Traumatic Experiences Affecting Children in Institutions of Care for Orphans in Kiambu County, Kenya

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Abstract

Childhood emotional trauma can have negative impact on the individual as adults in many ways. The purpose of this study was to ascertain the traumatic experiences endured by children in institutions of care for orphans in Kiambu County, Kenya. The study was carried out in Kiambu County within institutions of care for orphaned and vulnerable children. The target population for this study was all children in 50 registered institutions of care within Kiambu County aged between 11 and 17 years. Data was collected using a structured researcher-administered questionnaire. Descriptive analysis was conducted with the aid of SPSS. The study found that 37.5% had probable PTSD, 21% had moderate PTSD, 19.1% severe PTSD and 18.5% had below threshold PTSD. Results indicated that 24.8% had traumatic experience and depression at a moderate level and 24.2% and 16.6% had it at a mild and moderately severe level. Results also show that majority of participants (76.3%) were diagnosed with panic disorder. Majority of participants (76.3%) were also diagnosed with anxiety disorder while 71.2% were diagnosed with separation anxiety disorder. The level of education of participants, having ever sought treatment for any psychological problem, history of childhood sexual abuse as well as history of traumatic events were significant to PTSD education and history of traumatic events were significant. The level of education was significant for all 3 conditions signifying that the level of education is an important predictor for trauma in children. The study concludes that children in orphan institutions of care have a high prevalence of PTSD and other comorbidities mainly anxiety and depression. Participants in lower primary had significantly higher trauma scores than their upper primary counterparts. This calls for interventions to manage PTSD in this population.

Keywords: Trauma, anxiety, panic, depression, orphans

INTRODUCTION

The American Psychological Association (as cited in Cluver & Gardner, 2006) defines trauma as the emotional response to a terrible event such as violence, natural disasters (calamity), accident, divorce, rape, or being separated from parents. The term represents responses that occur after an experience that is emotionally painful or distressful and which often ends up with lasting mental and physical effects (Jarero, Artigas, & Lena, 2008). Trauma is caused by exposure to actual or threatened death, serious injury, or sexual violence (Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 2013). More specifically, it results from directly experiencing the trauma event(s), witnessing in person the event as it occurred to another person, or from learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event must have been violent or accidental. The other cause of trauma could be through experiencing repeated or extreme exposure to aversive details of the traumatic event, such as first responders collecting human remains and police officer

repeated exposure to details on child abuse (Azami-Aghdash et al., 2015; Denton et al., 2017).

With specific reference to children, bad things, such as home destruction through natural disaster, physical abuse, or death of a parent, may happen in life as they grow up. While majority of the children are able to process and cope, for others such life calamities can have detrimental effects to the extent of getting stuck. Single or repeated experiences can result in extreme feelings of fear and a sense of loss (Edwards, 2009). These make them feel like they have no safety or control over their lives. These feelings may get into their continued physical, emotional, social and or intellectual developments. Most causes of childhood trauma include accidents, bullying and cyber bullying, death of parent or a loved one, emotional abuse or neglect, physical abuse or neglect, sexual abuse, separation from a parent or caregiver, domestic violence, parents with substance abuse or mental illness, stress caused by poverty, sudden or serious medical condition, violence at school/home, and war or terrorism.

According to Adler-Tapia & Settle (2008), childhood emotional trauma can have negative impact on the individual as adults in many ways. First, it can create false self; when one thinks that such created false self will help him/her to be cared for or loved by others. If the childhood trauma was as a result of neglect, sexual abuse or abandonment, the person ends up burying their feelings in order for them to get the love they missed. Second it can lead to victimhood thinking. This is explained by negative self-talk where the individual experiences life from a disempowered perspective and feeling like a victim who has no choices. Third, emotional trauma can occasion passive aggressiveness. Children who grew up in abusive environments and were not allowed expressing anger, they learned how to suppress it and hence express anger in unhealthy ways. Fourth, trauma has also been associated with passivity.

Unprocessed trauma can have long term effects on the quality and length of a person's life; it may interfere with a person's quality and length of life (Edwards, 2009; Cornine, 2013). When children experience trauma, they create an internal map of how the world is as a way of trying to cope. However, if they don't create a new internal map as they grow up, the old ways of interpreting the world may interfere with their ability to function as adult (Adler-Tapia & Settle, 2008). Childhood trauma experienced due to abandonment, may result in one burying anger and fear in the hope that they will not be abandoned again. One is not able to express their opinion and especially where it is different from others (Adler-Tapia & Settle, 2008).

