REVIEW ARTICLE

The Overwhelming Sadness of Being an "Orphan" with Parents: Depressive Symptoms Among Adolescents Aging Out of Haiti's Orphanages

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ABSTRACT

Most children living in Haiti's orphanages have at least one living parent and are placed in institutional care due to poverty. Raised separately from their parents, some may not establish family ties. This study examines symptoms of depression among Haitian youth near the time that they aged out of orphanage care (T1) as well as 8 months after leaving the institution (T2). Two hypotheses were tested using participant scores on the Center for Epidemiological Studies Short Depression Scale (CESD-10): (H1) Aging out youth who had contact with a family member would have fewer depressive symptoms at T2 compared to those who had no family contact and (H2) that youth who had contact with a parent would have fewer depressive symptoms at T2 compared with youth who only had contact with non-parental family members or who had no family contact at all. Support for both hypotheses was found, though it was noted that all youths who had no family contact were depressed at T1 as measured by the CESD-10 and continued to be depressed at T2. Implications for policy changes and interventions, particularly those aimed at developing social support, relationships with mentors or surrogate parents, and increasing family contact are presented.

Key words: Adolescents in institutional care, depression, family relationships, mentorship, orphanages, poverty, social support, Transition to adulthood

The exact number of children residing in Haitian orphanages is unknown. However, few of the children residing in out-of-home care are truly orphans. Over the past several decades, as religious missionary activity in the country has increased, the urban population has grown, and the Haitian economy has faltered, orphanages have increasingly become an alternative housing arrangement for families that cannot afford to feed, school, or clothe their children.[1-4] Because orphanage residents live separately from the protective influence and oversight of their biological families, these children are particularly vulnerable to negative outcomes, including abuse, school failure, and mental health problems such as anxiety and depression.[5-8]

Independent of their living situation, Haitian youth already contend with multiple vulnerabilities that increase the risk of developing depressive symptoms. These vulnerabilities include collective and interpersonal trauma including frequent natural disasters.[9-14] Lack of basic resources, exposure to violence, a social service department with weak enforcement powers, and nearly constant sociopolitical instability are also risk factors for Haitian adolescents and young adults.[15-21]

Adolescents aging out of orphanage care were interviewed within 3 months of their departure from the orphanage (T1) and again 8 months later (T2) regarding their experiences, their current circumstances, relationships with family members, access to services, experiences with mental health difficulties, and personal challenges. Basic demographic data on the youth and their situation were also obtained [Table 1]. This study examined the prevalence of depressive symptoms reported by adolescents transitioning to adulthood and sought

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Table 1: Demographics of the study sample

Demographic factors		Male	Female	All participants
Mean age at T2		19.31 years (SD:1.56)	18.97 years (SD:1.44)	19.13 years (SD:1.51)
Years of education completed at T1		6.83 years (SD: 4.24)	7.05 years (SD:4.18)	6.95 years (SD:4.21)
Location of orphanage	Urban area[1]	52.0% (143)	39.7% (123)	45.5% (266)
	Large city[2]	17.1% (47)	19.7% (61)	18.5% (108)
	Medium or small city[3]	12.0% (33)	15.5% (48)	13.8% (81)
	Town or large village[4]	7.6% (21)	12.6% (39)	10.3% (60)
	Rural[5]	11.3% (31)	12.6% (39)	12.0% (70)
Frequency of contact with family members while in the orphanage	No contact	5.8% (16)	3.9% (12)	4.8% (28)
	Saw family (but not parent) at least once a year	22.2% (61)	26.5% (82)	24.4% (143)
	Saw family (but not parent) less than once a year	4.0% (11)	2.6% (8)	3.2% (19)
	Saw family (including parent) at least once a year	34.9% (96)	32.3% (100)	33.5% (196)
	Saw family (including parent) less than once a year	33.1% (91)	34.8% (108)	34.0% (199)
Time in the orphanage before aging out	Less than 4 years	28.0% (77)	26.6% (82)	27.2% (159)
	4–7 years	58.5% (161)	58.7% (182)	58.6% (343)
	More than 7 years	13.5% (37)	14.7% (46)	14.2% (83)

to establish family contact as a risk or protective factor for depression among this population.

