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Behavioural and emotional profile of children in residential care in Greece

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Previous research has shown the harmful effects that out of home care can have on children. Specifically, institutionalized children experience high rates of developmental and psychological problems, and therefore special attention is needed so that a fast intervention can be achieved and further complications can be prevented. This paper focuses on building the psychological and behavioural profile of children living in four residential care units in western Greece, in respect to gender, age and nationality. 153 children (88 children in residential care and 65 children rearing in their families) participated in the study. The children age ranged from 6 to 18 years. Children's behavioural profile was assessed through Child Behaviour Checklist 6–18 (CBCL 6–18) and was afterwards analyzed with respect to variables such as age, gender and nationality. Children in residential care had higher rates of clinical/borderline range symptoms in Internalizing, Externalizing and Total Problems scale than their counterparts rearing at home. Specifically, they were more withdrawn/depressed and tended to indicate more rule-breaking behaviour. Both genders showed vulnerability in Internalizing behaviour scale, but girls presented higher rates than boys in the clinical range in Externalizing behaviour scale (22% vs 12%) and Total Problems scale (24% vs 5%). Finally, adolescents in residential care exhibit more internalizing symptoms in clinical range than younger children (22% vs 0%), whereas children of Greek nationality were more vulnerable than children of other nationalities, especially in externalizing behavioural symptoms (28% vs 6%). Our study suggests that children in residential care are at high risk for developing mental health issues. The finding that children are more withdrawn and depressed underlines the possible difficulties in establishing confident relations with peers and adults and can destruct their orientation towards social reality, exhibit mistrust to other people and cause insecurity for their future. There is a lack of longitudinal studies investigating children who have lived in institutions in Greece. Such studies would possibly reveal protective or aggravating parameters that have a positive or negative impact on the development of those children and the transition to adult life.

Key words: Mental health problems, institutionalized children, Child Behaviour Checklist, residential child care, emotional-behavioural problems, childcare center.

Introduction

Children growing up in out of home care have been consistently reported to present high rates of mental health problems,¹⁻³ reaching almost three times higher levels of psychopathology⁴ than children coming from disadvantaged families (i.e. unemployed parents) and five times more than children in family care. Out of these population institutionalized children appear to be the most vulnerable population^{4,5} presenting up to more than 50% psychiatric disorders.⁶

It is well known that childhood maltreatment is considered a major risk factor for mental health disorders during childhood and adulthood.⁷⁻¹⁰ Unfortunately, children rearing in residential care usually have already been exposed to many adversities including neglect, psychological, physical or sexual violence indicating that mental health problems might be the result of not only institutionalization but an interaction of pre-existing mental health conditions,¹¹ exposure to maltreatment,^{3,12} biological risk and resilience.²

In Greece according to latest report,¹³ there are 85 children institutions nationwide that host 2,825 children from all over the country as well as immigrant children mainly from Albania, Bulgaria, Romania and Nigeria. Only 28 of these institutions are public, while 57 are privately funded by Non-Government Organizations, churches and other associations. The philosophy that underpins these institutions is that children will either return to their biological family after this family is reinforced, be adopted or fostered. Only when none of these conditions are fulfilled, can children remain in the institution until they are at least 18 years old.

Greek family is generally child centered; however, some families cannot respond to this role due to social or financial hardships. Death of a parent or parents with medical conditions, financial hardships and inadequate access to schooling are important factors that could lead a child to institution, yet there is a lack of research regarding the psychological needs of these children.

Evaluations of the school records in public care institutions in Greece showed that children who were hosted there, had significantly more over-

all mental health problems.¹ The overall findings of the survey show that institutionalized children were better adapted and much less withdrawn and passive in the context of the institution than in classroom. Specifically, boys showed poor involvement within classroom, more emotional difficulties, communicational problems and over activity and were more distractible, while girls exhibited emotional difficulties. Furthermore, children living in institutions were found to enjoy less harmonious and trustful relationships with their peers. The interpretation of these behaviours according to the authors may be due to the absence of transactions (interaction) of children with people outside institution, the negative attitude of the school environment towards children who grew up in the institution, lack of individuality imposed by the conditions of the group living in the institution and the negative experiences most children have had prior to their admission to the institution. Nevertheless the duration of stay in a residential unit is the most valuable risk factor mental health issues.¹⁴

The purpose of this study was to address the psychological and behavioural profile of children living in four residential care units in western Greece and to identify whether age, gender and nationality have an impact on their psychosocial profile. Furthermore, to our knowledge, this is one of the few such studies to be carried out in this country.

