



# Coping and Mental Health of Children with Special Needs in the Gaza Strip



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## Abstract

**Aim:** The aim of the present study was to evaluate the prevalence of emotional and behavioral problems as estimated by the SDQ and coping strategies in Palestinian children with special needs in the Gaza Strip.

**Method:** The sample consisted of 79 children, parents and teachers. The age ranged from 5-17 years, mean age was 10.76.

**Measures:** Sociodemographic data was collected from parents, parents and teachers completed SDQ, while children completed Kidcope scale.

**Results:** Using SDQ for parents, 38% of children were rated as having psychological morbidity, 22.8% of them were hyperactive, 29.1% had emotional problems, 27.8% had conduct problems, 41.8% had abnormal peer problems, and 6.4% had abnormal prosocial behavior. Using SDQ for teachers, 26.6% of children were rated as having psychological morbidity, 11.4% of them were hyperactive, 2.5% had emotional, 24.1% had conduct problems, 21.5% had abnormal peer problems, and 14.1% had abnormal prosocial behavior. Children used a variety of coping strategies, the most common coping strategies were: wish the problem had never happened (91.2%), try to feel better by spending time with others like family, grown-ups or friends (86.8%), try to sort out the problem (82.4%), try to calm themselves down (82.1%), and try to sort out the problem by doing something or talking to someone about it (77.9%). The results showed that there was significant negative correlation between total coping strategies total SDQ- parents and emotional problems rated by parents.

**Clinical implications:** As a result of this study, service providers should concentrate on increasing services for the child with disability and assisting families to obtain information about available resources. Welfare officers have the responsibility to make sure that families receive appropriate financial assistance, especially caregivers of lower education and who themselves had medical problems. By understanding the circumstances of families caring for a child with disability, service providers can identify areas for improvement in the delivery of disability services. Future research is needed to assess caregivers of younger children and with more severe disability needed support services most.

**Keywords:** Children; Special needs; SDQ; Coping; Gaza strip

## Introduction

Worldwide, an estimated 5% of children (about 93 million) aged 0–14 years have moderate or severe disability, with estimates ranging from 2.9% in high-income countries to 4.4-6.4% in low-income and middle-income countries [1].

Behavioral and emotional disorders include a wide range of behavioral patterns, ranging from externalizing to internalizing behavior disorders as well as combined behaviors that include features of both subtypes. Externalizing behaviors are actions that direct problematic energy outward and may include behaviors such as verbal and physical aggression, hyperactivity, noncompliance, and delinquent acts. In contrast, internalizing behaviors are directed toward the self that include social withdrawal, depression, substance abuse, feeding and eating disorders, anxiety, and schizophrenia [2]. Various studies have

compared the total scores for problems between deaf and hard hearing students and hearing students using the Strengths and Difficulties Questionnaire [SDQ] [3]. Cerebral palsy (CP) is the most common cause of motor impairment in children, frequently resulting in a life-long disability in children. However, few studies have investigated the behavioral and emotional problems of children with CP. In an European multicenter study using a mental health screening instrument, Strengths and Difficulties Questionnaire (SDQ), found one in four children aged 8-12 years with CP had scores indicating mental health problems. They concluded with a need for in depth interviews to learn more about the extent of mental health problems in children with CP [4]. A similar population study from Iceland, where preschool children with CP were included, found a three to four fold increased risk for emotional and behavioral problems for these children compared

to controls [5]. Other studies reported that children with CP suffered more often from emotional problems, peer problems, social withdrawal, attentional problems or dissocial behavior [6]. Matilla et al. [7] reported that 74% of children aged 9-16 years with Asperger's syndrome (AS)/ high-functioning autism (HFA) have co-existing psychiatric disorders.

Horiuchi et al. [8] in the study of 173 patients with Autistic Spectrum Disorder (ASD) (age: 4-16 years) and 173 age- and sex-matched community children (control group). The Strengths and Difficulties Questionnaire scores were significantly higher in children with ASD than controls at all ages. The score of total difficulties was significantly higher in girls with ASD than in boys, while the score in male controls was significantly higher than in female controls.

