

A 27 item scale each item consists of three statements and the child chooses and ticks the one that best describes his/her state during the past two weeks. According to severity of symptom, the statements are scored from 0 to 2. Thus the total score varies from 0 to 54. Half the items are written such that the first statement represents the severest form of the symptom while the other half represents the opposite. Cut off scores provided by the scale were used. They differed according to age and gender (Gharieb, 1988)

Statistical Analysis

The statistical analysis was done using an IBM compatible computer and statistical for MS Windows 95 statistical package. Statistical analysis was done according to Ingelfinger et al. (1994), and Knapp and Miller (1992) Descriptive statistics was presented in frequency tables means, standard deviations and

range whenever appropriate. Analytical tests used included unpaired student t test (two sided) for comparing means of two groups. Significance level of 0.05 and 0.01 was used throughout all statistical tests within this study. Tabulation was also done according to Knapp and Miller (1992).

RESULTS

Characteristics of the sample:

74 orphans were equally distributed as regards sex. Age range was from 9 - 12 years (mean 10.6 1.35)

74 school children were equally distributed as regards sex. Age range was from 9 - 12 years (mean 10.3 1.12)

Table I showed that orphans had significantly higher percentage of phobias than the control group, 45.9 % and 27.1% respectively and $P = 0.02$.

Table II showed that orphans had higher mean of score on phobia subscale than the control group 11.72 and 8.13 respectively and $P = 0.00001$.

They also differed significantly on scores of fear of darkness, animals closed places. (Claustrophobia), and $p = 0.00001$.

Social phobia and fear of heights were also statistically significant with $p = 0.00001$ and 0.005 respectively.

Table III showed that the percentage of orphans was a bit higher than the con-

trol group on the CDI, 21.6% and 18.9% respectively but without significant statistical difference $p = 0.89$.

Table IV showed means of scores of CDI. The total mean of scores of the orphans and the control group was 15.44 and 14.07 respectively with $P = 0.49$. There were no marked difference among the six domains of the CDI (mood, self image, relations, school, somatic and suicide).

The significant differences between the two groups were in the area of sadness, loneliness, problems with homework and sleep, they all had $P = 0.01$.

Table V showed the percentage of psychiatric diagnoses among the orphans and the control groups. Enuresis (22.9%) of the orphans was the most common diagnosis on axis I compared to (6.7%) of the control group.

Mental retardation was the most common diagnosis on axis II. It was (12.1%) among the orphans and (2.4%) of the control group. Comparing between the orphans and the control group, there were separation anxiety disorder (14.8%) and (4.1%) sleep disorders (14.8%) and (6.7%), academic disorder (13.5%) and (10.8%), dysthymic disorder (12.1%) and (4.1%), attention deficit hyperactivity disorder (9.4%) and (8.1%) respectively.

While the following were present in considerable percentages in orphans and the control group, conduct disorder was (16.2%) and (8.1%), identity problem

Table 1
Shows Number and Percentage of Phobia (Score > 90) among Orphans and School Children (Control Group)

	Phobic		Non Phobic		Total	
	Number	%	Number	%	Number	%
Orphans	34	45.9	40	54.1	74	100
Control group	20	27.1	54	72.9	74	100

$$\chi^2 14.8359 \quad P = 0.02^*$$

Table 2
Show Mean of Score Obtained on Phobia Scale and its Subscales

Scale	Orphans		Control Group		t	P
	Mean	St. dev.	Mean	St. dev.		
Total phobia	11.72	3.2	8.13	4.32	4.99	0.0001*
Darkness	4.03	1.56	0.47	0.28	57.39	0.00001*
Animals	2.27	1.25	0.41	0.31	33.27	0.00001*
Claustrophobia	1.51	0.98	0.32	0.31	24.44	0.00001*
Social	0.49	0.69	0.16	0.28	8.29	0.0001*
Height	1.31	0.72	0.58	0.40	13.77	0.005*
Disease	0.77	0.62	0.67	0.53	7.36	0.36
Insects	0.31	0.29	0.41	0.32	7.32	0.49

* Highly significant

Table 3
Shows Number and Percentage of Depression among Orphans and School Children on CDI

	Depressed		Non Depressed		Total	
	Number	%	Number	%	Number	%
Orphans	21	28.4	53	71.6	74	100
Control group	18	24.3	56	75.7	74	100

$\chi^2 0.8182$ $P = 0.89^*$

Table 4
Shows Distribution of Mean of Scores of Depression on CDI among Orphans and Control Group.