Material and method

In order to examine the behavioural profiles of the children, the psychologist or the social worker of four residential units in western Greece were requested to fill the Greek Version of the parent form of Child Behaviour Checklist (CBCL), which is meant to be completed either by parents or surrogates. Furthermore, demographic data were provided about study children such as age and nationality. In order to sustain confidentiality and anonymity, index numbers were assigned to each child and data analysis was blinded. Permission to carry out the study was granted by the board of directors of each of the participating residential unit and the University Hospital of Patras Research Ethics Committee.

The Child Behavior Checklist (CBCL 6–18) is a widely used caregiver report form, identifying emotional and behavioural problems in children.¹⁵ The time frame for item responses is the past six months. It consists of 113 items, scored on a three-point Likert scale (0=absent, 1=occurs sometimes, 2=occurs often). Behaviour problem items provide scores for eight clinical syndromes (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behaviour, and Aggressive Behaviour), two broad-band Scale (Internalizing Behaviour Problems, summarizing Withdrawn/Depressed, Somatic Complaints and Anxious/Depressed syndromes and Externalizing Behaviour Problems, summarizing Rule-Breaking Behaviour and Aggressive Behaviour syndromes) and finally a Total Behaviour Problems Scale, which is the sum of the scores of all 8 syndromes. Raw scores of each Scale (i.e., Internalizing Behaviour Problems, Externalizing Behaviour Problems and Total Problems) correspond to T-scores (standardized scores) according to ASEBA Standard depending on age and gender of the subject/participant, with higher raw scores and T-scores reflecting more problematic behaviour.

The current study analyzed raw scores and T-scores for the clinical syndromes scales and the three broader scales. T-scores ≥ 64 on the Internalizing, Externalizing, or Total Problem scale are considered in the clinical range, indicative of deviant behaviour in the range of children referred for professional mental health evaluation for behavioural or emotional problems.¹⁵ The CBCL has been reported to have good internal consistency with syndrome scale ranging from between 0.78 and 0.97.¹⁵

Statistical analysis was performed with respect to three Behaviour Scales: (i) Internalizing (i.e. Withdrawn/Depressed, Somatic Complaints, Anxious/Depressed syndromes), (ii) Externalizing (i.e., Rule-Breaking Behaviour, Aggressive Behaviour syndromes), (iii) Total Problems Scale (all 8 syndromes). Specifically, descriptive analysis in the raw scores was performed in each syndrome, expressed as median value and quartiles (lower and upper), as well as range values (minimum, maximum) for both groups (study and control) and for both genders (boys, girls).

Furthermore, distribution (number and percentage) of the study and control groups within normal, borderline or clinical ranges for Internalizing Behaviour, Externalizing Behaviour and Total Problems Scale was performed.

Finally, two-tailed Mann-Whitney U test for unpaired (raw scores) data was used for comparisons between study and control group (as a whole and with respect to gender). Differences were considered statistically significant if p-values were lower than $p < 0.05$ in Internalizing and Externalizing and Total Problems Scales, as well as in the syndromes Social, Thought and Attention Problems. For each syndrome of the Behaviour Scale, Bonferroni correction was applied to adjust to multiple comparisons (significance level: $\alpha = 0.05/3 = 0.017$ for Internalizing Behaviour syndromes, $\alpha = 0.05/2 = 0.025$ for Externalizing Behaviour syndromes).

The study group was also statistically analyzed for each Behaviour Scale with respect to gender (Boys vs Girls), age (range: 6-11 years-old vs range: 12-18 years-old), and nationality (Greek vs Other), using also the two-tailed Mann-Whitney U test for unpaired (raw scores) data. Differences were considered statistically significant if p-values were lower than $p < 0.05$. For each syndrome of the three Behaviour scales, Bonferroni correction was also applied to adjust to multiple comparisons. All analyses were performed using the IBM SPSS Statistics, version 24.

Results

Table 1 provides demographic characteristics of our sample. The mean age (\pm standard deviation) of the children studied was 15.2 ± 3.0 years, ranging from 6-18 years old. In addition, we included 65 children from the local community, living with their parents, used as controls. The mean age (\pm standard deviation) of the control subjects was 14.7 ± 3.8 years, ranging from 6–18 years old.

