

A Study on the Mental Health Status of Children Living in Orphanages in Kashmir

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Abstract: ***Background:** The number of orphans in Kashmir has risen over a period of two and a half decades so has the number of orphanages. The children living in orphanages develop psychiatric morbidity which usually remains neglected. **Methodology:** A cross sectional study design was adopted and the study was conducted in orphanages in 6 randomly selected districts of Kashmir during April 2014 - March 2015. Assessment of factors that might be associated with psychiatric morbidity in the defined population was also carried out. **Results:** Among 450 children, 38% suffered from psychiatric morbidity. Of these, 33.3% had attention problems, 23.75% were depressed and 21.4% suffered from anxiety as per the Child Behaviour Check-List. The age (p value <0.001), type of orphan (p value 0.001), cause of death of parent (p value <0.001), social change occurring within family (p value <0.001), duration of stay in orphanage (p value <0.001) and involvement of siblings in labour (p value 0.008) have a significant association with psychiatric morbidity. **Conclusion:** Prevalence of psychiatric morbidity among children living in orphanages is very high. This calls for prompt attention towards the needs of this vulnerable and neglected section of the society.*

Keywords: Mental health, orphans, orphanage, psychiatric morbidity

1. Introduction

A child is primarily defined by age, with most common consensus being less than 18 years¹. The most accepted definition of orphan is “a child who has lost both parents through bereavement. However, this definition is often extended to include the loss of parents through desertion or abandonment where the parents are unable or unwilling to provide for the child”². According to the joint report of UNICEF (United Nations Children's Fund), about 153 million children are orphans worldwide, 17.8 million of them have lost both parents³. The number of orphans in India stands at approximately 55 million children of age 0 to 12 years, which is about 47% of the overall population of 150 million orphans in the world^{4,5}. According to a UK based NGO “Save the Children”, there are 2.14,000 orphans in Kashmir and 37 % of them were orphaned due to the armed conflict⁶. UNICEF estimates that at least 2.2 million children in the world live in orphanages³. The study titled “Orphaned in Kashmir- The State of Orphans in Jammu and Kashmir” reveals that the study conducted in six districts of the state reveals that 37 per cent of the orphans lost one or both parents due to the conflict while 55 percent were orphaned due to the natural death of parents and remaining eight percent due to other reasons.⁶

Irudayasamy (2006) in a study revealed that children who are orphans face many psychological disorders. At the age when they need much support from their parents and siblings to cope up with physical and emotional development, the loss of their parents make them more prone to psychological disorders. The attachment with the siblings and their impact is necessary for a growing child, and missing this link because of orphanages will also add up to their psychological problems.⁷ It is known that profound loss in childhood is a precipitant for symptoms of disabling psychiatric disorder, like PTSD⁸. To prevent these sequelae, such children need to receive adequate care from caregivers⁹. “Orphanage” is used to refer

to facilities for the short- or long-term care of a child other than in a family setting. Children living in orphanages are one of the most vulnerable groups in a society; many of them have to live with repeated neglect, abuse or fear¹⁰. Poor care giving; lack of stimulation and the absence of a consistent caregiver have been implicated in the negative outcomes among institutionalized children. Orphanage placement puts young children at increased risk of serious infectious illness and delayed language development. In early childhood, the long term institutionalization increases the likelihood that impoverished children will grow into psychiatrically impaired and economically unproductive adults who fail at interpersonal relationships and have serious problems parenting their own children¹¹. Thus, children in foster care have a disproportionately high prevalence of mental health disorders. More than 50 years of research provides convincing evidence that the type of institutional care provided in western countries had a detrimental effect on cognition, behavioral, emotional and social development of young children.

Globally one in every five children and adolescent suffer from a mental disorder and two out of five who require mental health services do not receive them. It is expected that by 2020 childhood neuropsychiatric disorder will rise to over 50% and will become one of five most common reasons of morbidity, mortality and disability among children¹². The knowledge of prevalence of psychiatric morbidity among orphanage children is important in estimating burden of problem in this vulnerable group. This study is an attempt to provide health professionals with reliable information on the magnitude of the problem which will be valuable for programme planning, priority allocation and mobilizing political commitment.

2. Objectives

To assess the prevalence of psychiatric morbidity among children living in orphanages of Kashmir Valley, and to

assess the factors associated with psychiatric morbidity in the defined population.