Weber et al. [9] in a two-center cross-sectional study, caregivers of 121 adults and 88 children were asked to assess behavior of the patients through the parent/caregiver forms of the Child Behavior Checklist (CBCL), the Strengths and Difficulties Questionnaire (SDQ), and the Vineland Adaptive Behavior Scale II (VABS). Questionnaires were returned from 43 adults and 39 children. Results showed that in both groups they found the same frequency of abnormalities in attention problems (32.4 vs. 36.1%) and social interaction problems (32.3 vs. 33.3%) in the CBCL, and peer problems (38.9 vs. 75.7%) in the SDQ. Children show a lower percentage of abnormal prosocial behavior (41.7 vs. 16.2%) and lower abnormal rates of communication (88.2 vs. 61.5) and daily living skills (90.0 vs. 71.8), whereas the level of abnormalities in both groups in these dimensions of VABS notably high.

### Coping Strategies

According to Lazarus and Folkman's coping defined as: 'constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' [10]. Furthermore, Lazarus [11] said coping involves a reaction focused on changing psychological stress within the context of an unfavorable person-environment relationship. Coping with disability has been described from a developmental perspective [12-14], and aspects of coping among children and adolescents with and without congenital physical disabilities have been compared in a few studies [15,16]. However, empirical research on coping strategies among children and adolescents with mobility impairment is scarce, and the relation to demographic data, disability characteristics and well-being is largely unexplored. Hearing loss is one of the disabilities in children, studies exploring coping with the psychosocial experiences of hearing loss have distinguished between engaged copings and disengaged coping [17]. Engaged coping involves taking action to manage the effects of hearing loss, such as using hearing aids or communication strategies. Disengaged coping refers to avoiding addressing hearing loss, such as by denying or ignoring it, or by withdrawing from social situations. The aim of the present study was to evaluate the prevalence of emotional and behavioral problems as estimated by

the SDQ and coping strategies in Palestinian children with special needs in the Gaza Strip.

### Setting and Sample

The population of this study included a total of 100 parents and teachers attending Al Amal City Centre of Ability Development, Khan Younis. The complex of buildings of this center, include-hospital, clinics, EMS services and training, College of Ability Development, Psycho-social Centre, Rehabilitation Centre (parent and baby program; special kindergarten; special training program; special education school, vocational training, physiotherapy, speech therapy, physical education and range of arts-open studio, music, toy library, library, computer centre, etc.), children's club, museum, commercial shops, production workshops, Repair & adaptation of assistive devices workshop, main theatre, small theatre, fitness centre, sports hall, all-purpose hall, restaurant & cafeterias, garden/playground. Al Amal City is a community centre, and the main beneficiaries of the range of programs and services are children, youth and adults living in the Khan Younis governorate, but there are also others from Rafah, mid-area, Gaza and the north. In addition to the number of persons with disabilities and their families and other children and adults from the community receiving benefit from programs and services of Al Amal City, it is also an important training centre for students in different specialties (rehabilitation, occupational therapy, social work, administration, library science, computer, etc) from universities and colleges of the Gaza Strip.

### Measures

#### Sociodemographic characteristic questionnaire

This questionnaire includes sex, age, place of residence, parental information, and family income.

#### Strengths and difficulties questionnaire (parents and teachers) [3]

The SDQ is a brief screening scale for emotional and behavioral problems among young people aged 4-17 years of age [18]. The questionnaire is one of the most commonly used scales in the assessment of children's strengths and difficulties in child psychiatry [19-21]. It consists of 25 items, 14 describe perceived difficulties, 10 perceived strengths and one is neutral ('gets on better with adults than with other children'). Each perceived difficulties item is scored on a 0-2 scale (not true, somewhat true, certainly true). Each perceived strengths item is scored in the reverse manner, i.e. 2: not true, 1: somewhat true, 0: certainly true. There are three versions of this questionnaire, one for parents, teachers, and one for children above 11 years. The 25 SDQ items are divided into scales of Hyperactivity, Emotional Problems, Conduct Problems, Peer Problems and Prosocial Scale (five items per scale). A score is calculated for each scale (range 0-10) and a total difficulties score for the four scales (excluding prosocial behavior, which was considered different from psychological difficulties), i.e. a range of 0-40. The SDQ has been previously used in the Palestinian culture [22,23]. In this study, internal

consistency for parents from using Cronbach's Alpha was high ( $\alpha=0.84$ ); the split half reliability of the scale was ( $\alpha=0.79$ ).

