



المركز الفلسطيني للديمقراطية وحل النزاعات

PALESTINIAN CENTER FOR DEMOCRACY & CONFLICT RESOLUTION

A Study of the Psychosocial, Educational, Economic, Emotional and Legal Needs of Gaza Orphans

After Two and a Half Years of the Israeli War on the Gaza Strip

An Integrated Mixed-Methods Field Study

STUDY PERIOD

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Research Team

Research Leadership and Field Team Responsible for Data Collection and Analysis

1 Research Leadership

3 Roles

- Principal Investigator **Saeed Ahmad Al-Maqadmeh**
- Statistical Analysis, Review & Design **Mohammad Omar Al-Habbash**
- Field Team Manager **Rabea Mohammad Hamouda**

2 Field Team

17 Researchers

1 Ibtihal Samir Ismail	2 Adiba Jabr Khader Karaja	3 Mahdi Jawad Al-Hattab
4 Huda Bassam Deeb Al-Naffar	5 Heba Nabil Al-Shawa	6 Samah Wael Faisal Khudair
7 Mu'tasim Mahmoud Abd Awad	8 Alaa Majdi Al-Ghafri	9 Nasma Samir Hamouda
10 Sahar Saeed Issa Abu Eita	11 Amani Marwan Adnan Mohammad Khaled	12 Aya Mahmoud Ruwaished
13 Mujahid Ahmad Yousef Abu Halabiya	14 Saja Ishaq Abd Shaheen	15 Islam Ishaq Shaheen
16 Ziad Hussein Ziad Al-Toum	17 Mohammad Ezzat Roshdy Abu Sido	

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Statistical Symbols

Guide to Symbols Used in This Study

1 Sample & Central Measures

Symbol	Full Name	Interpretation
n	Sample Size	Total number of participants or sub-group
M	Mean (Arithmetic Average)	Sum of values divided by n
SD	Standard Deviation	Spread/dispersion around the mean
%	Percentage	Proportion expressed per 100
df	Degrees of Freedom	Number of independent values in a statistical calculation

2 Significance, Correlation & Effect Size

Symbol	Full Name	Interpretation
p	p-value (Statistical Significance)	Probability of observing the result by chance; $p < 0.05$ = statistically significant
α	Cronbach's Alpha (Internal Reliability)	Measures consistency of a scale; $\alpha \geq 0.70$ = acceptable
F	F-ratio (ANOVA)	Ratio of between-group to within-group variance
η^2	Eta-squared (Effect Size)	Proportion of variance explained; small ≥ 0.01 , medium ≥ 0.06 , large ≥ 0.14
ρ	Spearman's Rho	Non-parametric rank correlation coefficient
r	Pearson's r	Linear correlation coefficient for interval data
B	Regression Coefficient (Unstandardized)	Change in outcome per unit change in predictor

Study Glossary

Methodological and Clinical Terms Used in This Study

1 Instruments & Tools

Term	Full Name	Notes
SDQ-25	Strengths & Difficulties Questionnaire (25 items)	Validated psychosocial screening tool for children
CRIES-8	Children's Revised Impact of Event Scale (8 items)	Trauma/PTSD screening; uses non-linear scale: 0, 1, 3, 5
PTSD	Post-Traumatic Stress Disorder	Clinical threshold on CRIES-8: score ≥ 17
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy	Recommended intervention for acute trauma cases
ANOVA	One-Way Analysis of Variance	Tests differences across three or more groups
Mann-Whitney U	Mann-Whitney U Test (Non-parametric)	Used for small samples or ordinal data

2 Study-Specific Concepts

Term	Meaning in the Context of This Study
De-facto Orphan	Child whose father is missing/presumed dead without a death certificate; administratively invisible
Structural Maternal-Orphan Exclusion	Systematic exclusion of maternal orphans from entitlements because the father (the "breadwinner") is alive
Mother as Security Anchor	Transfer of the child's safe base to the widowed mother after paternal loss
Depleted Caregiver	Mother performing the role of two parents while carrying her own grief
Skill Gap vs Capacity Gap	Two competing explanations for caregiving failure: lack of parenting skills vs. exhausted physical/emotional capacity
Gendered Parentification	Role reversal differentiated by gender: girls assume domestic burdens; boys take on external labour
Compensatory Control	Child seizes the absent father's authority through dominance and over-responsibility
Emotional Role Reversal	Child absorbs mother's grief, carrying it alongside his/her own

Term	Meaning in the Context of This Study
Paternal Lineage Solidarity	Extended paternal family rallying around the orphan after the father's death
The Age-16 Cliff	Abrupt termination of sponsorship at age 16, while the child remains financially dependent
Survivor's Guilt	Child's guilt for remaining alive while family members perished
Active Acute PTSD	Avoidance attempts are present but overwhelmed by intrusive re-experiencing (flashbacks, nightmares)
SDQ Blind Spot	SDQ's failure to detect acute trauma in sole survivors, as exposed by CRIES-8 comparison
Deferred Gendered Role-Model	Boys' need for a male role model matures in adolescence, making it a delayed rather than immediate loss
Existential Longing	Silent yearning to rejoin the deceased father, co-existing with early awareness of death
Whole-Family Care	Intervention model mandating integration of mothers into all child-focused programs
Convergent Validity	Consistency across multiple indicators confirming the same finding
Transferability	Applicability of findings to similar contexts; not statistical generalisation
Constructivist Grounded Theory	Inductive conceptual interpretations derived from data, not imposed prior to analysis
Straight-lining	Respondent selects the same answer for all items; flagged as a data quality issue
Deemed Orphan (اليتيم حكماً)	A child classified as an orphan by legal or religious ruling despite the biological father being technically alive — applicable when the father is permanently absent, imprisoned for life, legally incapacitated, or declared dead by judicial order. Distinct from the "de-facto orphan" (whose father is missing under rubble) and from the paternal orphan (whose father is confirmed dead). Recognised in Islamic jurisprudence and some civil codes as a basis for extending orphan entitlements.
Methodological Triangle (المثلث المنهجي)	The study's three-vertex design: (1) Quantitative — structured questionnaire with SDQ-25 + CRIES-8 (n=671); (2) Institutional/Educational qualitative — semi-structured in-depth interviews with specialists, teachers and officials (n=11); (3) Direct child voice — focus group discussions with orphaned children (7 sessions, ~60 children). The three vertices are integrated through the Explanatory Sequential Design: quantitative findings drive qualitative enquiry, which in turn explains the quantitative patterns; each figure is supported by a voice and each voice by a figure where possible.

Table of Contents

★	Executive Summary	1
1	Introduction — Context and Research Problem	3
1.1	General Context: An Unprecedented War	3
1.2	Orphans in Gaza: The Doubly Vulnerable Population	5
1.3	Research Problem and Literature Gap	5
2	Study Methodology	6
2.1	Study Design	6
2.2	Data Collection Instruments	8
2.3	Study Population and Sample	10
2.4	Study Limitations	11
2.5	Field Team Training	12
2.6	Ethical Considerations	12
2.7	Quality Control and Verification Procedures	13
2.8	Challenges and Difficulties	14
3	Study Findings	14
3.1	Section A — Baseline Data	14
3.2	Section B — Impact of Paternal Loss	22
3.3	Section C — Impact of Maternal Loss	30
3.4	Section D — Guardianship, Care and Identity	38
3.5	Section E — The Sole Survivor and CRIES-8	47
3.6	Section F — Psychological Measures (SDQ-25)	50
3.7	Section G — Community Perception, Identity and Hope	63
3.8	Section H — Needs and Participation in Support Programs	69
4	Conclusions and Strategic Recommendations	74
4.1	Core Conclusions	74
4.2	Intervention Priorities	75
4.3	Recommendations by Dimension	76
4.4	Proposed Program Framework	76
4.5	Required Legislative Reforms	78
4.6	Calls for Future Research	78
★	References	79

Executive Summary

Psychosocial, Educational, Economic, Emotional and Legal Needs of Gaza Orphans After Two and a Half Years of the War — Mixed-Methods Field Study (671 Children · 11 In-Depth Interviews · 7 Focus Groups)

The war on Gaza has produced a generation of orphans that nearly quadrupled in two and a half years, reaching approximately 64,000 children. This study does not merely count them — it listens to them: to 671 orphaned children, to their guardians, teachers and specialists, through two internationally validated psychometric instruments (SDQ-25 and CRIES-8) and qualitative sessions that carry the child's direct voice. The central finding is striking in its simplicity: **the median orphan in this sample falls exactly at the clinical referral threshold** — meaning that disorder has become the norm, not the exception. This is a population-level crisis, not isolated individual cases waiting for a clinic.

53.65%

Above the SDQ referral threshold (Mean 17.23 = the threshold itself) — approximately 5× the normative reference rate

89.87%

Lost their father to war — war-bereavement with compound trauma, not natural orphanhood

88.24%

Of sole survivors above the post-traumatic stress threshold (CRIES-8)

81.22%

Of guardians themselves report a need for psychological support

76.45%

Living in tents — tent-dwelling is an independent psychological risk factor

68.41%

Above the emotional subscale threshold — a silent internalising signature exceeding what the total score captures

◆ Reality Across the Six Dimensions

Psychological

The **median orphan is at the threshold** (53.65% above 17, M=17.23), with a predominantly **internalising** profile (emotional 68.41% + peer 55.74%) surpassing the externalising (behavioural). Yet **prosocial behaviour is preserved in 72.4%** — the most powerful therapeutic lever available.

Emotional

Loss of the father dismantles a **triad** (protection, provision and tenderness, ~74% each); loss of the mother leaves **the missing embrace** (88.46% — the highest consensus in the study). **76.92%** fear losing whoever remains of their family.

Social

Economic

The community **both embraces and wounds simultaneously**: 70% of peers behave normally, yet **50.52% were subjected to hurtful remarks** and **28.91% carry internalised stigma**. Stigma is harsher in the camp than in school.

Near-universal financial hardship (78.19%) is the gateway to child labour (16.54%, boys ×4) and school dropout. Material support is **the top self-reported need (85.10%)** — no psychological recovery is possible on an empty stomach and under a tent.

Legal

Entitlement distortion: the maternal orphan is excluded because the father — "the breadwinner" — is alive. The **"de-facto orphan"** (whose father is missing without a death certificate) is administratively invisible; 18.75% have no documented guardianship, and sponsorship is cut off at age 16.

Institutional & Services

The caregiver themselves is depleted (81.22%). Families reject the "sick child" model (only 2.83% use clinics), preferring non-stigmatising community-based formats (group sessions 56.48% · play 53.65%) in the spaces where the child lives.

◆ The Most Vulnerable Groups — Triage Priorities

1

The Sole Survivor: 88.24% above the PTSD threshold, yet the total SDQ score classifies 52.9% as "moderate" — active acute trauma that SDQ alone fails to detect.

2

The Maternal Orphan: highest emotional distress (61.5%) but lowest total SDQ score (34.6%) — a silent wound that routine screening overlooks.

3

Children Who Have Psychologically Withdrawn from Education: 96.2% above the threshold — the strongest single warning indicator in the entire study.

4

Tent-Dwelling Children: tent residency is an independent risk factor (elevates risk ~1.6×); Deir al-Balah shows the highest distress rates.

5

Boys in the Paternal Vacuum: a "desire for revenge" trajectory emerges specifically among males — absent among girls.

6

Double Orphans: descriptively lowest distress (43.8%) — consistent with grandparent absorption (non-significant difference, n=32), yet 34.38% report existential loneliness despite having shelter.

◆ Three Findings That Reframe Intervention

1) The silent wound runs deeper than the total score reveals. Screening by SDQ total score alone misses the most internalised sufferers — the maternal orphan (an emotional subscale gap of ~27 points) and the sole survivor (88.24% on CRIES vs 52.9% on SDQ). Accurate triage requires **subscale-level screening combined with a trauma-specific instrument, not the total score alone**.

2) Environment determines severity more than type of loss. After controlling for all covariates in a multivariate model, **school disengagement** remains the strongest independent predictor of distress, followed by tent residency and governorate — while type of orphanhood, sex, and child labour do not independently predict severity. Type of loss shapes the *profile* of the wound; environment determines its *intensity*. Both leverage points — education and shelter — are modifiable.

3) The parental mirror. The father represents shield and provision; the mother represents embrace and emotional co-regulation. Neither can fully substitute for the other — this is the logical foundation for the shift from "child sponsorship" to **whole-family care**, and from defining entitlement through loss of the breadwinner to defining it through need for care.

◆ Proposed Response Framework

- | | |
|---|---|
| <p>1 Mobile Triage and Psychological First-Aid Units (the core of the response): Go to the child — through play, drawing, storytelling and Qur'an. Non-stigmatising, using appropriate subscale screening, not total-score screening alone.</p> | <p>2 Whole-Family Care: Mothers must be integrated into every child-focused intervention programme — caregiver support (primarily the mother) alongside the child, with no less than 30% of programme resources allocated to caregivers.</p> |
| <p>3 Integration into Learning Spaces: As the strongest protective factor identified, embedding support within educational settings, with early prevention that fills the paternal vacuum with constructive meaning before it is filled by the desire for revenge.</p> | <p>4 Specialist Capacity Building: Training a cadre that can detect the silent wound, manage screening and conduct psychological first aid — the precondition that precedes everything else: <i>"No triage without a trained eye."</i></p> |

All of the above rests on structural reform: **redefining orphan entitlement around need for care rather than loss of the breadwinner**; a unified national body for orphan affairs with a fund to invest their assets; a documentation campaign that recognises the "de-facto orphan" — and shelter as an advocacy priority, not a promise.

CORE CONCLUSION

When **the median orphaned child stands at the clinical referral threshold**, individual therapy waiting in a clinic cannot meet a population-level crisis. What is required is a population-level response, built on **whole-family care** and **redefining who qualifies as an orphan around need for care**. In devastated Gaza, recovery cannot be built on absent infrastructure — only on what holds: **people and meaning** — a supported caregiver, a trained facilitator, a safe space however modest. The difference between a generation that collapses and a generation that holds is **an intervention decision, not a fate**.

Introduction

1.1 General Context: An Unprecedented War in Palestinian History

The Palestinian people are living through the most devastating period in their contemporary history. The comprehensive war declared on the Gaza Strip since 7 October 2023 has taken on a level of violence unprecedented in its intensity and the scale of its consequences. According to international legal assessments and UN Special Rapporteurs, this war has surpassed the Nakba of 1948 in terms of daily casualty rates and the comprehensive scale of structural destruction. The UN Special Rapporteur has described it as **genocide** and **systematic destruction of civilian habitat (domicide)** ¹, with every aspect of life in the Strip targeted: housing, civil documentation, healthcare, education, infrastructure, the economy and the natural environment.

◆ Scale of Human Loss

Palestinian fatalities exceeded **73,770 martyrs** as of 3 May 2026 according to Gaza's Ministry of Health and OCHA ², of whom approximately **80%** were civilians; in targeted residential buildings, **70%** of the dead were women and children according to the UN High Commissioner for Human Rights ³. The Ministry of Health reports an estimated **8,000 bodies remaining under the rubble** — unrecoverable due to equipment scarcity (only one working excavator in the Strip), as returnees continue to flow back to destroyed areas following the October 2025 ceasefire ⁴. Among the casualties: **270 journalists**, more than **400 healthcare workers** and **593 humanitarian workers** (including **391 UNRWA staff members**) — the largest loss of life in the history of UN institutions ². **UN Women** estimated that more than **38,000 women and girls** were killed between October 2023 and December 2025 — at a rate of **47 women and girls per day** ⁵; the total population of the Strip has declined to **2,114,301 people** — 10% below mid-2025 estimates ⁶.

◆ Scale of Urban and Infrastructure Destruction

The most recent **UNOSAT** assessment (October 2025) found that approximately **81%** of all structures in the Strip had been damaged — totalling **198,273 structures**. Of these, **123,464 were completely destroyed**, **17,116 severely damaged**, **33,857 moderately damaged** and **23,836 likely damaged** ⁷. A more recent assessment published in April 2026 by a UN Expert Panel placed the number of residential units destroyed or damaged at over **371,000 units**, with approximately **1.9 million people displaced** and **60% of the population without shelter** ⁸. The destruction extended to all vital service sectors — hospitals, schools and road networks — as part of this comprehensive urban destruction ⁷.

On essential services, only **296 of 683 health-service points (43%)** remain operational, with **16 of 73 wastewater treatment stations (22%)** functioning — resulting in **40,000 cubic metres of untreated wastewater discharged daily** directly into the sea and groundwater ². The United Nations, World Bank and European Union estimate reconstruction costs at over **USD 70 billion** ⁹.

◆ Displacement and Food Security Crisis

The vast majority of the Strip's population is experiencing **repeated displacement**, with many families having moved dozens of times. Since the ceasefire of 10 October 2025, OCHA reported that **833,000 people** had changed their location and that **60% of households** were experiencing difficulty accessing clean drinking water ². On food security, the **IPC** classified over **1.6 million Palestinians (77% of the population)** in Phase 3 (Crisis) or above for the period December 2025 – April 2026 — of whom **571,000 are in Phase 4 (Emergency)** and **1,900 in Phase 5 (Famine)**. The IPC estimates that **132,000 children under five** will suffer acute malnutrition by June 2026, with **41,000 severe cases** at risk of imminent death ¹⁰.

◆ Scale of Psychological Destruction

A narrative review from the WHO Regional Office for the Eastern Mediterranean (WHO EMRO, 2025) and studies in Lancet Psychiatry (2026) have documented unprecedented rates of mental health disorders: **61%** of adults in Gaza suffer from PTSD, **41%** from anxiety and **38%** from depression — with nearly one in five adults experiencing suicidal ideation on an almost daily basis ¹¹ ¹². UNICEF reported that more than **one million children** require mental health and psychosocial support (MHPSS) services, and that **96%** of Gaza's children feel that death is imminent ¹³.



1.2 Orphans in Gaza: The Doubly Vulnerable Population

Within this humanitarian landscape, **orphaned children** stand out as one of the most structurally vulnerable groups. An orphaned child in Gaza simultaneously bears the loss of a providing parent, loss of shelter, repeated displacement, educational disruption and the absence of any sense of security — at a critical developmental stage for personality formation. **Riyad al-Baitar, Deputy Assistant Minister of Social Development**, stated in an interview with the Qatar News Agency (QNA) on the occasion of *Arab Orphan Day* on 1 April 2026 that the number of orphans in Gaza had risen to **64,616 children**, of whom **55,157** lost their breadwinner during this war — compared to approximately **17,000 orphans** before October 2023, representing an approximately fourfold increase ¹⁴.

Our field study data (n=671) reveal that orphanhood in Gaza is **war-bereavement** first and foremost. Some **89.87%** of the orphans lost their parent as a direct consequence of war — through direct bombardment (86.29%) or war-related indirect causes (3.58%) — with **96.13%** being paternal orphans, a demographic pattern reflecting the targeting of adult males. Most strikingly, **all double orphans (32 children, 100%)** lost both parents through direct bombardment. This composition distinguishes **war-orphanhood** — with its compound trauma — from natural orphanhood, and demands a context-specific reading of these children's needs.

A structurally distinct group revealed by the study's qualitative evidence is **"De-facto Orphans"** — children of martyrs missing under the rubble who are not officially registered as orphans due to the absence of a death certificate, and are therefore denied sponsorship and associated rights. With approximately **8,000 bodies** still under the rubble, this registration gap is widening, producing an orphanhood that is statistically invisible.

*"These figures do not reduce orphans to victims alone — they frame them as **rights-holders** entitled to protection, sponsorship, healthcare and psychosocial support, education, and the safeguarding of identity and documentation. These are rights guaranteed by binding international instruments: the Convention on the Rights of the Child (CRC), the Fourth Geneva Convention on the protection of civilians in war, and the UN Guidelines for the Alternative Care of Children (2010)."*

1.3 Research Problem and Literature Gap

International agencies produce abundant humanitarian reports on the general situation in the Gaza Strip. However, **peer-reviewed scientific literature** addressing the *integrated needs* — psychosocial, educational, economic, emotional and legal — of orphaned children specifically after October 2023 remains limited, within the bounds of our

literature review. The majority of previous studies have concentrated on separate trajectories: overall population mental health indicators, trauma symptoms in children generally, or macro-level humanitarian conditions across the Strip.

The orphaned child as a **unit of analysis in its own right** has rarely received integrated study — one that brings together all six dimensions in a single research framework, drawing on the child's direct voice alongside those of caregivers and teachers, while complementing this with statistical framing using standardised instruments (SDQ-25 and CRIES-8). The need is further compounded by the nearly fourfold increase in orphan numbers during the war. This study makes a **qualitative contribution** to available knowledge about this population in its current context, and provides a foundation upon which sponsorship, psychosocial intervention and educational programme design can be built.

Study Methodology

2.1 Study Design

This study constructs a comprehensive picture of the reality of orphaned children in the Gaza Strip through **four sequential, mutually reinforcing phases**. It begins with a broad quantitative phase on a large sample, mapping general patterns and measuring psychosocial indicators using standardised child instruments. It then moves to two qualitative phases — in-depth interviews with specialists, teachers and officials, followed by focus group discussions with the orphaned children themselves — which add lived context to the figures and explain what the data reveals. It concludes with an integrative phase that merges quantitative and qualitative outputs into one coherent interpretive framework that can serve as the basis for designing sponsorship and psychosocial intervention programmes.

This type of design is known in contemporary methodological literature as an **Explanatory Sequential Mixed-Methods Design** — a well-established framework presented by *Creswell & Plano Clark*, one of the most widely used mixed-methods references in the world today ¹⁵. The study adopted this design because it offers what no single phase could provide alone: the combination of *breadth of representation* from the quantitative phase with *depth of meaning* from the qualitative.

◆ Temporal and Functional Category

The study is **Cross-sectional** — capturing reality at a single point in time. Data were collected across a continuous window between February and May 2026, with no subsequent longitudinal follow-up. It is **Descriptive-Analytical** in function — combining two objectives: *describing* orphans' reality across the six dimensions (psychological, social, educational, economic, emotional, legal) as it stands, and *analysing* the relationships between these dimensions and relevant contextual variables (type of orphanhood, cause of death, duration of loss, educational status, child labour and current place of residence).

◆ Rationale for Design Choice

The choice of a mixed-methods design was not a formal decision — it is grounded in three substantive justifications:

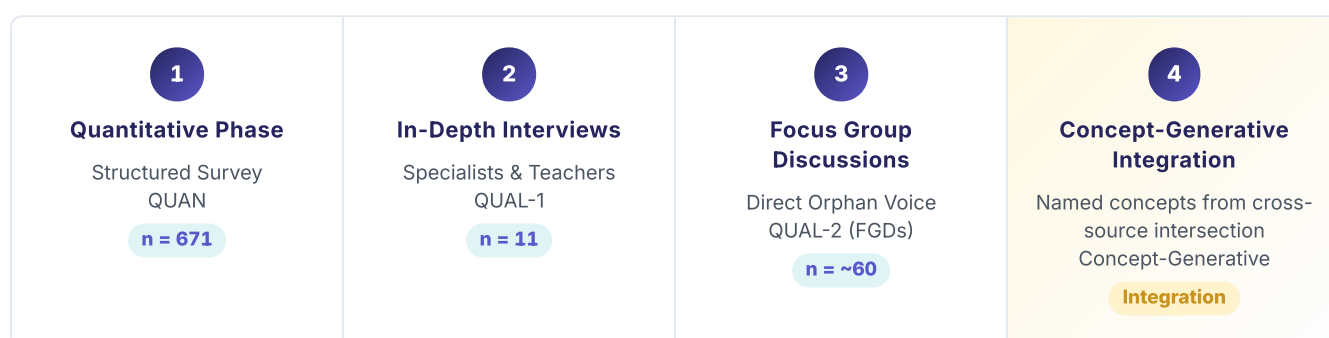
- **Multidimensionality of the study domains:** The six needs cannot be captured by a single instrument — the quantitative phase reveals prevalence and statistical relationships using standardised child measures; the qualitative phase reveals meaning and lived context through the voice of the child, caregiver and teacher.
- **Vulnerability of the target group:** Orphaned children in a war context — relying on the survey alone would strip them of their direct voice; relying on qualitative methods alone would sacrifice the representational framework needed for policy-level recommendations.
- **Nature of programmatic outputs:** The targeted recommendations require both quantitative evidence (to justify intervention to policymakers and stakeholders) and qualitative evidence (to design services responsive to the actual context of children and caregivers).