BACKGROUND

The period in the lifespan in which a young person transitions from adolescence to young adulthood is marked by vulnerability; youths between the ages of 18 and 24 are at a greater risk for mental health challenges, accidents (particularly those involving risky behaviors), exposure to sexually transmitted infections, sexual assault victimization, and abuse of alcohol and other substances.[22-26] Vulnerability during this time is due to many internal and external factors and can be complicated by one's social environment, access to resources, health, lifestyle, family history, and experiences of systemic oppression.[22,25,27,28] Social workers and other mental health professionals have an obligation to be aware of and respond to the increased risks for poor mental health outcomes during this period. While some risks for psychological problems can be mitigated, not all vulnerabilities are fully understood, particularly for youth from non-dominant cultures, lower income communities, and developing countries.[12,17,19,25]

It is during this period of heightened vulnerability that most of the youth who age out of Haiti's orphanages transition to another living situation. While not all youths develop mental health problems during this period, the risk for young people increases during this time independent of experiences of institutionalization in residential care facilities. This study explored if the risk for depression was impacted by the child's relationships with family members.

Extensive research (primarily from developed countries) has been conducted on children in out-of-home care. Such research has found that the more time a child spends being cared for outside the home, the greater the likelihood that they will exhibit mental health problems during early adulthood.[28-30] Children who are live in institutional care are more likely to exhibit symptoms of mental illness that similar children living in family homes or with foster families. The process of transitioning from institutional care to independence can exacerbate existing symptoms of mental illness and can magnify the negative impacts of these symptoms on the youth's daily life.[27-30]

However, there are variables that can act as protective factors, mitigating risk for mental illness and other poor outcomes in adulthood, such as supportive networks, the quality and quantity of interpersonal relationships, and access to resources to meet basic needs for housing, food, clothing, medical care, education, and transportation.[27-31] Relationships, of all types, are a protective factor for aging out youth: Friendships, relationships with supportive adults including social workers and teachers, relationships with family members, and relationships with parents or other parental figures.[28,31-35]

1 Includes cities of 200,000+ people and those cities located directly adjacent to a city with more than 200,000 inhabitants
2 City of more than 100,000 people but less than 200,000
3 City with at least 20,000 people but less than 100,000 people
4 Town or village with at least 5,000 but less than 20,000 people
5 Village with less than 5000 people or a rural area outside of a village

METHODOLOGY

The study used data collected by the author in cooperation with Haitian social workers over a 2-year period. Originally, this research project sought to examine the protective factor of social support for orphans transitioning into adulthood. However, it was difficult to identify true orphans among the study population. Of 603 youth identified for inclusion in the study, 585 had at least one living parent (more than half of these had two living parents). Of those who were "orphaned with parents," many maintained relationships with family members [Table 1]. Nearly two-thirds had been placed in orphanages in urban areas or large cities (of these more than half had family members residing in rural areas at least a full day's travel away). Nearly, all had been placed in the orphanage due to familial poverty.

Data collection included both qualitative interviews at T1 and T2 as well as quantitative data collection using a survey format. Youth completed the survey on an iPad. They both read and heard each question; written questions were presented in Haitian Creole and French as all Haitians speak Haitian Creole, but some only learn to read and write in French. Interviews were conducted by Haitian social workers and Haitian social work students supervised by the author. Informed consent was obtained from both the youth and the adult who was legally responsible for their care (if the youth was under 18 at the time of the initial interview); all interviews at T2 were with youth who had already reached the age of majority.

In qualitative interviews with orphanage residents both before and after aging out of care, the young people expressed a great deal of anger, anxiety, and sadness about being separated from their parent(s) for extended periods of time. Some youth feared that they were bad, unlovable, or had done something to cause the parent to leave them (many cited specific incidents of illness, misbehavior, or family conflict that they believed led to their placement in the orphanage). Symptoms of depression were frequently mentioned in qualitative interviews [Figure 1]. Both boys and girls reported overwhelming feelings of sadness and/or worthlessness, crying spells, irritability, and somatic symptoms including unexplained headaches, stomach aches, and dizziness.