3. Methods

A cross sectional study design was adopted and multistage random sampling technique was employed. Two districts were randomly selected from each of the three zones of Kashmir Valley. After obtaining a list of orphanages and permission to conduct the study from the Department of Social Welfare, one male and one female orphanage, registered as well as unregistered were selected from each district. The inclusion of unregistered orphanages was subject to availability of such orphanages and their willingness to participate in the study. The study was conducted over a period of one year during April 2014 - March 2015.

The sample size was calculated by using the following equation,

$$n = \frac{z^2 p(1-p)}{e^2}$$

where,

Z = 1.96 for 95 % confidence level or 5 % level of significance

p = 0.05, which gives us the maximum sample.

Level of precision is 5%.

As the data on prevalence of psychiatric morbidity among children living in orphanages in Kashmir Valley was limited, the sample size was calculated by assuming the prevalence of psychiatric morbidity to be 50% and as such the sample came out to be 384. To avoid the influence of non-responders, a sample size of 450 was taken for the study.

The number of children in the age group of interest in each orphanage was obtained. Further, appropriate selection of subjects from each orphanage was carried out by PPS (Probability Proportionate to Size) sampling till the required sample size was achieved. Approval for conducting the study was obtained from the Institutional Ethics Committee, Sher-i-Kashmir Institute of Medical Sciences. The study was conducted after obtaining written permission from the Social Welfare Department, Kashmir Division and the Heads of the Institutions selected for the study purpose. The nature and purpose of the study and the procedure involved was explained to the study subjects and their consent was obtained after assuring them of utmost confidentiality.

Inclusion criteria: Children in the age group of 10 - 18 years residing in orphanages.

Exclusion criteria: Children suffering from mental retardation, children afflicted by deaf-mutism and children refusing to participate in the study.

Two standard study instruments were used to assess the psychiatric morbidity among the study subjects: Modified Mini Screen Scale (MMS) and Child Behaviour Check List Scale.

The commencement of the study was preceded by a short period of training in the proper administration of the study instruments in the Department of Psychiatry at the Sheri Kashmir Institute of Medical Sciences Medical College, Bemina. The Modified Mini Scale, a validated mental health screening instrument, was used as an initial screening tool to identify children who required further psychiatric evaluation. The Child Behavioural Check List Scale was used to further assess the study subjects who had scored $\geq 6-10$ on the MMS. The CBCL was administered to the care-giver.

A semi-structured, pre-tested study instrument was used to assess the psychosocial characteristics of the study subjects in order to establish a connection, if any, with the mental health status of the study subjects.

Data was analyzed using SPSS Version 20. Appropriate statistical methods (Chi-square test, Fishers exact tests and logistic regression test) were applied as per requirement. P value < 0.05 was taken as significant.

4. Results

Table 1: Distribution of study subjects as per socio-demographic profile

S. No	Socio-demographic characteristics		Males N=325 (72.2%)		Females N=125 (27.8%)		Total (450)	
			No.	%	No.	%	No.	%
1	Age	10-14 yrs	209	77.4	61	22.6	270	60
		14-18yrs	116	64.4	64	35.6	180	40
2	Type of family	Nuclear	143	67.5	69	32.5	212	47.1
		Joint	182	76.5	56	23.5	238	52.9
3	Background	Rural	321	73.3	117	26.7	438	97.3
		Urban	04	33.3	08	66.7	12	2.6
4	Type of orphanage	Registered	299	71.2	121	21.8	420	93.3
		Unregistered	26	86.7	04	13.3	30	6.7
5	Type of orphan	Maternal	02	28.6	05	71.4	07	1.5
		Paternal	287	76.3	89	23.7	376	83.6
		Both	02	20	08	80	10	2.2
		Social	34	59.6	23	40.4	57	12.7
6	*Socio-economic status	I	-	-	-	-	-	-
		II	-	-	1	0.8	1	0.2
		III	12	80	3	20	15	3.3
		IV	156	76.4	48	23.6	204	45.4
		V	157	68.2	73	31.8	230	51.1

*as per Modified BG Prasad's Scale

Table-1 depicts the socio-demographic profile of the study population. It was observed that out of the total study population, 72.2% were males and 27.8% were females. The percentage of study participants belonging to the age group of 10-14 years was 60%, in the age bracket of 14-18 years, it was 40%. Regarding the type of family, it was found that 52.9% belonged to joint family and 47.1% hailed from nuclear family. Further, it was observed that majority (93.3%) of the participants belonged to orphanages registered with government and only 6.7% were residents of unregistered orphanages. Regarding the type of orphan, it was found that majority (83.6%) were paternal orphans followed by social orphans (12.7%) whereas maternal orphans constituted only 1.5% of the study participants. It was found that majority of the participants belonged to the

SE class V (51.1%) and class IV (45.4%) whereas only 3.3% and 0.2% of the participants belonged to SE class III and II respectively.