◆ Implementation Phases

The design was implemented across four sequential phases, moving from the broad quantitative to the specific qualitative and finally to integration:

Phase	Instrument	Size	Methodological Objective
1	Structured Quantitative Survey	671 children	Map general patterns and standardised psychosocial indicators
2	In-Depth Interviews with Specialists, Teachers and Officials	11 interviews	Understand the institutional and educational framing and service delivery mechanisms
3	Focus Group Discussions (FGDs) with Orphaned Children	7 sessions / ~60 children	Generate the direct, unmediated voice of the orphaned child
4	Concept-Generative Integration	—	Generate named conceptual frameworks from the intersection of all three sources — moving beyond indicator comparison to build an integrated interpretive framework that can support programmatic recommendations

◆ Visual Integration Diagram



This methodological sequence can be described as "three lenses on a single reality": **the statistical lens**, which measures numerical prevalence; **the institutional and school lens**, which reflects the administrative, educational and service framing; and **the orphaned child's direct lens**, which carries lived meaning. Yet integration in this study **does not stop at comparing the three sources** (conventional triangulation) — it generates a **named conceptual framework** — such as "De-facto Orphan" and "Mother as Security Anchor" — which is presented and discussed in the Findings chapter. This integration draws on contemporary mixed-methods literature: the Creswell & Plano Clark framework ¹⁵, Moran-Ellis's "following a thread" technique ¹⁶, and Guetterman's "joint display" approach ¹⁷. It feeds into Chapter 4 with theoretically grounded recommendations, not mere descriptive lists.

2.2 Data Collection Instruments

The study employed **five integrated instruments** for data collection, divided into two groups: three quantitative instruments that together constitute the *structured survey* administered to the 671-child sample, and two qualitative instruments (an in-depth interview guide + a focus group discussion guide). Each instrument was selected for a specific methodological reason; both psychometric scales are internationally validated instruments designed specifically for children, with prior applications in Palestinian samples, enabling normative comparison.

◆ Part I: Quantitative Instruments (Structured Survey)

The structured survey comprises **three integrated instruments**: two internationally standardised child scales (SDQ-25 for the full sample · CRIES-8 for sole survivors) — each published in a peer-reviewed journal with prior applications in Gaza — supplemented by a locally developed survey designed by the Centre's team for the context (Sections A–H). The table below presents the technical specifications of each instrument; the methodological note that follows documents the scoring of both scales:

Instrument	Developer · Year	Items	Range	Threshold	α	What It Measures
SDQ-25 Strengths & Difficulties Questionnaire	Goodman · 1997, 2001 ¹⁸	25	0–40 +	≥ 17	0.743 (n=671)	Child difficulties (emotional · conduct · hyperactivity · peer) + prosocial behaviour
CRIES-8 Children's Revised Impact of Event Scale	Smith et al. · 2003 ¹⁹	8	0–40 ±	≥ 17	0.750 (n=17)	Child post-traumatic stress symptoms (intrusion + avoidance) — sole survivors only
PCDCR Local Survey PCDCR Local Survey (Sections A–H)	PCDCR Team · 2026	—	—	—	—	Baseline data + impact of paternal/maternal loss + guardianship and identity + community perception + needs

(†) SDQ-25 uses a 3-point scoring: "Not True" = 0 · "Somewhat True" = 1 · "Certainly True" = 2. It includes **five reverse-scored items** (items 7, 14, 15, 17, 18) recoded 2→0 and 0→2 before summation. **Total Difficulties Score** = four subscales × 5 items = 20 items (range 0–40), referral threshold ≥ 17 . (‡) CRIES-8 uses the scale's standard coding (Never = 0 · Rarely = 1 · Sometimes = 3 · Often = 5), range 0–40, risk threshold ≥ 17 per Smith et al. ¹⁹; administered to sole survivors only (n=17). Clinical thresholds are grounded in peer-reviewed literature on Gaza children's mental health ²⁰, standards for cultural adaptation of scales ²¹, and Palestinian trauma scale adaptation experience ²².

Digital Data Collection Platform: KoboToolbox

The survey was built in *XLSForm* format on **KoboToolbox** and administered via smartphones, incorporating: **(1)** conditional branching logic (Skip Logic) to bypass inapplicable sections (e.g. the sole-survivor section only appears for the relevant group); **(2)** automatic validation constraints to reduce entry errors; **(3)** GPS coordinate recording to confirm location without revealing identity. The platform was chosen for its suitability to the Gaza context: offline operation with subsequent synchronisation, data encryption and direct export to analysis formats without manual re-entry.

◆ Part II: In-Depth Interview Guide

A semi-structured instrument of **22 open-ended questions** covering the study's six dimensions and their institutional and educational frameworks. **11 interviews** were conducted through purposive sampling — **seven fully structured** and four **conversational** — encompassing: **(a) care specialists** (psychologists · social worker · orphan programme coordinator), **(b) teachers** in displacement schools, and **(c) officials and leadership** (camp supervisor · educational institution directors · sponsorship association). This diversity exposes potential *administrative bias* by comparing how different actors frame the same reality; it serves a dual function: **verification** of quantitative findings + **qualitative deepening** of the institutional and educational context.

◆ Part III: Focus Group Discussion Guide

A qualitative instrument targeting *the direct voice of the orphaned child*, comprising **25 questions** across the same study dimensions, supported by **interactive activities** designed specifically for children (identity cards · colours for mood expression · projective drawing · symbolic animal selection). **7 focus groups** were conducted with approximately **60 children** (8–10 per session), some mixed and some gender-separated, in displacement camps and schools, with special coverage of martyrs' children as a distinct category. Each group was managed by **two researchers** (facilitator + note-taker), with sessions respecting children's developmental sensitivities. These groups complete the triangulation loop between the statistics (n=671), specialist and teacher testimony, and the children's direct voice.

◆ Part IV: Quantitative and Qualitative Analysis Methodology

Quantitative analysis was conducted across **three graduated layers** in Python (pandas · scipy · statsmodels libraries), moving beyond description to inference:

- **(1) Descriptive statistics:** Frequencies and proportions (round-half-up), means and standard deviations for each item.
- **(2) Bivariate inferential statistics:** One-way ANOVA and independent-samples t-tests for group comparisons, with **effect sizes** (η^2 and Cohen's d) alongside p-values — to distinguish statistical significance from practical importance, and to avoid over-interpreting differences with small effect sizes.
- **(3) Multivariate inferential statistics:** **Multiple linear regression** on the continuous SDQ total score, and **binary logistic regression** on the referral threshold (≥ 17), to isolate independent predictors from confounding — with partial η^2 (Type II ANOVA) and multicollinearity diagnostics (VIF). (Presented in Section F, Table 52.)
- **(4) Reliability:** Cronbach's alpha (α) for each scale and subscale, with an explicit distinction between reliability (α) and validity (supported by methodological triangulation).

Qualitative data (11 interviews + 7 focus groups) were analysed **thematically (Thematic Analysis)** — extracting recurring patterns and naming concepts — then integrated with quantitative findings through the **Mixed-Methods Triangulation** detailed in 2.1, so that every number is anchored by a voice, and every voice by a number wherever possible.

2.3 Study Population and Sample

The study population comprised **orphaned children in the Gaza Strip**, numbering **64,616 children** according to the latest figures from the Palestinian Ministry of Social Development (1 April 2026). Three complementary samples were drawn from this population in line with the mixed-methods design: **671 children** in the quantitative component (after cleaning 688 raw records); **11 interviews** with specialists, teachers and officials; and **approximately 60 children** in 7 focus groups.

◆ Geographical Distribution of the Quantitative Sample across Study Governorates (n = 671) ◆

1	Gaza Governorate		397 children	59.17%
2	North Gaza		163 children	24.29%
3	Deir al-Balah		111 children	16.54%

PCBS 2023 Reference: Gaza 51.7% · North Gaza 27.6% · Deir al-Balah 20.7%

The distribution is close to the reference population structure of the Palestinian Central Bureau of Statistics (PCBS 2023)⁶, with a relative concentration in Gaza Governorate. The quantitative collection did not cover Khan Younis and Rafah due to the inaccessibility of safe entry (detailed in 2.4), but the covered areas host — after displacement — orphans from all governorates, so the sample captures the unified post-displacement reality.

◆ Sampling Methodology: Snowball Sampling

The study used **Snowball Sampling** for both quantitative and qualitative components. The sample begins from initial entry points (Seeds) — caregivers, community leaders, camp and school administrations — expanding progressively through *sequential referrals* to other orphaned families meeting the selection criteria.

This choice was not arbitrary — it is an **academically recognised research methodology** adopted for data collection from *hidden and hard-to-reach populations*, as established by Atkinson & Flint (2001)²³. Cohen & Arieli (2011) further confirmed that this methodology is **the most appropriate — and sometimes the only feasible** — approach in armed conflict contexts, where probability sampling loses its practical validity²⁴.

◆ Justification in the Gaza Context

Classical probability sampling became technically impossible in this context for four structurally interconnected reasons:

1. **Collapse of the formal sampling frame:** No current, accessible centralised registry of orphans exists — particularly given the "de-facto orphan" category that is unregistered by definition.
2. **Repeated forced displacement:** The majority of orphaned families have been displaced multiple times — any address-based sampling loses the family before reaching it.
3. **Destruction of fixed addresses:** 76.45% of orphans in our sample live in tents — no fixed address means no spatial sampling frame.
4. **Social sensitivity of the subject:** Discussing loss, trauma and need only opens through *network trust* (a referral from a caregiver, camp leader or teacher) — a precondition probability sampling cannot provide.

◆ Limits of Statistical Interpretation

Despite multiple quality mechanisms (17 researchers = 17 independent sampling networks · dozens of entry points · structured geographical distribution · voluntary participation without incentive), the methodological limits are stated transparently. This sample **describes patterns** within a large, geographically distributed group (n = 671) and claims **transferability** to similar contexts — not **precise statistical representativeness** of all orphans in the Strip. The percentages reported are strong directional indicators, not final population parameters. Any figure projected onto the total population is explicitly noted as a *guiding estimate*. This distinction is maintained throughout all chapters.

2.4 Study Limitations

This study is bounded by limits that frame the scope of its findings and the domain of their transferability; these must be taken into account when reading the conclusions and recommendations:

◆ Temporal Limitation

The study was conducted between **February and May 2026**, during a window following the October 2025 ceasefire and coinciding with the onset of return waves to destroyed areas. The snapshot of reality captured by this study is that of this window, and does not generalise to earlier or later phases without additional evidence. As a **cross-sectional design** it captures a moment, not a trajectory — it cannot track deterioration or recovery curves over time. The study therefore recommends a **longitudinal** follow-up of a sub-sample (Research Call 4.6).

◆ Spatial Limitation — Access Constraint, Not Design Choice

Field data collection covered **Gaza City and surroundings, the remaining areas of North Gaza and Deir al-Balah**. No independent quantitative collection was conducted in Khan Younis or Rafah — not as a research choice but **due to the inaccessibility of safe entry** caused by military operations, forced evacuation and the shrinking of the inhabited space in the south during the collection period. This does not, however, mean that southern orphans are absent from the sample: after two and a half years of continuous displacement, "place of original residence" has lost its meaning as a classification unit, and large numbers of southern families have been displaced to Gaza and Deir al-Balah. **The actual spatial sampling unit is the child's current location, not their place of origin**. The covered areas thus host a displaced mix from all governorates, reflecting a largely unified reality. **And methodologically — for disciplined generalisation:** the quantitative findings represent **the northern and central governorates** (Gaza, North Gaza, Deir al-Balah); any projection to the south (Khan Younis and Rafah) is read through **transferability** to similar contexts, not as absolute statistical fact for the entire Strip.

◆ Thematic Limitation

The study is confined to the **six integrated needs**: *psychological, social, educational, economic, emotional and legal*. Physical health status or clinical diagnostic detail are not independently addressed except insofar as they intersect with these six domains.

◆ Measurement Limitation: Reliability vs. Validity

SDQ-25 total reliability was acceptable (Cronbach's $\alpha = 0.743$) and CRIES-8 reliability was good ($\alpha = 0.750$). However, the **Peer Problems subscale ($\alpha = 0.315$)** was lower — a structurally expected result with five-item subscales, representing a **known reliability constraint, not a validity defect**. Rare subgroups — sole survivors ($n=17$), maternal orphans ($n=26$), double orphans ($n=32$) — are treated **descriptively** rather than for generalising inference; they require future **larger purposive sampling**. The standardised scales (SDQ/CRIES) — which have prior application precedents with Gaza children ²⁰ — were applied without a **local pilot study** for the tent-living environment, which was not feasible in the narrow wartime window; future studies are recommended to conduct local pre-validation (4.6). These are **design constraints stated transparently**, to be read in their light — methodological triangulation that establishes validity does not cover over the reliability constraint (α); they are different properties, neither substituting for the other.

2.5 Field Team Training

The field team comprised **17 researchers**, selected from 24 trainees who completed an intensive training programme designed by the Centre's team. Final selection was restricted to those who passed the competency assessment, applying the principle of *Competency-Based Selection*.

The training spanned **25 hours** covering the skills required to implement the study with child-sensitive practice:

#	Training Module	Content
1	General Research Skills	Field research methodology, research ethics with children, communicating with vulnerable groups
2	Administering the Quantitative Questionnaire	SDQ-25 and CRIES-8 item explanation, handling sensitive questions, referral procedures on risk indicators
3	Focus Group Facilitation with Children	Ice-breaking, active listening, projective activities, group dynamics, developmental sensitivity
4	In-Depth Interview Skills	Active listening, follow-up questions, accurate documentation, managing critical situations
5	KoboToolbox Platform	Downloading forms, data entry, saving data, synchronisation, GPS coordinate management

2.6 Ethical Considerations

The study adhered to the ethical standards adopted in research with **children** in conflict settings, in recognition of the nature of the participants (orphaned children in a vulnerable situation) and the sensitivity of the study's themes (loss of family, trauma, need). This was implemented through:

1. **Dual informed consent:** obtaining the consent of the *caregiver or guardian* first, then the *child's own assent* for those aged 13 and above, with an explanation of the nature of the study and the right to withdraw or skip any question without consequences.
2. **Confidentiality and identity protection:** no direct identifying data were recorded in the quantitative questionnaire; in the interviews and focus groups, codes (I1, I2, FG1, FG2...) were used in analysis and documentation.
3. **Digital data protection:** encrypted storage on KoboToolbox, access restricted to the authorised analysis team, and GPS recording without linking it to the child's identity.
4. **Referral and child protection protocol:** the team was trained to detect risk indicators (self-harm, suicidal ideation, violence or exploitation, acute cases) and to activate immediate referral — applying the principle that *"the child's right to care takes precedence over the research's right to data."*
5. **Balancing documentation and protection:** on the most sensitive topics, the team respected the child's silence and unwillingness to elaborate, documenting only what was voluntarily disclosed, without pressure.

2.7 Quality Control and Verification Procedures

Data were subjected to **seven quality control tests** before any analysis, plus item-by-item reconciliation against KoboToolbox. The raw sample stood at **688 records; 17 were excluded** (two researchers with repetitive patterns + one test questionnaire), yielding a **clean sample of 671 children** with **100% match** on verified items. The seven tests were:

#	Test	Purpose
1	Response Uniformity — SDQ-25	Detecting identical responses across all items ($\geq 90\%$ same value)
2	Complete Record Duplication	Detecting duplicate records at the questionnaire level
3	Unrealistically Fast Completion	Detecting unconscious rapid responses warranting review
4	Researcher-Level Pattern Repetition	Detecting potential bias in the researcher's administration approach
5	Low Within-Questionnaire Variance	Detecting mechanical responses without genuine engagement
6	Positive/Negative Contradiction	Detecting internal inconsistency between positive and negative items (prosocial behaviour vs. difficulties)
7	Cross-Section Logical Inconsistency	Detecting overall inconsistency across questionnaire sections

The seventeen excluded records were removed **with documented transparency** in the analysis report, applying the golden rule: "*for review, not accusation*". The clean sample ($n = 671$) forms the basis for all subsequent analyses.

◆ Methodological Note on Theoretical Construction

The named theoretical concepts in the Findings chapter — "De-facto Orphans", "Structural Maternal-Orphan Exclusion", "Mother as Security Anchor", "First-Aid Not Developmental Care", "Gendered Militarization Pathway" — are **conceptual interpretations inductively derived from qualitative data** following *Constructivist Grounded Theory* (Charmaz, 2014²⁵), not assumptions imposed prior to data collection. The team acknowledges that another reader may organise the same data within a different framework, and that distinguishing between *empirical findings* (numbers and quotes) and *theoretical framing* (overarching frameworks) is necessary for a critical reading of the study.

Qualitative analysis applied the *Joint Display* principle (Creswell & Plano Clark, 2018¹⁵): an explicit separation between "*Participant Voice*" in quotation boxes and "*Analyst Voice*" in interpretation boxes — in accordance with APA 7 Qualitative Reporting Standards.

2.8 Field Challenges and Difficulties

The implementation of this study faced a number of field and contextual challenges that must be disclosed with full transparency:

- 1. Inaccessibility of Khan Younis and Rafah:** Military operations, forced evacuation and prohibitive travel costs during the collection period limited access to the two southern governorates.
- 2. Power and Internet Outages:** A daily challenge across the collection, analysis and writing phases alike; its impact on the field phase was mitigated by activating KoboToolbox's offline mode, while analysis and writing required flexibility in scheduling.
- 3. Developmental Sensitivity of Interviewing Children:** Avoiding re-traumatisation required a slower pace, interactive activities and a trained facilitator at all times.

4. **Psychological Burden on the Field Team:** Daily exposure to children's trauma narratives required regular group debriefing sessions.
5. **Unstable Security Environment:** Alerts and displacement waves interrupted some sessions and required rescheduling of several interviews and focus groups.

Study Findings

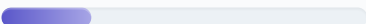
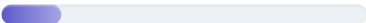
3.1 Section A — Basic Demographics

This section maps the demographic and contextual profile of orphans in the sample (n=671). Each item is presented with a frequency table, a focused analytical reading, and a forward link to subsequent sections. All percentages are computed from **raw counts** using round-half-up rounding; the raw counts are exact and sum to 671, and rounded percentage totals may differ from 100.00% or from their partial sums by ± 0.01 due to rounding alone, without any effect on count accuracy. The percentages describe **the sample** (n=671) as transferable indicators, not statistical generalisations to the population (see 2.3–2.4). The section pauses at two policy-critical items — education (A10) and child labour (A11) — with a preliminary qualitative lens that prepares for their in-depth analysis in subsequent sections, without pre-empting the full theoretical framing.

◆ A1. Governorate

The valid sample (n=671) was distributed across three governorates. Gaza Governorate leads with **397 children (59.17%)**, followed by North Gaza (163, 24.29%) and Deir al-Balah (111, 16.54%). For comparison with the reference population structure of the Palestinian Central Bureau of Statistics (PCBS 2023) across the three governorates: Gaza 51.7% · North Gaza 27.6% · Deir al-Balah 20.7% ⁶. Khan Yunis and Rafah were excluded due to unsafe access conditions (Chapter 2). Table (1) presents the distribution:

◆ Table (1) Sample distribution by governorate (n = 671) ◆

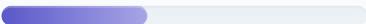
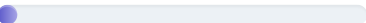
Category	Count	Percentage and distribution
Gaza	397	59.17% 
North Gaza	163	24.29% 
Deir al-Balah	111	16.54% 
Total	671	100.00%

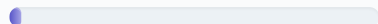
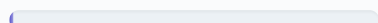
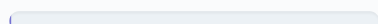
Gaza and North Gaza together account for 83.46% of the sample — an expected concentration given that the most intense military operations occurred there and that these areas absorbed internally displaced persons from across all governorates.

◆ A2. Respondent's Relationship to the Child

86.88% of responses came from the mother (47.24%) or the child themselves — those aged 13 or above (39.64%) — two direct sources that raise the reliability of the SDQ and CRIES scales. Table (2) presents the breakdown:

◆ Table (2) Respondent's relationship to the child (n = 671) ◆

Category	Count	Percentage and distribution
Mother	317	47.24% 
Child themselves (aged 13+)	266	39.64% 
Grandfather / Grandmother	36	5.37% 

Category	Count	Percentage and distribution
Uncle / Aunt (paternal or maternal)	21	3.13% 
Father	17	2.53% 
Adult sibling	7	1.04% 
Residential care institution	5	0.75% 
Unrelated person	2	0.30% 
Total	671	100.00%

Only five cases (0.75%) are in residential care institutions, despite 49 double orphans or sole survivors being present in the sample — the community-based system absorbs orphans without recourse to institutional care.

◆ A3. Child's Sex

A balanced distribution: **346 males (51.56%)** versus 325 females (48.44%), a ratio of 1.06:1 consistent with the population structure of children in Gaza — enabling reliable gender comparisons on the psychometric scales. Table (3) presents the breakdown:

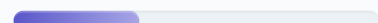
◆ **Table (3) Child's sex (n = 671)** ◆

Category	Count	Percentage and distribution
Male	346	51.56% 
Female	325	48.44% 
Total	671	100.00%

◆ A4. Age Group

Ages were distributed near-equally across three groups: **14–18 years (239, 35.62%)** · 10–13 years (230, 34.28%) · 6–9 years (202, 30.10%) — enabling robust age-group comparisons. Table (4) presents the breakdown:

◆ **Table (4) Child's age group (n = 671)** ◆

Category	Count	Percentage and distribution
14 – 18 years	239	35.62% 
10 – 13 years	230	34.28% 
6 – 9 years	202	30.10% 
Total	671	100.00%

The 14–18 age group includes cases at the upper boundary of the SDQ normative range (designed for ages 4–17), requiring caution when comparing against international norms.

◆ A5. Orphanhood Type

88.82% are paternal orphans (596) — the dominant category — followed by double orphans (32, 4.77%), maternal orphans (26, 3.87%), and sole survivors (17, 2.53%). The combined proportion of father-bereaved children reaches **96.13%** — a classic demographic pattern for war casualties (adult male targeting). Table (5) presents the distribution:

◆ **Table (5) Orphanhood type (n = 671)** ◆

Category	Count	Percentage and distribution
Paternal orphan (mother alive)	596	88.82% 
Double orphan (both parents deceased)	32	4.77% 
Maternal orphan (father alive)	26	3.87% 
Sole survivor	17	2.53% 
Total	671	100.00%

The two most vulnerable sub-groups — double orphans (32) and sole survivors (17), totalling 49 children — are analysed as distinct sub-categories in Sections D and E respectively.

◆ A6. Cause of Parental Death

89.87% lost their parent to the war (86.29% by direct bombardment + 3.58% through war's indirect circumstances) — the overwhelmingly dominant cause of orphanhood in the sample. Table (6) presents the breakdown:

◆ **Table (6) Cause of parental death (n = 671)** ◆

Category	Count	Percentage and distribution
Death directly from bombardment or war	579	86.29% 
Natural death or illness prior to the war	48	7.15% 
Indirect death due to war conditions	24	3.58% 
Other or multiple causes	13	1.94% 
Missing — fate unknown	7	1.04% 
Total	671	100.00%

Striking finding: all double orphans (32 children, **100%**) lost both parents to direct bombardment, as did **94.12%** of sole survivors — war is the exclusive producer of double orphanhood, distinguishing war orphanhood (compound trauma) from natural bereavement. (*Both percentages are descriptive for small sub-groups: n=32 and n=17.*)

◆ A7. Duration Since Parental Loss

87.33% lost their parent within the past three years or less (1–3 years: 448 · 6 months–1 year: 123 · under 6 months: 15) — a striking alignment with the onset of hostilities in October 2023. Table (7) presents the breakdown:

◆ **Table (7) Duration since parental loss (n = 671)** ◆

Category	Count	Percentage and distribution
1 to 3 years	448	66.77% 
6 months to 1 year	123	18.33% 
More than 3 years	85	12.67% 
Under 6 months	15	2.24% 
Total	671	100.00%

More than one-fifth of the sample lost their parent within the past year — the war is still producing new orphans, and these children are expected to carry the highest levels of acute trauma symptoms.