**The kidcope [24]**

This self-report checklist [24] requires the child to think about a specific situation and to assess which of 15 coping strategies they have used. The strategies and items are distraction (e.g. try to forget it; do something else to forget it); social withdrawal (stay on your own; keep quiet about the problem); cognitive restructuring (try to see the good side of things); self-criticism (blame yourself for causing the problem); blaming others (blame someone else for causing the problem); problem solving (try to sort the problem out by thinking of answers or talking to someone about it; try to sort it out by doing something); emotional regulation (shout, scream, get angry; try to calm yourself down); wishful thinking (wish the problem had never happened; wish you could make things different); social support (try to feel better by spending time with others like family-parents, brothers or sister; try to feel better by spending time with friends); resignation (do nothing because the problem could not be solved). The child rates both use and perceived effectiveness of each strategy. The authors conceptually selected the strategies after reviewing the coping literature. The scale has been used with healthy adolescents, pediatric patients and children attending a diabetic camp. The psychometric properties have been reported and indicate moderate to high correlations between Kidcope and the Coping Strategies Inventory and Adolescent Coping Orientation for Problem Experiences (ACOPE) [24]. Reliability, determined by assessing coping strategies across two similar situations found moderate correlations (.56-.72) with test-retest correlation assessed over 3-7 days demonstrating acceptable levels of reliability (correlations .41-.83). In this study, internal consistency for using Cronbach's Alpha was high ( $\alpha=0.78$ ); the split half reliability of the scale was (0.73).

**Study Procedure**

A permission was granted from Amal center Administration. Another letter was send to parents explaining the aim of the study and about their right not to participate with their children in study and ask them to sign the letter and send it back to the center with children if they agree to participate with their children in the study. Data was conducted by 3 trained social workers and community mental health workers with previous experiences in data collection in similar research. Data was collected in September 2009.

**Analysis**

The survey questionnaire was quantitatively analyzed by statistical package for the social sciences (SPSS win, Ver. 20). Frequency distribution was used in statistical analysis. Independent t-test for the sample and One-way.

Analysis of Variance (ANOVA) was used as the main statistical techniques in the study. The t-test was used to determine any statistically significant differences caused by children's gender

and mental health problems, whereas ANOVA was employed to determine any statistically significant differences among parents with regard to their education, place of residence, type of work, number of siblings, and child's age. Pearson correlation test was used to test the correlation between children mental health rated by parents and teachers and coping strategies.

**Results**

**Socio-demographic characteristics of study population**

Overall, of 100 participants recruited, 79 parents and teachers (79%) completed the SDQ. The final sample consisted of 79 children with special needs (36 girls, 43 boys), aged 5 years to 17 years and their parents and teachers, 54.4% were boys and 45.6% were girls. The age ranged from 5-17 years, mean age was 10.76 (SD=2.40).

Children families consisted of large number of children, as 13 (16.7%) had 4 or less children, 35 families (44.9%) had 5-7 children, and 30 families (38.5%) had 8 or more children. Forty-five (60.8%) live in the city, 18 of children (24.3%) live in camps, and 14/9% live in village (Table 1).