Table 2: Distribution of study subjects by MMS scores (Modified Mini Screening)

MMS score	Males		Females		Total		p Value
	No.	%	No.	%	No.	%	
≤ 5	209	64.3	70	56	279	62	0.104
≥ 6-10	116	35.7	55	44	171	38	
Total	325	100	125	100	450	100	

Table-2 depicts the distribution of study subjects by MMS scores and its association with gender. It was found that 64.3% males had MMS score <5 as compared to 56.0% in females whereas 44.0% females had MMS score of ≥ 6-10 in comparison to 35.7% of males. Overall, the association between MMS scores and the gender was found to be insignificant (p value=0.104).

Table 3: Psychiatric morbidity as per CBCL (Child Behaviour Check List) Scale among the study subjects

Syndrome	Males		Females		Total		p value
	No.	%	No.	%	No.	%	
Anxious and depressed	35	62.5	21	37.5	56	21.4	0.467
Depressed	43	69.4	19	30.6	62	23.75	0.525
Somatic complaints	-	-	05	100	05	1.91	0.004
Social problems	32	74.4	11	25.6	43	16.4	0.194
Attention problems	61	70.1	26	29.9	87	33.3	0.287
Rule breaking behaviour	-	-	03	100	03	1.1	0.037
Aggressive behaviour	02	40	03	60	05	1.91	0.337
Total	173	66.2	88	33.8	261	100	

Table-3 depicts the psychiatric morbidity as per Child Behaviour Check List Scale among children in orphanages. It was observed that Anxiety/depressed was found more in males (62.5%) as compared to their female counterparts (35.7%). Similarly, depression (69.4%), attention problems (70.1%) and social problems (74.4%) were found more in males. However, disorders like somatic problems (100.0%), rule breaking behaviour (100%) and aggressive behaviour (60%) was found to be higher in females. Of these, somatic complaints and rule breaking behaviour were found to be significantly associated with gender (p value<0.05).

Table 4: Association of various factors with psychiatric morbidity among study subjects

Parameter		Without psychiatric morbidity		With psychiatric morbidity		Total		p Value
		No.	%	No.	%	No.	%	
Age Group	10-14 years	205	75.9	65	24.1	270	100	<0.001
	14-18 years	74	41.1	106	58.9	180	100	
Type of orphan	Maternal	01	14.3	06	85.7	07	100	0.001
	Paternal	228	60.6	148	39.4	376	100	
	Both	05	50.0	05	50.0	10	100	
	Social	45	78.9	12	21.1	57	100	
Social change within family	Mother remarried	29	39.2	45	60.8	74	100	<0.001
	Nuclearization	18	47.4	20	52.6	38	100	
	Economic problems	194	66.4	98	33.6	292	100	
	Father remarried	01	50.0	01	50.2	02	100	
Duration of stay	≤ 1 year	37	84.1	07	15.9	44	100	<0.001
	> 1 year	199	56.7	152	43.3	351	100	
Type of family	Nuclear	134	63.2	78	36.8	212	100	0.618
	Joint	145	60.9	93	39.1	238	100	
Orphanage location	Urban	140	61.90	86	38.10	226	100	0.981
	Rural	139	62.10	85	37.90	224	100	
Type of orphanage	Registered	263	62.6	157	37.4	420	100	0.311
	Unregistered	16	53.3	14	46.7	30	100	
Total		279	62.0	171	38.0	450	100	

Table - 4 depicts association of psychiatric morbidity with different parameters among the children in orphanages. The association between different age groups and psychiatric morbidity was found to be statistically highly significant (p<0.001) with prevalence of psychiatric morbidity being more in the age group of 14-18 years (58.9%) as compared to younger age group of 10-14 years (24.1%). The overall association between the type of orphan and psychiatric morbidity was found to be statistically highly significant (p<0.001) with prevalence of

psychiatric morbidity being highest among maternal orphans (85.7%). It was also found that of the total study participants whose mother had remarried, 60.8% had psychiatric morbidity. 52.6% of subjects whose families underwent nuclearization and 33.6% of children whose family faced economic problems had psychiatric morbidity. The association between the social change in the family and psychiatric morbidity was found to be statistically highly significant (p<0.001). It was observed that psychiatric morbidity was higher among participants

whose duration of stay was > 1 year (43.3%) as compared to those whose stay duration was ≤ 1 year (19.2%) and this difference was statistically significant (p<0.001). There was no significant association of psychiatric morbidity with type of orphanage, location of orphanage or type of family.