◆ **A8. Current Living Arrangement**

84.05% live with their mother (564) — logically consistent with 88.82% paternal orphanhood. The mother is the backbone of orphan caregiving. Table (8) presents the breakdown:

◆ **Table (8) Child's current living arrangement (n = 671)** ◆

Category	Count	Percentage and distribution
With mother	564	84.05% 
With grandparent(s)	56	8.35% 
With uncle / aunt or relatives	26	3.87% 
With father	16	2.38% 
With adult sibling	6	0.89% 
With neighbours or unrelated family	3	0.45% 
Total	671	100.00%

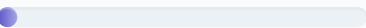
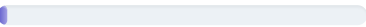
Any psychosocial support programme for orphans must include the mother as a mandatory component — she herself needs support (addressed in Section H).

◆ **Integration with the Widows Study:** Given that **84.05%** of orphans live with their mother and **96.13%** are father-bereaved, the primary caregiver of the orphan is — in the overwhelming majority of cases — **a widowed mother**. The Centre's companion study on widows in Gaza (n=729) documented that this same mother carries elevated psychological distress and bears sole financial responsibility for the household ²⁶. This intersection makes **the family unit (the widowed mother + the orphaned child) a single intervention unit**, not two separate individuals, and grounds the principle of **Whole-Family Care** elaborated in the Chapter 4 recommendations.

◆ **A9. Presence of Siblings**

92.25% have siblings living with them (619) — a well-established psychosocial protective factor that buffers the impact of bereavement. Table (9) presents the breakdown:

◆ **Table (9) Presence of siblings (n = 671)** ◆

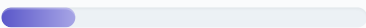
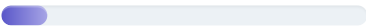
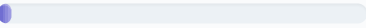
Category	Count	Percentage and distribution
Yes, living together	619	92.25% 
No siblings	35	5.22% 
Yes, but separated by displacement or war	17	2.53% 
Total	671	100.00%

52 children (7.75%) face compound isolation: 35 with no siblings + 17 separated by displacement — a priority group for individual psychosocial intervention.

◆ **A10. Educational Status**

16.10% are out of education (108 children: 82 stopped due to the war + 26 due to psychological condition), in addition to 20.27% with irregular attendance — compared to near-universal enrolment before the war. Table (10) presents the breakdown:

◆ **Table (10) Child's educational status (n = 671)** ◆

Category	Count	Percentage and distribution
Enrolled regularly	427	63.64% 
Partially enrolled, frequent absences	136	20.27% 
Dropped out due to the war	82	12.22% 
Dropped out due to psychological condition	26	3.87% 
Total	671	100.00%

3.87% (26 children) dropped out for psychological reasons — an early-warning indicator of severe adaptive disorders requiring urgent clinical screening (addressed in detail in Section F).

◆ **A cautious reading of the regular-enrolment figure (63.64%):** With approximately 81% of the sector's infrastructure (including schools) damaged ⁷, the category "regularly enrolled" should be read as **regular attendance in available but severely degraded education** — small-group circles and educational tents with minimal daily hours — not a return to pre-war conditions. The figure is internally consistent (regular attendance as reported by mothers: 63.41% ≈ self-reported: 62.03%), but reflects strong environmental variation (tent settings: 60.23% vs. permanent buildings: 74.68%), and **one third of orphans (36.36% · 244 children) remain outside regular attendance**. The testimonies below capture this degraded and insufficient education (analysed in full in Section F).

“

"Schools have been turned into shelter centres, and educational centres charge fees and are not available everywhere."

— **ORPHAN PROGRAMME COORDINATOR** — Collapse of the educational infrastructure

“

"[The war] has made education a thing of the past, because what the orphan thinks about is how to get firewood, fill water jugs, and find a loaf of bread."

— **PSYCHOSOCIAL SPECIALIST** — Survival priorities displace learning

“

"In my experience, the proportion of children who have dropped out of education reaches 70%."

— **DISPLACEMENT CAMP MONITOR** — Dropout rate in camp settings

“

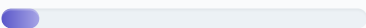
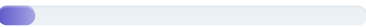
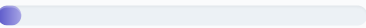
"No, not always — sometimes in winter I miss school."

— Orphan child in a focus group — Interrupted attendance (winter and tent conditions)

◆ A11. Child Forced to Work for Household Subsistence

16.54% are working (111 children), of whom 42 (6.26%) have left school entirely to work — a complete collapse of the childhood trajectory. Table (11) presents the breakdown:

◆ **Table (11) Child forced to work (n = 671)** ◆

Category	Count	Percentage and distribution
No	493	73.47% 
Yes, part-time alongside school	69	10.28% 
Not applicable (too young)	67	9.99% 
Yes, left school to work full-time	42	6.26% 
Total	671	100.00%

The gender gap is stark: boys work at **4 times the rate of girls** (26.01% vs. 6.46%) — an early collapse of the male childhood trajectory after paternal loss.

◆ **A cautious reading of the child-labour figure (16.54%):** Field estimates diverge markedly — from a programme coordinator estimating that around 40% of children are working (driven by the need to provide for the mother), to a teacher characterising those who drop out for work as "a small number." This divergence is itself a methodological signal: the quantitative figure (16.54%) is better understood as a **lower bound**, as it likely excludes informal survival labour (collecting firewood, carrying water, street vending, domestic chores), and rises to 18.38% among children of working age (excluding the 67 "too young" cases). Whatever its precise scale, two phenomena stand behind it: **Gendered Parentification** — the son assumes the absent father's provider role — and a psychological motive reported among some: the drive to **embody the father's identity**, not merely to meet economic need. The early responsibility is broader than formal employment and is analysed in full in Section B (B2). The testimonies below capture this diversity.

“

"I started helping my mother by carrying my siblings, fetching firewood, getting food from distribution points and water from queues. I have no time to play. I feel like everything is on me."

— Orphan girl in a focus group — Gendered burden and loss of play

“

"They work to provide for the mother, but not many — between 12 and 15 years old, roughly 40%."

— **ORPHAN PROGRAMME COORDINATOR** — Field estimate (40%) exceeds the quantitative figure (16.54%)

“

"Those who drop out for work are a small number... the motives for going to work are not economic necessity but a psychological drive to assume the father's identity."

— **TEACHER** — "Small" estimate (contra 40%) and the father-identity motive

◆ A12. Place of Residence

76.45% are living in tents (513 children) — three-quarters of orphans have no built shelter, representing a severe housing crisis. Table (12) presents the breakdown:

◆ **Table (12) Place of residence (n = 671)** ◆

Category	Count	Percentage and distribution
In own tent	304	45.31%
In family's tent	169	25.19%
In relatives' house	73	10.88%
In own house	44	6.56%
In sponsor's house	41	6.11%
In relatives' tent	40	5.96%
Total	671	100.00%

Deir al-Balah is the most severely displaced: **93.69%** of its orphans are in collective tents — it is a refuge area for internally displaced persons from Gaza City and North Gaza, and requires safe psychosocial spaces within displacement camps as an urgent intervention priority.

◆ A13. Access to Communication (Phone or Device)

96.87% have a means of communication (650) — enabling effective remote psychosocial support programmes (Tele-MHPSS) for clinical follow-up. Table (13) presents the breakdown:

◆ **Table (13) Access to a communication device (n = 671)** ◆

Category	Count	Percentage and distribution
Yes	650	96.87%
No	16	2.38%
No response	5	0.75%

Category	Count	Percentage and distribution
Total	671	100.00%

16 families (2.38%) with no means of communication warrant alternative outreach mechanisms (scheduled field visits) before being considered lost to follow-up.

◆ Summary: Basic Demographics

The basic demographic data present a coherent picture: **war orphans** (89.87% lost their parent to the war; 96.13% father-bereaved; with double orphanhood exclusively produced by direct bombardment at **100%**), of whom **84.05%** live with a **widowed mother carrying sole caregiving responsibility**, **76.45%** reside in **tents without built shelter**, and who lost their parent recently (87.33% within three years, aligned with October 2023). The erosion of childhood runs deeper than the raw figures suggest: the **63.64%** "regular enrolment" most likely represents regular attendance in a collapsed educational system (most schools damaged or converted into shelters), not adequate schooling, with **one third of orphans (244 children)** outside regular attendance altogether. The **16.54%** child-labour rate is a lower bound concealing informal survival labour — field estimates vary widely — behind which stands the figure of the **Parentified Child**: the son assuming the absent father's provider role (boys work at 4 times the rate of girls). These converging features — war orphanhood, exhausted sole caregiver, tent shelter, and the erosion of education and childhood — frame a context that deeply explains what subsequent sections will document: the impact of paternal loss (Section B), maternal loss (Section C), through to the psychometric scales (Section F). These are not "ordinary orphans" but war children in a fragile environment, carrying adult roles before their time.

3.2 Section B — Impact of Paternal Loss

This section applies to **paternal orphans whose mothers are alive** (sub-sample n=596; double orphans and sole survivors are routed past this section by the questionnaire logic, and are addressed in Section D). Items B1–B6 are measured on a four-point scale (always=4 · often=3 · sometimes=2 · never=1), and B7 is a multiple-choice item. Applying the **Methodological Triangle** (Triangulation) principle, each quantitative item is followed by a direct qualitative testimony from the interviews or focus groups where available. Percentages are calculated from a base of 596 using round-half-up rounding (a difference of ±0.01 is possible).

◆ B1. Severe Financial Hardship Since the Father's Loss

Financial hardship leads the entire section: **78.19%** of orphan families experience it "always" or "often" (466 out of 596), with a mean of **3.14 out of 4**, and **97.48%** experience it to some degree. Table (14) presents the breakdown:

◆ Table (14) Severe financial hardship since the father's loss (n = 596) ◆

Rating	Count	Percentage and distribution
Always applies	231	38.76% 
Often applies	235	39.43% 
Sometimes applies	115	19.30% 
Never applies	15	2.52% 
Total	596	100.00%

Loss of the father = loss of the primary breadwinner. Financial hardship is the direct gateway to child labour (16.54%, A11) and educational dropout (16.10%, A10).

QUAL Breadwinner Loss and the Sponsorship Gap

Practitioners frame paternal loss first and foremost as a **breadwinner loss** — "loss of the source of income, creating a need for a sponsor to fill his place" — to the point where the definition of entitlement itself rests on this logic (father = breadwinner). Focus groups reveal the lived dimension of the loss: acute food insecurity — one meal a day, dependence on soup kitchens and food coupons. Both data sources converge on financial hardship (78.19%, B1) as the gateway, intersecting with 74.50% who miss material support (B7), 16.54% child labour (A11), and 16.10% educational dropout (A10). A **key point of divergence** emerges, however, between the framing and the lived reality: the promised sponsor rarely materialises ("no regular sponsorships" in testimonies), leaving the widowed mother to substitute for the breadwinner — unpaid and without institutional support. This phenomenon of **Maternal Breadwinner Substitution** was reported by 7 out of 8 participants in one focus group, consistent with 84.05% living with their mother (A8). It transforms **the Sponsorship Gap** from an absent system into a burden borne by an exhausted mother. A second divergence: the aggregate 78.19% conceals a **Stratified Deprivation** — children of martyrs are relatively less deprived compared to the general orphan population, who depend more heavily on soup kitchens. The explicitly voiced **food longing** (meat and eggs) gives flesh and blood to these figures — a **Quant → Qual cross-reference** with the highest-ranked material need (85.10%, H) and loss of material support (74.50%, B7): the qualitative data do not repeat the number but reveal its *lived depth*. The testimonies below capture the institutional framing and the depth of food deprivation.

“*"A child who has lost his father has lost affection, support and livelihood — he needs a sponsor to provide for him."*

— **SPONSORSHIP ASSOCIATION OFFICIAL** — Institutional breadwinner framing (father = breadwinner)

“*"We live off the soup kitchen and food coupons."*

— Orphan child in a focus group — Food insecurity (one meal a day)

“*"Meat and chicken — I wish we had them. My mother can't afford them."*

— Orphan child in a focus group — Depth of food deprivation (craving for protein)

◆ B2. Weight of Age-Inappropriate Responsibility

58.22% carry responsibility beyond their years "always/often" (347), with a mean of **2.66 out of 4** — a collapse of normal childhood and the emergence of the Parentified Child phenomenon. Table (15) presents the breakdown:

◆ **Table (15) Child's sense of carrying age-inappropriate responsibility (n = 596)** ◆

Rating	Count	Percentage and distribution
Always applies	141	23.66% 
Often applies	206	34.56% 
Sometimes applies	155	26.01% 
Never applies	94	15.77% 

Rating	Count	Percentage and distribution
Total	596	100.00%

58.22% (347 children) carry age-inappropriate responsibility "always/often", and **84.23% to any degree** — a direct risk indicator for the collapse of normal childhood (the Parentified Child); the majority are burdened, not "divided." The 15.77% "never" is a minority that does not counterbalance this majority. The evidence that the burden translates into real behavioural harm: it converts, among boys, into actual child labour (boys at 4× the rate of girls, A11).

QUAL Gendered Parentification and Compensatory Control

Focus groups reveal **role reversal**: the child assumes the provider role prematurely through **unpaid survival burdens** — carrying water, queuing at soup kitchens, fetching bread, caring for younger siblings. Practitioners in interviews frame this as **Compensatory Control**: the child seizes the absent father's authority through dominance, control, and premature responsibility. This is why the responsibility burden (58.22%, B2) far exceeds formal employment (only 16.54%, A11) — the burden is real but unpaid and therefore not classified as "work." The Methodological Triangle provides a Quant–Qual reading of the Parentified Child without false equivalence with the employment figure. The key divergence is that this role reversal is **Gendered Parentification**: girls assume **domestic burdens** (washing, cooking, water-carrying, sibling care) inside the tent, while boys move toward **external labour** (market stalls, firewood-cutting, waste collection) — a split consistent with male child labour at 4× the female rate (26.01% vs. 6.46%, A11) and with the "gendered concerns" noted by practitioners (girls/marriage, boys/work). The burden is singular in its weight but dual in its face. The testimonies below capture the female domestic burden, the male role reversal, and the compensatory control dynamic.

“

"I'm the oldest — everything falls on me. I feel suffocated, like I can't breathe, as if I'm carrying a responsibility heavier than my age."

— Orphan girl in a focus group — Female domestic burden (Parentification)

“

"My father used to bring everything. Now I'm the one who has to bring everything, and I feel exhausted and can't cope."

— Orphan boy in a focus group — Male role reversal (taking over the provider role)

“

"I started working and I sleep exhausted from roaming the streets all day."

— Orphan boy (10–11 years) in a focus group — Exhaustion of early external labour

“

"He is characterised by arrogance, dominance, responsibility-seeking and control."

— **PSYCHOSOCIAL SPECIALIST** — Compensatory control (seizing the father's authority)

◆ B3. Lack of Safety and Protection Since the Father's Absence

63.76% feel unsafe "always/often" (380), with a mean of **2.80 out of 4**, and **91.61%** to some degree — the father was the source of both symbolic and practical protection. Table (16) presents the breakdown:

◆ **Table (16) Child's sense of lack of safety and protection (n = 596)** ◆

Rating	Count	Percentage and distribution
Always applies	148	24.83%

Rating	Count	Percentage and distribution
Often applies	232	38.93%
Sometimes applies	166	27.85%
Never applies	50	8.39%
Total	596	100.00%

63.76% (380 children) feel unsafe "always/often", and **91.61% to any degree** — an overwhelming majority and a risk indicator predictive of elevated scores on the SDQ Emotional subscale (Section F): anxiety, nightmares, and fear.

QUAL Loss of the Secure Base and the Protection Vacuum

Practitioners in interviews trace the sense of insecurity to the father having been the **Secure Base** in personality formation (particularly for ages 3–8), whose absence produces chronic fear and loss of support, expressed in children's voices as **painful comparison with peers** who still have fathers. Focus groups reveal, however, that the fear is not only existential but also **contextually situational in a war environment**: sensory fear of aircraft sounds and bombardment, recurring separation anxiety ("when I'm alone," fear when family members are late returning), and a **Protection Vacuum** that leaves the child exposed to bullying without a male figure to shield him. A **key divergence** emerges: the secure base transfers emotionally to the mother (children feel safe with her; A8: 84.05% live with her), yet the sense of insecurity remains high (63.76%) — because the mother fills **attachment security** but not **external protection security** in a war-and-displacement environment. What was lost with the father was not love but the **shield**. This is consistent with 74.50% missing safety and protection (B7) and is compounded by direct exposure to bombardment. The testimonies below capture the situational fear, the formative lost secure base, and the protection vacuum.

“*When I'm alone, nobody checks on me... fear of loud sounds and bombing... when someone upsets me and bullies me.*”

— Orphan children in a focus group — Situational fear (abandonment + sensory + protection vacuum)

“*The 3–8 age group — they lose the foundational security for personality formation.*”

— **PSYCHOSOCIAL SPECIALIST** — Formative Secure Base

“*His personality has become weak — he has lost security and support.*”

— **TEACHER** — Protection vacuum and loss of male backing

◆ **B4. Mother's Difficulty Compensating for the Father's Absence**

56.54% of mothers find it very difficult to compensate for the father's absence (337) "always/often", with a mean of **2.66 out of 4**, and **89.60%** to some degree — the caregiver herself is depleted. Table (17) presents the breakdown:

◆ **Table (17) Mother's difficulty compensating for the father's absence before the child (n = 596)** ◆

Rating	Count	Percentage and distribution
Always applies	118	19.80%

Rating	Count	Percentage and distribution
Often applies	219	36.74%
Sometimes applies	197	33.05%
Never applies	62	10.40%
Total	596	100.00%

56.54% (337 mothers) find it very difficult to compensate for the father's absence "always/often", and **89.60% to any degree** — meaning that the very pillar of caregiving (84.05% live with the mother, A8) is itself depleted. For this reason, mothers must be integrated into any child-focused intervention programme.

QUAL The Depleted Caregiver — Skill Gap vs Capacity Gap

Practitioners in interviews interpret the mother's inability to compensate through two divergent frameworks. The first is a **Skill Gap** — the caregiver "cannot provide sufficient affection and wants guidance" in managing the orphan's emotions and behaviour, a deficit remediable through counselling. The second is a **Capacity Gap** — caregiving is "emergency-based, not developmental, because the caregiver is herself exhausted materially and psychologically," the mother being a **victim caring for a victim**, lacking not love but energy. This distinction is decisive for intervention: counselling alone cannot reach an exhausted mother, and the quantitative evidence favours the capacity gap (H4: 81.22% of caregivers need psychological support; A8: 84.05% — the burden rests on the mother). The paradox is that the mother — the **best type of caregiver** for orphans (more attentive and consistent than a grandfather or uncle) — remains structurally incapacitated because she is **performing the role of two parents while carrying her own grief**. The picture is closed by **Emotional Role Reversal**: the child sees his mother weeping and absorbs her sorrow on top of his own — the other face of the Parentified Child (B2). The testimonies below capture both the skill and capacity gaps and the role reversal.

“

"The care is emergency-based, not developmental — because the caregiver is still exhausted and depleted, both materially and psychologically."

— **PSYCHOSOCIAL SPECIALIST** — Capacity gap (the depleted caregiver)

“

"The challenge: inability to provide sufficient affection; they want someone to guide them in handling the orphan's emotions."

— **TEACHER** — Skill gap (need for guidance)

“

"When I see my mother sitting and crying while looking at photos of my father on her phone."

— Orphan child in a focus group — Emotional role reversal (child absorbs mother's grief)

“

"When our house was bombed I go to mum and I keep crying."

— Orphan child in a focus group — Refuge in the mother, but consolation remains incomplete

◆ B5. Anger or Aggression Towards the Mother or Siblings

41.95% display anger or aggression "always/often" (250), with a mean of 2.37 — yet notably, **22.48% (134 children)** **never display anger**, the highest "never" rate among all negative-impact items (B1–B5). Table (18) presents the breakdown:

♦ **Table (18) Child displaying anger or aggression due to bereavement (n = 596)** ♦

Rating	Count	Percentage and distribution
Always applies	106	17.79%
Often applies	144	24.16%
Sometimes applies	212	35.57%
Never applies	134	22.48%
Total	596	100.00%

41.95% (250 children) display anger or aggression "always/often" — typically **displaced** onto the mother and siblings (safe targets) rather than the source of pain. The 22.48% "never" does not necessarily indicate healthy adaptation: some may be concealing **emotional suppression (depressive internalisation)** that is more dangerous than overt anger — a subgroup warranting separate clinical screening.

QUAL **Anger Displacement and the Externalising–Internalising Poles**

Practitioners in interviews identify anger and aggression as one of the most prominent symptoms of orphanhood, and describe it as **age-graded**: young children express it through crying and involuntary enuresis; adolescents through violence, raised voices, and claiming the father's authority. Focus groups (children's voices) confirm that the primary trigger is **any reference to the father**, and that anger is **displaced** onto the mother and siblings because they are the safe targets. The key divergence is that overt anger (41.95%) is only one pole — **Externalising** — matched by a silent pole of **Internalising**: withdrawal and silence (documented cases of a child with "not a word, not a reaction, not a movement" after witnessing his father's death). The 22.48% "never" may therefore be not the least affected but the **most suppressed** — making the "absence of anger" a potential warning sign rather than reassurance. This bipolar distribution is consistent with the SDQ structure (Section F): the Conduct and Hyperactivity subscales for externalising, the Emotional subscale for internalising. The testimonies below capture the trigger, the age gradient, and the silent pole.

“

"When I argue with my friends and one of them says something bad about my father, I start crying and get angry and want to hit him."

— Orphan child in a focus group — Anger trigger (reference to the father)

“

"Young children express their anger through crying; adolescents through violence and raised voices."

— **PSYCHOSOCIAL SPECIALIST** — Age gradient (externalising)

“

"A first-grade boy always sits silent — not a word, not a reaction, not a movement... a deep silence since he witnessed his father's death."

— **INSTITUTION MANAGER** — The silent pole (depressive internalisation)

♦ **B6. Deterioration of the Child's Relationship with the Father's Family After His Death**

The relationship with the father's family deteriorated "always/often" for **33.72%** (201), but **40.94% (244) responded "never applies"** — the **single largest category**, indicating that the father's family remained close to the child (a positive indicator), with the highest variance in the section (SD=1.14). Table (19) presents the breakdown:

◆ **Table (19) Deterioration of the child's relationship with the father's family after his death (n = 596)** ◆

Rating	Count	Percentage and distribution
Always applies	111	18.62%
Often applies	90	15.10%
Sometimes applies	151	25.34%
Never applies	244	40.94%
Total	596	100.00%

40.94% (244) showed no deterioration — the father's family remained close (a positive indicator), against **33.72% who did deteriorate**; the highest variance in the section (SD=1.14) reflects **two opposing trajectories**: a paternal network that rallies more closely around the orphan, and another that withdraws or discriminates against him.

QUAL Paternal Lineage Duality — Solidarity vs Exclusion

The Methodological Triangle interprets the high variance (SD=1.14) through two trajectories determined by the structure of paternal lineage. In the positive trajectory, **Paternal Lineage Solidarity** is activated: the grandmother and the father's family rally around the orphan after the death, to the point where the grandmother becomes even closer than she was before. In the negative trajectory, **In-Law Discrimination** emerges: harsh treatment in the uncle's household; the uncle's wife prioritises her own children over the orphan in allocating pocket money. The decisive axis between the two trajectories is **the Maternal Pivot**: as long as the mother is present as caregiver, contact with the father's family may cool (complementing the Maternal Breadwinner Substitution dynamic, B1); but if the mother remarries or is absent, the child migrates to the grandmother and the father's family — an expression of what the widows study terms "paternal lineage claim" ²⁶ (the child as an extension of the paternal lineage). The 40.94% "no deterioration" is therefore not a guaranteed network but a **conditional** one, contingent on this pivot — a resource that can be activated, not an automatic substitute. The testimonies below capture both the solidarity and exclusion poles and the maternal pivot.

“

"My grandmother started loving me more — before, she used to fight with my father."

— Orphan child in a focus group — Paternal lineage solidarity after death

“

"The orphan complains of mistreatment by his uncle's wife — she gives her own children pocket money but not him."

— **TEACHER** — In-law discrimination

“

"My grandmother understands me. My mother doesn't live with us — she remarried, and I hate her husband, so I don't go to her."

— Orphan child in a focus group — Maternal pivot (migration to grandmother after mother's remarriage)

“

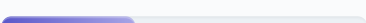
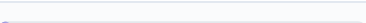
"The mother looks for her own life and remarriage, so the child goes to the grandmother — who may be uneducated or elderly, resulting in care deficits."