**Table 1:** Socio-demographic characteristics of study population (N=79).

Sex	N	%
Male	43	54.4
Female	36	45.6
Age Mean 10.76 (SD = 2.40)		
<b>Place of Residence</b>		
City	45	60.8
Camp	18	24.3
Village	11	14.9
No. of siblings		
Less than 4	13	16.7
5-7 children	35	44.9
More than 8 children	30	38.5
Maternal job		
House wife	77	97.5
Employee	2	2.5
Maternal education (in years) Mean=10.57 (SD=2.57)		
Paternal education (in years) Mean=11.12 (SD=3.98)		
Paternal job		
Unemployed	31	39.2
Simple worker	12	15.2
Employee	32	40.5
Merchant	4	5.1

**Psychological symptoms of children rated by parents using SDQ –parents form**

The most common psychological symptoms rated by parents were: shares readily with other children (treats, toys, pencils etc.) (78.5%), kind to younger children (75.9%), often volunteers to help others (parents, teachers, other children) (70.9%),

considerate of other people's feelings (62.8%), helpful if someone is hurt, upset or feeling ill (60.8%), gets on better with adults than with other children (41.8%), restless, overactive, cannot stay still for long (39.2%), has at least one good friend (39.2%), can stop and thinks things over before acting (38%), many fears, easily scared (38%), easily distracted, concentration wander (30.4%), and often has temper tantrums or hot tempers (25.3%).

**General mental health problems using SDQ by parents**

**Prevalence of general mental health problems using SDQ by parents:** Using SDQ for parents, 38% of children were rated as having psychological morbidity (were considered as having a problem) (cut-off point =17-40), 22.8% of them were hyperactive (7-10), 29.1% had emotional problems (5-10), 27.8% had conduct problems (4-10), 41.8% had abnormal peer problems (4-10), and 6.4% had abnormal prosocial behavior (0-4). Independent t test showed no gender differences in total SDQ-parents. One-way Analysis of Variance (ANOVA) tests showed no significant differences in number of siblings and total SDQ parents (Table 2).

**Table 2:** Prevalence of general mental health problems using SDQ by parents.

Parents-Report	Normal	Borderline	Abnormal
SDQ-psychological morbidity by parents	46.8	15.2	38
Hyperactivity	65.8	11.4	22.8
Emotional problems	59.5	11.4	29.1
Conduct problems	59.5	12.7	27.8
Peer problems	30.4	27.8	41.8
Prosocial behavior	87.2	6.4	6.4

**Psychological symptoms of children rated by teachers:** The most common psychological symptoms rated by parents were: Shares readily with other children (treats, toys, pencils etc.) (68.9%), kind to younger children (54.7%), restless, overactive, cannot stay still for long (44%), often volunteers to help others (parents, teachers, other children) (44%), helpful if someone is hurt, upset or feeling ill (40%), considerate of other people's feelings (30.7%), has at least one good friend (29.3%), often fights with other children or bullies them (21.3%), and can stop and thinks things over before acting (21.3%).

**Prevalence of general mental health problems using SDQ by teachers:** Using SDQ for teachers, 26.6% of children were rated as having psychological morbidity (cut-off point =17-40), 11.4% of them were hyperactive (7-10), 2.5% had emotional problems (5-10), 24.1% had conduct problems (4-10), 21.5% had abnormal peer problems (4-10), and 14.1% had abnormal prosocial behavior (0-4). One-way Analysis of Variance (ANOVA) tests showed no significant differences in number of siblings and

total SDQ teachers (Table 3).

**Table 3:** Prevalence of general mental health problems using SDQ by teachers.

Teachers-Report	Normal	Borderline	Abnormal
SDQ-psychological morbidity by teachers	46.8	26.6	26.6
Hyperactivity	68.4	20.3	11.4
Emotional problems	89.9	7.6	2.5
Conduct problems	60.8	15.2	24.1
Peer problems	57	21.5	21.5
Prosocial behavior	75.6	10.3	14.1

**Coping with trauma and stress in children (Kidcope):** Children used a variety of coping strategies, the most common coping strategies used by children to overcoming the problems and stress were: wish the problem had never happened (91.2%), try to feel better by spending time with others like family, grown-ups or friends (86.8%), try to sort out the problem (82.4%), try to calm themselves down (82.1%), and try to sort out the problem by doing something or talking to someone about it (77.9%). Independent t test showed no gender differences in total coping strategies of children (Table 4).