Studies have shown that today trauma and traumatic experiences is a global concern (Kraan, Velthorst, Smit, de Haan, & van der Gaag, 2015; Crespo & Fernández-Lansac, 2016; Kolaitis, 2017; Van der Kolk, 2017). Kolaitis (2017) put the global estimate on the prevalence of the effects of trauma as follows: Psychological 11.1%, physical 10.8%, sexual 22%, witnessed domestic violence to mother 12.5% and substance use in household at 25.6%. Nowadays, with the growing number of countries involved in family, political, economic or tribal-fueled conflict more children have come to suffer the consequences, and subsequently become traumatized. In times of family or societal conflict, children experience increased risk of exposure to violence, physical and sexual abuse, exploitation and emotional neglect, along with an increased risk for death (Skinner et al., 2006). Furthermore, diseases such as HIV/AIDS have caused the deaths of many parents, thereby leaving behind children who do not only suffer the traumatic effects of losing a parent but are also at greater risk of psychological disturbances and poor quality of life (Mutiso, Musyimi, Tele, & Ndetei, 2017). These overwhelming experiences have an impact on the development of children, their attitudes toward society, their relationships with others, and their outlook on life in general.

In Kenya, many traumatic events have been recorded in the recent years whose consequences have been direr among children (Murunga, 2011). It is estimated that nine percent of children have lost their father, four percent have lost their mother and two percent have lost both parents (Mutiso, et al., 2017). Most of these children seek refuge in institutions of care, commonly referred as "children's homes". Unfortunately, Orphans and Vulnerable Children (OVCs) are often left unprotected after the loss of parents, placement in temporary shelters, or loss of contact with caregivers hence exposing them to further trauma (Mutiso, et al., 2017).

Children exposed to traumatic events may have a higher prevalence of post-traumatic stress disorder (PTSD) than adults in the general population (Gabbay, Oatis, Silva, & Hirsch, 2004). For children in residential care, the prevalence of mental illness rates, including PTSD, have been found to consistently exceed established rates for youth within the community (Gearing, et al., 2015; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). A study conducted in South Africa found that children orphaned by AIDS scored above the cut-off for Post-Traumatic Stress Disorder (Cluver & Gardner, 2006) while a study focusing on 354 Congolese orphans revealed that 39% of the orphans had PTSD (Makaya, et al., 2002). This study sought to identify the traumatic experiences children in institutions of care for orphans in Kiambu County, Kenya, have been exposed to.

MATERIALS AND METHODS

A quantitative descriptive approach was used to identify the traumatic experiences children in institutions of care for orphans in Kiambu County, Kenya, have been exposed to. The study was carried out in Kiambu County within institutions of care for orphaned and vulnerable children. Kiambu is a cosmopolitan county which has similar social cultural setting yet the institutions of child care are run and managed differently. The target population for this study was all children in 50 registered institutions of care within Kiambu County aged between 11 and 17 years. A reconnaissance survey showed that out of the 50 institutions 16 were eligible for the study. Quantitative data was collected utilizing a structured questionnaire.

The processing and analysis of quantitative data occurred in stages during stage1, all completed questionnaires were scrutinized at the field by the researcher to ensure completeness of the data, including the unique identifier of the child for ease of follow up should the data suggest emergency interruption. For data entry, a template was created in SPSS version 23. The template defined the name (field name), the type (character or numeric) as well as the length (the maximum number of characters in the field) for each variable, and for numeric variable, the number of decimal places. After creation of the template data was entered into a password protected database. On completion of data entry, data cleaning and validation were performed using SPSS by comparing the entered data with the raw data forms and running of frequencies, scatterplots to detect unusually entered values.

The researcher first submitted the proposal to the Institutional Review Board at USIU- A for approval of the study before the collection of data. Permission to do the study was sought from National Science and Technology (NACOSTI). After ethical approval had been obtained, the researcher explained to the participants the purpose the study and an informed assent/consent was obtained from them prior to recruitment into the study. To ensure that confidentiality is observed, before any study procedures had commenced, each research team member signed an ethically binding document that protects the rights of children including protecting their confidentiality and that each research team member had the responsibility to protect the children emotionally and physically.