— **INSTITUTION MANAGER** — Maternal pivot and fragility of the paternal-family substitute

◆ B7. What the Child Misses Most Since His Father's Death

Bereavement is led by a triad embodying the three paternal roles: **safety and protection (74.50%)** and **material and financial support (74.50%)** and **paternal affection and warmth (72.65%)**, followed by **a male role model and example (36.41%)**. Table (20) presents the breakdown:

◆ **Table (20) What the child misses most since his father's death (n = 596 · multiple choice)** ◆

What the child misses	Count	Percentage of 596
Safety and protection	444	74.50% 
Material and financial support	444	74.50% 
Paternal affection and warmth	433	72.65% 
A male role model and example	217	36.41% 
Dignity and status among peers	58	9.73% 
Does not speak about the father's absence	20	3.36% 

The loss is led by a closely clustered paternal triad (~74% for safety, support, and affection each), mirroring B1 (78.19% financial hardship) and B3 (63.76% lack of safety) — reinforcing the validity of the indicators. This is a Quant→Quant cross-reference = **Convergent Validity**; the Methodological Triangle's Quant→Qual cross-reference follows in the analysis below.



QUAL

The Paternal Triad and the Deferred Role-Model

The Methodological Triangle reveals that paternal loss is not a single loss but a simultaneous **Paternal Triad**: the father was **protector** (safety 74.50%), **provider** (support 74.50%), and **nurturer** (affection 72.65%) at once — three roles collapsing together, which explains the co-occurrence of financial hardship, insecurity, and grief throughout this entire section. Notably, **a male role model (36.41%)** ranked roughly half the triad — not because identity is less important, but because it is a **Deferred Gendered Role-Model** that matures in adolescence and concerns boys more than girls (consistent with "gendered concerns": work for boys, marriage for girls, and the gendered burden in B2); the young child misses the shield, the bread, and the embrace before he misses the role model. Beneath all of this lies the deepest layer: **Existential Longing** — an early awareness of death coexisting with a silent yearning to be reunited with the father. Here the true Methodological Triangle completes itself: Quant (B7) ↔ children's qualitative voice. The testimonies below capture the layers of the triad and the longing.



"When dad isn't here I sit and cry... I keep missing my dad."

— Orphan child in a focus group — Loss of affection and warmth (daily grief)



"I just don't want to die like my dad."

— Orphan child in a focus group — Existential longing and early awareness of death



"A fatherless child lacks material support, moral support, and a sense of self."

— **CAMP MONITOR** — The paternal triad (support + protection + affection)



"The concerns: the future, marriage for girls, and work for boys."

— **PSYCHOSOCIAL SPECIALIST** — The deferred gendered role-model

◆ Summary — Section B: Impact of Paternal Loss

Paternal loss transforms the child from a recipient of care into a bearer of its burdens, and the Quant–Qual Methodological Triangle confirmed every dimension — not merely through agreement but by revealing the **structure of the crisis** beneath the figures. The near-universal financial hardship (78.19%, $M=3.14$) is not relieved by a promised sponsor who is usually absent, but substituted by an **unpaid widowed mother** (Maternal Breadwinner Substitution); the inverted childhood (58.22%) is **gendered** — boys toward external labour (16.54%, males $\times 4$) and girls toward domestic burdens; the sense of insecurity (63.76%) remains elevated despite the secure base transferring to the mother, because what was lost is **protection security, not attachment security** (the shield, not the love); the mother — the best of all caregivers — fails structurally not for lack of skill but from **depleted capacity** (81.22% of caregivers need psychological support); overt anger (41.95%) is only one pole against a **silent internalised pole** that may be more dangerous in the 22.48% "who never display anger." The paternal family network is dual-trajectory (40.94% solidarity against withdrawal and discrimination), governed by the **maternal pivot** — a conditional resource, not a guaranteed substitute. What the child misses most is captured in a **Paternal Triad** (protection, provision, and affection, $\sim 74\%$ each), followed by a deferred male role-model (36.41%). **Bridge to Section C:** If paternal loss strikes the shield and the bread, the loss of the mother — the subject of the next section — strikes the very core of emotional regulation itself, in a smaller group ($n=26$) that is, as we shall see, the most structurally excluded from services.

3.3 Section C — Impact of Maternal Loss

This section applies to **maternal orphans whose fathers are alive** (sub-sample $n=26$; doubly orphaned children and sole survivors skip to Section D per questionnaire logic). Items C1–C7 are measured on a four-point scale (always=4 · often=3 · sometimes=2 · never=1), and C8 is a multiple-choice item. **Critical methodological caveat:** the sample is small (every 2 children $\approx 7.7\%$), so the figures are read as transferability, not statistical representation, and comparisons with Section B ($n=596$) require small-sample tests (Mann-Whitney), not ANOVA. Nevertheless, the Methodological Triangle reveals a consistent pattern: the maternal orphan is **triply hidden** — smallest in number (3.87%, A5), definitionally excluded from the label "orphan," and statistically camouflaged (C1). Percentages are from a base of 26 with round-half-up rounding. (*Methodological note: focus groups comprised mainly paternal orphans, so qualitative analysis for this section draws primarily on interviews [key informants]; child voice cited here concerns phenomena shared across orphan types, such as fear of losing the surviving parent.*)

Structural Exclusion of the Maternal Orphan: Six independent interview sources agree that the maternal orphan is **the least likely to receive services**, and there is an explicit institutional rationale: eligibility definitions tie "orphanhood" to paternal loss (the provider), so a child whose mother dies but whose father is alive **is not considered an orphan** and is referred to relief, not sponsorship. Definitional exclusion thus converges with numerical scarcity (3.87%) and statistical camouflage (C1) to produce a category that is **the most deeply bereaved and least served**.

“

"A child whose mother died is not considered an orphan and receives no assistance — whereas the paternal orphan has a mother present who asks about her child's welfare."

— **ORPHANAGE OFFICIAL** — the definitional exclusion mechanism

“

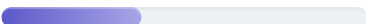
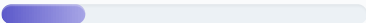
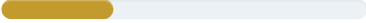
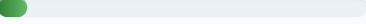
"We do not have maternal orphans and do not work with them because the father is present and the source of income... a child who lost his mother falls under relief, not sponsorship."

— **SPONSORSHIP ASSOCIATION OFFICIAL** — the declared exclusion policy (father = provider)

◆ C1. Deep, persistent grief since mother's death

61.54% exhibit deep persistent grief "always/often" (16 of 26), with a mean of **2.92 out of 4**, and **92.31%** to any degree — only two children show no grief at all. Table (21) shows:

◆ **Table (21) Child expressing deep, persistent grief since mother's death (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	10	38.46% 
Often applies	6	23.08% 
Sometimes applies	8	30.77% 
Never applies	2	7.69% 
Total	26	100.00%

61.54% (16 of 26) exhibit deep persistent grief "always/often," and **92.31% to any degree** — the mother is not easily replaced emotionally, confirmed in C8 (88.46% miss physical warmth and affection — the highest consensus in the entire study).

QUAL The Lost Embrace & the Screening Camouflage

Specialists in the interviews frame the mother as the **center of emotional regulation** for the child in Palestinian culture, making her loss a grief that is **deeper and longer-lasting** than the father's — "the maternal orphan lacks tenderness more." This is consistent with the quantitative data: 61.54% deep grief (C1) and 88.46% miss emotional warmth (C8). But **the measured evidence** (computed from raw data, n=26) reveals the **Screening Camouflage: 61.5% of maternal orphans exceed the emotional disturbance threshold** versus only **34.6% exceeding the total difficulties threshold** — a gap of approximately **27 points, the largest among all categories** (versus ~15 points for paternal orphans). The total score classifies them as "lowest difficulty" (34.6% versus 55.0% for paternal orphans) not because they experience less pain, but because their pain is **Internalizing**: the conduct scale (mean 2.38) and peer scale (3.42) are the lowest among all categories, pulling down the total, while the emotional wound and section indicators remain acute (88.46% miss physical warmth, 76.92% separation anxiety). Screening by total score alone **drops the largest share of suffering maternal orphans**, colluding — unintentionally — with the structural exclusion above. The quotes below embody the emotional centrality of the mother and the depth of loss.

“

"The maternal orphan needs more care — they lack tenderness more than the paternal orphan."

— **TEACHER** — depth of emotional loss (mother cannot be replaced)

“

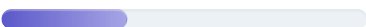
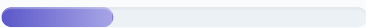
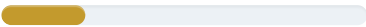
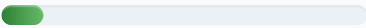
"The maternal orphan lacks affection and tenderness."

— **CAMP MONITOR** — mother as center of emotional regulation

◆ C2. Searching for a mother substitute in the surroundings (grandmother, aunt, teacher)

65.38% seek a mother substitute "always/often" (17 of 26), with a mean of **2.88 out of 4**, and **88.46%** to any degree — the most pervasive need in the section. Table (22) shows:

◆ **Table (22) Child searching for a mother substitute in their surroundings (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	9	34.62% 
Often applies	8	30.77% 
Sometimes applies	6	23.08% 
Never applies	3	11.54% 
Total	26	100.00%

65.38% (17 of 26) seek a mother substitute "always/often," and **88.46% to any degree** — an urgent functional need (not voluntary adaptation) that requires provision of a stable, nurturing maternal figure.

QUAL Attachment Reconstruction & the Fragile Substitute

The interviews interpret the search for a mother substitute as **Attachment Reconstruction**: an urgent functional need (65.38% "always/often," 88.46% to any degree) rather than voluntary adaptation, directed toward the grandmother, aunt, or teacher. But **the divergence point** is that this near-universal need is met by a **Fragile Substitute**: the quality of the substitute determines the quality of adaptation, and the available substitute is often inadequate — an elderly grandmother or a rotating teacher who cannot fill the mother's role. Having "someone" available does not suffice unless they are **stable and nurturing**; thus the variable "with whom the child lives" (A8) becomes a key determinant of this category's fate, and connects to the mother figure in B6 (who holds the child after loss). The quotes below embody the need and the fragility of the substitute.

“

"Searching for a substitute in adolescence — especially for girls."

— **SOCIAL WORKER** — Attachment Reconstruction (functional need)

“

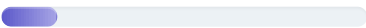
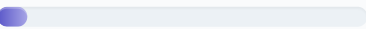
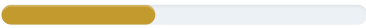
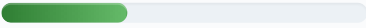
"He goes to the grandmother, and the grandmother may be uneducated or elderly — so care becomes deficient."

— **ORPHANAGE OFFICIAL** — fragility of the maternal substitute

◆ C3. Decline in interest in hygiene or appearance

Only **23.08%** show a decline "always/often" (6 of 26) — the lowest item in the section — with a mean of **2.04 out of 4**, while **34.62%** show no decline at all. Table (23) shows:

◆ **Table (23) Decline in child's interest in hygiene or appearance (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	4	15.38% 
Often applies	2	7.69% 
Sometimes applies	11	42.31% 
Never applies	9	34.62% 
Total	26	100.00%

This is the lowest item in the section (23.08% "always/often," 34.62% "never"), but its low rate is a **superficial indicator, not a sign of wellbeing**: hygiene decline is a recognized symptom of childhood depression, and its absence does not negate the deeper grief (C1) or separation anxiety (C4), which are the most severe items in the section.

QUAL The Mask of Formal Stability

Decline in interest in hygiene and appearance is a clinical indicator of childhood depression (DSM-5), and it registered lowest in the section (23.08% "always/often"). But **reading it requires caution**: its low rate does not mean "the substitute network is working" — the father or grandmother may maintain **formal daily stability** (food, clothing, hygiene) while **emotional care remains absent** — which C8 reveals clearly: 88.46% miss physical warmth versus only 11.54% who miss stability and routine. Hygiene is the visible surface of an iceberg whose submerged mass is grief and anxiety — the same face seen in the **Screening Camouflage (C1)**: the behavioral surface declines while the emotional interior remains acute. (Caveat: n=26 is small; interpretation is clinical, not generalizing.) The quotes below embody the behavioral indicator and emotional withdrawal.

“

"Neglect of hygiene, breaking pencils and tearing stationery."

— **TEACHER** — behavioral indicator of childhood depression

“

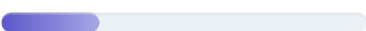
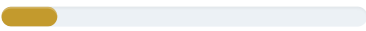
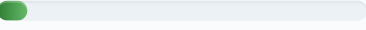
"As the child grows older, they tend toward isolation and solitude."

— **SOCIAL WORKER** — emotional withdrawal beneath the mask

◆ C4. Intense fear of losing remaining family members

76.92% exhibit intense fear "always/often" (20 of 26) — **the highest in the section** — with a mean of **2.96 out of 4** and the lowest variance (SD=0.87); only two children are free of it. Table (24) shows:

◆ **Table (24) Child's intense fear of losing remaining family members (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	7	26.92% 
Often applies	13	50.00% 
Sometimes applies	4	15.38% 
Never applies	2	7.69% 
Total	26	100.00%

76.92% (20 of 26) fear losing remaining family "always/often" — **the highest in the section** with the lowest variance (SD=0.87, highest consensus) — acute separation anxiety representing the **first clinical priority** for this category.

**QUAL****Acute Separation Anxiety — Pathological or Reality-Based?**

Fear of losing remaining family tops the entire section (76.92% "always/often") with the lowest variance (SD=0.87) — meaning the highest consensus among children, making it a near-universal phenomenon rather than an outlier. Clinically framed as **Acute Separation Anxiety** following maternal loss. But a **fundamental point of divergence** asserts itself in Gaza's context: this fear is not a morbid illusion but **Reality-Based Hypervigilance** — the surviving father may actually be killed in an ongoing war, making the fear **rational, not neurotic**. This inverts the logic of intervention: it is not treated by convincing the child "there is no danger" but by providing **actual stability, protection, and threat reduction**. This is consistent with the wartime situational fear in B3, and this category is likely the **first clinical priority**. The quote below embodies the clinical framing of separation anxiety.



"Fear, tension, and insecurity."



PSYCHOLOGIST

— clinical framing of separation anxiety

◆ C5. Insufficient daily care due to pressure of circumstances on the father

38.46% do not receive adequate daily care "always/often" (10 of 26), with a mean of **2.38 out of 4**, while only **19.23%** receive it fully. Table (25) shows:

◆ **Table (25) Child not receiving adequate daily care (pressure of circumstances on the father) (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	5	19.23%
Often applies	5	19.23%
Sometimes applies	11	42.31%
Never applies	5	19.23%
Total	26	100.00%

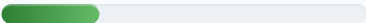
38.46% (10 of 26) do not receive adequate daily care due to pressure of circumstances on the father "always/often," while only **19.23%** receive it fully — more than one third in structural partial neglect.

◆ C6. Insufficient attention due to father's preoccupation

46.15% do not receive adequate attention "always/often" (12 of 26), with a mean of **2.38 out of 4** and a near-equal distribution across categories. Table (26) shows:

◆ **Table (26) Child not receiving adequate attention (father's preoccupation) (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	5	19.23%
Often applies	7	26.92%
Sometimes applies	7	26.92%

Category	Count	Percentage and Distribution
Never applies	7	26.92% 
Total	26	100.00%

46.15% (12 of 26) receive insufficient attention due to the father's preoccupation "always/often" — nearly half; a **functional reason** (work pressure, sole breadwinning, displacement) addressed by economic and service support, not custody transfer.

QUAL The Father Does Not Automatically Become a Mother: The Functional Care Gap

C5 and C6 reveal that the surviving father — even if willing — **does not automatically fulfill the mother's role**: 38.46% without adequate daily care and 46.15% without adequate attention, for **functional rather than capability reasons** — war and displacement pressure, the burden of sole breadwinning, and **absence of experience in daily care** that culturally remained the mother's role. This framing is critical for intervention: the functional gap is addressed by economic and service support (childcare, parenting counseling, burden relief) not custody transfer. It is the **mirror of B4**: just as the mother fails to compensate for the father due to exhausted capacity, the father fails to compensate for the mother due to absent role and experience — neither parent is a complete substitute for the other. The quotes below embody the father's preoccupation and experience gap.

“

"For the maternal orphan, the father has no time for care and has other responsibilities."

— **ORPHANAGE OFFICIAL** — functional gap (the burdened father)

“

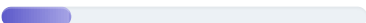
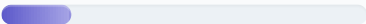
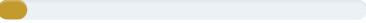
"Some are disengaged due to ignorance."

— **SOCIAL WORKER** — gap in daily caregiving experience

◆ **C7. Insufficient attention due to father's unfit caregiving**

More than half of fathers are fit (**53.85%** "never applies"), yet **38.46%** suffer unfit fathering "always/often" (10 of 26), with the highest variance in the section (SD=1.25). Table (27) shows:

◆ **Table (27) Child not receiving adequate attention (father's unfit caregiving) (n = 26)** ◆

Category	Count	Percentage and Distribution
Always applies	5	19.23% 
Often applies	5	19.23% 
Sometimes applies	2	7.69% 
Never applies	14	53.85% 
Total	26	100.00%

More than half of fathers are fit (53.85% "never"), but **38.46% (10 of 26)** suffer unfit fathering "always/often" — with the highest variance in the section (SD=1.25): sharp polarization between "fully fit father" and "fully unfit father." These ten are at **genuine clinical risk requiring immediate child protection intervention**.

**QUAL****The Fitness Gap & When Custody Must Move**

C7 differs fundamentally from C5/C6: not a **functional gap** (burdened but willing father) but a **Fitness Gap** — addiction, psychiatric disorder, disability, or **remarriage that marginalizes the child**. The highest variance in the section (SD=1.25) confirms **sharp polarization with no middle category**: 53.85% fully fit fathers versus 38.46% dangerously unfit. This distinction is the **practical decision pivot**: the functional gap is addressed by support, while the fitness gap requires **child protection intervention and legally studying custody transfer** to grandparent or uncle/aunt. The ten "always/often" are not a marginal number in a sample of 26 — they are **more than a third** requiring urgent individual assessment. The quote below embodies the fitness deficiency and benefit extraction from guardianship.



"Some guardians take the sponsorship only for personal benefit — not to help the child."

**TEACHER**

— Fitness Gap (benefit extraction, not care)

♦ C8. What the child misses most since mother's death

Physical warmth and affection (88.46%) leads by a wide margin, followed by **daily care and attention (50%)**, **someone to listen and understand them (42.31%)**, and **a sense of security (38.46%)**; the lowest is **stability and routine (11.54%)**. Table (28) shows:

♦ **Table (28) What the child misses most since mother's death (n = 26 · multiple choice)** ♦

What the child misses	Count	% of 26	
Physical warmth and affection	23	88.46%	
Daily care and attention	13	50.00%	
Someone to listen and understand them	11	42.31%	
Sense of security	10	38.46%	
Stability and routine	3	11.54%	

88.46% (23 of 26) miss "physical warmth and affection" — **the highest consensus rate in the entire study** — followed by daily care (50%) and someone to listen and understand (42.31%), while stability and routine ranks lowest (11.54%).

**QUAL****The Lost Embrace & the Parental Mirror**

C8 distills the essence of maternal orphanhood into one dominant longing: **physical warmth and affection (88.46%)** — the highest consensus in the entire study — followed by the mother's multiple functions: daily care (50%) and someone to listen and understand (42.31%). The low "stability and routine" (11.54%) does not indicate wellbeing but confirms the **Mask of Formal Stability (C3)**: routine persists while the embrace is absent. Here the **Parental Mirror** is complete: the paternal orphan lacks the shield and the bread (material/security triad, B7), and the maternal orphan lacks the embrace (dominant emotional longing) — the mother is embrace, the father is protection and provider, and neither fully replaces the other. This mirror is the logical foundation for **Whole-Family Care** ²⁶ rather than individual guardianship. The quotes below embody the dominance of the embrace and the parental mirror.

“

"The paternal orphan: security and material support · The maternal orphan: a mother's tenderness and affection."

— **SOCIAL WORKER**

— parental mirror (mother is embrace, father is protection)

“

"The maternal orphan is the most vulnerable and least supported — or receives no support at all."

— **CAMP MONITOR**

— the lost embrace meets exclusion

◆ Section C Summary — Impact of Maternal Loss

Section C reveals that maternal orphanhood is a **triply hidden tragedy**: smallest in number (3.87%), definitionally excluded (the father-provider lives, so the child is not considered an "orphan"), and statistically camouflaged. Its impact is distinctly **internalizing**: near-universal separation anxiety (76.92%, highest consensus) + deep grief (61.54%) + an overwhelming longing for physical warmth (88.46%) — an internalizing structure that pulls the overall SDQ to its lowest (34.6% versus 55.0% for paternal orphans), **and the gap is not even statistically robust (ANOVA $p=0.075$, $\eta^2=1.03\%$)** — yet the system treats this category as "least difficult," so the measurement camouflage colludes with structural exclusion. The surviving father does not automatically compensate for the mother: a **functional gap** for the majority (addressed by support) versus a **dangerous fitness gap** for ten (approximately one third) requiring protection and potential custody transfer. **The major structural paradox**: the system ties eligibility to paternal loss (the provider), automatically granting orphan status to the paternal orphan — even though his mother is already providing unpaid breadwinning (B1) — while denying it to the maternal orphan whose father is incapable of embrace; eligibility follows the provider's presence, not the care need, and such logic is flawed on both ends. The **Parental Mirror** is complete: the father is shield and provider, the mother is embrace and emotional regulator, and neither is a complete substitute for the other — this is the logical foundation for **Whole-Family Care** ²⁶ rather than individual guardianship. **Bridge to Section D**: if losing one parent leaves the other as an incomplete substitute, Section D addresses those who lost both — doubly orphaned children and the sole survivor — where the entire network of substitutes collapses, and guardianship, identity, and alternative care emerge as the pillars of survival.

3.4 Section D — Guardianship, Care, and Identity

This section applies to **doubly orphaned children** (sub-sample $n=32$; the sole survivor has Section E with the CRIES-8 scale). The section addresses the **structure of guardianship, alternative care, and identity** following the complete collapse of the parental network. Items D4–D8 use a four-point scale; D1/D2/D3/D10 are single-choice items; D9 is multiple choice. **Methodological caveat**: the sample is small ($n=32$, each child $\approx 3.1\%$), so the figures represent transferability, not statistical generalization, and qualitative analysis draws primarily on interviews (key informants). The governing paradox: the legal structure and shelter are largely in place, but **the emotional gap is wide** — shelter does not create belonging. Percentages are from a base of 32 with round-half-up rounding.

◆ D1. Who takes custody of the child

96.88% of doubly orphaned children have a stable family guardian (31 of 32): grandparent first at **53.13%**, then paternal/maternal uncles and aunts at 31.25%, followed by adult siblings at 12.50%. Table (29) shows:

♦ **Table (29) Who takes custody of the child (n = 32)** ♦

Guardian	Count	Percentage and Distribution
Grandfather / Grandmother	17	53.13%
Paternal uncle / aunt or maternal uncle / aunt	10	31.25%
Adult brother / sister	4	12.50%
No permanent guardian	1	3.13%
Total	32	100.00%

96.88% (31 of 32) have a stable family guardian — grandparent first (53.13%), then uncles and aunts (31.25%) — the extended family does not abandon the doubly orphaned child; yet **one child has no permanent guardian**, requiring immediate child protection.

♦ D2. Legal guardianship status

81.25% of guardianships are formally registered (26 of 32), but **18.75% (6 children)** lack clear legal documentation (4 without custody documents + 1 informal family agreement + 1 "don't know"). Table (30) shows:

♦ **Table (30) Legal guardianship status (n = 32)** ♦

Status	Count	Percentage and Distribution
Formally registered	26	81.25%
Child without custody documents	4	12.50%
Informal family agreement	1	3.13%
Don't know	1	3.13%
Total	32	100.00%

81.25% (26) of guardianships are formally registered, but **18.75% (6 children)** lack clear legal documentation — at risk of losing inheritance, relief, and education rights.



QUAL

The Kinship Network Embraces While the Law Stumbles (Family Embrace vs Institutional Vacuum)

The Methodological Triangle reveals a **structural duality**: the extended family **embraces** the doubly orphaned child (96.87% have a permanent guardian, 53.13% with grandparents) — with virtually no guardianship via strangers or institutional placement. But the **legal framework stumbles** (18.75% without documentation) for structural reasons articulated by practitioners: **court paralysis** and targeting of registry offices, **absence of a unified supervisory body**, and the **barrier of opening bank accounts** that blocks financial sponsorship disbursements. Most critically, the **Age-16 Cliff**: guardianship support ends while the child is still unable to support themselves. Warm family embrace thus rests on a fragile **institutional vacuum** — justifying field calls for **a unified general orphan welfare authority and an investment fund for orphans' assets**; this connects to the fragile substitute (C2) and paternal lineage solidarity (B6). The quotes below embody the institutional vacuum and the proposed solution.