**Table 4:** Frequency of coping category scores used by children.

	Yes (%)	No (%)
1.Try to forget it	45.8	54.2
2.Do something like watch TV or play a game to forget it	27.8	72.2
3.Stay on your own	73.5	26.5
4.Keep quiet about the problem	39.7	60.3
5.Try to see the good side of things	27.9	72.1
6.Blame yourself for causing the problem	55.9	44.1
7.Blame someone else for causing the problem	29.4	70.6
8.Try to sort out the problem	17.6	82.4
9.Try to sort out the problem by doing something or talking to someone about it	22.1	77.9
10.Shout, scream or get angry	61.8	38.2
11.Try to calm yourself down	17.9	82.1
12.Wish the problem had never happened	8.8	91.2
13.Wish you could make things different	27.9	72.1
14.Try to feel better by spending time with others like family, grown-ups or friends	13.2	86.8
15.Do nothing because the problem couldn't be solved	58.8	41.2

**Relationship between children mental health rated by SDQ-parents and teachers and coping strategies:** Pearson correlation test was used to test the correlation between children mental health rated by parents and teachers and coping strategies.

The results showed that there was significant negative correlation between total coping strategies total SDQ- parents ( $r = -0.27, p = 0.001$ ) and emotional problems rated by parents ( $r = -0.27, p = 0.001$ ) (Table 5).

**Table 5:** Relationship between children mental health rated by SDQ-parents and teachers and coping strategies.

	Total Coping
SDQ- psychological morbidity by parents	-0.27*
Hyperactivity by parents	-0.16
Emotional problems by parents	-0.27*
Conduct problems by parents	-0.21
Peer problems by parents	-0.15
Prosocial behavior by parents	0.2
SDQ- psychological morbidity by teachers	-0.02
Hyperactivity by teachers	0.05
Emotional problems by teachers	-0.04
Conduct problems by teachers	-0.01
Peer problems by teachers	-0.01
Prosocial behavior by teachers	-0.05

**Prediction of coping strategies by mental health problems rated by teachers and parents:** In a linear regression model, mental health problems rated by parents and teachers were entered as an independent variables and total coping strategies

as dependent variable. Psychological morbidity by parents was negatively predicting coping strategies: ( $\beta = -0.28, t(79), p < 0.001$ ),  $R^2 = .07, F(1, 79) = 5.47, p < .01$  (Table 6).

**Table 6:** Linear regression model of mental health of children rated by parents and teachers and total coping strategies.

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	11.21	0.54		20.74	0	10.13	12.29
SDQ- psychological morbidity by parents	-0.09	0.03	-0.28	-2.56	0.01	-0.16	-0.02

**Discussion**

Using SDQ for parents, our study showed that 38% of children were rated as having psychological morbidity, 22.8% of them were hyperactive, 29.1% had emotional problems, 27.8% had conduct problems, 41.8% had abnormal peer problems, and 6.4% had abnormal prosocial behavior. No gender differences in total SDQ-parents. Using SDQ for teachers, 26.6% of children were rated as having psychological morbidity, 11.4% of them were hyperactive, 2.5% had emotional problems, 24.1% had conduct problems, 21.5% had abnormal peer problems, and 14.1% had abnormal prosocial behavior. No significant differences in total SDQ teachers and number of siblings. Similarly in study of mental health problems of children diagnosed with CP in Gaza, showed that prevalence of child behavior problems rated by parents was (37%). While, the prevalence of child behavior problems rated by therapist was (44.7%). There was discrepancy on detection of caseness between parents and therapists. Therapists were detecting child behavior problems in CP children more than the parents. There were no statistical significance differences between boys and girls in total child emotional and behavioral problems

and internalizing problems, however boys scored more than girls in externalizing problems [25]. Our results support previous findings regarding a high prevalence of emotional and behavioral problems in children with CP (46%) [26]. The proportion of children with possible psychopathology in our study is similar to the proportion a study (40%), using similar instruments (a direct interview with Strength and Difficulties Questionnaire (SDQ) [4]. In another study of 374 traumatized children in Gaza Strip. The study showed that 59.9% of children rated themselves as having psychiatric morbidity compared to 61.5% by parents' report, 17.4% reported hyperactivity compared to 23.5% by parents' report, 57.2% reported emotional problems compared to 51.9% by parents' report, 72.7% reported conduct problems compared to 82.1% by parents report, 32.9% reported peer relationships compared to 40.6% by parents' report, and 8% reported social problems compared to 13% by parents' report [27]. Furthermore, Thabet et al. [23] in study of a sample consisted of 391 disable Palestinian children in the Gaza Strip which was selected randomly from the data base of two NGOs working with such group of children. The results showed that children reported mean conduct disorder was 1.33; oppositional disorder was 5;