	Orphans		Control Group		t	P
	Mean	St. dev.	Mean	St. dev.		
Total Depression	15.44	6.58	14.07	7.52	6.68	0.49
Mood						
Sadness	1.49	0.81	0.62	0.52	18.22	0.01*
Irritability	0.49	0.32	0.69	0.42	9.92	0.91
Crying	0.94	0.65	0.82	0.71	8.71	0.43
Disinterest	0.72	0.51	0.94	0.64	6.92	0.58
Pessimism	0.82	0.62	0.71	0.58	9.64	0.22
Anticipation	0.54	0.49	0.82	0.41	7.42	0.84
Self Image						
Being Bad	0.92	0.72	0.72	0.45	9.21	0.64
Inadequacy	0.58	0.43	0.84	0.62	8.71	0.92
Self Blame	0.74	0.62	0.92	0.81	4.26	0.94
Self Hate	1.01	0.81	0.91	0.55	17.72	0.72
Indecisiveness	0.56	0.44	0.64	0.41	8.41	0.56
Inferiority	1.21	0.82	0.18	0.62	16.69	0.67
Looks	0.91	0.71	0.92	0.41	14.29	0.86
Relations						
Socialization	0.49	0.39	0.74	0.52	10.42	0.93
Loneliness	1.62	0.64	0.58	0.41	16.82	0.01*
No Friends	0.92	0.82	0.81	0.62	9.22	0.42
Not Loved	0.51	0.41	0.62	0.41	8.61	0.86
Disobedience	0.46	0.32	0.84	0.62	9.72	0.43
Fighting	0.86	0.74	0.58	0.39	10.23	0.81
School						
No Enjoyment	0.67	0.48	0.52	0.43	9.71	0.72
Problems with Homework	1.62	0.93	0.69	0.52	14.62	0.01*
Academic Deterioration	0.89	0.64	0.94	0.71	11.66	0.94
Somatic						
Sleep	1.51	0.82	0.64	0.31	8.68	0.01*
Appetite	0.68	0.43	0.74	0.62	6.21	0.98
Aches	0.92	0.87	0.81	0.59	7.31	0.82
Fatigue	0.74	0.49	0.47	0.41	7.91	0.71
Suicide						
Want to	1.21	0.71	0.92	0.68	5.26	0.81

* = Statistically Significant

Table 5
Shows Psychiatric Diagnoses among the Orphans and the Control Group, According to DSM IV

Diagnoses	Orphan		Control	
	Number	%	Number	%
Axis I				
Enuresis	17	22.9	5	6.7
Separation Anxiety Disorder	11	14.8	3	4.1
Dysthymic Disorder	9	12.1	3	4.1
Academic Problems	10	13.5	8	10.8
Sleep Disorders	11	14.8	5	6.7
Attention Deficit	7	9.4	6	8.1
Hyperactivity Disorder				
Oppositional Defiant Disorder	10	13.5	4	5.4
Conduct Disorder	12	16.2	6	8.1
Indemnity Problem	8	10.8	5	6.7
Axis II				
Mental Retardation	9	12.1	2	2.7

(10.8%) and (6.7%) while oppositional defiant (13.5%) and (5.4%), respectively.

DISCUSSION

Recently, there has been an increase in the number of orphanages and much care has been given by the Ministry of Social Affairs as well as funds by the people to these orphanage. The orphans live a difficult life in these orphanages under social and cultural circumstances that have a negative effect on their lives.

This work aims to study the effect of orphanages on the emotional and psychiatric status of the orphans. Discussion of the important findings of the phobia scale, CDI and different psychiatric diagnoses will take place.

One of the important results of our study was that the orphans were significantly more phobia than the school children. They represented (45.9%) and (27.1%) respectively.