Table 5: Association of cause of death of parent with psychiatric morbidity among study subjects

Cause of death of parent	Without psychiatric morbidity		With psychiatric morbidity		Total		p Value
	No.	%	No.	%	No.	%	
	Conflict	46	44.2	58	55.8	104	
Illness	136	66.0	70	34.0	206	100	
Accidental	37	55.2	30	44.8	67	100	
Homicide	15	93.8	01	6.2	16	100	
Total	234	59.5	159	40.5	393#	100	

57 social orphans

Table - 5 depicts the association of psychiatric morbidity with the cause of death of parents. It was observed that the main contributing factors of cause of death of parents with psychiatric morbidity were as a result of armed conflict

(55.8%) followed by accidents (44.8%) and illnesses (34.0%). The overall association between the cause of death of parents and psychiatric morbidity was found to be statistically highly significant (p<0.001).

Table 6: Association of involvement of siblings in labour with psychiatric morbidity among study subjects

Siblings involved in labour	Without psychiatric morbidity		With psychiatric morbidity		Total		p Value
	No.	%	No.	%	No.	%	
Yes	42	50.6	41	49.4	83	100	0.008
No	228	66.3	116	33.7	344	100	
Total	270	63.2	157	36.8	427#	100	

#23 study subjects without any siblings

Table - 6 depicts the association between siblings involvement in labour with psychiatric morbidity. It was found that among participants whose siblings were involved in labour, 49.4% had psychiatric morbidity as compared to 33.7% among those whose siblings were not involved in any kind of labour and this difference was found to be statistically significant (p=0.008).

Table 7: Binary logistic regression of various factors associated with psychiatric morbidity

Parameter	P value	Odds Ratio (OR)	95% CI for OR		Reference	
			Lower	Upper		
Age Group	14-18 years	0.000	4.624	2.792	7.658	10-14 years
Gender	Female	0.000	6.637	2.571	17.138	Male
Family Type	Nuclear	0.316	1.303	0.777	2.183	Joint
Type of Orphanage	Unregistered	0.891	1.069	0.413	2.764	Registered
Type of Orphan	Maternal	0.002	75.932	4.917	1172.559	Social
	Paternal	0.184	1.782	0.759	4.180	
	Both	0.000	29.273	4.376	195.816	
Social Change in Family	Nuclearization	0.060	0.364	0.127	1.045	Mother Remarried
	Economic Struggle	0.000	0.255	0.136	0.478	
	Father Remarried	0.844	1.403	0.048	40.953	
	No Idea	0.000	0.085	0.024	0.307	
Duration of Stay	>1year	0.004	2.674	1.361	5.255	≤1year

Table-7 shows that on multivariate analysis, higher prevalence of psychiatric morbidity was seen in the 14-18 year age group (p <0.001) with children belonging to this age bracket having a 4.624 times higher risk of having psychiatric morbidity in comparison to children between 10-14 years of age. A higher prevalence was also observed among females (p <0.001) with 6.637 times higher risk of having psychiatric morbidity in comparison to males. It was found that maternal orphans had a 75.932 times higher risk of having psychiatric morbidity (p=0.002) and children who had lost both parents had a 29.273 times higher risk of having psychiatric morbidity (p <0.001) as compared to social orphans. It was also observed that the risk of psychiatric morbidity was 11.764 times higher among those children whose mother had remarried as compared to those children who had no idea of any social change occurring in the family (p <0.001). These children also had a 3.921 times higher risk of psychiatric morbidity in comparison to those whose families were facing economic problems (p<0.001). Children who had been in the orphanage for >1 year had a 2.674 times higher risk of psychiatric morbidity (p=0.004) as compared to those who had been in the orphanage for ≤1 year.

5. Discussion

Our study was one of the first of its kind as it aimed at assessment of socio-demographic profile and psychiatric morbidity among children living in orphanages in Kashmir while prior studies were not so extensive. The study included 11 registered and 3 unregistered orphanages selected from 6 districts of Kashmir Valley. Of these, 6 orphanages were exclusively for girls while 8 orphanages catered exclusively to boys.