“

"There is no fairness in distribution and no clear mechanism... no primary supervisory body for orphan guardianship."

— **SOCIAL WORKER** — the institutional vacuum

“

"Their guardianship ends when they reach 16 — an age that is far too young given their inability to support themselves."

— **TEACHER** — the Age-16 legal cliff

“

"What is needed: a general orphan welfare authority, a fund to invest their assets, and a unified system."

— **INSTITUTIONAL SPONSORSHIP EXPERT** — the proposed structural solution

◆ D3. Child's sense of stability at the guardian's home

65.63% feel a sense of belonging (21 of 32) — only two thirds — while **34.38% (11 children)** are in psychological instability: 8 with anxiety + 2 fearing relocation + 1 feeling like a burden. Table (31) shows:

◆ **Table (31) Child's sense of stability at the guardian's home (n = 32)** ◆

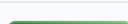
Status	Count	Percentage and Distribution
Feels a sense of belonging	21	65.63% 
Sometimes experiences periods of anxiety	8	25.00% 
Fears being moved to another place	2	6.25% 
Feels like a burden or a guest	1	3.13% 
Total	32	100.00%

65.63% (21) feel a sense of belonging, but **34.38% (11 children)** are in psychological instability (anxiety + fear of relocation + feeling like a burden) — shelter alone is not enough.

◆ D4. Feeling alone in the world even among those who care

34.38% feel lonely "always/often" (11 of 32), with a mean of **2.16 out of 4**, while 34.38% never feel this way. Table (32) shows:

◆ **Table (32) Child feeling alone even among those who care (n = 32)** ◆

Category	Count	Percentage and Distribution
Always applies	5	15.63% 
Often applies	6	18.75% 
Sometimes applies	10	31.25% 
Never applies	11	34.38% 
Total	32	100.00%

34.38% (11) feel lonely "always/often" even among those who care for them — an **Existential Loneliness** unique to doubly orphaned children — offset by 34.38% who never feel it (successful guardianship eliminates it).

**QUAL****Shelter ≠ Belonging, and the Third Paradox**

Although shelter is structurally secured, **one third of doubly orphaned children (34.38%) remain in psychological instability** and 34.38% in **Existential Loneliness** — "the first to lose everything" even among those who care — so **shelter does not create belonging**. This is fed by **guardianship mobility** (field practitioners estimate its historical movement among relatives' homes at up to 50%, typically following the **mother's remarriage** — though the survey shows a current permanent guardian for the majority, D1), producing **Burden Feeling** — which is precisely the quantitative item D3 "feels like a burden or guest." Here a **potential Buffering Hypothesis** appears: the doubly orphaned children's overall SDQ (43.8%) is **descriptively lower** than the paternal orphan's (55.0%) despite losing both parents — a **statistically non-significant difference** ($n=32$, $p=0.075$) consistent with the hypothesis that intensive grandparental embrace may buffer distress, without being proven by the cross-sectional design, even as the section's wounds (D4/D6: 34% loneliness, 53% comparisons) persist. It is the mirror of Section C's camouflage: there a hidden wound, here a real buffer — both warn against sorting by SDQ total alone (see F3). The Bright Exception lights the way: where stable supportive care was available, the impact of mobility clearly diminished. The quotes below embody the burden feeling and the bright exception.

“

"This dispersion makes the child feel like a burden on those they live with."

— **PSYCHOLOGIST** — Burden Feeling (matching item D3)

“

"There is no provision of stable housing for the orphan and the consequences are severe... they feel insecure, unstable, deficient, and deprived."

— **PSYCHOLOGIST** — mobile shelter does not create belonging

“

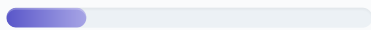
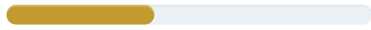
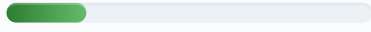
"The survivor moves between the grandmother's house and the uncle's house... yet shows no ill effects — she is excelling."

— **TEACHER** — the Bright Exception (supportive care neutralizes mobility)

◆ D5. Refusing to mention parents or showing painful reactions when reminded of them

37.50% show painful reactions "always/often" (12 of 32), with a mean of **2.31 out of 4**, and 78.13% to any degree. Table (33) shows:

◆ **Table (33)** Refusing to mention parents or painful reactions when reminded of them ($n = 32$) ◆

Category	Count	Percentage and Distribution
Always applies	5	15.63% 
Often applies	7	21.88% 
Sometimes applies	13	40.63% 
Never applies	7	21.88% 
Total	32	100.00%

37.50% (12) show painful reactions or refuse to mention parents "always/often," and 78.13% to any degree — **Memory Avoidance** is a defensive mechanism that defers mourning rather than completing it.

**QUAL****Memory Avoidance — A Defense That Defers Mourning**

Refusing to mention parents and the painful reactions when reminded (37.50% "always/often," 78.13% to any degree) is a **psychological defense mechanism (Memory Avoidance)** that disrupts natural mourning and defers adaptation rather than completing it; the child who "appears normal" on the surface may have their suppression erupt later (in adolescence or adulthood). Field practitioners warn that memory itself is a **double-edged instrument** — it soothes some children and burdens others "depending on the child" — so confrontation should never be imposed. This avoidant pole is the mirror of "memory-seeking" (D7): children divide between the **adaptive one who builds a bond** and the **avoider who suppresses it**, each requiring a different intervention — safe dialogue opening for the avoider, not flooding them with memory. The quote below embodies the duality of memory.



"Memories can be a driver for success, and can also negatively affect the child's mental state — it depends on the child themselves."

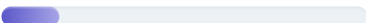
**TEACHER**

— memory as a double-edged instrument (the rationale for avoidance)

◆ D6. Comparing themselves to children who have two parents and showing pain

53.13% compare themselves "always/often" (17 of 32) — the strongest of items D4–D6 — with a mean of **2.44 out of 4**, and 75% to any degree. Table (34) shows:

◆ **Table (34) Child comparing themselves to children who have two parents (n = 32)** ◆

Category	Count	Percentage and Distribution
Always applies	5	15.63% 
Often applies	12	37.50% 
Sometimes applies	7	21.88% 
Never applies	8	25.00% 
Total	32	100.00%

53.13% (17) compare themselves to children with two parents and show pain "always/often" — **the strongest of items D4–D6**; downward comparison is a well-established trigger for childhood depression, renewed with every peer encounter.

**QUAL****Downward Comparison & Internalized Inferiority**

Comparing oneself to children with two parents (53.13% "always/often" — the strongest of items D4–D6) is a **well-established trigger for childhood depression** that renews with every peer encounter at school or in the community. The field reveals its internal driver: a feeling of **"deficiency and that society is unjust"** and of being "less than others" — **Internalized Inferiority** that feeds on comparison and feeds it in return, compounded by **sibling dispersal** which deepens alienation and loneliness. It is an extension of the painful peer comparison in B3, and connects to the "deficient and wronged" pole of the dual identity (D9). The intervention implication: supportive peer groups + school awareness + sensitivity-based curricula break the cycle of comparison. The quotes below embody the internalized deficiency and alienation.

“

"A feeling of deficiency and that society is unjust because they lost a parent... they feel shame."

— **CAMP MONITOR** — the driver of comparison (deficiency and injustice)

“

"They feel loneliness, alienation, injustice, and are separated from their siblings."

— **SOCIAL WORKER** — alienation and sibling dispersal

◆ D7. Searching for their parents' stories, photographs, or any memory of them

78.13% seek memories of their parents "always/often" (25 of 32) — **the highest item in the section** — with a mean of **3.06 out of 4** (SD=0.88), and 93.75% to any degree. Table (35) shows:

◆ **Table (35) Child searching for memories of their parents (n = 32)** ◆

Category	Count	Percentage and Distribution
Always applies	11	34.38% 
Often applies	14	43.75% 
Sometimes applies	5	15.63% 
Never applies	2	6.25% 
Total	32	100.00%

78.13% (25) seek memories of their parents "always/often" (93.75% to any degree) — **the highest item in the section, and a positive adaptive indicator**: healthy mourning that builds an identity which includes the parents rather than denying them (tools: photo albums, stories, keepsakes).

**QUAL**

Memory-Seeking — Healthy Multi-Modal Mourning

Unlike avoidance (D5), searching for parents' stories and photographs (78.13% "always/often," 93.75% to any degree — the highest item in the section) represents a **positive adaptive indicator**: healthy mourning that builds an identity encompassing the parents rather than denying them. The field reveals the **multi-modal nature of memory-seeking**: the mobile phone as a contemporary photo archive, a keepsake the father used to love, and **visiting the grave and making supplication during prayers** as mourning rituals. But it matters **more to the adolescent** than to the young child (a developmental threshold), and is a **double-edged instrument** (may drive toward success or become a burden) — so Memory Boxes are **not a universal prescription** but require individual assessment. This is consistent with the quantitative data (G7: 42.18% find memories a source of reassurance). The quotes below embody the media of memory-seeking.

“

"When they hold something their father used to love, or a photo of him — it connects them to their father."

— **PSYCHOLOGIST** — keepsakes and photographs as memory bridges

“

"Memories of the father, visiting the father's grave, and making supplication in prayer for the father."

— **TEACHER** — the plurality of mourning rituals

◆ D8. Feeling guilty as if their parents' death was their fault

75% show no guilt at all (24 of 32) — the highest "never" rate in the study — with a mean of **1.44 out of 4** (the lowest), yet **12.50% (4 children)** feel this way "always/often." Table (36) shows:

◆ **Table (36) Child feeling guilty as if their parents' death was their fault (n = 32)** ◆

Category	Count	Percentage and Distribution
Always applies	2	6.25% 
Often applies	2	6.25% 
Sometimes applies	4	12.50% 
Never applies	24	75.00% 
Total	32	100.00%

75% (24) show no guilt at all — **the highest "never" rate in the entire study** (they understand the death was not their fault); but **4 children (12.50%)** carry clinical Survivor's Guilt and require individual intervention.



QUAL

Survivor's Guilt — A Clinical Minority Amid a Reconciled Majority

This item stands out as **the least severe in the section** (mean=1.44; 75% "never" — the highest "never" rate in the entire study), which is a **positive signal**: most doubly orphaned children **understand that the death was not their fault** and do not carry its weight. But **4 children (12.50%)** carry **Survivor's Guilt** "always/often" — genuine clinical cases requiring individual intervention, where the guardian's and practitioner's reassurance that "this was not your fault" is an essential component of treatment. This is the **milder face** of what intensifies in the sole survivor who witnessed the death directly (see E3: guilt + death-wishing): the distinction is that the doubly orphaned child typically **did not witness the event**, making guilt rarer; while the witness carries a deeper and more severe guilt — a distinction that guides clinical screening priority.

◆ D9. How the child introduces themselves to others

37.50% introduce themselves by their parents' name (12 of 32 — the symbolic bond continues), 11 respond "normally" and 7 with "pride," while a third are in identity confusion. Table (37) shows:

◆ **Table (37) How the child introduces themselves to others (n = 32 · multiple choice)** ◆

Option	Count	% of 32
Introduces themselves by their parents' name	12	37.50% 
Normally	11	34.38% 
With pride	7	21.88% 
Doesn't know how to answer	7	21.88% 
Avoids talking about their family	4	12.50% 

37.50% (12) introduce themselves by their parents' name (the symbolic bond continues), while a **third** (7 who don't know how to answer + 4 who avoid) are in identity confusion. (*Multiple choice — responses overlap and should not be summed as separate percentages.*)

**QUAL****The Dual Conflicting Identity: The Deficient & Wronged vs. the Proud Child of a Martyr**

The doubly orphaned child carries **two conflicting identities**: "**The Deficient and Wronged**" (a feeling of deficiency, shame, and being "less than others" = **Internalized Inferiority**) versus "**The Proud Child of a Martyr**" (pride in the parent and a desire to emulate them). The therapeutic key is that **successful intervention builds on the proud identity to compensate for the deficient one**. The **Father as Identity Model** stands out: the child aspires to emulate their father's profession — an aspiration that can be built upon (and may veer toward revenge if neglected). But a third of the category is in **identity confusion** (doesn't know how to introduce themselves or avoids it) and needs peer groups to build a personal narrative. (This extends to Section G: societal perception and identity.) The quotes below embody the two poles of identity and the father as model.

“

"Most introduce themselves: 'I am the son/daughter of the martyr' and they take pride in it — but some children don't like to introduce themselves as orphans."

— **TEACHER** — the two identity poles (pride vs. concealment)

“

"They see themselves as wanting to be like their father: a carpenter, a teacher, a police officer."

— **TEACHER** — the father as identity model

“

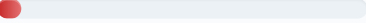
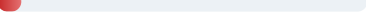
"They see themselves as having a deficiency and being less than others."

— **PSYCHOLOGIST** — Internalized Inferiority

◆ D10. Status of the child's civil documents (birth certificate, identity card)

87.50% have complete documents (28 of 32), but **12.50% (4 children)** have lost them entirely or partially. Table (38) shows:

◆ **Table (38) Status of the child's civil documents (n = 32)** ◆

Status	Count	Percentage and Distribution
All present	28	87.50% 
All lost	2	6.25% 
Some missing	2	6.25% 
Total	32	100.00%

87.50% (28) have complete civil documents, but **12.50% (4 children)** have lost them entirely or partially — administratively "invisible children," denied access to formal schooling, sponsorship, and inheritance rights; a targeted document replacement campaign before the school year is required.

◆ Section D Summary — Guardianship, Care, and Identity

Section D reveals a **central paradox**: the existing structure appears solid on the surface (96.88% have a permanent guardian, 81.25% have formal guardianship, 87.50% have complete documents), yet **shelter does not create belonging** — one third (34.38%) are in psychological instability, 34.38% experience existential loneliness, and 53.13% make painful downward comparisons. The older generation (53.13% grandparents) embraces this category above an **institutional vacuum**: 18.75% without legal documentation, an Age-16 Cliff in guardianship support, and no unified supervisory body — compounded by the **Deemed Orphan** (paternal loss with no trace or records, unregistered) and the administratively "invisible child" (4 without documents). A **potential Buffering Hypothesis** glimmers here: this category's overall SDQ (43.8%) is descriptively lower than the paternal orphan's (55.0%) despite having lost both parents — a statistically non-significant difference (n=32) consistent with the hypothesis that intensive grandparental embrace may buffer distress (not proven by the cross-sectional design), even as the section's wounds persist (53.13% comparisons, 34.38% loneliness). It is the mirror of Section C's camouflage (hidden wound): here a real buffer — and both warn against sorting by SDQ total alone. A **healthy trajectory** is nonetheless visible: 78.13% are memory-seekers (adaptive mourning) and 75% carry no guilt — a solid foundation for recovery if supported by stable care and a proud identity. **The emerging recommendation**: a unified general orphan welfare authority + an investment fund + an urgent documentation campaign + psychosocial support for the guardian (not shelter alone). **Bridge to Section E**: if the doubly orphaned child finds some buffer in siblings and grandparent, the **sole survivor** — subject of the next section — has lost the entire network, and is the most traumatized on CRIES-8, even though the SDQ total alone would not reveal it.

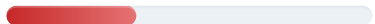
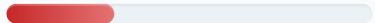
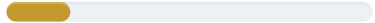
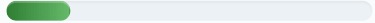
3.5 Section E — The Sole Survivor and the CRIES-8 Scale

This section applies to the **sole survivor** — a child who lost their entire family (sub-sample n=17; the smallest and most traumatized category). It administers the **Children's Revised Impact of Event Scale (CRIES-8)** ¹⁹ with its non-linear scoring (never=0 · rarely=1 · sometimes=3 · often=5; total 0–40, PTSD probability threshold ≥17), with two subscales: Intrusion and Avoidance — matching the international standard without conversion. **Strengthened methodological caveat**: n=17 is very small (each child = 5.88%), so the figures are **individual descriptive, not statistically generalizable** — best read as **seventeen independent clinical cases**, not a "category." Percentages are from a base of 17.

◆ E1. Traumatic exposure — witnessing death directly

82.35% (14 of 17) were directly exposed to witnessing the death of family members, including **29.41% (5)** who were buried under rubble with the bodies, and 35.29% (6) who witnessed the death of more than one person. Table (39) shows:

◆ **Table (39) Sole survivor's exposure to witnessing the death of family members (n = 17)** ◆

Status	Count	Percentage and Distribution
Yes, witnessed the death of more than one family member	6	35.29% 
Yes, was buried under rubble with them	5	29.41% 
Yes, witnessed the death of one family member	3	17.65% 
No	3	17.65% 
Total	17	100.00%

This is not ordinary bereavement but a **direct life/death threshold experience**: **82.35% (14)** witnessed the death, and **5 children** waited for rescue buried under rubble among the bodies of their family — a traumatic exposure that exceeds what any scale can capture.


QUANT
Beyond Bereavement: Mortal-Threshold Trauma

The sole survivor differs qualitatively from all other orphan types: their loss was coupled with **direct traumatic exposure at the mortal threshold** — seeing the bodies, fearing for their own life, waiting under the rubble, then being rescued. **35.29% (6)** witnessed the death of more than one person in a single event — multi-source exposure that elevates the risk of **Complex PTSD**. For this reason, measuring "difficulties" on the SDQ alone is insufficient for this category; the wound here is **acutely traumatic** and demands a specialized instrument (CRIES-8), as will become evident below. The quotes in E3 embody the depth of this exposure.

◆ E2. CRIES-8 results — active acute trauma pattern

The CRIES-8 mean reached **23.41 out of 40** (SD=8.45; range 5–36) — well above the threshold — exceeded by **88.24% (15 of 17; 95% CI ≈ 66–97%)**, including **29.41% (5) in severe trauma (≥30)**. Table (40) shows the distribution of sole survivors' responses across the eight CRIES-8 items in raw counts (total 17 per item), with Intrusion items distinguished from Avoidance items:

◆ **Table (40)** Distribution of sole survivors' responses across CRIES-8 items (n = 17) ◆

Question	Type	Often	Sometimes	Rarely	Never	Mean
1. Thoughts about the incident come to them against their will	Intrusion	10	4	2	1	3.76
2. Tries to put thoughts of the incident out of their mind	Avoidance	2	8	4	3	2.24
3. Images of the incident suddenly intrude on their mind	Intrusion	6	7	3	1	3.18
4. Avoids anything that reminds them of the incident	Avoidance	5	5	4	3	2.59
5. Wakes at night with dreams about the incident	Intrusion	7	7	1	2	3.35
6. Tries not to talk about the incident	Avoidance	5	6	3	3	2.71
7. Tries not to think about the incident	Avoidance	3	6	4	4	2.18
8. Waves of painful emotions overwhelm them	Intrusion	7	7	2	1	3.41

Mean per item out of 5 (scale values: 0, 1, 3, 5); sum of item means may differ from subscale mean by ±0.01 due to rounding. *Note: The values 0, 1, 3, 5 are the design of the original international CRIES-8 scale.*

These scores distribute across clinical referral categories as shown in Table (41):

◆ **Table (41)** Distribution of sole survivors across referral categories (CRIES-8, n = 17) ◆

Range — Clinical Classification	Count	Percentage and Distribution
0–16 — Below referral threshold	2	11.76% 
17–29 — Probable PTSD (referral)	10	58.82% 

Range — Clinical Classification	Count	Percentage and Distribution
30–40 — Severe trauma (intensive intervention)	5	29.41% 
Total	17	100.00%

The subscales reveal the trauma pattern (Table 42): **Intrusion dominates over Avoidance**, and all four Intrusion items occupy the top four ranks in severity.

◆ **Table (42) CRIES-8 subscales: Intrusion vs Avoidance (n = 17)** ◆

Subscale	Mean (0–20)	SD	α
Intrusion (items 1/3/5/8)	13.71	5.06	0.742
Avoidance (items 2/4/6/7)	9.71	6.28	0.887
Difference (Intrusion – Avoidance)	+4.00	—	71% >

88.24% (15 of 17) exceed the PTSD threshold, and **29.41% (5)** are in severe trauma. Intrusion (13.71) exceeds Avoidance (9.71) in 71% — an **active acute trauma pattern**: the child tries to push the memory away but fails, so thoughts, images, and nightmares intrude upon them.

QUANT Active Acute PTSD & the SDQ Blind Spot

The dominance of **Intrusion over Avoidance (+4.0, in 71%)** points to **PTSD in an active acute phase**: avoidance attempts are present but fail, so intrusive thoughts, images, and nightmares prevail (they topped ranks 1–4). The appropriate treatment is **TF-CBT** with cognitive processing and imaginal exposure. Most critically for the study: this same survivor scored a "moderate" SDQ total (52.9% above threshold) while scoring **88.24%** on CRIES — strong evidence that **SDQ for chronic difficulties does not capture acute trauma**, and that CRIES-8 is a necessity not a luxury (directly confirming the recommendation in F3: screen with the appropriate instrument, not total score alone). The quotes below embody the intrusion, guilt, and death-wishing.

◆ **E3. The clinical reality — the Survivor's Triad**

Behind the numbers lies a documented clinical reality: all interviewed field practitioners (7/7) agree that the sole survivor's condition is "very poor," and a triad — survivor's guilt, death-wishing, and isolation — consistently triangulates the CRIES findings.

**QUAL****The Survivor's Triad: Guilt, Death-Wishing, and Isolation**

The interviews triangulate the CRIES findings with three consistently agreed-upon features. **(1) Survivor's Guilt** (6/7): "feels guilty for still being alive while their family died" — the standard clinical definition, persisting into adulthood. **(2) Death-wishing**: affirmed by a field supervisor and documented in the live testimony of a 15-year-old sole survivor relayed by her teacher — supported by the quantitative data (29.41% in severe trauma). **(3) Isolation** (6/7) matches the Avoidance subscale. The field distinguishes **two clinical subtypes** (mirroring B5's poles): the **externalizing type** (aggressive behaviors) versus the **withdrawn type** (introversion and silence). An additional dangerous dimension unique to this category: **risk of exploitation and abuse** for a survivor with no family protection. Yet **hope is documented**: the survivor herself later became an academic achiever after receiving supportive care — the trajectory is reversible. (*Methodological note: one field voice observed that some young children "call the displacement a trip and don't talk about their lives" — this may be avoidance/suppression, not recovery; their silence should not be read as reassurance.*) The quotes below embody the triad and the risk of exploitation.

“

"They feel guilty for still being alive while their family died."

— **PSYCHOLOGIST** — Survivor's Guilt (the standard clinical definition)

“

"I wished I had been with them when the bombardment came."

— Testimony of a sole survivor (15 years old), relayed by her teacher — death-wishing (live evidence)

“

"Most of them wish for death — there is no family to embrace them and heal their wounds."

— **CAMP MONITOR** — death-wishing (field observation)

“

"The sole survivor needs intensive intervention... and follow-up: whether any violations have been committed against them."

— **INSTITUTIONAL SPONSORSHIP EXPERT** — risk of exploitation (survivor without family protection)

◆ Section E Summary — The Sole Survivor + CRIES-8

The sole survivor represents the **apex of the vulnerability hierarchy**: the smallest category (n=17) and the most severely traumatized. **82.35%** were directly exposed to witnessing death (29.41% buried under rubble with the bodies), bringing **88.24% to the PTSD threshold** (and 29.41% to severe trauma) with an **active intrusive-dominant pattern** (Intrusion 13.71 > Avoidance 9.71). The field triangulates this with the triad of **guilt, death-wishing, and isolation**, alongside an exploitation risk unique to those with no family protection. The overarching methodological lesson — and the heart of the screening paradox in Section F — is that this child, whom the SDQ classifies as "moderate" (52.9%), is **in fact the most traumatized** (88.24% on CRIES): they cannot be screened accurately except with the appropriate instrument, and both scales are necessary. Yet the **recovering survivor** proves that stable supportive care reverses the trajectory. **Priority**: every sole survivor needs an **individual clinical file** — TF-CBT + protection from exploitation + stable alternative care. **Bridge to Section G**: having inventoried the internal wound across Sections B–F, the next section turns to the **external environment** — how society views the orphan, and how they build their identity and hope.

3.6 Section F — Psychometric Measures (SDQ-25)

This section presents the results of the **Strengths and Difficulties Questionnaire (SDQ-25)** — the world's most widely used child mental-health screening tool ¹⁸ — applied to the **full sample (N=671)**. Each item is coded: not true=0 · somewhat true=1 · certainly true=2 (with items F7/F14/F15/F17/F18 reverse-scored), and four subscales (emotional, conduct, hyperactivity, peer problems = 20 items, 0–40) combine into the **Total Difficulties Score**, with referral threshold ≥ 17 ; the prosocial subscale (F21–F25) is scored separately. The whole section converges at this point: **the unified scale translates the qualitative severity of Sections B–D into a comparable number**, and reveals why the suffering of some groups remains hidden.