mean overanxious was 6.75; separation anxiety mean was 6.36; and depression was 7.57. There were statistically significant differences toward boys in depression. According to parents, mean conduct disorder mean was 1.94; mean oppositional disorder was 6.09; mean overanxious was 7.47; separation anxiety mean was 6.48; and mean depression was 9.6. The study showed that mean depression in boys was 10.4 compared to 8.9 in girls. There were statistically significant differences toward boys in depression. Recently in a study a sample of 816 middle school students from both genders, who were randomly selected from different schools in two big cities in Oman, participants' self-ratings were the highest on the emotional symptoms (29.2%) and peer problems (20.2%) subscales, followed by hyperactivity (17.4%) and conduct problems (13.8%). With regards to the borderline range, participants were rated the highest on emotional symptoms (15.1%), peer problems (15.3%) followed by conduct problems (13.1%) and hyperactivity (12.9%), respectively. Almost half of the participants showed some type of emotional and behavioral difficulties as reflected by the difficulty score (32.1% in the clinical range and 20% in the borderline range) [28].

Children used a variety of coping strategies, the most common coping strategies used by children to overcoming the problems and stress were: wish the problem had never happened (91.2%), try to feel better by spending time with others like family, grown-ups or friends (86.8%), try to sort out the problem (82.4%), try to calm themselves down (82.1%), and try to sort out the problem by doing something or talking to someone about it (77.9%). Independent t test showed no gender differences in total coping strategies of children. The results showed that there was significant negative correlation between total coping strategies total SDQ- parents and emotional problems rated by parents. Previous studies of traumatized children in the Gaza Strip showed that Palestinian adolescents mainly cope commonly by developing social support, investing in close friends, and/or engaging in demanding activities. The study showed that adolescents experienced traumatic experiences developed less social support and positively asked more professional support as coping strategies [29,30].

Studies exploring coping with the psychosocial experiences of hearing loss as one of the disabilities in children have distinguished between engaged copings and disengaged coping [17]. Engaged coping involves taking action to manage the effects of hearing loss, such as using hearing aids or communication strategies. Disengaged coping refers to avoiding addressing hearing loss, such as by denying or ignoring it, or by withdrawing from social situations. In another study of children in south of Gaza Strip, Thabet [23] showed that children used a variety of coping strategies. The most common coping strategies used by children were: 71.6% of children said they go along with their parents and rules, 64.1% try to improve themselves (get body in shape, get better grades, etc.), 64.1% of them pray, 59.9% work hard on schoolwork or other school projects, 52.8% do things

with their family. While the least common coping strategies used were: drinking beer, using sedatives (4.6%) and smoking (3.1%).

### Implications

For the time being, service providers should concentrate on increasing services for the child with disability and assisting families to obtain information about available resources. Welfare officers have the responsibility to make sure that families receive appropriate financial assistance, especially caregivers of lower education and who themselves had medical problems. By understanding the circumstances of families caring for a child with disability, service providers can identify areas for improvement in the delivery of disability services. Future research is needed to assess caregivers of younger children and with more severe disability needed support services most. More attention should also be directed at children with learning disability so that their caregivers get the information and coping strategies that they need [31-34].

### Limitations of the Study

The study is restricted by some limitations that hinder the generalization of its findings:

- A. The number of children with disability was relatively low. Therefore, I am still hesitant to generalize the interpretation of this analysis since the number of children with disability in each behavior is small.
- B. The study sample includes parents and teachers of children with different types of disability attending one center for such group and from only one city in Gaza Strip (Khan Younis).
- C. The study uses mainly the questionnaire as a research instrument, whereas other instruments such as interviews and observation reports were not used.
- D. Data were collected using a survey model.

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