As far as prevalence of psychiatric morbidity is concerned, our study showed results similar to those obtained by Rahman W et al¹² with a total prevalence of 40.35%. Margoob MA et al¹³ in their study in an orphanage in Kashmir found the prevalence of psychiatric morbidity to be 45.7%.

As per the Child Behaviour Check List Scale, a study by El Koumi MA et al¹⁴ observed the prevalence of attention problems to be 43.77% and anxious/depressed behavior as 20%. In a study by Rahman W¹², it was observed that the

prevalence of conduct disorders in two orphanages was higher in girls (8.5% and 5.1%) as compared to boys (3.9% and 2.1% respectively). A study carried out in London and Middlesex found conduct disorder to be more common among girls. Studies by Rahman W et al¹² and Zakaria et al¹⁵ have, however, found the male sex to be associated with higher psychiatric morbidity. Rahman W et al¹² in a study in two orphanages found the psychiatric morbidity in boys to be 51.9% and 41.7% whereas the prevalence among girls was found to be 38.0% and 31.6% respectively.

The higher prevalence among **maternal orphans** reflects the role of maternal deprivation towards increasing the susceptibility to psychiatric morbidity¹⁶. **Social orphans** have a persistent feeling of being unwanted and abandoned by their living parents, a factor which may contribute to psychiatric morbidity^{17,18}.

Sudden, traumatic and violent events resulting in parental deaths have a great impact on the minds of the children predisposing them to psychiatric problems¹³. According to the Save the Children Report⁶, the proportion of children orphaned due to conflict is highest (56 percent) in Anantnag district of south Kashmir, followed by Ganderbal (48 percent), Baramulla (33 percent) and Rajouri (31 percent). Study reveals that five percent of the orphans were either physically abused or intimidated, such as having guns pointed at them, threatened by armed actors, accused of providing support to the fighting sides, physically assaulted and hurt, used as bait to capture their parents or as human shields during the conflict. "Among the orphans attending schools, a large number said that the main distraction in school was that they had worries about their families (28 per cent), noise of explosions during conflict (19 percent) and intimidating presence of troops (13 per cent)," the study reveals.⁶

According to the survey, one-third of the orphans had faced emotional stress during the conflict. "While 38 per cent felt despair and scepticism about the future, 32 per cent said that their anxiety was triggered by sudden loud noises or seeing battle uniforms,

Goodwin and Bowlby argue that any amount of orphanage experience is harmful; the damage being greatest during the first year of life and increasing dramatically with length of stay in an institution^{19,20}.

Naqshbandi et al (2012) in a study observed that one of the effects of nuclearization and urbanization is directly on these orphan children. After the death of their parents, they are forced to live their life in institutions, where they miss every emotional attachment like sibling, relatives and social relationship, and importantly they miss the customs, culture, tradition, norms and regulations of the society. They grow up in institutional culture where they do not enjoy these things. Because of lack of psychologists or psycho-socio caregivers, or case social workers, the children were still living in the traumatic status of their lives.²¹

The children who have lost their parents are most vulnerable, because they do not have the emotional and physical maturity to address their psychological trauma

associated with parental loss. In the society, orphan children can be considered to be at more risk than average children (Subbarao and Coury, 2004).²²

Musisi et al. (2008) in a study did a comparison of the behavioural and emotional disorders among primary school-going orphans and non-orphans in Uganda. They show that emotional, behavioural as well as psychiatric disorders occur in these orphan children. Counselling and psychology should be taught to the caretakers and teachers of children living in orphanages, and they clearly pointed out the psycho-socio problems with children who have lost their parents.²³

Most of the respondents felt that it will be difficult for them to adjust in the conventional society after leaving the institution; because of institutionalization, the gap which has been created between them and the socio-cultural aspect of the society plays in their minds.²¹ Nunokawa (2007), observed that those who are living in the institutions labelled, raised questions about their identity. The symptoms of care pointed are de-individualization, where an individual loses or reduces the power of his thoughts and action and is dependent on the institution, and deculturalization, where the individual picks up the institutional values and attitudes which differ from his previous culture. Children in institutions are likely to face considerable problems in adjusting to life outside the institutions.^{21,24}

6. Conclusion

Given the high prevalence of psychiatric morbidities among children living in orphanages and to avoid its hazardous effect on the community, we recommend proper supervision of the orphanages by the supervising authorities and regular training courses for the caregivers to help improving their children caring skills. Psychiatric surveillance for the children residing in orphanages must be available and continuous for early detection and treatment of psychiatric disorders. Furthermore, more studies on orphanages are needed to be carried out with longer period of follow up in the Kashmir.