For the purposes of this paper, the 18 adolescents who are true orphans were excluded from the analysis and analysis focused exclusively on the majority of the youth: The young people with parent(s) who grew up in orphanage care separated from their family. Depression was measured using the CESD-10. This 10-item screener is a short version of the 20-item CESD developed in the 1970s by the United States National Institute of Health researcher Lenore Radloff. It is scored by summing the points for all questions. A score of 10 or higher is considered to demonstrate the symptomology of depression and further evaluation and/or treatment is recommended. The CESD-20 was developed by Radloff in 1977 for the purposes of providing researchers in the field of depression epidemiology with a tool for assessing depression. Before its development, the only depression assessment tools available to researchers were oriented towards use in health care, rather than research, settings. Researchers, however, discovered that many elderly individuals found the questionnaire be confusing and time consuming to fill out.[36] Using item-total correlations, a shorter and simpler version was developed as part of the Established Populations for Epidemiological Studies of the Elderly project. This version of the CES is widely used with vulnerable populations other than just elderly individuals: Immigrants, refugees, people with low literacy, disabled individuals, low-income adults, and people impacted by crime.[37,38]

The CESD-10 contains 10 items. Possible responses fall on a 4-point scale indicating frequency (none – most of the time). Responses are divided into positive mood items (items 5 and 8) and negative mood items (items 1, 2, 3, 4, 6, 7, 9, and 10). Scores on positive items are reversed and final score reflects the sum of total item scores. Higher scores indicate greater number of depressive symptoms. The CES-10 has excellent internal consistency (Cronbach's alpha = 0.86) as well as excellent test-retest reliability (ICC = 0.85). Test-retest reliability for individual items is only poor to adequate (ICC = 0.36–0.68). Two studies, one involving middle-aged participants (n = 40) and a second involving older adults (n = 68), found high levels of specificity and sensitivity. Positive predictor value was 85% in the former group and 35% in the latter.[36] Prior studies of youth and young adults in Haiti using the CES-10 have found the instrument to be internally reliable and correlated to other depression measures.[36-40]

My assumption was that contact with family members, particularly parents, would be associated with fewer depressive symptoms in young adults. Youths were administered the survey in the 3 months before they aged out of orphanage care (T1) and then again within 8 months of leaving the orphanage (T2). While I assumed that depressive symptoms might increase between T1 and T2 for all groups, I hypothesized that (1) youth who had contact with a family member would have fewer depressive symptoms as measured by the CESD-10 score at T2 compared to youth with no family contact and (2) that youth who had contact with a parent would have fewer depressive symptoms as measured by the CESD-10 score at T2 compared with youth who had only contact with non-parental family members or who had no family contact at all.

I began by coding each case based on the frequency of contact with parent(s) and/or other family members before