◆ F1. Core Numbers — The Orphan at the Threshold

The mean Total Difficulties Score is **17.23 out of 40** (SD=5.75) — exactly at the referral threshold — exceeded by **53.65% (360 children)**. Table (43) shows the level distribution:

◆ **Table (43) Distribution of SDQ-25 Total Difficulties Score levels (N = 671)** ◆

Level (Range)	Count	Percentage and Distribution
Normal (0–15)	264	39.34% 
Borderline (16)	47	7.00% 
Clinical — warrants referral (≥ 17)	360	53.65% 
Total	671	100.00%

The average orphan's score is 17.23, and the referral threshold is 17 — meaning the **median orphan** (the child with the average score, not an exceptional case) has already reached the score that means "needs specialist referral." **More than half exceed this threshold: 53.65% (360 children)** — including 290 (43.22%) in the moderate range (17–24) and 70 (10.43%) in the severe range (25–40) requiring immediate referral. In short: **disorder is the norm, not the exception.**



QUANT

The Orphan-at-Threshold: A Structural Finding

The most alarming fact is that **the mean itself (17.23) equals the referral threshold** — meaning **the median orphan in this sample sits precisely at the clinical boundary** — in the range that **warrants clinical assessment**, not merely "at-risk." (The threshold is a screening tool, not a final diagnosis.) This aligns with practitioners observing compound symptoms (fear, enuresis, aggression, withdrawal) graded by age. It does not mean the rest are "normal": the threshold is a conservative screening tool, and children below it may still carry sub-threshold symptoms. For reference: Goodman's normative bands ¹⁸ place roughly **10% of the general child population** in the clinical range (≥ 17) — so **53.65%** here equals approximately **five times** the reference rate, placing this sample at the outer edge of studies on war-exposed children in Gaza. **Intervention implication:** orphaned children under war cannot be treated as isolated individual cases — what is required is a **Population-Level Response**, not a clinic waiting for referrals.

◆ F2. The Five Subscales — An Internalizing Profile

The subscales reveal a **dominant emotional signature**: emotional problems are highest (68.41%), then peer problems (55.74%), while conduct (34.58%) and hyperactivity (23.25%) are lower, and prosocial behaviour is preserved in the majority. Table (44) shows caregivers' responses across all twenty-five SDQ-25 items in raw counts (total 671 per item, no missing values):

♦ **Table (44)** SDQ-25 item-by-item response distribution, grouped by subscale (N = 671) ♦

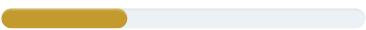
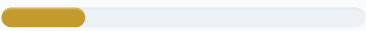
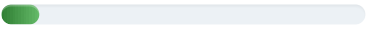
Item	Not True	Somewhat True	Certainly True	Mean (out of 2)
① Emotional Subscale (F1–F5) · Internalizing · Subscale mean 5.55 / 10 · 68.41% above threshold (≥5) — highest				
F1. Complains of headaches, stomachaches, or nausea	268	256	147	0.82
F2. Appears worried or troubled	135	315	221	1.13
F3. Unhappy, despondent, or cries frequently	107	315	249	1.21
F4. Nervous, clingy with adults, loses confidence easily	112	325	234	1.18
F5. Many worries, easily frightened	114	301	256	1.21
② Conduct Subscale (F6–F10) · Externalizing · Subscale mean 2.87 / 10 · 34.58% (≥4)				
F6. Temper tantrums or hot temper	129	305	237	1.16
F7. Generally obedient, does what adults ask ^U	57	290	324	0.60
F8. Often fights with other children or bullies them	308	243	120	0.72
F9. Lies or cheats	488	145	38	0.33
F10. Steals from home, school, or elsewhere	637	26	8	0.06
③ Hyperactivity Subscale (F11–F15) · Externalizing · Subscale mean 4.97 / 10 · 23.25% (≥7)				
F11. Restless, overactive, cannot stay still for long	214	216	241	1.04
F12. Constantly fidgeting or squirming	161	294	216	1.08
F13. Easily distracted, difficulty concentrating	144	319	208	1.10
F14. Thinks things out before acting ^U	161	319	191	0.96
F15. Sees tasks through to the end, good attention ^U	97	341	233	0.80
④ Peer Problems Subscale (F16–F20) · Internalizing · Subscale mean 3.83 / 10 · 55.74% (≥4) — second highest				
F16. Tends to play alone rather than with others	351	175	145	0.69
F17. Has at least one good friend ^U	93	258	320	0.66
F18. Generally liked by other children ^U	35	275	361	0.51
F19. Picked on or bullied by other children	355	194	122	0.65
F20. Gets on better with adults than with other children	73	316	282	1.31
⑤ Prosocial Behaviour (F21–F25) · Strength scale (score ≤4 is the adverse indicator; items are not reverse-scored) · Subscale mean 7.28 / 10 · only 10.58% below threshold (≤4)				

Item	Not True	Somewhat True	Certainly True	Mean (out of 2)
F21. Considerate of other people's feelings	34	277	360	1.49
F22. Shares readily with other children	49	287	335	1.43
F23. Helpful to someone who is hurt, upset, or ill	34	291	346	1.46
F24. Kind to younger children	55	273	343	1.43
F25. Volunteers to help others	37	276	358	1.48

The **bold** count in each row = **the most common response**. ^U = reverse-scored item (2→0 before summing); mean shown after reversal. Item mean is out of 2; subscale mean is out of 10. Coloured row headers distinguish the domain: **internalizing** · **externalizing** · **preserved positive**. Subscale mean may differ from the sum of item means by ±0.01 due to rounding.

These items aggregate into five subscales as shown in Table (45):

◆ **Table (45) Five SDQ-25 subscales (N = 671)** ◆

Subscale	Mean ± SD	Threshold	% Clinical and Distribution	α
Emotional Problems (F1–F5)	5.55 ± 2.44	≥5	68.41% 	0.708
Peer Problems (F16–F20)	3.83 ± 1.84	≥4	55.74% 	0.315
Conduct Problems (F6–F10)	2.87 ± 1.84	≥4	34.58% 	0.543
Hyperactivity (F11–F15)	4.97 ± 2.12	≥7	23.25% 	0.493
Prosocial Behaviour (F21–F25)	7.28 ± 2.25	≤4	10.58% 	0.792
Total Difficulties (20 items)	17.23 ± 5.75	≥17	53.65%	0.743

The profile is **internalizing**: emotional problems (68.41%) and peer problems (55.74%) — anxiety, sadness, and withdrawal — clearly dominate conduct and hyperactivity. This is a particular risk signal because internalizing symptoms are **less visible and therefore more easily overlooked** than noisy externalizing ones.

**QUAL****The Internalizing Profile & Preserved Prosociality**

The quantitative profile aligns with interview testimony: **internalizing** symptoms (fear, sadness, withdrawal, somatic complaints) are more prominent than **externalizing** ones (aggression, hyperactivity) — exactly the pattern in B5 (anger vs. the more dangerous pole of silence) and the internalizing dominance in Section C. Correlation structure confirms it: conduct×hyperactivity ($r=0.46$) form a coherent externalizing cluster, while emotional problems are more independent; and **internalizing (emotional+peer) exceeds externalizing (conduct+hyperactivity) by mean-range comparison across every orphan category** — a conclusion that does not depend on different thresholds. (*Methodological note: the Peer Problems subscale has low internal consistency ($\alpha=0.315$) — a known SDQ cross-cultural limitation — so the internalizing conclusion rests primarily on the robust Emotional subscale ($\alpha=0.708$); Peer Problems is a supporting signal, not a sole pillar.*) The positive surprise is that **Prosocial Behaviour is normal in 72.4%** (cooperation, helping, consideration; with 17.0% borderline and 10.58% impaired — using Goodman's three-band classification) — a **Preserved Prosociality** that serves as a therapeutic foundation, even though 71 children (10.58%) show a clear deficit. The orphaned child is **wounded internally but has not lost their social humanity** — and this is the most important therapeutic lever in the section. The internalizing profile is further supported by an **independent qualitative triangle**: in a self-ranked symptom exercise within a girls' focus group, **sleep difficulties, persistent sadness, chest tightness, and crying alone** topped the list — all internalizing, matching the dominance of the Emotional subscale (68.41%). The quotes below embody the internalizing profile and the preserved strength.

“

"Children aged seven to ten show: mental drifting, shyness, silence, crying for no reason, and extreme sensitivity to the slightest event."

— **TEACHER** — the internalizing profile (quiet symptoms that go unnoticed)

“

"I just want to rest and sleep well... I often sit alone and cry."

— Testimony of an orphaned girl in a focus group — the internalizing wound in the child's own words (insomnia and crying alone)

“

"We ran a Quran memorisation competition and a large group participated... they are all committed and integrated into the community."

— **DIRECTOR OF AN ORPHAN INSTITUTION** — preserved prosocial behaviour (resilience in practice)

◆ F3. The Central Question: Does the Total Score Reveal Differences by Type? (Camouflage, Measured)

Here the threads of Sections C and D converge into **evidence measured from the raw data**. Table (46) compares the Total Score against the Emotional subscale by orphan type, and between them lies the **revealing gap**:

◆ **Table (46) SDQ by orphan type: Total Difficulties vs. Emotional subscale (N = 671)** ◆

Orphan Type	n	Mean	SD	Total ≥ 17	Emotional ≥ 5	Gap
Paternal orphan	596	17.42	5.71	55.0%	69.6%	+14.6
Sole survivor	17	16.88	5.12	52.9%	64.7%	+11.8
Doubly orphaned	32	15.66	6.67	43.8%	53.1%	+9.3
Maternal orphan	26	15.04	5.44	34.6%	61.5%	+26.9

The difference in Total Score between types is **statistically non-significant** (ANOVA $F=2.312$, $p=0.075$, $\eta^2=1.03\%$ only) — meaning **orphan type alone does not determine distress severity** (environment is far stronger, see F4). But the crucial finding is that the **gap (Emotional – Total) peaks at the maternal orphan (+27 points)** versus +14.6 for the paternal orphan — this gap reveals that their distress is **fundamentally internalizing**, appearing on the Emotional subscale, not the total. *(Maternal/sole-survivor/doubly-orphaned sub-groups are small ($n=26/17/32$) — read as transferable signals, not representative estimates; the gap is descriptive, not a significance test.)*


QUANT
A Distinct Distress Signature per Orphan Type

The power of this reading is that it exploits **all five SDQ subscales** and anchors them with **CRIES-8**, revealing for each type a **distinct clinical signature** — a far sharper picture than any summary number allows:

① **Paternal orphan — the broadest and highest (transparent):** the largest group ($n=596$, 89% of the sample, the classic war-orphan experience) and the highest actual distress on both scales (total 55%, emotional 69.6%) — and their total **faithfully reflects their reality** (moderate gap +14.6, no hiding). They are **the reference against which all other types are measured**.

② **Maternal orphan — silent internalizing wound:** the highest emotional score (61.5%; 95% CI $\approx$ 43–78%) despite the lowest total (34.6%), with the largest gap +27 — because their suffering is **silent and emotional** rather than noisy and behavioural, surfacing on the Emotional subscale.

③ **Sole survivor — acute trauma:** their chronic everyday difficulties are "moderate" (SDQ 52.9%) but their acute trauma is the severest (CRIES-8 88.24%, Section E) — each scale illuminates a different dimension: SDQ the chronic daily burden, CRIES the post-event trauma.

④ **Doubly orphaned — a possible buffering pattern:** the lowest distress descriptively (43.8%, gap +9.3; difference non-significant, $n=32$) — consistent with the containment of grandparents and siblings (53% living with them), not concealment (although Section D wounds remain: 53% make downward comparisons).

Practical value: these differentiated signatures enable precise screening — capturing both the maternal orphan's emotional wound and the sole survivor's acute trauma simultaneously — and represent the payoff of the **multi-layer reading (subscale profile + CRIES)** that surpasses conventional total-score screening.


QUAL
The Quietest Wound Runs Deepest

The **child's voice in focus groups** and the **practitioner's voice in interviews** give this number its human face: the wound that the total score alone does not show is the **silent** wound. **Point of convergence:** the deepest injuries are the quietest on the surface — the field describes the withdrawn child who gives "not a word, not a reaction," the sole survivor who avoids mentioning the incident, the maternal orphan who mourns in silence — and none of these register heavily on a total score driven by noise, not stillness. **Point of divergence:** the child lives it as **emptiness and longing**, while the practitioner reads it as a **blind spot in screening** — and more dangerously: a welfare policy that excludes the maternal orphan structurally because "the father is present," so screening only by total score colludes with **structural exclusion (Section C)**. **Quantitative bridge:** maternal orphan's emotional gap +27 (the largest) · sole survivor CRIES 88.24% vs. SDQ 52.9%. Key concepts: Internalizing Camouflage · Screening Blind Spot · Total-Only Screening Collusion. The quotes below embody the silent longing, the loss of joy, and the system that drops some children.

“

"I want my mother and father."

— Longing of an orphaned child — even the child embraced by grandparents carries a silent longing (focus group)

“

"We were happy when dad was with us. Now he's gone... we don't feel any joy."

— Testimony of an orphaned girl in a focus group — loss of joy (Anhedonia): a silent wound matching item F3 ("unhappy or despondent") without raising the conduct total

“

"Sometimes three or four organisations provide support to one orphan, while other children receive support from none... because the mother cannot register the children, so they lose their right."

— **INSTITUTIONAL SPONSORSHIP EXPERT** — the system drops some: a parallel blind spot to screening by total score alone

Methodological recommendation for practice: these type-specific signatures translate into a **practical multi-layer screening protocol for war-context children:** **(1)** Screen using subscale profiles, with the Emotional subscale flagged first — captures the internalizing maternal orphan; **(2)** CRIES-8 is mandatory for every sole survivor or direct witness of death — captures acute trauma; **(3)** Check the subscale profile before ruling out any low-total category from priority. A protocol made possible by the breadth of instruments in this design, raising the precision of resource targeting.

◆ F4. Variance Explainers — Environment, Not Loss Type

Section F3 showed that **orphan type shapes the profile of distress** — a distinct clinical signature for each type — but that its total score **does not explain the variation in severity** ($\eta^2=1.03\%$, non-significant). The more important intervention question remains: what determines **who is most severely affected**? Each predictor is examined in turn — **governorate, age, gender, cause of death, educational status** — revealing a single overarching rule: **environment determines the severity of the wound more than the type of bereavement**. A summary box ranking all predictors by effect size (η^2) follows.

◆ SDQ by Governorate

Distress varies geographically in a **significant** pattern: **Deir al-Balah** leads by a clear margin — 67.6% above threshold ($M=18.72$) — followed by **Gaza City** (52.9%, $M=17.29$) then **North Gaza** (46.0%, $M=16.07$). Table (47) shows:

◆ Table (47) SDQ by governorate (N = 671) ◆

Governorate	n	Mean	SD	Above threshold (≥ 17)	%
Deir al-Balah	111	18.72	5.67	75	67.6%
Gaza City	397	17.29	5.62	210	52.9%
North Gaza	163	16.07	5.90	75	46.0%

The comparison covers the three governorates included in the quantitative data collection (northern and central zones); **Khan Yunis and Rafah** were not included due to safe-access constraints, not a research choice (see 2.4, geographic limitation) — findings apply to the covered governorates; transferability to the south is inferential, not a statistical certainty.

**QUANT****The Tent as an Independent Risk Factor**

One-way ANOVA revealed a significant difference between governorates: $F(2, 668) = 7.178, p < 0.001, \eta^2 = 2.10\%$. The striking finding is that **Deir al-Balah** — a receiving zone, not a front-line area — has the highest distress; the explanation lies in housing conditions, not location: **93.7% of orphans in Deir al-Balah live in tents** (A12). Accordingly, **place of residence itself ($\eta^2=4.83\%$)** outperforms governorate as a predictor — living in a tent raises psychological risk by approximately **1.6×** compared to a built structure, making it an **independent, actionable risk factor** (reconstruction is preventive psychological intervention, not merely humanitarian relief).

**QUAL****The Tent as Suffocation, Displacement as Uprooting**

The **child's voice in focus groups** and the **practitioner's reading in interviews** converge: children describe the tent as a daily suffocation (heat, cold, shared bathrooms, no privacy, no space to play), while practitioners document how **repeated displacement dismantles peer networks and extinguishes motivation. Point of convergence:** the environment (tent + uprooting) is an independent wound added to the bereavement wound, not absorbed by it. **Point of divergence:** the child lives it as an immediate sensory distress; the practitioner reads it as a cumulative erosion of drive and trust. **Quantitative bridge:** residence ($\eta^2=4.83\%$) > governorate (2.10%) > orphan type (1.03%). Key concepts: Tent as Independent Risk · Serial Displacement · Motivational Blunting. The quotes below embody the tent and the uprooting.



"Dilapidated, burning hot in summer and freezing in winter, shared bathrooms unfit for use shared by a large number of families, and no privacy."

— Orphaned children describing their tents in a focus group
— the tent as a daily burden



"I feel suffocated and stifled living in this tent... we cry and choke."

— Testimony of orphaned girls in a focus group — the tent as psychological suffocation



"It affected their relationships with friends, their schooling, their behaviour, and their trust in their surroundings — and they lost their motivation."

— **ORPHAN PROGRAMME COORDINATOR** — displacement dismantles the network and extinguishes motivation

◆ **SDQ by Age Group**

Age groups do not differ significantly, but the **transitional group (10–13)** leads — 60.9% above threshold ($M=17.74$) — followed by ages 6–9 (51.0%) then 14–18 (49.0%). Table (48) shows:

◆ **Table (48) SDQ by age group (N = 671)** ◆

Age Group	n	Mean	SD	Above threshold (≥ 17)	%
10 – 13 years	230	17.74	5.62	140	60.9%
6 – 9 years	202	17.36	6.00	103	51.0%
14 – 18 years	239	16.64	5.63	117	49.0%

**QUANT****Transitional-Age Fragility**

ANOVA found no significant difference between age groups: $F(2, 668) = 2.234, p = 0.108$ (non-significant), $\eta^2 = 0.66\%$ — distress is **uniform across ages** and intervention must not be restricted to any single age group. That said, the descriptive reading suggests the **transitional group (10–13)** peaks — the developmental threshold between childhood and adolescence, the most fragile juncture for processing loss — while the oldest group (14–18) is somewhat lower, possibly due to more mature coping mechanisms or reduced self-report tendency. Conclusion: intervention covers all ages with particular attention to the transitional group.

◆ **SDQ by Gender**

Gender does not produce a significant difference in Total Score: **males 57.5%** (M=17.55) and **females 49.5%** (M=16.89). Table (49) shows:

◆ **Table (49) SDQ by gender (N = 671)** ◆

Gender	n	Mean	SD	Above threshold (≥ 17)	%
Male	346	17.55	5.89	199	57.5%
Female	325	16.89	5.59	161	49.5%

**QUANT****Divergence in Pathway, Not Severity**

The gender difference did not reach statistical significance: $t = 1.507, p = 0.132$ (non-significant), Cohen's $d = 0.116$ (negligible effect) — so it is not accurate to say males are "more disturbed." The real difference is not in the **degree** of distress but in its **pathway**: males tend toward externalizing trajectories (which may extend to a revenge pathway, see F5), while females tend toward internalizing responses and domestic burden (B2). Screening by total score alone conceals this gender-based divergence that is clinically critical for targeting interventions.

◆ **SDQ by Cause of Death**

Cause of death produces a **significant** difference: those whose relatives are missing are highest — 85.7% above threshold (M=20.71) — followed by direct war death (54.9%), then natural/illness (43.8%), then indirect war (37.5%). Table (50) shows:

◆ **Table (50) SDQ by cause of death (N = 671)** ◆

Cause of Death	n	Mean	SD	Above threshold (≥ 17)	%
Missing (fate unknown)	7	20.71	6.40	6	85.7%
Direct war death	579	17.44	5.66	318	54.9%
Natural / illness	48	16.08	6.05	21	43.8%
Indirect war death	24	15.25	4.87	9	37.5%
Other	13	13.85	7.60	6	46.2%

**QUANT****Ambiguous Loss and Frozen Grief**

ANOVA revealed a significant difference: $F(4, 666) = 3.195, p = 0.013, \eta^2 = 1.88\%$. Despite the small "missing" group ($n=7$), the signal is strong: **Ambiguous Loss** — with no body and no grave — freezes grief (Boss 1999): the child cannot begin mourning because they are still hoping/fearing/not knowing. **Direct bombardment (54.9%) also exceeds natural death (43.8%)** because sudden shock without preparation causes acute trauma. Both groups warrant specialised protocols (Ambiguous Loss + acute bombardment trauma), not generic support.

**QUAL****Anticipatory Grief and the Deemed Orphan**

The **children's voices in focus groups** and the **practitioners in interviews** both distinguish between two different traumas. **Point of convergence:** sudden bombardment is more severe than an expected death (consensus 7/7 in interviews + quantitative: $17.44 > 16.08$). **Point of divergence:** the child describes the pain; the practitioner names the mechanism — **"Anticipatory Grief"**: an expected death (illness) allows partial psychological preparation that softens the trauma, whereas bombardment strikes with no preparation. The most dangerous category with no closure at all: the **"Deemed Orphan"** — whose parent disappeared without a trace — no mourning, no civil registration. **Quantitative bridge:** missing 85.7% (highest) > war 54.9% > natural 43.8%. Key concepts: Anticipatory Grief · Ambiguous Loss · Deemed Orphan (اليتم حكما). The quotes below embody both pathways.

“

*"Loss through bombardment: severe trauma.
Natural death: moderate trauma."*

—

PSYCHOLOGIST

— trauma graded by mode of loss

“

*"Natural death — he had been psychologically
prepared for this loss."*

—

SOCIAL WORKER

— Anticipatory Grief (preparation softens the blow)

“

*"The Deemed Orphan: the one who lost their
father without a trace — not registered in the
orphan civil records and with no legal guardian
alive."*

—

INSTITUTIONAL SPONSORSHIP EXPERT

— Ambiguous

Loss (highest SDQ: 85.7%)

“

*"The thing that upsets me most is my father's
martyrdom... when we go out with mum, we feel
something is missing."*

—

— Testimonies of orphaned children in a focus group — the father's death tops the list of distress

◆ **SDQ by Educational Status — the Strongest Predictor**

The single strongest predictor in the entire study is educational status: **those who stopped schooling for psychological reasons have 96.2% above threshold** ($M=23.19$) — followed by partial attendance (62.5%), then war-forced dropout (58.5%), then regular attendance (47.3%). Table (51) shows:

◆ **Table (51) SDQ by educational status — strongest predictor ($\eta^2=6.62\%$) (N = 671)** ◆

Educational Status	n	Mean	SD	Above threshold (≥ 17)	%
Stopped for psychological reasons	26	23.19	4.31	25	96.2%
Partial (frequent absences)	136	18.28	4.71	85	62.5%
Stopped due to war	82	18.15	5.77	48	58.5%

Educational Status	n	Mean	SD	Above threshold (≥ 17)	%
Regular attendance	427	16.36	5.84	202	47.3%

Psychological school dropout is a **red alarm**: 96.2% (25 of 26) above threshold ($M=23.19$) — with a **49-point gap** from regular attenders (47.3%), the largest gap between any two groups in the entire study. Immediate psychological screening for every child who stopped school for psychological reasons = Priority #1.

**QUANT**

The Strongest Predictor — and a Bidirectional Relationship

This is **the strongest relationship in the entire study**: $F(3, 667) = 15.773, p < 0.001, \eta^2 = 6.62\%$. The relationship is **bidirectional**: psychological school dropout is both a **symptom** of distress and a **cause** of it simultaneously — losing the school as a daily anchor deepens the wound, creating a vicious cycle. Regular attenders are the lowest (47.3%) — confirming that **education is the primary protective line**. Intervention recommendation: **school-based integrated MHPSS (School-Based MHPSS)** + graduated reintegration for dropouts.