RESULTS

Participants' Demographic Characteristics

The majority 60.5% (n=95) of participants in the study were girls as shown in Table 1. Slightly below half 49% (n=73) were aged between 11 and 13 years. Results shows that 26% (n=32) were in grade 7, 19.5% (n=24) were in grade 6 while 16.3% (n=20) were in grade 5. Among participants who were in high school, 40% (n=12) were in Form 1 while an equal number 40% (n=12) were in Form 3.

Results in Table 1 shows that 37.6% (n=59) had been in the institution for between 1 and 5 years while those who had been in the institution for between 6 and 10 years accounted for 33.1% (n=52). Slightly less than half 47.1% (n=74) indicated that their mother was alive while 40.1% (n=63) indicated that she was not. Slightly less than half 48.7% (n=74) indicated that they did not know whether their father was alive or not while 37.5% (n=57) indicated that he was.

The study results shows that 23.8% (n=30) were third born in their family while an equal number 23.8% (n=30) were first born. Results shows that 35.3% (n=54) had 1 brother while 26.8% (n=41) did not have a brother. Similarly, 35.1% (n=53) had 1 sister while 24.5% (n=37) did not have a sister. Majority of the participants 78.4% (n=120) did not have a brother staying in the institution while 72.4% (n=113) did not have a sister staying in the institution.

Table 1: Participants Demographic Characteristics

Demographic Characteristic	Categories	Frequency	Percent
Gender	Boy	62	39.5
	Girl	95	60.5
	Total	157	100
Age	11-13	73	49
	14-15	38	25.5
	16-17	38	25.5
	Total	149	100
Class	1	2	1.6
	2	1	0.8
	3	12	9.8
	4	14	11.4
	5	20	16.3
	6	24	19.5
	7	32	26
	8	18	14.6
	Total	123	100
Length of stay in the institution (years)	<1	17	10.8
	1-5	59	37.6
	6-10	52	33.1
	11+	29	18.5
	Total	157	100.0
Form	1	12	40
	2	6	20
	3	12	40
	Total	30	100
Mother alive	No	74	47.1
	Yes	63	40.1
	I don't know	20	12.7
	Total	157	100
Father alive	No	21	13.8
	Yes	57	37.5
	I don't know	74	48.7
	Total	152	100
Birth order	1st	30	23.8
	2nd	21	16.7
	3rd	30	23.8
	4th	25	19.8
	5+	20	15.9
	Total	126	100.0
Number of brothers	0	41	26.8
	1	54	35.3
	2	33	21.6
	3	13	8.5
	4+	12	7.8
	Total	153	100.0
Number of sisters	0	37	24.5
	1	53	35.1
	2	30	19.9
	3	15	9.9
	4+	16	10.6

	Total	151	100.0
Brother staying in the institution	No	120	78.4
	Yes	33	21.6
	Total	153	100
Sister staying in the institution	No	113	72.4
	Yes	43	27.6
	Total	156	100

Participants' Psychological, Sexual Abuse and Trauma History

Majority of the participants 89.7% (n=139) indicated that they had no history of childhood sexual abuse. Majority of the participants 71% (n=110) had history of adverse childhood events. Slightly above half 53.3% (n=81) had a history of a traumatic event. The vast majority of participants (90.1%) had no disability as indicated in table 2 below.

Table 2: Participants' Psychological, Sexual Abuse and Trauma History

Problem	Response	Frequency	Percent
History of childhood sexual abuse	Yes	16	10.3
	No	139	89.7
	Total	155	100
History of adverse childhood events	Yes	110	71
	No	45	29
	Total	155	100
History of traumatic events	Yes	81	53.3
	No	71	46.7
	Total	152	100
Disability	Yes	15	9.9
	No	137	90.1
	Total	152	100

Traumatic experiences of children in institutions of care for orphans

Table 3 below indicated that majority of the participants (69.9%) had not experienced serious natural attack. Under community violence, majority (80%) had been slapped, punched or beat up by someone not in their family. Majority (70.3%) had also seen someone slapped, punched or beat up in your community. Under domestic violence, majority (78%) had been slapped, punched or beat up in your family while 74.8% had seen someone slapped, punched or beat up in their family. The vast majority (90.4%, 87.9%) had never had someone older touching their private parts or someone forcing or pressuring them to have sex respectively. Slightly above half (57.4%) had also never had a stressful or scary medical procedure.