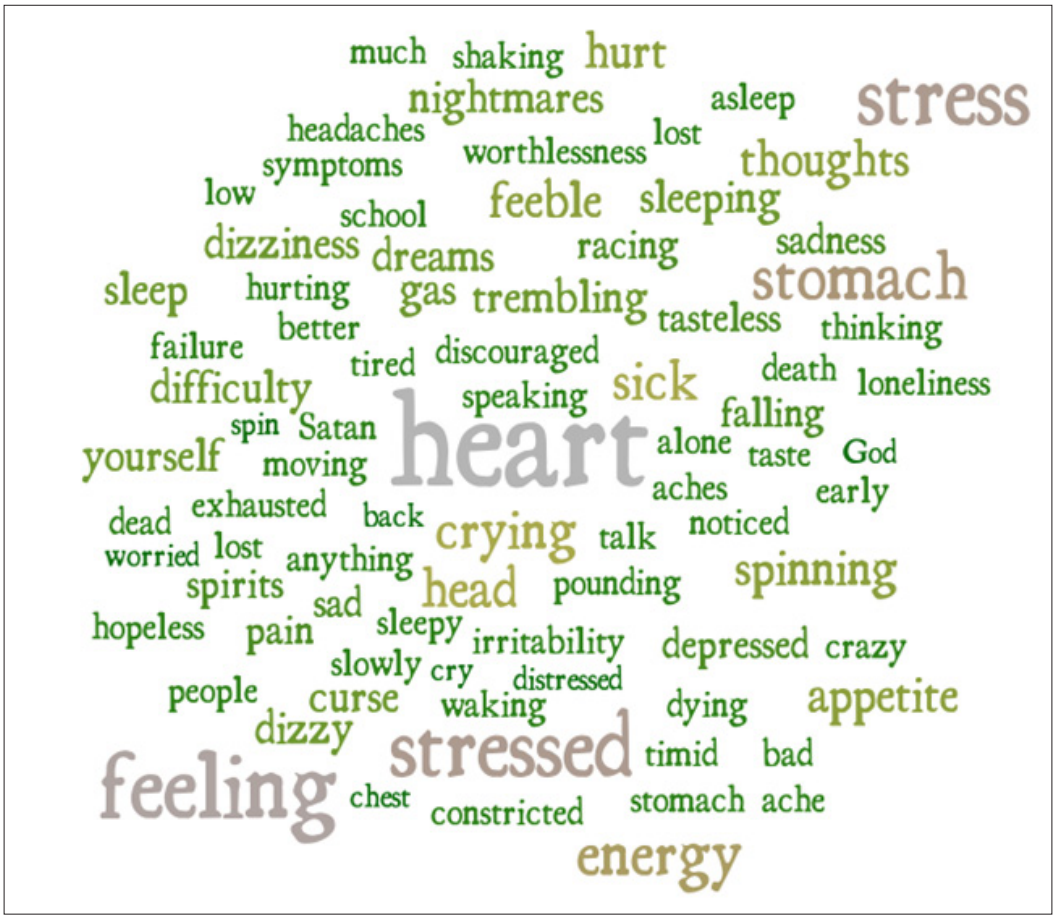

Figure 1: Word cloud of symptoms described by Haitian youth aging out of orphanage care[6]

leaving the orphanage. I also recoded the CESD-10 to create a binomial variable to indicate if the youth met or did not meet the threshold for a diagnosis of depression based on the measure at TI and/or T2. I tested both variables for normality and found that they were normally distributed. I then compared the means for CESD-10 scores in each group at T1 and T2.

FINDINGS

Surprisingly, I found that overall depression scores decreased between T1 and T2 during a time of heightened stress and change [Table 2]. This was unexpected. However, examining the data further sheds some light on the nuances of factors that may impact depression scores after the transition to independence [Table 3]. Youth who had no family contact all scored high enough on the CESD-10 to be classified as depressed at T1 [Figure 2]. These same youth continued to be depressed at T2 and though the mean depression score for this group decreased slightly between T1 (28.57) and T2 (26.29) the standard deviation of the mean increased dramatically from 1.93 at T1 to 4.91 at T2, indicating both a less kurtotic curve after aging out of orphanage care and more variation among youth, with some experiencing alarmingly deeper lows on the depression scale while others stayed the same or improved (slightly).

My first hypothesis was that youth who had contact with a family member would have fewer depressive symptoms as measured by the CESD-10 score at T2 compared to youth with no family contact. It is clear that fewer youth were depressed at T2 than at T1 if they had contact with any family member [Figure 2 and Table 2]. Similarly, H2 was also supported in that contact with parents appeared to be a protective factor for depression at T2 [Figure 2 and Table 2]. To test these findings, I ran a one-way ANOVA on the CESD-10 scores at T1 and T2 by contact type; I found a significant difference between the groups of contact type [Table 4].

6 Respondents were asked: "When you think about this situation, do you have any symptoms of an emotional or physical malady? If so, please describe what you are feeling." The size of the word indicates its relative frequency in transcripts of qualitative interviews. The larger the word, the more frequently it was mentioned by respondents. Words were translated from Haitian Creole into English by the research team. In some cases, the English words were grouped because there was no direct translation from Haitian Creole into English. For instance, several words and phrases indicating a feeling of being annoyed or easily irritated were all translated to the single English word "irritability."