**QUAL**

School as Anchor — and Dropout as Collapse

Practitioners in interviews and children in focus groups agree: the war nearly completely dismantled education — schools bombed and converted to shelters, the need for breadwinners, psychological states that preclude concentration (dropout estimates reach 70% in camps) — while children describe their attempts to continue despite burdens (carrying water, working) that steal their time. **Point of convergence**: dropout is a systemic outcome, not an individual failure. **Point of divergence**: the practitioner sees it as a risk indicator; the child lives it as a daily struggle between "the stall and the school." The protective anchor: **school rebuilds the network that displacement destroys** — keeping the child in school is preventive intervention. **Quantitative bridge**: education $\eta^2=6.62\%$ (strongest) + 16.10% out of education (A10). Key concepts: School as Anchor · Systemic Dropout · Vicious Cycle. The quotes below embody them.

“

"The combined impact of orphanhood and war has greatly damaged the educational process, due to the absence of proper and adequate educational service providers for orphans."

— **CAMP MONITOR** — collapse of the educational structure (absence of service providers)

“

"Their academic level has declined and they are deprived of going to school... the proportion not enrolled in education does not exceed 30%."

— **ORPHAN PROGRAMME COORDINATOR** — educational dropout (declining standards)

“

"To pass the Tawjihi [national exams]."

— The wish of an orphaned child in a focus group — clinging to education despite circumstances

**QUANT****Environment Determines Severity More Than Loss Type**

Ranking predictors by effect size (η^2) delivers a decisive policy sequence: **educational status (6.62%, strongest) > residence/tent (4.83%) > child labour (2.60%) > governorate (2.10%) > cause of death (1.88%) > age (0.66%) > duration (0.48%)** — and all of them **outperform orphan type in explaining total score severity (1.03%, non-significant)**, even though type shapes the **profile** of distress rather than its intensity (F3). Crucially, **time does not heal**: those bereaved >3 years ago (49.4%) $\approx$ those bereaved <6 months ago (46.7%) — because the surrounding crisis continues. **Intervention conclusion**: healing the wound runs through the **environment** — keeping the child in education, providing stable shelter, and ensuring stability — not through clinical psychological support alone.

◆ SDQ — The Multivariate Model: Who Is the Independent Predictor?

The comparisons above are **bivariate** (each factor alone), and factors are interrelated (education, tents, and governorate are correlated). To isolate the **independent predictor** from this entanglement, a **multivariate regression** was run (linear on the continuous total, logistic on the ≥ 17 threshold; $N=671$) simultaneously controlling for all factors. Table (52) summarises each predictor's independent contribution after adjusting for the others:

◆ **Table (52) Multivariate regression for SDQ total — independent contribution of each predictor (N = 671)** ◆

Predictor (Reference)	Partial η^2	F	p	Main independent effect
Education (ref: regular)	6.71%	15.76	<0.001	Psychological dropout: +6.75 pts (strongest)
Governorate (ref: North Gaza)	2.90%	9.83	<0.001	Deir al-Balah: +2.91 · OR=2.86
Tent (vs. non-tent residence)	1.40%	9.34	0.002	+1.67 pts · OR=1.60
Age (ref: 14–18)	1.00%	3.31	0.037	10–13: +1.24 · OR=1.80
Orphan type (ref: paternal)	0.60%	1.32	0.267	Non-significant
Gender (male)	0.06%	0.42	0.519	Non-significant
Child labour	0.01%	0.03	0.852	Non-significant

Linear model: $R^2=12.7\%$ ($F(13,657)=7.33$, $p<0.001$) · Variance Inflation Factor $VIF<1.6$ for all predictors (no harmful multicollinearity) · Partial η^2 = each predictor's contribution after adjusting for the others (Type II ANOVA) · OR from logistic model on ≥ 17 threshold. The odds ratio for psychological dropout is large but its confidence interval is wide (96.2% of them are above threshold, $n=26$); the linear independent effect (+6.75) is the stable estimate used.

**QUANT****Multivariate Confirmation: Environment Predicts Severity, Not Bereavement Type**

After controlling for all factors simultaneously, **education remains the strongest independent predictor** (partial η^2 6.71%; psychological dropout raises the total +6.75 points — the single largest increment, with 96.2% above threshold) — followed by **governorate** (Deir al-Balah OR=2.86) and **tent residence** (OR=1.60, which remains independently significant even after controlling for governorate, with VIF ruling out multicollinearity). All are **environmental**. In contrast, **orphan type** ($p=0.27$), **gender** ($p=0.52$), and **child labour** ($p=0.85$) **do not independently predict severity** — notably, the bivariate effect of child labour ($\eta^2=2.60\%$) **disappears** after controlling for education, meaning it overlaps with educational disruption and does not act independently. Thus **the model demonstrates, by controlling for entanglement**, what the bivariate comparisons indicated: **environment determines severity; bereavement type shapes the profile, not the intensity (F3)**. The modest R^2 (12.7%) is expected in psychological screening, reflecting individual, caregiving, and resilience factors (F5) in the residual — not a model weakness. **Intervention implication:** the two strongest actionable levers are **keeping the child in education** and **moving them out of a tent**.

◆ F5. Two Opposing Pathways: Resilience and the Time-Bomb

The numbers are not complete without a final question: what makes the difference between an orphan who endures and one who collapses? Interviews and focus groups agree that the difference **lies not in the child but in what is provided to them** — and they reveal two pathways: ready protective factors, and a preventable time-bomb.

The equation is simple and stark: **a nurturing caregiver + education + meaning = resilience; neglect + child labour + the father vacuum = collapse**. The difference between them is **an intervention decision, not destiny**.

**QUAL****Ready Protective Factors**

The field (7/7) agrees that the **containing caregiver** is the primary resilience factor — with the corollary that **those displaced with no embrace are most at risk of collapse**. The **Qur'an and prayer** emerge as a cross-group resilience factor (G7: a source of reassurance for 28.32%), with a **significant developmental ceiling**: faith does not operate therapeutically without awareness and maturity (under age 8, it has no measurable effect) — a distinction that protects against a one-size-fits-all prescription. **Play with peers, post-traumatic growth** ("we became stronger and more resilient"), and the **preserved prosocial behaviour (72.4%, F2)** complete the picture. Protective levers are available and culturally accepted — intervention does not start from zero. The quotes below embody them.



"We became stronger and more resilient."

— Testimonies of orphaned adolescents in a focus group — post-traumatic growth (PTG)



"Faith and religion help greatly with recovery and have a major impact on their character."

— **ORPHAN PROGRAMME COORDINATOR** — faith as a culturally accepted resilience factor

**QUAL****The Preventable Gendered Time-Bomb**

On the other side, focus groups reveal a dangerous trajectory: **five of eight boys (FG2) want to "carry arms for revenge,"** repeated projectively (lions "to protect their family," falcons "to fly after the enemies"). Crucially, this pathway is **gender-specific and completely absent among girls and among children of martyrs** — meaning it is the **result of a vacuum, not destiny**. The quantitative data supports this: no significant gender difference on the SDQ total (males 57.5% vs. females 49.5%, $d=0.116$) — the divergence is in **pathway, not degree**: males toward externalizing/revenge, females toward internalizing and domestic burden (B2). This connects directly to **the loss of the male role model (B7)** and "compensatory control (B2)": when the father-model is absent and no alternative meaning fills the void, the **revenge pathway** may fill it. These — not emotional symptoms alone — are the **long-term social cost** of neglecting male orphans. The implication is explicit: **Prevention of Violent Extremism (PVE)** begins by targeting adolescent boys early with alternative-meaning activities (sports, skills, volunteering, mentorship) that fill the father's absence before revenge fills it. The **fillability of the void** is confirmed by the projective tool itself: alongside lions and falcons, one child chose "a dove tired of wars who wants to reach his father" and another "mint, to be useful" — existential longing and altruism sit alongside aggression, meaning the void accepts alternative meaning when filled early. The quotes below embody the pathway, its spectrum, and its driver.



Lions "to protect their family" · Falcons "to fly after the enemies" · A dove "tired of wars, wanting to go to its father" · Mint "to be of use to people."

— Projective tool ("If you were not human, what would you be?") in a focus group (boys) — a spectrum from protection and revenge to existential longing and altruism



When asked what he wants to become, he expressed — in so many words — a desire to carry weapons to avenge whoever killed his father.

— **TEACHER** — observing the revenge pathway (paraphrased to preserve neutrality and protect the child)

◆ Section F Summary — Psychometric Measures (SDQ-25)

The section summarises the unified psychological dimension: the **"average orphan" sits at the referral threshold** ($M=17.23$, 53.65% above it) — so the crisis is **population-level, not individual**, and cannot be addressed by a clinic waiting for referrals. The profile is **internalizing** (emotional 68.41% + peer 55.74% > conduct), with **preserved prosocial behaviour (72.4%)** as a therapeutic lever. The most important methodological finding is that **the total score alone is insufficient for screening**: the maternal orphan is lowest (34.6%) despite having the largest emotional gap (27 points), and the sole survivor is "moderate" on SDQ (52.9%) while 88.24% exceed the CRIES threshold — screening must use **subscale profiles + CRIES, not total score alone**. It is also demonstrated that **environment determines severity more than loss type**: education ($\eta^2=6.62\%$; psychological dropout 96.2%) then governorate then tent — confirmed by the **multivariate model** (education is the strongest independent predictor; orphan type is non-significant after controlling for entanglement) — and **time does not heal** because the crisis continues. Finally, the difference between **resilience** (containing caregiver + meaning + education) and the **gendered time-bomb** (father vacuum → revenge pathway in boys, absent among girls and martyrs' children) is **an intervention decision, not destiny**. **Bridge to Section G**: having inventoried the internal wound through Sections B–F, the next section asks how the **external environment** — society's gaze, identity, and hope — amplifies or softens what the preceding sections described.

3.7 Section G — Society's Gaze, Identity, and Hope

If the preceding section (F) measured the **internal wound**, this section asks about the **external environment**: does society *hold* the orphaned child, or does it wound them a second time? It applies to the **full sample (N=671)** across three axes: **(1) society's gaze and stigma (G1)**, **(2) identity and self-description (G2)**, and **(3) hope, belonging, and sources of reassurance (G3)**. What emerges is that orphanhood carries a **secondary social experience** — the child is defined by their loss in the eyes of others — yet this runs in parallel with genuine resilience levers.

◆ G1. Society's Gaze — Between Containment and Stigma

The first three items reveal a dual picture: **the majority of peers contain the child** (70.04% normal treatment), but a **wounding minority, hurtful words, and an internalised stigma** form a daily social burden. Tables (53–55) show the three items:

◆ **Table (53) G1 — How other children treat the orphan (N = 671)** ◆

Pattern of treatment	Count	Percentage and Distribution
Normally	470	70.04% 
With excessive sympathy that embarrasses them	100	14.90% 
Sometimes with mockery or hurtful words	53	7.90% 
Does not mix with other children	28	4.17% 
With avoidance	20	2.98% 
Total	671	100.00%

◆ **Table (54) G2 — Exposure to hurtful words or painful comparisons (N = 671)** ◆

Frequency	Count	Percentage and Distribution
Never applies	332	49.48% 
Sometimes applies	220	32.79% 
Often applies	98	14.61% 
Always applies	21	3.13% 
Total	671	100.00%

Mean = 1.71 out of 4 · SD = 0.83.

◆ **Table (55) G3 — Feeling shame or avoiding mention of their situation in front of others (N = 671)** ◆

Frequency	Count	Percentage and Distribution
Never applies	250	37.26% 
Sometimes applies	227	33.83% 
Often applies	133	19.82% 
Always applies	61	9.09% 
Total	671	100.00%

Mean = 2.01 out of 4 · SD = 0.97.

Stigma is a widespread experience, not a marginal one: although 70.04% of peers are containing, **50.52% (339 children) were exposed to hurtful words at any level** (including 17.74% "always/often"), and **62.74% (421) feel shame at any level** (including 28.91% "always/often" = explicit internalised stigma), while **29.96% (201)** experience abnormal treatment from peers. In other words: **one in every four children** endures a daily social wound on top of the wound of bereavement.



QUANT

Stigma as a Second, Internalizing Wound (Measured, Not Assumed)

Stigma does not occur in isolation from Section F — and **the link here is measured, not assumed**: hurtful words (Table 54) and shame (Table 55) correlate **positively and significantly with internalizing symptoms** (emotional + peer problems) — **$p=+0.38$** for hurtful words and **$p=+0.29$** for shame ($p<0.001$ for both) — the very same internalizing signature that dominated F2 (68.41%/55.74%). Stigma therefore deepens the **silent wound** that may evade screening (F3): the ashamed child hides their bereavement just as they hide their distress (B5: the silence pole is the more dangerous). This measured correlation has a direct field witness: when children were taunted about their loss, they **"became sad and went silent"** — mockery translates into internalizing silence, not protest — the lived face of the figure $p=+0.38$ (a qualitative ↔ quantitative convergence point). (*The correlation is cross-sectional and supports the relationship, not the direction of causation.*) Most critically for methodology: **"excessive sympathy" (14.90%) is not neutral** — it entrenches the identity "orphan = permanent loss" rather than a recoverable experience (Internalized Grief Stigma). Shame also drives avoidance of group treatment — directly connecting to the screening recommendation (F3: subscale screening) and the preference for non-stigmatising models (H2).



QUAL

Locational Stigma: The Camp Is Harsher Than the School

Children in focus groups and teachers in interviews agree on a fine distinction: stigma **concentrates in the camp/displacement environment, not in the structured school**. **Point of convergence**: where structure is absent (the camp), the wound of comparison and mockery intensifies; where it is present (the school), it eases. **Point of divergence**: the child experiences it as exclusion and a painful comparison that sometimes turns to aggression; the teacher reads it as a classroom dynamic requiring educational intervention. **Quantitative bridge**: 29.96% abnormal peer treatment · 28.91% internalised stigma · linked to F4 (tent as independent risk factor). **A reversed face uncovered only by the qualitative (Complementarity): Aid Envy** — the orphan hears from peers "I wish we were orphans so we'd get sponsorship"; the support that meets the **highest material need (85.10%, H1)** and extends as structural sponsorship (96.88% for doubly-orphaned, D1) simultaneously produces a relational distortion unmeasured by the quantitative stigma items. **A significant point of divergence**: the quantitative data portrays the orphan as a *beneficiary*; the qualitative reveals that this same benefit becomes a *wound*. Key concepts: Internalised Stigma · Harmful Pity · Locational Stigma · Aid Envy. The quotes below embody the painful comparison, the locational stigma, and its reversed face (Aid Envy).

“

"Other people have something extra that we don't — a father."

— Testimony of orphaned children in a focus group — the perceived difference as the basis of stigma

“

"I wish we were orphans so we'd get sponsorship!"

— What the orphan hears from their peers when receiving sponsorship (focus group) — the reversed face of stigma: Aid Envy distorts the peer relationship

“

"My friends in the camp say: our dad takes us to the sea and gives us pocket money, and you poor thing have no father — so every time I see them I throw stones at them and fight with them."

— Documented case of an orphaned child in a shelter centre, relayed by their teacher — painful comparison turning to aggression

“

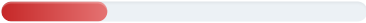
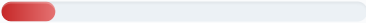
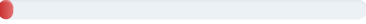
"At school it's normal, but at the displacement centre it's different."

— **TEACHER** — locational stigma (the camp is harsher than the structured school)

◆ G2. Identity and Self-Description

When the child describes themselves (multiple-choice question), a **predominantly active identity** emerges: the most common self-description is "trying to adapt," not "doing fine." But a segment carries a **sense of injustice** and another is in **identity concealment**. Table (56) shows:

◆ **Table (56) G4 — How the child describes themselves (multiple choice · N = 671)** ◆

Description	Count	Percentage of 671
Trying to adapt despite the difficulties	395	58.87% 
Coping normally	340	50.67% 
Feels a sense of injustice and oppression	195	29.06% 
Never talks about themselves	97	14.46% 
Does not know who they are after losing their family	29	4.32% 

Multiple-choice question: each child may choose more than one description (average 1.57 descriptions); percentages **do not sum to 100% and do not represent mutually exclusive categories**.

Adaptation is agency, not denial: the most common description "trying to adapt" (58.87%) contains an implicit acknowledgement of real difficulties being actively faced — not "doing fine." Against this, **29.06% (195 children) feel a sense of injustice and oppression** (not fleeting emotions but an indicator of lost existential justice), and **approximately 126 children (14.46% who never talk about themselves + 4.32% who don't know who they are) are in identity concealment or identity confusion** warranting clinical examination.

**QUANT****A Split Identity: Coping Agency vs. Injustice and Concealment**

The most important aspect of the number is that children define their experience through **"trying to adapt" (denoting agency) more than "normal" (denoting denial)** — this supports a **strengths-based therapeutic approach** rather than a deficit-oriented one, consistent with preserved prosocial behaviour (72.4%, F2). But **injustice (29.06%)** is a thread running across sections: it intensifies in those who witnessed death directly (Section E: sole survivor, guilt-injustice triad), and may evolve in boys toward the **revenge pathway** (F5) and in girls toward silent internalizing. The **identity concealment (~126)** is the silent wound (F3) at the identity level — and complements D9 (how the child introduces themselves externally: the pride of "son of a martyr" versus hiding orphan status). (*Methodological note: multiple-choice question — percentages must not be summed.*)

**QUAL****Between Pride, Injustice, and a Lost Compass**

The **child's voice** and the **practitioner** both agree that identity after loss **oscillates**. **Point of convergence:** the child who compares themselves to peers with a living father experiences an existential injustice; the practitioner observes in the sole survivor a **lost identity** that needs "a clear sense of who they are." **Point of divergence:** some children carry the identity as **pride** (son of a martyr); others hide it in **shame** (G3) — a split that explains the multiplicity of self-descriptions. **Quantitative bridge:** 29.06% injustice · ~126 identity concealment · 4.32% "doesn't know who they are." Key concepts: Split Identity · Existential Injustice · Coping Agency. The quotes below embody the oscillation.

“

"When I see my cousins with their father, it really upsets me and makes me ask: why does their father exist and mine died?"

— Testimony of an orphaned child in a focus group —
existential injustice through comparison

“

"The sole survivor grows up under difficult and fragile conditions, without knowledge of themselves or their identity."

— **CAMP MONITOR** — identity loss (connects to Section E)

“

"Before the war I was very shy and didn't interact with people."

— Testimony of an orphaned teenage girl — and 6 of 8 in the group shifted from shyness to active engagement (coping agency)

◆ **G3. Hope, Belonging, and Sources of Reassurance**

Despite loss and stigma, **wide resilience levers remain:** the majority still dream, feel loved, and have a "safe person." Tables (57–59) show:

◆ **Table (57) G5 — Does the child still have dreams and wishes they want to fulfil? (N = 671)** ◆

Frequency	Count	Percentage and Distribution
Often applies	265	39.49%
Always applies	241	35.92%
Sometimes applies	134	19.97%
Never applies	31	4.62%
Total	671	100.00%

Mean = 3.07 out of 4 · SD = 0.86 — **the highest mean in all of Section G.**

♦ **Table (58) G6 — Does the child feel that someone truly cares about and loves them? (N = 671)** ♦

Frequency	Count	Percentage and Distribution
Often applies	289	43.07% 
Always applies	175	26.08% 
Sometimes applies	156	23.25% 
Never applies	51	7.60% 
Total	671	100.00%

Mean = 2.88 out of 4 · SD = 0.88.

♦ **Table (59) G7 — What currently gives the child the greatest sense of reassurance (multiple choice · N = 671)** ♦

Source	Count	Percentage of 671
Someone they love and trust	527	78.54% 
Play or a beloved activity	357	53.20% 
Memories of their parents	283	42.18% 
Faith and prayer	190	28.32% 
Daily routine	47	7.00% 
Nothing clear	11	1.64% 

Multiple-choice question — percentages do not sum to 100%.

Despite everything, hope is nearly universal: **75.41% (506) still dream** (95.38% at any level), **69.15% (464) feel loved**, and **78.54% (527) have a "safe person."** But an **extinguished minority** requires immediate clinical priority: **31 children (4.62%) have no dreams at all**, **51 (7.60%) never feel loved**, and **11 (1.64%) have no source of reassurance whatsoever.**

**QUANT****A Stated Source of Reassurance ≠ Proven Protective Effect**

Descriptively: "someone they love and trust" tops the stated reassurance sources (78.54%), ahead of play, memories, and faith. But **honesty requires testing the protective effect on the SDQ total, not merely accepting prevalence:** hope (dreams, G5) is a **significant, if modest, protective factor** ($p=-0.18$, $p<0.001$: those who dream report less distress), while **feeling loved (G6) has a negligible effect** ($p=-0.07$), and **having a "safe person" (G7) does not correlate significantly with a lower total score** in this snapshot (mean for those with a safe person 17.32 vs. 16.90 for those without — Mann-Whitney $p=0.32$, Welch t $p=0.44$) — most likely because both are **near-universal (ceiling effect)**, because a "source of reassurance" is not necessarily a "protection against chronic disorder," and because the cross-sectional design cannot track the protective trajectory (see 2.4, Limitations). **Balanced conclusion:** the nurturing caregiver remains the **cornerstone of resilience in qualitative testimony** (F5, consensus 7/7) and the most commonly cited source of reassurance — without claiming for it a quantitative protective effect that did not emerge here. **Whole-Family Care** ²⁶ — which redefines eligibility around **care need** rather than breadwinner loss (the link with Sections C and D) — therefore remains justified by **need, prevalence, and the methodological triangle**, not by claiming a quantitative correlation. Routine (7.00% only) reflects environmental instability (F4). The **extinguished minority** (without dreams/love/reassurance) overlaps with the severe range in F1 = top screening priority.

**QUAL****One Relationship Is Enough: The Child Names Their Safe Person**

Children's testimonies in focus groups align with the practitioner: when a child is asked who they turn to, they name **a specific person** (the mother, the grandparent, sometimes a teacher), and find reassurance in the Quran and play. **Point of convergence:** a single trusted relationship is the driver of reassurance — and in field judgement the driver of recovery too (qualitative testimony; no quantitative effect on total score demonstrated, as noted) — exactly as the field sees the nurturing caregiver as the cornerstone of resilience. **Point of divergence:** the child names a concrete person; the practitioner names a **system that must be built** (comprehensive care that supports the caregiver themselves). **Quantitative bridge:** safe person 78.54% > play 53.20% > memories 42.18% > faith 28.32%. Key concepts: Secure Base · Hope as Protection · Whole-Family Care. The quotes below embody them.



"I prefer my mother to listen to me."

— Testimony of an orphaned child in a focus group — the safe person identified by name (others mentioned grandparent or teacher)



"I feel at peace when I listen to the Quran, recite it, and pray for God's mercy and forgiveness for my parents."

— Consensus among orphaned children in a focus group — faith as a source of reassurance (G7)



"The mother's care is good and she takes great care of the child."

— **TEACHER** — quality of the nurturing caregiver as the foundation of reassurance

◆ Section G Summary — Society's Gaze, Identity, and Hope

The section answers its central question: society **both contains and wounds**. While 70% of peers are containing, **50.52% were exposed to hurtful words and 28.91% carry an internalised stigma** — a **second wound that feeds the internalizing profile** (F2) and deepens the silent wound (F3), concentrated locationally in the camp, not the school. At the identity level, children define themselves through **"trying to adapt" (agency, not denial, 58.87%)**, with a segment of **injustice (29.06%)** crossing over to the sole survivor (Section E) and the revenge pathway (F5), and **~126 in identity concealment**. Yet the section closes on good news: **hope is near-universal (75.41%)**, and **"the safe person" tops stated sources of reassurance (78.54%)** — qualitatively consistent with F5 (the nurturing caregiver as the cornerstone of resilience) and a launching point for **Whole-Family Care** ²⁶ (even though no quantitative protective effect on the total score emerged in this cross-sectional snapshot — only hope alone $p=-0.18$). Both layers of exclusion persist: informal social exclusion (stigma here) and institutional structural exclusion of the maternal orphan (Sections C/D and F3's camouflage). Both amplify the wound. **Bridge to Section H:** if "the safe person" is the engine of recovery, the next section asks: what needs must be met to build and sustain that person?

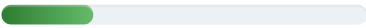
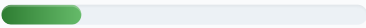
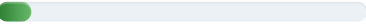
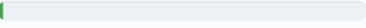
3.8 Section H — Needs and Participation in Support Programmes

Here the diagnosis — SDQ, CRIES, and all preceding sections — converts into **policy and programme priorities**. Rather than assuming what orphaned children need, the study listened to **caregivers and children themselves** — and the answers are anchored in the reality of Gaza: material needs and housing first, with the psychological wound silent beneath them, and the caregiver themselves exhausted. This section applies to the **full sample (N=671)** across three axes: the needs hierarchy (H1), service form and location (H2), and the exhausted caregiver (H3).