Table 3: Experience with Traumatic Events

Traumatic Experience	Response	
Natural Disaster (ND)	No %	Yes %
Serious natural attack	69.9	30.1
Community Violence (CV)		
Robbed by threat, force or weapon	74.7	25.3
Slapped, punched or beat up by someone not in your family	20.0	80.0
Seeing someone slapped, punched or beat up in your community	29.7	70.3
Attacked stabbed shot at or hurt badly	68.0	32.0
Seeing someone attacked, stabbed, shot at, hurt badly or killed	44.5	55.5
Being around war	57.5	42.5
Domestic Violence (DV)		
Slapped, punched or beat up in your family	22.0	78.0
Seeing someone slapped, punched or beat up in your family	25.2	74.8
Sexual Abuse (SA)		
Someone older touching your private parts	90.4	9.6
Someone forcing or pressuring for sex	87.9	12.1
Traumatic Grief (TG)		
Serious accident or injury	47.7	52.3
Someone close to you dying suddenly or violently	50.7	49.3
Medical Trauma (MT)		
Stressful or scary medical procedure	57.4	42.6
Other stressful or scary event	50.7	49.3

According to the results presented in Table 4, 37.5% (n=111) had probable PTSD.

Table 4: General Prevalence of Traumatic Experience

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Normal - not clinically elevated	29	9.8	18.5	18.5
	Moderate trauma-related distress	17	5.7	10.8	29.3
	Probable PTSD	111	37.5	70.7	100.0
	Total	157	53.0	100.0	
Missing	System	139	47.0		
Total		296	100.0		

Majority of the respondents (62.9%) indicated that the traumatic experience interfered with their school work. As shown in Table 5, 55.7% and 56.9% indicated that the traumatic experience interfered with their general happiness and getting along with others respectively.

Table 5: Effect of Trauma

Did the problems you marked interfere with	No	Yes
Getting along with others	43.1	56.9
Hobbies/fun	45.1	54.9
School/work	37.1	62.9
Family relationships	49.3	50.7
General happiness	44.3	55.7

As shown in Table 6 indicated belelow, 21% had moderate PTSD, 19.1% severe PTSD and 18.5% had below threshold PTSD.

Table 6: Prevalence of Traumatic Experience and PTSD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below threshold	29	18.5	18.5	18.5
	Subclinical – Mild	17	10.8	10.8	29.3
	Mild	13	8.3	8.3	37.6
	Moderate	33	21.0	21.0	58.6
	Moderately Severe	27	17.2	17.2	75.8
	Severe	30	19.1	19.1	94.9
	Extremely Severe	8	5.1	5.1	100.0
	Total	157	100.0	100.0	

Table 7 shows that 30.6% did not have traumatic experience and depression however, 24.8% had it at a moderate level and 24.2% and 16.6% had it at a mild and moderately severe level.

Table 7: Prevalence of Traumatic Experience and Depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	48	30.6	30.6	30.6
	Mild	38	24.2	24.2	54.8
	Moderate	39	24.8	24.8	79.6
	Moderately severe	26	16.6	16.6	96.2
	Severe	6	3.8	3.8	100.0
	Total	157	100.0	100.0	

Majority of participants (76.3%) were diagnosed with panic disorder. Majority of participants (76.3%) were diagnosed with anxiety disorder while 71.2% were diagnosed with separation anxiety disorder as indicated in table 8 below.

Table 8: Prevalence of Traumatic Experience and Depression

	No	Yes
Panic Disorder clustera	23.7	76.3
Generalized Anxiety clustera	56.4	43.6
Separation Anxiety Disorder clustera	28.8	71.2
Social Anxiety Disorder clustera	48.7	51.3
Significant School Avoidance clustera	46.8	53.2
Anxiety disorder clustera	23.7	76.3

Table 9 below shows the results of socio-demographic factors associated with PTSD scores (CPSS-Scores). Participants who had sought psychological treatment had significantly higher scores of PTSD (25.02±10.7) as compared to those who hadn't (25.02±10.7, p=0.020). Participants who had history of childhood sexual abuse had significantly higher

scores of PTSD (29.63±11.23) as compared to those who hadn't (21.54±10.31, p=0.004). Participants who had history of traumatic events had significantly higher scores of PTSD (25.41±9.73) as compared to those who hadn't (19.13±10.66, p<0.001.