Table 2: Comparison of mean depression scores at T1 and T2 based on contact with family members

Contact type	T1: CESD-10 score				T2: CESD-10 score			
	Mean	SD	Std. error	95% CI	Mean	SD	Std. error	95% CI
No contact with family (*n*=28)	28.57	1.933	0.365	27.82–29.32	26.29	4.913	0.928	24.38–28.19
Saw family (but not parent) at least once a year (*n*=143)	16.40	8.089	0.676	15.06–17.74	10.69	8.416	0.704	9.29–12.08
Saw family (including parent) at least once a year (*n*=196)	16.89	7.248	0.518	15.87–17.91	11.05	8.314	0.594	9.87–12.22
Saw family (but not parent) less than once a year (*n*=19)	18.84	6.898	1.583	15.52–22.17	19.68	6.709	1.539	16.45–22.92
Saw family (including parent) less than once a year (*n*=199)	16.58	7.018	0.498	15.60–17.56	16.80	7.527	0.534	15.75–17.85
Total (*n*=585)	17.29	7.641	0.316	16.67–17.91	13.92	8.865	0.367	13.20–14.64

Table 3: Multiple comparisons of contact types at T2 using a Tukey honest significant difference test

(I) Contact	(J) Contact	Mean difference (I-J)	Std. error	Sig.	95% confidence interval	
					Lower	Upper
No contact with family	Saw family (but not parent) at least once a year	15.600*	1.633	0.000	11.13	20.07
	Saw family (including parent) at least once a year	15.240*	1.596	0.000	10.87	19.61
	Saw family (but not parent) less than once a year	6.602*	2.349	0.041	0.17	13.03
	Saw family (including parent) less than once a year	9.487*	1.595	0.000	5.12	13.85
Saw family (not parent) at least once a year	No contact with family	–15.600*	1.633	0.000	–20.07	11.13
	Saw family (including parent) at least once a year	–0.361	0.8690	0.994	–2.74	2.02
	Saw family (but not parent) less than once a year	–8.999*	1.929	0.000	–14.28	–3.72
	Saw family (including parent) less than once a year	–6.114*	0.866	0.000	–8.48	–3.74
Saw family (including parent) at least once a year	No contact with family	–15.240*	1.596	0.000	–19.61	–10.87
	Saw family (but not parent) at least once a year	0.361	0.869	0.994	–2.02	2.74
	Saw family (but not parent) less than once a year	–8.638*	1.899	0.000	–13.83	–3.44
	Saw family (including parent) less than once a year	–5.753*	0.795	0.000	–7.93	–3.58
Saw family (not parent) less than once a year	No contact with family	–6.602*	2.349	0.041	–13.03	–0.17
	Saw family (but not parent) at least once a year	8.999*	1.929	0.000	3.72	14.28
	Saw family (including parent) at least once a year	8.638*	1.899	0.000	3.44	13.83
	Saw family (including parent) less than once a year	2.885	1.897	0.549	–2.31	8.08
Saw family (including parent) less than once a year	No contact with family	–9.487*	1.595	0.000	–13.85	–5.12
	Saw family (but not parent) at least once a year	6.114*	0.866	0.000	3.74	8.48
	Saw family (including parent) at least once a year	5.753*	0.795	0.000	3.58	7.93
	Saw family (but not parent) less than once a year	–2.885	1.897	0.549	–8.08	2.31

*The mean difference is significant at the 0.05 level

While an ANOVA can tell us if the results are significant overall (they were), it is unable to determine where those differences lie. To further understand the relationship that physical connection to family members and parents has on depression of Haitian youth after aging out of orphanage care, I ran a Tukey's honest significant difference test. This is a *post hoc* test based on the studentized range distribution and it compares all possible pairs of means to determine which specific groups means are different.[41] The results of this test also demonstrate support for both hypotheses 1 and 2 [Table 3]. While the number of depressed youth remained unchanged between T1 and T2 for those who had no family contact (n=28, all of whom were depressed at both T1 and T2), the numbers of depressed youths decreased in both of the groups that had family contact [Figure 2].

Table 4: One-way ANOVA for CESD-10 scores at T1 and T2

	Sum of squares	df	Mean square	F	Sig.
T1: CESD-10 score					
Between groups	3853.383	4	963.346	18.474	.000
Within groups	30244.795	580	52.146		
Total	34098.178	584			
T2: CESD-10 score					
Between groups	9677.485	4	2419.371	38.747	.000
Within groups	36215.205	580	62.440		
Total	45892.691	584			