Table 2 provides the trends in behaviour profiles (median, quartiles and range) in study group ($n=88$) and control group ($n=65$), as well as corresponding results with respect to gender. P-values obtained from statistical analysis of behaviour (Mann-Whitney U test) of study group vs control group, are also provided in table 2. Specifically, statistically

Table 1. Demographic characteristics of study and control groups (number and percentage).

Age/Nationality	Study Group (n=88)		Control Group (n=65)	
	Boys	Girls	Boys	Girls
6–11/Greek Nationality	6 (7)	4 (5)	18 (28)	20 (31)
6–11/Other Nationality	2 (2)	0 (0)	0 (0)	0 (0)
12–18/Greek Nationality	7 (8)	26 (29)	13 (20)	14 (21)
12–18/Other Nationality	27 (31)	16 (18)	0 (0)	0 (0)
Total	42 (48)	46 (52)	31 (48)	34 (52)

significant differences are obtained in “Internalizing Behaviour” scale, mainly due to statistically significant differences in “Withdrawn/Depressed” syndrome, as well as in “Rule-Breaking Behaviour” syndrome. Results from the statistical analysis of behaviour (Mann-Whitney U test) with respect to gender are also provided in table 2. Specifically, boys of the study group scored significantly higher in “Internalizing Behaviour” and “Withdrawn/Depressed” syndrome, whereas girls of study group scored significantly higher only in “Withdrawn/Depressed” syndrome.

Table 3 shows the trends in behavioural profiles (median, quartiles and range) within study group (n=88) with respect to gender, age and nationality of study group. Although differences were found in median values between boys and girls, statistically significant differences were obtained only in “Attention Problems” syndrome. With respect to age (ranges: 6-11 years-old vs 12–18 years-old), statistically significant differences were produced in “Internalizing Behaviour” scale and “Withdrawn/Depressed” syndrome. Finally, with respect to nationality, statistically significant differences were obtained in “Externalizing Behaviour” and “Total Problems” scale, as well as in “Aggressive Behaviour”, “Social Problems” and “Attention Problems” syndromes.

Distribution of study group within normal, borderline or clinical ranges for Internalizing Behaviour, Externalizing Behaviour and Total Problems scale is presented in table 4. Study children’s behavioural or emotional problems were reported in 19% (11% borderline, 8% clinical) on Internalizing Behaviour scale

(Boys: 19%, Girls: 20%), in 17% (2% borderline, 15% clinical) on Externalizing Behaviour scale (Boys: 12%, Girls: 22%), and in 15% (5% borderline, 10% clinical) on Total Problems scale (Boys: 5%, Girls: 24%). Table 5 provides information on distribution of study group subjects within normal, borderline or clinical ranges regarding age and gender in Internalizing Behaviour, Externalizing Behaviour and Total Problems scale with respect to clinical pathology for study and control groups. High rates of pathology were reported in adolescents of both genders in Internalizing Behaviour scale (boys 24% and girls 22%, respectively). In Total Problems scale 24% of girls, aged 12–18, were reported in borderline / clinical range, vs 3% of boys 12–18 years old.

Finally, table 6 shows the differences within normal, borderline or clinical ranges regarding gender, age and nationality in the study group. Specifically, regarding age the greatest differences were obtained in Externalizing Behaviour (22% in girls vs 12% in boys) and in Total Problems scale (24% in girls vs 5% in boys), respectively. In Internalizing Behaviour scale 19% of boys vs 20% of girls are in the borderline-clinical range. Regarding age, the greatest differences in the clinical pathology were obtained in Internalizing scale. Specifically, 22% of children aged 12–18 vs 0% of children 6–11 years old were reported to be in borderline-clinical range. As for nationality, the greatest differences in the clinical pathology were reported in Externalizing Behaviour scale (28% of Greek children are in borderline-clinical range vs 6% of Other Nationality children) and in Total Problems scale (28% vs 2%, respectively).

Table 3. Results of behaviour (median, lower-upper quartiles and range) of 88 study children with respect to gender, age and nationality, as well as corresponding p-values obtained from statistical analysis (Mann-Whitney U Test). Statistically significant differences are marked in boldface p-values.