Table 9: Socio-Demographic Factors Associated with PTSD

Variable	Category	N	Mean	SD	p-value
Age in years	11-13 Years	77	21.77	11.30	0.747
	14-15 Years	39	21.97	9.69	
	16-17 Years	40	23.30	9.78	
Gender	Boy	62	22.03	10.25	0.762
	Girl	95	22.56	10.88	
Education Level	Lower Primary	29	25.17	12.07	0.152
	Upper Primary	94	20.90	9.93	
	Secondary	29	22.28	9.71	
Length of Institutionalization	<1	19	22.58	13.95	0.290
	1-5	54	24.11	10.03	
	6-10	65	20.48	10.49	
	11+	19	23.53	8.30	
Number of Siblings	0	15	20.00	9.93	0.591
	1	29	21.86	8.95	
	2	32	23.66	11.85	
	3	27	20.33	10.88	
	4+	51	23.51	10.99	
Has Sibling in the institution	No	89	21.42	10.36	0.214
	Yes	65	23.58	11.04	
Birth order	1	31	20.77	9.68	0.607
	2-3	51	23.08	10.03	
	4+	44	21.93	10.77	
Orphan	Yes	86	22.53	10.91	0.811
	No	71	22.13	10.29	
Ever sought treatment for any psychological problem	No	93	20.89	10.32	0.020
	Yes	57	25.02	10.70	
History of childhood sexual abuse	No	139	21.54	10.31	0.004
	Yes	16	29.63	11.23	
History of adverse childhood events	No	45	19.73	9.59	0.055
	Yes	110	23.35	10.91	
History of traumatic events	No	71	19.13	10.66	<0.001
	Yes	81	25.41	9.73	
Any form of disability?	No	137	21.74	10.55	0.150
	Yes	15	25.87	9.89	

Factors associated with PTSD, Depression and Anxiety

Table 10 below shows the results of socio-demographic factors associated with PTSD scores (PHQ-9). Education (p=0.052), ever sought treatment for any psychological problem (p=0.032), history of childhood sexual abuse (p=0.014) as well as history of traumatic events (p=0.000) were significant. As shown in Table 10, participants in lower primary had significantly higher PTSD scores (31.38± 11.62) than their upper primary counterparts (24.82±12.54). Participants who had ever sought treatment for any psychological problem had significantly higher PTSD scores (30.14±12.94) that those who had not (25.6±12.11). Participants who had a history of childhood sexual abuse had significantly higher PTSD scores (34.13±13.75) than those who had not (25.81±12.61). In addition, results show that participants who had history traumatic events had significantly higher PTSD scores (30.46±12.38) than those who did not (23.30±12.14).

Table 10: Socio-Demographic Factors Associated with PTSD scores

Variable	Category	N	Mean	SD	p-value
Age in years	11-13 Years	77	25.81	13.09	0.731
	14-15 Years	39	27.10	11.48	
	16-17 Years	40	27.68	13.84	
Gender	Boy	62	27.26	11.50	0.666
	Girl	95	26.35	13.73	
Education Level	Lower Primary	29	31.38	11.62	0.052
	Upper Primary	94	24.82	12.54	
	Secondary	29	26.45	13.51	
Length of Institutionalization	<1	19	27.68	14.46	0.911
	1-5	54	25.74	13.72	
	6-10	65	26.94	12.29	
	11+	19	27.68	11.37	
Number of Siblings	0	15	24.93	10.61	0.654
	1	29	28.10	12.31	
	2	32	26.81	13.73	
	3	27	23.59	12.41	
	4+	51	27.71	13.83	
Has Sibling in the institution	No	89	26.16	13.00	0.618
	Yes	65	27.22	12.94	
Birth order	1	31	25.16	11.17	0.714
	2-3	51	27.18	12.79	
	4+	44	25.50	12.49	
Orphanhood Status	Yes	86	26.43	13.58	0.768
	No	71	27.04	12.03	
Ever sought treatment for any psychological problem	No	93	25.60	12.11	0.032
	Yes	57	30.14	12.94	
History of childhood sexual abuse	No	139	25.81	12.61	0.014
	Yes	16	34.13	13.75	
History of adverse childhood events	No	45	23.71	10.67	0.067
	Yes	110	27.90	13.63	
History of traumatic events	No	71	23.30	12.14	0.000
	Yes	81	30.46	12.38	
Any form of disability?	No	137	26.10	12.79	0.303
	Yes	15	29.67	11.51	