◆ H1. The Actual Needs Hierarchy — Poverty and Housing First

When families are asked what they actually need (not what is imagined for them), the answer comes straight from **the reality of Gaza**: money and housing before anything else. Table (60) shows:

◆ Table (60) H1 — Top three immediate needs for the child (multiple choice · N = 671) ◆

Need	Count	Percentage of 671
Financial support	571	85.10% 
Safe and stable housing	405	60.36% 
Recreational and creative arts activities	320	47.69% 
Specialist psychological support for the child	317	47.24% 
Re-enrolling them in education	167	24.89% 
Psychological support for the caregiver too	146	21.76% 
Social network (connecting them with children)	61	9.09% 
Identity and civil documentation	9	1.34% 

Multiple-choice question — percentages do not sum to 100%.

Poverty is the first perceived need, not trauma: financial support tops the list with near-unanimous consensus — **85.10% (571 caregivers)** — followed by safe housing at **60.36% (405)**. Specialist psychological support for the child was mentioned by only **47.24% (317)** — a figure **lower than the measured need on every scale:** below the conservative SDQ total threshold (53.65%, 360 children), and **far below the true internalizing signature** (Emotional subscale 68.41%, 459 children — a gap of roughly 21 percentage points). The core of the wound: survival needs eclipse the silent psychological injury; the caregiver does not perceive it fully, just as the total score fails to capture it in F3.


QUANT
Survival Priority Eclipses the Invisible Wound

The policy implication is twofold. **The first is direct:** money and housing are the first lived need — consistent with severe financial hardship (B1, 78.19%), child labour (A11, 16.54%), and tent living (A12, 76.45%) — there is no effective psychological support on an empty stomach under a torn tent. **The second is more dangerous:** the gap between perceived psychological need (47.24%) and measured reality is **wider than it appears** — it falls below the conservative threshold (53.65%) and below **the emotional signature by roughly 21 percentage points (68.41%)**; and the Screening Camouflage paradox (F3) means that even the total score itself understates the true number (maternal orphan and sole survivor are hidden). The caregiver thus replicates — at the perceptual level — the same error as total-score-only screening: they miss the silent internalizing wound. **Psychological support must therefore be offered proactively, not waited for**, bundled into the material relief package rather than separated from it. **Similarly for education — a revealing paradox:** despite being the **strongest predictor of distress in the entire study** (F4, $\eta^2=6.62\%$; psychological dropout 96.2% above threshold), only 24.89% listed re-enrolment among the three urgent priorities. This is **not disinterest:** the "re-enrolment" item concerns those currently outside education (16.10%, A10), so requesting it (24.89% = 167) **exceeds that group's size** = genuine demand from those it concerns. But its ranking behind money and housing under survival pressure means families may **neglect the single strongest protective factor**; therefore **education must be protected proactively** (like psychological support) so emergencies do not consume it. **Intervention implication:** an integrated package (cash + housing + bundled psychological support + education protection) — not competing parallel tracks.


QUAL
The Family's Own Voice: Survival First, the Need Beneath It

The **caregiver's voice in open-text survey responses** aligns with the **practitioner in interviews:** families name concrete survival needs (a dilapidated tent, a child who left school to work), while practitioners name the developmental needs beneath them that are unmet. **Point of convergence:** current care is "first aid" that sustains life, not "development" that builds the child. **Point of divergence:** the family sees money and housing as an urgent end; the practitioner sees them as an **enabling precondition** for any subsequent recovery. **Quantitative bridge:** financial 85.10% · housing 60.36% · the psychological gap 317/360. **Triangulation (Triangulation):** the child's voice completes the triangle — children placed "a safe, stable place with our mothers and siblings" at the top of their own wishes; their priority is stability-with-family, not housing-as-structure, an alignment between caregiver, practitioner, and child that paves the road directly toward Whole-Family Care (H3). Key concepts: First-Aid not Developmental Care · Poverty as Eclipse · Integrated Package. The quotes below embody the family's voice.

“

"We have been living in a tent for 18 months."

— Caregiver's open-text survey response — housing as the first priority

“

"He left school to support his siblings."

— Caregiver's open-text survey response — poverty driving child labour (A11)

“

"We want to keep living in a safe, stable place with our mothers and siblings."

— The wish of orphaned children in a focus group — stability-with-family, not housing-as-structure (points toward Whole-Family Care, H3)

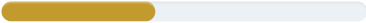
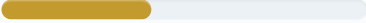
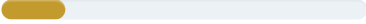
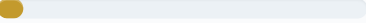
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"The quality of care is basic and does not meet orphans' needs... failure to meet the child's needs: financial, social, economic, educational, and academic."— **PSYCHOLOGIST** — developmental needs beneath the survival surface

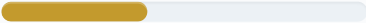
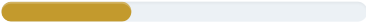
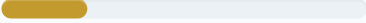
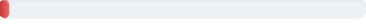
◆ H2. Service Form and Location — Rejecting the "Sick Child" Model

When asked **how** and **where** support should be delivered, Gaza families clearly reject the "sick child in a clinic" model and prefer **non-stigmatising, child-proximate formats**. Tables (61) and (62) show:

◆ **Table (61) H2 — Most appropriate type of psychological support for the child (multiple choice · N = 671)** ◆

Type of support	Count	Percentage of 671
Support groups with other orphaned children	379	56.48% 
Play therapy and creative activities	360	53.65% 
Programmes including both child and caregiver	282	42.03% 
Individual sessions with a specialist	275	40.98% 
Spiritual and religious support	116	17.29% 
Do not know what is most suitable	46	6.86% 

◆ **Table (62) H3 — Preferred location for service delivery (multiple choice · N = 671)** ◆

Location	Count	Percentage of 671
Any safe location	400	59.61% 
Community or camp service centre	269	40.09% 
School or educational centre	240	35.77% 
Home visits	156	23.25% 
Clinic or hospital	19	2.83% 

Both questions are multiple-choice — percentages do not sum to 100%.

A clear message to programme designers: **deliver support where the child lives, framed as an activity — not a disease**. Non-stigmatising formats lead — support groups (56.48%), creative play (53.65%), family programmes (42.03%) — ahead of individual clinical sessions (40.98%); and "any safe location" (59.61%) then community centre (40.09%) then school (35.77%) — while **clinic/hospital is chosen by only 2.83%**: an explicit rejection of the "sick child" model.



QUANT

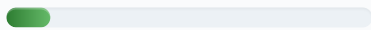
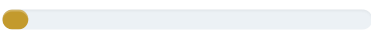
Community-Based, Non-Stigmatising Service — Not a Waiting Clinic

This preference aligns with the stigma wound in Section G: where 28.91% are ashamed to mention their orphanhood (G3), a "psychologist's appointment" becomes a stigma threat — so the caregiver retreats to group/creative formats. It also aligns with the F1 finding: **the crisis is population-level and demands a population-level response, not a clinic waiting for referrals** (2.83%). **Methodological note:** preference does not necessarily equal effectiveness — individual sessions remain an important tool, but must be delivered within a non-stigmatising frame (embedded in an activity or school). The school (35.77%) reaches the largest stable segment (427 regular attenders, A10) — making **School-Based integrated MHPSS** the broadest delivery channel (F4). **The scalable triple-channel:** school + community centre + home visit.

◆ H3. The Exhausted Caregiver — From Child Sponsorship to Whole-Family Care

Here lies the core wound on which all recommendations are built: **an exhausted caregiver produces an exhausted child**. When caregivers were asked directly about themselves, the disclosure was stark. Table (63) shows:

◆ **Table (63) H4 — Does the caregiver themselves need psychological support? (N = 671)** ◆

Response	Count	Percentage and Distribution
Yes	545	81.22% 
No	81	12.07% 
Have not thought about it	45	6.71% 
Total	671	100.00%

81.22% (545 caregivers) explicitly acknowledge needing psychological support — the highest rate of explicit acknowledgement in the entire study. This is not just the child's need but the need of **the entire orphaned household**. A broken and exhausted caregiver cannot, on their own, hold a wounded child.



QUANT

Whole-Family Care — the Central Recommendation

The most alarming aspect of the figure is a revealing gap: caregivers listed "psychological support for the caregiver" as a child priority in only **21.76%** (H1), yet when asked directly, **81.22%** acknowledged the need — a **~60-point awareness gap**. The caregiver automatically classifies their own need as "secondary" and therefore does not request it — **which is why intervention must proactively offer it, not wait for the request**. This crowns the study's entire thread: the mother cannot compensate for the absent father (B4, 56.54%), "the safe person" is the top source of the child's reassurance (G7, 78.54%), and the nurturing caregiver is the cornerstone of resilience (F5) — so when the caregiver collapses, the child collapses. **Policy conclusion:** the shift from "child sponsorship" to **Whole-Family Care** ²⁶ — a package that supports the caregiver (primarily the mother: 84.05% of caregivers, A8) alongside the child, allocating **at least 30% of programme resources to caregiver support** — and redefining orphan eligibility around **care need rather than breadwinner loss** (the link with Sections C and D).

**QUAL****Child, Family, and System All Point to the Caregiver**

Three voices converge: the **caregiver in open-text responses** cries out for their child; the **field researcher** flags cases for immediate referral; and the **practitioner** links the child's recovery to the caregiver's health. **Point of convergence:** the containing relationship is the engine — and the caregiver's health is its condition. **Point of divergence:** the family requests for their child first (and overlooks themselves); the practitioner insists that supporting the caregiver is not a luxury but a precondition for any child intervention to succeed. **Quantitative bridge:** 81.22% need support · 60-point awareness gap · 84.05% of caregivers are mothers. Key concepts: Whole-Family Care · Proactive Offer · Caregiver Awareness Gap. The quotes below embody them.



"The girl needs immediate intervention because she is very withdrawn."

— Caregiver's open-text survey response — an explicit cry for help for their child



"The child needs full support... and needs security very much."

— Observation by a field researcher — flagging a case for immediate referral



"The better the caregiver's relationship with the child, the more it helps the child adapt."

— **ORPHAN PROGRAMME COORDINATOR** — caregiver health as a precondition for the child's recovery

◆ Section H Summary — Needs and Participation (The Intervention Verdict)

This section places its finger on the **core of the wound** as the families themselves see it: in Gaza, **money (85.10%) and housing (60.36%) come first** — no effective psychological support on a hungry stomach under a torn tent. But the psychological wound **does not disappear — it goes silent**: the caregiver perceives it in only 47.24% while our instruments reveal a far greater need (total 53.65%, emotional signature 68.41%) — and the total score itself camouflages it (F3) — so it must be delivered **proactively**, bundled into the relief package, **in a safe location and in schools and community centres, not in a clinic that only 2.83% chose**. Above all else: **the caregiver themselves is broken (81.22%)**, so the answer is not "child sponsorship" but **Whole-Family Care** ²⁶ — cash + housing + community-based non-stigmatising psychological support + explicit caregiver support (≥30% of resources), with eligibility redefined around **care need, not breadwinner loss**. **Bridge to Chapter 4:** these priorities — in their Gaza-grounded order — form the body of the strategic recommendations.

Conclusions and Strategic Recommendations

4.1 Core Conclusions

These conclusions synthesise what Sections A–H demonstrated through figures and testimonies, ordered from the general to the specific — each anchored to measured evidence:

The Organising Conclusion: Gaza's orphanhood is **a structural population-level crisis, not isolated individual cases** — its wound is silent and internalising, its severity shaped by **environment rather than type of loss**, and compounded by a distorted entitlement system and a depleted caregiver.

- 1. A population-level crisis:** The SDQ mean (17.23) equals the referral threshold, and 53.65% (360 children) exceed it — including 70 (10.43%) in the severe range — making disorder the norm rather than the exception. What is needed is a population-level response, not a clinic waiting for referrals.
- 2. A silent internalising wound obscured by the total score:** The internalising signature (emotional 68.41%) outweighs the externalising (behavioural), and the total score conceals the most internalised cases (maternal orphan gap: +27 points; sole survivor: 88.24% on CRIES vs 52.9% on SDQ). Triage must use subscale scoring + CRIES, not the total score alone.
- 3. Environment determines severity — not type of loss:** Multivariate regression showed that education is the strongest independent predictor (partial η^2 6.71%), followed by shelter/tent residency, while type of orphanhood, sex and child labour are non-significant — the type of loss shapes the profile of distress, not its intensity.
- 4. Entitlement logic is distorted (the study's primary theoretical contribution):** The current system grants orphan status based on loss of the *breadwinner* (the father), not need for *care* — structurally excluding the maternal orphan (Sections C/D), while measurement camouflage (F3) compounds that exclusion.
- 5. Poverty and shelter first — the wound beneath them:** Families prioritise money (85.10%) and shelter (60.36%) first, while psychological support (47.24% self-reported vs 68.41% measured) and education (the strongest protective factor) are relatively neglected under survival pressure — intervention must be proactive, not demand-driven.
- 6. The depleted caregiver:** 81.22% of caregivers acknowledge their own need for psychological support — a depleted caregiver produces a depleted child, and no solution exists without **whole-family care**.
- 7. A preventable gendered time-bomb:** The revenge trajectory among boys — entirely absent among girls and martyrs' children — is the product of a vacuum, not fate. Early prevention (PVE) is feasible and far cheaper than its social cost.

4.2 Intervention Priorities

These recommendations are grounded in **reality, not paper**: a nearly totally destroyed sector, with no houses being built, no heating available and no functioning clinics (only 43% of health points operational; 833,000 displaced) ². We therefore **promise only what exists** — building on **what holds: people and meaning** — the caregiver, the trained facilitator, the safe space however modest, and the anchors of Quranic circles, play and drawing. **The cheapest and deepest-impact interventions are those that require no infrastructure — only people and attentive listening** — reaching the child where they are, not where we wish they were.

First Priority — Psychological Debriefing Activities (the core of the response): The wound we documented is **silent and internalising** (emotional 68.41%), and the child conceals it out of shame (28.91% stigma, G3) — they do not need a "clinic" but **a safe channel to release what they suppress**. Guided play, drawing, drama, storytelling, sport and Quranic circles are **the most suitable, effective and lowest-cost modalities**: delivered by a trained facilitator in any safe corner (tent or yard) with no infrastructure, and framed as **activity — not illness**, so stigma does not undermine them. These are what families actually prefer (creative play 53.65%, group sessions 56.48%), what children find reassuring (drawing, play, Qur'an, G7), and they build on **children's preserved resilience (72.4%)**. Not a leisure luxury — the **realistic treatment for the silent wound: it gives the suppressed child a voice**.

Second Priority — The Cash Lifeline: Regular cash sponsorship (the top self-reported need, 85.10%) reaches children without requiring infrastructure, and removes the pressure of child labour (A11), allowing the child to remain a child.

Third Priority — Supporting the Depleted Caregiver: Mothers must be integrated into every child-focused intervention programme — 81.22% of caregivers request support for themselves. Group debriefing and support sessions for mothers (84.05% of caregivers), delivered with the same non-stigmatising approach, protect the child by protecting the person who holds them. Whole-family care — not child sponsorship alone.

Fourth Priority — Mobile Triage for Extreme Cases: Mobile field teams (not a clinic that waits) using subscale + CRIES screening, referring the most severe cases immediately: those who stopped school for psychological reasons (96.2%), sole survivors (88.24%), those whose relatives are missing, and the emotionally extinguished (31 with no dreams, 51 with no love, 11 with no sense of safety) — field researchers were already identifying these cases.

Fifth Priority — Preserving Meaning and Learning: Keeping the child in any available learning space (school, educational tent or centre), and a meaning pathway for adolescent boys (sport, skills, volunteering, mentoring) that fills the vacuum before the desire for revenge does.

On Shelter (the second-ranked need, 60.36%) — we must be honest: No relief programme can build houses in rubble, or heat a tent without fuel. Our role here is **advocacy, not a promise**: that orphaned families receive **priority in transitional shelter and reconstruction** when these become available, while mitigating the current shelter's impact on children as much as possible. Acknowledging the limits of what can be achieved is part of responsible recommendation.

4.3 Recommendations by Dimension

These priorities are distributed across the six dimensions, all grounded in reality and in what can actually be delivered:

Psychologically: Non-stigmatising collective debriefing activities first, then mobile subscale + CRIES triage for the most severe — both preceded by **training a cadre that can detect the silent internalised wound** (Component 4), because there is no triage without a trained eye (F3, E). **Educationally:** Keeping the child in any available learning space and embedding activities within it; community-based alternatives where schools are destroyed (F4).

Economically: Regular cash sponsorship that ends the need for child labour (H1, A11). **Socially and in terms of shelter:** Breaking stigma through inclusive groups (orphans + non-orphans, not exclusive separation) (G1); shelter as

advocacy (priority for orphans in reconstruction), not a promise of non-existent housing. **Emotionally:** Strengthening the "safe person" — the nurturing caregiver — rather than unknown programmes (G7, F5). **Legally:** Civil documentation, unified sponsorship framework and continuity beyond age 16 (Section D).

4.4 Proposed Programme Framework

All recommendations converge in one integrated model grounded in the findings: **Whole-Family Care** ²⁶ — not isolated "child sponsorship".

These priorities translate into **four service components** framed on the internationally recognised IASC MHPSS intervention pyramid — supported by a **regular cash lifeline** (the top need, 85.10%) and surrounded by **shelter as advocacy, not a promise** — led by a local institution with its field network:

Component (Function)	What It Delivers	Evidence from the Study	Measurement Indicator
① Mobile Psychological Debriefing and Triage Units Core of the Response	Teams of trained facilitators (task-shifting under specialist supervision, IASC): collective debriefing sessions (play · drawing · drama · storytelling · sport · Quranic circles) + real-time subscale and CRIES triage — in tents, with no infrastructure, framed as activity not illness.	Silent internalisation 68.41% concealed by total score (F3); 360 children above the threshold.	Decline in proportion above subscale threshold (pre/post); number of extreme cases referred.
② Whole-Family Care and Caregiver Support	Support groups for caregivers (mothers 84.05%) + parenting guidance + linkage to cash sponsorship; allocating ≥30% of programme resources to the caregiver.	81.22% of caregivers request support for themselves; the nurturing caregiver is the pillar of resilience (F5).	Reduction in caregiver burnout; continuity of nurturing presence.
③ Learning-Integrated Support and Boys' Prevention	Embedding debriefing and triage in learning spaces; re-integrating dropouts; a meaning pathway for adolescents + vocational training (and income-generating projects where market recovery permits) before the "age-16 cliff".	Education is the strongest determinant of distress ($\eta^2=6.62\%$; children who stopped for psychological reasons: 96.2%); revenge trajectory is preventable.	Child retention/return to learning; reduction in deviant behaviour; adolescent enrolment in training or income.
④ Specialist Cadre Training The Foundation Preceding All Others	An accredited programme training staff, teachers and facilitators in: detecting the silent internalising wound · triage protocol (prioritising emotional subscale + CRIES for sole survivors and witnesses of death) · debriefing management · differentiated protocols · "do no harm" — delivered via Training of Trainers (ToT) for a permanent local cadre.	The most important finding (the wound is camouflaged and silent, F2/F3) is lost without a trained eye.	Number accredited; triage consistency across assessors; quality of referrals.

Backbone and Coordination: All components are linked by a **unified triage and referral system** (subscale + CRIES) operated by the **trained cadre (Component 4)** through the field researcher network, connected to what remains of the health system for referrals. The model is built on **Palestinian local leadership** that owns the field and the data, supported by **technical and financial backing** and coordination with MHPSS clusters — ensuring **capacity building (Component 4), sustainability and high resource efficiency** (people and meaning, not infrastructure). Monitoring and evaluation uses the same study instruments (baseline and endline on subscales + CRIES) — so the study is not merely a diagnosis but **an impact measurement framework**.

The model applies **differentiated pathways by profile, not type of loss**: an "ambiguous loss" protocol for those whose relatives are missing; CRIES-8 for the sole survivor; a meaning pathway (sport/skills/volunteering/mentoring) for adolescent boys to prevent the revenge trajectory — with **emotional subscale prioritisation** in triage so that the internalised are not camouflaged.

4.5 Required Legislative Reforms

The study's most significant contribution extends beyond programmatic intervention to **reform of the entitlement definition itself**:

The Central Reform — Redefining Orphan Entitlement around "Need for Care" rather than "Loss of the Breadwinner": The current system ties entitlement to the loss of the father-breadwinner, structurally excluding the **maternal orphan** (the least served despite carrying the most deeply camouflaged internalising wound) and ignoring the **"de-facto orphan"** (those whose relatives are missing without civil registration). A definition centred on **need for care** does justice to both ²⁶.

The decisive question remains: **who implements this in the current governance vacuum** (collapse of formal institutions)? We do not demand legislation from an absent authority — instead, we distinguish honestly between two graduated levels:

Level One — Implementable Now (without waiting for the state), through two complementary pathways:

(a) A Sponsorship Institutions Coalition: adopts the "need for care" standard in its own eligibility criteria — so that the maternal orphan and "de-facto orphan" are included — and establishes a **shared registry** ending duplication and fragmentation; enshrines **sponsorship continuity beyond age 16**; establishes a **joint fund for investing orphans' assets**, providing a recurring resource rather than intermittent relief (field call, Section D); and integrates caregiver support as a right, not charity.

(b) Activating reform committees — community mediation and customary arbitration, an existing mechanism with established practice that operates when the state is absent — covering: mediation in **guardianship and custody disputes** that destabilise the child (Interview 10); protecting **the orphan's inheritance rights** from the paternal family (B6); adjudicating eligibility by need for care through community consensus; and **community witnessing** as temporary documentation for "de-facto orphans." **With an indispensable rights safeguard (do no harm):** training members in children's rights and gender sensitivity (through Component 4) so that customs do not reproduce the exclusion of maternal orphans, girls or inheritance deprivation — these committees are **a conditioned equity instrument, not a rubber-stamp for custom**.

Level Two — Requiring authority and graduated advocacy: Formal civil documentation for unregistered children (wartime births and those whose relatives are missing); formal codification of the redefined entitlement; and a **unified national body for orphan affairs** with decision-making powers and budgets — uniting scattered efforts under a single framework (field call, Section D) — for which the **coalition and its shared registry serve as the nucleus** — beginning with **temporary documentation through trusted local entities** until institutions recover. This moves reform from **what is possible today** to **what is aspired to tomorrow**, without paralysing delay.

4.6 Calls for Future Research

The study declares its limitations transparently and converts them into a research agenda that will raise the methodological and statistical edifice in the future:

1. **Longitudinal study:** Following a sub-sample over time to track deterioration and recovery curves — transcending the constraint of the current cross-sectional design.
2. **Pilot study and local re-validation:** Of SDQ/CRIES scales in the tent-living environment, particularly the Peer Problems subscale with low consistency ($\alpha=0.315$).
3. **Disproportionate stratified purposive oversampling of rare subgroups:** Increasing sole survivors ($n=17$), maternal orphans (26) and double orphans (32) to ~50–60 each, with **statistical weighting** to preserve overall estimates from bias. Current confidence intervals are wide by the nature of small samples (maternal orphan emotional: 61.5%, 95% CI $\approx$ 43–78%; sole survivor: 88.24%, $\approx$ 66–97%) — expansion narrows them and enables multivariate inference rather than description alone.
4. **Geographical expansion:** Including Khan Younis and Rafah when safe access becomes feasible, extending representation from the northern/central governorates to the full Strip.
5. **Advanced analyses:** Subscale $\times$ type of orphanhood intersections, and comparison with a Gaza children baseline, to deepen the quantitative evidence on camouflage.
6. **Evaluation of community justice mechanisms:** Studying the effectiveness of **reform committees** in protecting orphan rights (sponsorship, custody, inheritance) and their **gendered impact** — these legal dimensions exceed what the current psychosocial instrument measured, and merit dedicated research assessing intervention effect rather than its premise.

◆ Study Closing Statement

Gaza's orphanhood is **a deep, silent population-level wound** — its severity forged by environment, compounded by a distorted entitlement system and a depleted caregiver. Yet the study closes on hope: **resilience is preserved, hope is near-universal, and the levers are available and culturally accepted**. The difference between a generation that collapses and one that holds is not fate — it is **an intervention decision** — and this study, with its figures and testimonies, is its map. Whole-Family Care and redefining entitlement around need for care are **the heart of the answer to the heart of the wound**.

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