Scale/syndromes	Gender			Age			Nationality		
	Boys (n=42)	Girls (n=46)	p	6-11 years (n=12)	12-18 years (n=76)	p	Greek (n=43)	Other (n=45)	p
Internalizing Problems	6.5 (3-10) [1-14]	4 (2-10) [0-21]	0.211	2.5 (1-6) [1-10]	6.5 (3-10) [0-21]	0.030	6 (3-10) [0-21]	6 (2-10) [0-17]	0.737
Withdrawn/Depressed	2.5 (1-4) [0-8]	2 (0-5) [0-9]	0.296	0 (0-2) [0-4]	2 (1-5) [0-9]	0.009	3 (1-5) [0-8]	2 (1-4) [0-9]	0.444
Somatic Complaints	1 (0-2) [0-3]	0 (0-2) [0-7]	0.060	0 (0-2) [0-4]	1 (0-2) [0-7]	0.779	0 (0-2) [0-4]	1 (0-2) [0-7]	0.727
Anxious/Depressed	2 (1-4) [0-9]	2 (1-4) [0-16]	0.196	1.5 (0-2) [0-5]	2 (1-4) [0-16]	0.123	2 (1-4) [0-16]	2 (1-4) [0-9]	0.859
Externalizing Problems	5 (3-8) [0-33]	3 (1-10) [0-41]	0.122	2.5 (1-17) [0-33]	4 (2-8) [0-41]	0.981	6 (2-14) [0-41]	3 (1-7) [0-25]	0.024
Rule-Breaking Behaviour	2 (1-4) [0-12]	1 (0-4) [0-20]	0.215	1 (0-5) [0-12]	2 (0-4) [0-20]	0.695	2 (0-5) [0-20]	2 (0-3) [0-11]	0.252
Aggressive Behaviour	3 (2-6) [0-21]	2 (0-4) [0-25]	0.127	3 (1-12) [0-21]	2 (1-5) [0-25]	0.589	4 (2-9) [0-25]	2 (1-4) [0-14]	0.011
Social Problems	1 (0-3) [0-6]	1 (0-4) [0-11]	0.532	3 (1-4) [0-8]	1 (0-3) [0-11]	0.154	2 (0-5) [0-11]	1 (0-2) [0-8]	0.027
Thought Problems	0 (0-1) [0-4]	0 (0-1) [0-6]	0.863	0 (0-1) [0-4]	0 (0-1) [0-6]	0.563	0 (0-1) [0-6]	0 (0-1) [0-3]	0.559
Attention Problems	1 (0-2) [0-9]	2 (0-6) [0-18]	0.013	1 (0-8) [0-12]	1 (0-3) [0-18]	0.990	2 (1-6) [0-18]	1 (0-2) [0-9]	0.001
Total Problems	15 (10-27) [3-65]	15 (5-38) [1-75]	0.786	12 (6-38) [5-65]	15 (9-29) [1-75]	0.985	19 (10-45) [3-75]	13 (6-26) [1-43]	0.017

Table 4. Results of behaviour (number and percentage) for Internalizing Behaviour, Externalizing Behaviour and Total Problems Scale with respect to clinical pathology for study and control groups (total, boys, girls).

Behaviour	Total					
	Boys			Girls		
	Study (n=88)	Control (n=65)	Study (n=42)	Control (n=31)	Study (n=46)	Control (n=34)
<i>Internalizing Problems</i>						
Normal Range	71 (81)	58 (89)	34 (81)	28 (90)	37 (80)	30 (88)
Borderline Clinical Range	10 (11)	3 (5)	6 (14)	1 (3)	4 (9)	2 (6)
Clinical Range	7 (8)	4 (6)	2 (5)	2 (7)	5 (11)	2 (6)
<i>Externalizing Problems</i>						
Normal Range	73 (83)	62 (95)	37 (88)	30 (97)	36 (78)	32 (94)
Borderline Clinical Range	2 (2)	1 (2)	2 (5)	0 (0)	0 (0)	1 (3)
Clinical Range	13 (15)	2 (3)	3 (7)	1 (3)	10 (22)	1 (3)
<i>Total Problems</i>						
Normal Range	75 (85)	61 (94)	40 (95)	29 (94)	35 (76)	32 (94)
Borderline Clinical Range	4 (5)	3 (5)	1 (3)	2 (6)	3 (7)	1 (3)
Clinical Range	9 (10)	1 (1)	1 (2)	0 (0)	8 (17)	1 (3)

Table 5. Results of behaviour (number and percentage) for Internalizing Behaviour, Externalizing Behaviour and Total Problems Scale with respect to clinical pathology for study and control groups.