This could be explained that being deprived from maternal warmth and paternal care make the orphans liable to different types of anxieties.

El-Ray (1999), found that (5.5%) of orphans suffered from specific phobias. She explained that the condition of orphans without family living in an institution exhibit all types of fear and pressure.

The difference between our result, and EL-Ray (1999), result (45.9%) and (5.5%) respectively, could be related to methodological differences that our study used a scale to diagnose the phobia, while EL-Ray (1999), used the DSM IV criteria for diagnosis, which depends on specific criteria rather than a questionnaire.

Moussa et al. (1999), found that (38.9%) of school children are phobia compared to our school children (control group) (27.1%) This could be explained by the large sample (838 students) taken by Moussa et al. (1999), with wider age range from 8-13 years, and the field of

study was both public and private schools in Greater Cairo representing low and high socio-economic classes.

Orphans differ significantly in different types of phobias. Orphans expressed more fear from darkness, animals, closed places, high places, and from people than did the school children.

Marks (1987) firmly believes that the young have fears that rise and fall in a predictable sequence at particular phases of development. This ontogenetic parade depends on genes interacting with an environment.

It seems that difficulty to belong to others and the role confusion expressed by the orphans are expressed by fears towards darkness, animals, and people. Phobias are also exaggerated in orphans who spend their nights lonely in beds in large wards without emotional care apart from few number of care givers who have their own problems.

On the contrary, Wolff et al. (1995), found that refugee children were afraid of animals or the dark, whereas the orphans sometimes organized excursions into the hills to hunt for snakes and often ran in the dark.

The other important result of our study is that (21%) of the orphans scored highly on CDI compared to (18.9%) of the school children. Although the difference was not statistically significant, it is still considered a high percentage.

Kovacs et al. (1984), found that (14%) of 9-15 year old child psychiatric out-patient were depressed. Rutter and Hersov (1985), found that misery and unhappiness represented (1.4%) of 10-11 year old children, increasing to approximately (4%) among 14-15 years old. Eley et al. (1998), accepted that (10-20%) of children aged 11 years are related as feeling miserable or depressed.

It looks that orphans suffering loneliness, are capable of experiencing depression and also they can report it accurately. Orphans who experience lack of supervision and poverty of cognitive stimulation, even if they live in prestigious orphanages could be the origin of the emotional and depressive symptoms.

Orphans experience lack of visits and neglect of support responsibilities by relatives showed progressive developmental deterioration. (Foster and Makufa 1997) These impairments result from a lack of sensory and social stimulation, with long hours spent without toys or interpersonal contact. (Juffer et al 1997).

Orphans differed significantly from the school children in sadness, loneliness, problems with homework and sleep. It seems that sadness and loneliness are reflected significantly in the school and somatic domains.

School represents an important sphere in children's life and it is considered, a challenge and an obligatory token for growing up. Kashani and McNaul, (1997), stated that poor school performance, a change in grades or academic failure may be important markers of adolescent depression related to impaired concentration, fatigue, withdrawal and chronic absenteeism.

Psychiatric Diagnosis of the Whole Sample.

It is noticed from the results that the percentage of different diagnoses among the orphans are higher than the school children. It could be explained, that living with parents could give some sort of defenses against everyday problems and mental illnesses.

The most prevalent diagnosis among orphans was enuresis (22.9%) compared to (6.7%) of the school children.

El-Ray (1999), found that (41.1%)

of orphans where diagnosed as enuretic. Depression, inability to resolve or contain high levels of anxiety, disturbance of home atmosphere and stressful life events are more frequently associated with enuretic children in orphanages (Wolff et al. 1995, El-Ray 1999).

The behavioral problems can be seen in many diagnoses. Conduct disorder in our study represented (16.2%) of the sample. Attention deficit hyperactivity disorder (9.4%) and oppositional defiant disorder (13.5%) El-Ray (1999), found near figures as (12.2%), (10%) and (6.6%) respectively.

It seems that the orphans may feel insecure, in spite of care received from the care-givers. This insecurity is reflected on their expression of aggression towards the society.