Table 11 below shows the results of socio-demographic factors associated with depression scores (PHQ-9). Participants who had history of traumatic events had significantly higher scores of depression (10.59±6.09) as compared to those who hadn't (7.46±5.27, p=0.001). Participants who were in lower primary had significantly higher scores of depression (10.90±6.29) as compared to those who were in upper primary (7.90±60.9) and those in secondary school (9.34±5.22), p=0.041.

Table 11: Socio-Demographic Factors Associated with Depression

Variable	Category	N	Mean	SD	p-value
Age in years	11-13 Years	77	8.58	5.82	0.626
	14-15 Years	39	9.08	6.14	
	16-17 Years	40	9.70	5.95	
Gender	Boy	62	9.24	6.16	0.712
	Girl	95	8.88	5.77	
Education Level	Lower Primary	29	10.90	6.29	0.041
	Upper Primary	94	7.90	5.63	
	Secondary	29	9.34	5.22	
Length of Institutionalization	<1	19	8.42	4.54	0.628
	1-5	54	9.30	6.65	
	6-10	65	8.57	5.73	
	11+	19	10.42	5.60	
Number of Siblings	0	15	7.80	4.89	0.788
	1	29	9.52	5.28	
	2	32	8.25	6.91	
	3	27	9.07	5.43	
	4+	51	9.53	6.33	
Has Sibling in the institution	No	89	8.76	6.01	0.546
	Yes	65	9.35	5.91	
Birth order	1	31	8.55	6.22	0.568
	2-3	51	8.51	5.88	
	4+	44	9.70	5.77	
Orphan	Yes	86	9.53	6.03	0.236
	No	71	8.41	5.75	
Ever sought treatment for any psychological problem	No	93	8.62	5.38	0.176
	Yes	57	9.96	6.59	
History of childhood sexual abuse	No	139	8.77	5.63	0.106
	Yes	16	11.31	8.11	
History of adverse childhood events	No	45	8.13	5.35	0.258
	Yes	110	9.32	6.10	
History of traumatic events	No	71	7.46	5.27	0.001
	Yes	81	10.59	6.09	
Any form of disability?	No	137	8.83	5.86	0.849
	Yes	15	9.13	5.18	

Table 12 below shows the results of socio-demographic factors associated with Anxiety scores (SCARED). Participants who were in lower primary had significantly higher scores of anxiety (44.52±13.39) as compared to those who were in upper primary (32.38±13.81) and those in secondary school (36.10±11.85), p<0.001. Participants who had sought psychological treatment had significantly higher scores of anxiety (39.25±14.92) as compared to those who hadn't (33.96±13.04, p=0.024). Participants who had history of adverse childhood events had significantly higher scores of anxiety (37.00±14.2) as compared to those who hadn't (31.78±13.98, p=0.039). Participants who had history of traumatic events had significantly higher scores of anxiety (39.33±13.23) as compared to those who hadn't (32.04±14.28, p=0.001).