Behaviour	Study Group (n=88)					
	Boys 6-11			Girls 12-18		
	Boys 6-11	Girls 6-11	Boys 12-18	Girls 12-18	Boys 6-11	Girls 12-18
<i>Internalizing Problems</i>						
Normal Range	8 (100)	4 (100)	26 (76)	33 (78)	16 (90)	11 (79)
Borderline Clinical Range	0 (0)	0 (0)	6 (18)	4 (10)	1 (5)	1 (7)
Clinical Range	0 (0)	0 (0)	2 (6)	5 (12)	1 (5)	2 (14)
<i>Externalizing Problems</i>						
Normal Range	6 (75)	2 (50)	31 (91)	34 (81)	17 (94)	12 (86)
Borderline Clinical Range	0 (0)	0 (0)	2 (6)	0 (0)	0 (0)	1 (7)
Clinical Range	2 (25)	2 (50)	1 (3)	8 (9)	1 (6)	1 (7)
<i>Total Problems</i>						
Normal Range	7 (87)	3 (75)	33 (97)	32 (76)	16 (89)	13 (93)
Borderline Clinical Range	0 (0)	1 (25)	1 (3)	2 (5)	2 (11)	0 (0)
Clinical Range	1 (13)	0 (0)	0 (0)	8 (19)	0 (0)	1 (7)

Table 6. Results of behaviour (number and percentage) for Internalizing, Externalizing and Total Problems Behaviour Scale with respect to clinical pathology for study group (gender, age, nationality).

Behaviour	Gender		Age			Nationality		
	Boys (n=42)	Girls (n=46)	6-11 years (n=12)	12-18 years (n=76)	Greek (n=43)	Other (n=45)		
Internalizing Problems								
Normal Range	34 (81)	37 (80)	12 (100)	59 (78)	35 (82)	36 (80)		
Borderline Clinical Range	6 (14)	4 (9)	0 (0)	10 (13)	4 (9)	6 (13)		
Clinical Range	2 (5)	5 (11)	0 (0)	7 (9)	4 (9)	3 (7)		
Externalizing Problems								
Normal Range	37 (88)	36 (78)	8 (67)	65 (85)	31 (72)	42 (94)		
Borderline Clinical Range	2 (5)	0 (0)	0 (0)	2 (3)	0 (0)	2 (4)		
Clinical Range	3 (7)	10 (22)	4 (33)	9 (12)	12 (28)	1 (2)		
Total Problems								
Normal Range	40 (95)	35 (76)	10 (84)	65 (85)	31 (72)	44 (98)		
Borderline Clinical Range	1 (3)	3 (7)	1 (8)	3 (4)	3 (7)	1 (2)		
Clinical Range	1 (2)	8 (17)	1 (8)	8 (11)	9 (21)	0 (0)		

Furthermore, a high percentage of Externalizing problems (17% vs 5%) were found in children of the study group comparing to their peers in home rearing, which is congruent with previous research reporting evidence of seven times more likelihood for children in care to have conduct disorders compared with children living with their families.¹⁸ Childhood maltreatment is well known that is responsible for mental health problems in these terms; one possible explanation is that children who grow up at an institution tend to show externalizing symptoms, because this is the form of protection of themselves from the inner emptiness and sense of abandonment.

Regarding gender, both boys and girls living in institutions were reported to experience more Internalizing and Externalizing problems in the clinical/borderline range than their counterparts in home rearing (table 4). Within the study group girls had more symptoms in the clinical range in Externalizing and Total Problems scale. Some researchers suggest that boys have more problems in school performance and adjustment than girls and present more "externalizing" behaviours and disorders (aggressiveness, rule-breaking or acting-out behaviours),^{1,5,19,20} yet other studies report that girls are more at risk.⁶ Our findings arouse our attention in general to children in residential units regardless of gender. Nevertheless, even though a portion of the study population is more vulnerable than their peers at home, the finding that the majority of children in the study group falls in the normal range (81%, 83% and 85% for internalizing, externalizing and total problems, respectively), strongly implies that residential care in Greece is largely effective and of adequate quality.