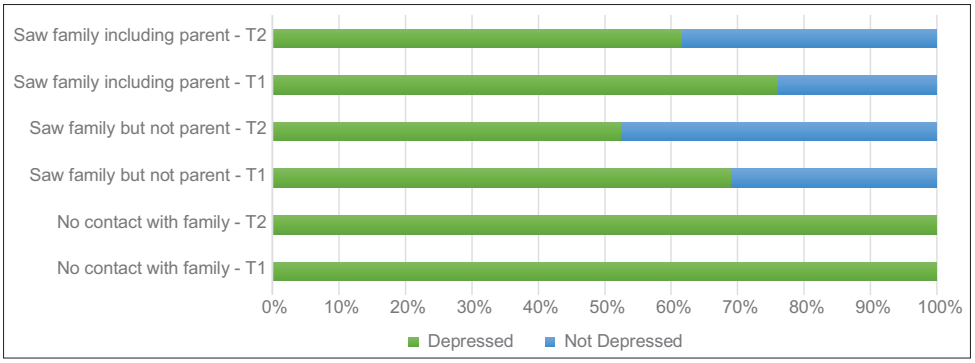

Figure 2: Percentage of depressed participants at T1 and T2 grouped by family contact type

DISCUSSION

Youths are at risk of depression when aging out of orphanage care, though this risk is lowered significantly when family members have a relationship with the youth. Depressive symptoms may either lessen or be less likely to appear if the youth has contact with his/her family of origin before and during the aging out process [Tables 2 and 3]. The only way to prevent Haitian youth from developing depression during the aging out process would be to eliminate the orphanage system entirely; youths who are raised in their own homes by family members would not be subjected to the psychological jolt of abruptly moving from institutional care to independence. Indeed, both living in and aging out of orphanage care appear to be associated with increased risk of depression [Figure 2 and Table 2]. Absent national policy that prevents youngsters from being placed in orphanages in response to familial poverty, organizational policies need to be adopted to reestablish and enhance familial relationships as well as to encourage parents and other relatives to maintain regular contact with the children they have placed in orphanage care. This could be instituted nationally by *L'Institut du Bien-Etre Social et de Recherchesh*e, a division of the Ministry of Social Affairs which is charged with overseeing orphanages and social service agencies throughout Haiti.

While ideally, young people would leave the orphanage already having established a strong relationship with a parental figure, for some youth, that may not be an option. In some cases, this may be because of orphanage policies that discourage family members from visiting or staying in touch with residents. It could also be due to the distance between their family home and the orphanage or because of the biological parents' unwillingness or inability to engage with the youngster in a parental relationship.

In cases where the family is absent, for whatever reason, it is even more important that a surrogate parent/mentor step in to support the youth as they age out and live in the world on their own for the first time.[32] This parental type role could be filled by an aunt, uncle, cousin, grandparents, godparent, or even a family friend or teacher.[32,42] Extensive research on children aging out of care has found that this relationship is key to the youth's ability to succeed and establish independence.[34,43-48]

CONCLUSION

Additional research is needed to establish the precise mechanism by which family and parental relationships with orphanage dwelling youth decrease risk for severe depression symptoms and protect against the development of depression to begin with. Examining the role that parents and surrogate parents/mentors plays in the lives of individual youth during this process appears to be key; it is not clear if the practical support, connection to others through a social network, emotional

support, teaching/coaching aspect of the relationship, or all four aspects, are what helps lessen depressive symptoms in youth as they age out of Haiti's orphanages.

The role of a surrogate parent/mentor should encompass more than simply providing practical instruction (e.g., financial coaching), though this is helpful and necessary for youth as they age out.[17,32] Coyle and Pinkerton (2012) argued that mentors can and should establish an emotional relationship with the youth that facilitates relational connection and helps the young person feel valued and included in society.[45] Supportive adult mentors, whether they are biologically related to the youth or not, provide an essential connection to ongoing networks of social support.[32,34,42] Mentorship and the support that come with it will not necessarily prevent all symptoms of depression, however, social support been associated with a lessening of the frequency and duration of depressive episodes in young adults.[25,27,31] Mentoring may increase the resilience of vulnerable Haitian youth. Based on the findings of this study and others, it may also be that social support reduces the likelihood of developing depressive symptoms during the transition to adulthood.

Declarations

This study was reviewed and authorized by the Institutional Review Boards of the University of North Carolina Wilmington and the State University of New York, College at Brockport. The author declares no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. The author received no financial support for the research, authorship, and/or publication of this article. The author is solely responsible for the content and writing of this report.

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