It is noticed that children in orphanages demonstrated aggression both passively through enuresis or explicitly as an overt aggressive behavior (El-Ray 1999) Kashani et al. (1991), reported that the use of verbal as well as physical aggression is significantly associated with the diagnosis of conduct disorder, Youssef et al. (1999) explained the disruptive behavior expressed by school children, by poor adult monitoring or being brought up by single parent.

It is still confusing to tell whether the aggressive behavior is due to genetic predisposition or due to environmental influence. O' Connor et al. (1998) agreed that adopted children with genetic risk for antisocial behavior receiving negative parenting are more liable to-externalizing behavior (delinquency, aggression).

This high difference goes with high scores obtained by phobia scale and CDI, and these results could be explained by the poor emotional environment in the orphanage.

Academic problems, identity problems and sleep disorders, are represented by (13.5%), (10.8%) and (14.8%) respectively among the orphans, compared to (10.8%), (6.7%) and (6.7%) respectively among school children.

It looks that the anxiety and depression experienced by the orphans are reflected on their educational career, identity and sleep habits. Although orphanage provides them with educational support and a financial support for the marriage, still these problems exist.

On Axis II, mental retardation, represented (12.1%) of the sample compared to (2.7%) of the control group. This could be due to the effect of poor environment in the orphanage. Frank et al. (1996), stated that the orphanage delays the young children language development.

El-Ray (1999), found that (24.4%) of orphans were mentally retarded. She attributed this to the result of sexual abuse to mentally retarded, or border line intelligent mother, or due to effects of the trials to get rid of pregnancy or bad conditions of pregnancy and delivery or may be due to under-nutrition.

If social and emotional care is provided, orphans will suffer less emotional or behavioral problems. Foster and Makufa (1997), stated that extended family networks are the primary resource for orphans though some relatives exploit orphans or fail to fulfil their responsibilities. Interventions are suggested which support community coping mechanisms by strengthening the capacities of families to care for orphans.

Recommendations

1) Orphanages are good places to raise the orphans, but continuous follow up is needed.

2) Community share in orphanage di-

rection is needed by providing moral, physical, psychological, and financial support.

3) Considering unchangeable care givers along the upbringing of the orphans is needed to establish long term relations.

4) Psychiatric services for the orphanages must be available for early detection and managing of psychiatric disorders.

5) Longitudinal researches to study the progress of the orphans along the cognitive, behavioral and emotional spheres, are needed.

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Les Dessordres Psychiques et emotionels chez un echantillon d'enfants Egyptiens dans un orphelinat residential

74 orphelins et 74 élèves ont été soumis à lechelle de phobie et de dépression.

Les orphelins avaient plus de phobie et de dépression que leurs contreparties. En plus, ils avaient plus de diagnostic d'énures et de désordre de conduite (selon Le DSM-IV système de diagnostique).

الاضطرابات النفسية في عينة من الأطفال المصريين في دار الأيتام

سعى هذا البحث في دراسة العلاقة بين الإقامة في أحد دور الأيتام وبين الإصابة بالأمراض النفسية. وقد أجرى هذا البحث على ٧٤ طفلاً وطفلة يقيمون في أحد دور الأيتام بالقاهرة. وتتراوح أعمارهم بين التاسعة والثانية عشر، وكان نصفهم من الذكور والنصف الآخر من الإناث، وقد اختيرت عينة ضابطة من أطفال المدارس والمتطابقين معهم في العمر ونوع الجنس ودرجة التعليم.

وقد أجريت على المجموعتين مقابلة نفسية وعدة اختبارات لقياس المخاوف والإكتئاب، وقد تم تشخيص المجموعتين بواسطة دليل التشخيص الأمريكي الرابع. وقد أظهرت الدراسة فروق ذات دلالة احصائية بين المقيمين بالملجأ والعينة الضابطة في مقياس المخاوف. كما سجل أطفال الدار درجات أعلى من العينة الضابطة علي مقياس الإكتئاب، ولكنها كانت بدون دلالة احصائية، وقد وجد أن أكثر التشخيصات تواتراً في هؤلاء الأطفال هي التسبول اللاإرادي بالإضافة إلى الاضطرابات السلوكية قلق الانفصال واضطرابات النوم.