Regarding age, adolescents were reported to present higher rates of Internalizing problems in the clinical/borderline range (22%), a conclusion which is consistent with previous research,⁶ and it is also evident that the older the child in care the more the psychosocial and academic problems. This finding could be due to the fact that older children already were exposed to many more adverse experiences before admission to the institution than younger children. Moreover, the longer a child lives in an institution, the more prone it is to

develop mental health issues due to the fact that the child is not growing up under what is considered to be a 'normal environment' for the nurturing of a child. It is admissible that children thrive better in 'bad' homes than in institutions. Finally, puberty is an age when many mental health problems can develop. It comes as no surprise that children in residential care develop more symptoms of mental health problems as they grow up, because this is in accordance with the development of mental health problems in general.²¹

Previous research suggests that immigration involves cumulative stress factors for children and youth, caused by leaving friends, community, home and homeland, learning a new language and new cultural norms, and sometimes witnessing their parents' failure in joining a new society,²² but surprisingly, Greek nationality children were found to exhibit more behavioural and psychological disturbances than children of other nationalities. Specifically, they had higher percentages of externalizing problems in clinical/borderline range (28% vs 6%) and also in Total Problems scale (28% vs 2%). One interpretation for this finding is that children of minorities inside an institution tend to exhibit solidarity and bond with each other which helps relieve the psychological pressure. Another interpretation is that Greek children are in residential care mostly because of severe malfunction of their family and having already suffer severe adverse life experiences such as abuse or maltreatment, whereas immigration children are in the institutions mainly for financial difficulties of the family and have regularly contact with their family. Also, it is possible that the personnel asked to fill in the questionnaires tend to underestimate the phenomenology of the behaviour of immigrant children, assuming it is normal for a child of other culture. Further studies should look deeper in this issue examining specific factors that could be protective for immigrant children.

The higher rates of mental health issues among children in care compared to children in family rearing, have led to concern as to whether the care system is the cause of these outcomes. When children become institutionalized, they receive a different type of care than the one received in the typical family environment. Each institution sets different

standards of care, nevertheless a high child to caregiver ratio is common along with inconsistent care giving and standardized procedures rather than a personalized care catered to individual needs and personal traits.²³ Nevertheless according to Rutter²⁴ the higher rates of mental health issues in this population might be a combination of early life adversities, attachment disorders due to experiences in early life before institutionalization and existing genetic risk factors, leading to the conclusion that disadvantageous conditions of institutional rearing are important factors yet they do not completely explain the increased rates of psychopathology in these children. Further investigation is needed on this matter.

It is of paramount importance the development and implementation of interventions, such as monitoring and accountability procedures, improvements in management structure and an increase in child to staff ratio. Crucial also is the need of making caregivers aware of children's rights and mental health issues in order to offer them customized care for specific mental health needs. This way, they can provide the best possible care, prevent further stigmatization of this vulnerable population and finally avoid being burned-out themselves.

At a national level, institutions are often not subject to the State and are therefore not monitored or inspected for adherence to national standards. Improved national oversight mechanisms would help improve quality of care and ensure that the same standards of care are answered by all these institutions.

Our study has several limitations. The size of our sample is one of the limits of this work even though previous studies used samples of comparable size in residential units. Furthermore, it would be useful to have a full medical and personal history record as these children might have experienced greater levels of adversity than children rearing in families, such maltreatment or violence and our results are attributed to other parameters beside institutionalization. Beside the aforementioned limitations, this study is important for the welfare care because this is the first study addressing mental and behavioural profile of this population recently in Greece.

Διερεύνηση του συμπεριφορικού και συναισθηματικού προφίλ των παιδιών που διαβιούν σε Κέντρα Παιδικής Προστασίας στην Ελλάδα