Table 12: Socio-Demographic Factors Associated with Anxiety Scores

Variable	Category	N	Mean	SD	p-value
Age in years	11-13 Years	77	35.49	15.22	0.855
	14-15 Years	39	36.44	13.90	
	16-17 Years	40	34.63	13.08	
Gender	Boy	62	32.79	13.78	0.048
	Girl	95	37.40	14.38	
Education Level	Lower Primary	29	44.52	13.39	<0.001
	Upper Primary	94	32.38	13.81	
	Secondary	29	36.10	11.85	
Length of Institutionalization	<1	19	37.84	15.33	0.705
	1-5	54	34.20	14.57	
	6-10	65	35.43	14.29	
	11+	19	37.74	12.84	
Number of Siblings	0	15	34.40	13.29	0.726
	1	29	34.86	13.05	
	2	32	38.00	14.64	
	3	27	32.85	14.18	
	4+	51	35.90	15.43	
Has Sibling in the institution	No	89	33.89	13.17	0.111
	Yes	65	37.62	15.64	
Birth order	1	31	34.26	13.37	0.864
	2-3	51	35.88	14.96	
	4+	44	35.89	14.85	
Orphan	Yes	86	35.37	13.91	0.842
	No	71	35.83	14.82	
Ever sought treatment for any psychological problem	No	93	33.96	13.04	0.024
	Yes	57	39.25	14.92	
History of childhood sexual abuse	No	139	34.88	13.53	0.152
	Yes	16	40.31	19.75	
History of adverse childhood events	No	45	31.78	13.98	0.039
	Yes	110	37.00	14.27	
History of traumatic events	No	71	32.04	14.28	0.001
	Yes	81	39.33	13.23	
Any form of disability?	No	137	35.03	14.32	0.411
	Yes	15	38.20	12.34	

DISCUSSION

The study sought to identify the traumatic experiences children in institutions of care for orphans in Kiambu County, Kenya, have been exposed to. The study found that 37.5% had probable PTSD, 21% had moderate PTSD, 19.1% severe PTSD and 18.5% had below threshold PTSD. Results indicated that 24.8% had traumatic experience and depression at a moderate level and 24.2% and 16.6% had it at a mild and moderately severe level. Results also show that majority of participants (76.3%) were diagnosed with panic disorder. Majority of participants (76.3%) were also diagnosed with anxiety disorder while 71.2% were diagnosed with separation anxiety disorder.

These results therefore show that PTSD, anxiety and depression were prevalent among children in institutions of care. The results of this study agree with findings of studies such as Atwoli (2015), Harder et al. (2012), Gore et al. (2011) and Merikangas et al. (2010) which have found a high level of mental disorders such as PTSD, anxiety and depression among orphaned children. The results of this study are also in agreement with some other

studies such as Bouras & Lazaratou (2012), Gionnopolou, (2012) and Moreno-Alcázar et al. (2017) which have shown that children who suffer from PTSD also exhibit with depression and anxiety.

The level of education of participants, having ever sought treatment for any psychological problem, history of childhood sexual abuse as well as history of traumatic events were significant to PTSD. education and history of traumatic events were significant for depression. Gender, education level, having ever sought treatment for any psychological problem, a history of adverse childhood events, history of traumatic events was significant for anxiety.

The level of education was significant for all 3 conditions signifying that the level of education is an important predictor for trauma in children. Participants in lower primary had significantly higher PTSD scores than their upper primary counterparts. Participants who were in lower primary also had significantly higher scores of depression as compared to those who were in upper primary and those in secondary school. In addition, participants who were in lower primary had significantly higher scores of anxiety as compared to those who were in upper primary and those in secondary school. These findings lend support to Gilliham, Cahill and Foa (2014), Khan et al. (2016) and Paul (2019).

The study found that majority of the respondents indicated that the traumatic experience interfered with their school work. In addition, most respondents indicated that the traumatic experience interfered with their general happiness and getting along with others respectively. This is similar to results of Perfect et al. (2016) who established that cognitive, academic, and teacher reported social-emotional-behavioral outcomes. Kavanaugh et al. (2017) also reported impairments in executive functions were the most frequent and severe reported impairments, although intelligence, language, visual-spatial skills, and memory are also at serious risk for compromised development following maltreatment.

CONCLUSION AND RECOMMENDATION

The study concludes that children in orphan institutions of care have a high prevalence of PTSD and other comorbidities mainly anxiety and depression. The high prevalence of PTSD, anxiety and depression among children in institutions of care for orphans is plausible due to traumatic experiences of not having a parent and life in the streets as well as in the institutions themselves. The high percentage of children with PTSD among this population can be explained by the fact that the family is the basic provider security to the child. When the family system is fragmented, it becomes the major cause of trauma to many children. Looking at their history into the homes, majority of them had passed through the government admission process which involves a lot of interrogation. This again is another cause of trauma to the children. Most of the children came from families where one or both of the parents was abusing drugs. Others had lost their parents to chronic illness such as HIV/AIDS. Prior to the death of the parent, the child had had to take over taking care of the ailing parent. This calls for interventions to manage PTSD in this population.

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