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Η βιβλιογραφία έχει ήδη αναδείξει τις βλαβερές επιπτώσεις στην ψυχοκοινωνική ανάπτυξη των παιδιών που μεγαλώνουν σε ιδρυματικές δομές. Αυτά τα παιδιά επιπρόσθετα από τις δυσκολίες της διαβίωσης στο ίδρυμα, έχουν πιθανότητα αντιμετωπίσει ήδη πολλαπλές αντίξοες συνθήκες, όπως πρώιμους αποχωρισμούς, παραμέληση, κακοποίηση, συγκρούσεις των γονέων τους, διάλυση της οικογένειας κλπ, με αποτέλεσμα να κινδυνεύει η ομαλή ψυχοκοινωνική τους ανάπτυξη. Η μελέτη επικεντρώνεται στη δημιουργία του ψυχολογικού και συμπεριφορικού προφίλ των παιδιών που ζουν σε 4 κέντρα παιδικής προστασίας στην Ελλάδα, και τη συσχέτιση των πληροφοριών αυτών με το φύλο, την ηλικία και την εθνικότητα. Στη μελέτη συμμετείχαν 153 παιδιά (88 παιδιά που διαβιούσαν σε κέντρα παιδικής προστασίας και 65 παιδιά που μεγάλωναν εντός της οικογένειας). Η ηλικία των παιδιών κυμαινόταν από 6 έως 18 ετών. Το προφίλ συμπεριφοράς των παιδιών αξιολογήθηκε μέσω του ερωτηματολογίου Child Behaviour Checklist 6-18 (CBCL 6-18), το οποίο συμπληρώθηκε από τους ψυχολόγους ή κοινωνικούς λειτουργούς των κέντρων. Τα αποτελέσματα ανέδειξαν ότι τα παιδιά που μεγαλώνουν στα κέντρα παιδικής προστασίας παρουσιάζουν μεγαλύτερα ποσοστά κλινικών και υποκλινικών συμπτωμάτων σε όλες τις κλίμακες, με προεξάρχοντα τα συμπτώματα απόσυρσης/κατάθλιψης, ενώ η διαφορά αυτή απαντάται και στα δυο φύλα ως προς τα παιδιά αντίστοιχου φύλου της ομάδας ελέγχου. Στην ομάδα των παιδιών που μεγαλώνουν στις δομές τα κορίτσια φάνηκε να αποτελούν την πιο ευάλωτη ομάδα με μεγαλύτερα ποσοστά κλινικών συμπτωμάτων, ωστόσο και τα δυο φύλα παρουσιάζουν υψηλότερα ποσοστά από κλινικά/υποκλινικά συμπτώματα σε σχέση με τα αντίστοιχα παιδιά που ζουν εντός οικογένειας. Ως προς την ηλικία οι έφηβοι (12–18) παρουσιάζουν περισσότερα εσωτερικευμένα κλινικά συμπτώματα από ότι τα μικρότερα παιδιά (6–11), ενώ τα παιδιά ελληνικής ιθαγένειας αναφέρθηκαν να αντιμετωπίζουν υψηλότερα ποσοστά στην κλίμακα Εξωτερίκευσης και στο συνολικό δείκτη προβλημάτων σε σχέση με τα παιδιά άλλης ιθαγένειας. Η μελέτη μας υποδηλώνει ότι τα παιδιά που βρίσκονται σε ιδρυματική φροντίδα διατρέχουν υψηλό κίνδυνο εμφάνισης ψυχοκοινωνικών προβλημάτων. Τα ευρήματα της μελέτης υπογραμμίζουν τις πιθανές δυσκολίες στη δημιουργία εμπιστοσύνης σχέσεων, οι οποίες μπορεί να υπονομεύσουν αργότερα τον προσανατολισμό τους προς την κοινωνική πραγματικότητα προκαλώντας ανασφάλεια για το μέλλον τους. Στον ελληνικό πληθυσμό υπάρχει έλλειψη διαχρονικών μελετών σε αυτό τον ευαίσθητο πληθυσμό. Τέτοιες μελέτες θα μπορούσαν ενδεχομένως να αποκαλύψουν προστατευτικούς ή επιβαρυντικούς παράγοντες στην ανάπτυξη αυτών των παιδιών, αναδεικνύοντας παράλληλα ευάλωτες υποομάδες σε αυτόν τον πληθυσμό. Η δημιουργία και εφαρμογή σύγχρονου θεσμικού πλαισίου λειτουργίας και εποπτείας των κέντρων παιδικής προστασίας στη χώρα μας κρίνεται ιδιαίτερα σημαντική, όπως και η συνεχιζόμενη εκπαίδευση και υποστήριξη του προσωπικού των κέντρων ώστε τα παιδιά αυτά να οδηγούνται απρόσκοπτα στην ενήλικη ζωή.

Λέξεις ευρητηρίου: Προβλήματα ψυχικής υγείας, ιδρυματοποιημένα παιδιά, Child Behaviour Checklist, ιδρυματική φροντίδα, συναισθηματικά-συμπεριφορικά προβλήματα, κέντρα παιδικής προστασίας.

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