7. Conflict of interest

None

8. Permission of Ethical Committee

Yes

References

- [1] Juvenile Justice (Care and Protection) Act 2000. www.law.yale.edu/rcw/rcw/jurisdictions/assc/india/india_juv_just.pdf Accessed on 04/12/2013.
- [2] D Skinner. Defining Orphan and Vulnerable Children, HSRC Publications South Africa 2008. p.8.
- [3] United States Government. Fifth Annual Report to Congress on PL 109-95. World's Vulnerable Children (2010). Retrievable at: http://pdf.usaid.gov/pdf_docs/PDACU307.pdf. Accessed on 15/06/2013.

- [4] GCM India, h.g.o.o.h.h (Producer). Retrieved from <http://gcmindia.org/orphan-homes.html> Accessed on 08/07/2013.
- [5] UNICEF. The state of the world's children 2006; excluded and invisible. United Nations Publications 2005.
- [6] Save the Children. Orphaned in Kashmir - The State of Orphans in Jammu and Kashmir. 2012.
- [7] Irudayasamy P. Institute of research and development and rural poor. 2006
- [8] Cournois F, The trauma of profound childhood loss: a personal and professional perspective. *Psychiatr Q* 2002. 73: 145-56.
- [9] Wolff PH, Tesfai B, Egasso H, Aradom T. the orphans of Eritrea: a comparison study. *J. Child Psychol Psychiatry* 1995. 36: 633-44.
- [10] Rutter M. Pathway from childhood to adult life. *Journal of Child Psychology and Psychiatry* 1989.30: 23-51.
- [11] Fawzy N and Fouad A. Psychosocial and Developmental Status of Orphanage Children: Epidemiological Study. *Current Psychiatry* 2010.12: 41-48.
- [12] Rahman W, Mullick MSI, Pathan MAS, Chowdhury NF, Shahidullah M, Ahmed H, Roy S, Mazumder AH, Rahman F. Prevalence of Behavioural and Emotional Disorders among the Orphans and Factors Associated with these Disorders. *Bangabandhu Sheikh Mujib Medical University Journal*, 2012; 5 (1): 29-34.
- [13] Margoob MA, Rather YH, Khan AY, Singh GP, Malik YA, Firdosi MM, Shiekh AA. Psychiatric disorders among children living in orphanages - Experience from Kashmir. *JK Practitioner* 2006. 13(suppl 1): S53-S55.
- [14] El Koumi MA, Ali YF, ElBanna EA, Youssef UM, Raya YM, Ismail AA. Psychiatric Morbidity among a Sample of Orphanage Children in Cairo. *International Journal of Pediatrics* 2012..
- [15] Zakaria Z, Yaacob B, Jamil M. Psychiatric Morbidity among Children and Adolescents Living in Orphanages, Kota Bharu, Malaysia. *International Medical Journal* 2008. 15: 183
- [16] Freud A, Solint A, Goldstein H. Beyond the Best Interest of the Child. New York Free Press 1973. 17-20, 31, 40, 49, 105-106.
- [17] Cicchetti D and Barnett D. Attachment organization in maltreated preschoolers. *Developmental Psychopathology* 1991.4: 397-411
- [18] Anna T and Smyke. Attachment disturbances in young children: The continuum of caretaking causality. *Journal of American Academy of Child Adolescent Psychiatry* 2002.41(8): 972-82.
- [19] Goodwin DK. No Ordinary Times. Simon and Schuster N.Y, 1994.p 416.
- [20] Bowlby J. Maternal Care and Mental Health. Geneva, World Health Organisation 1951.
- [21] Naqshbandi MM, Rashmi Sehgal, Fahim ul Hassan. Orphans in orphanages of Kashmir "and their Psychological problems". *International NGO Journal* Vol. 7(3), pp. 55-63, October 2012
- [22] Subbarao K, Coury D. Reaching out to Africa's orphans: A framework for public action: World Bank Publications. 2004
- [23] Musisi S, Kinyanda E, Nakasujja N, Nakigudde J (2008). A comparison of the behavioral and emotional disorders of primary school –going orphans and non-orphans in Uganda. *Afr. Health Sci.* 7(4):202–13
- [24] Nunokawa J. Afterword: Now They Are Orphans. Orphan Report, <http://news.xinhuanet.com/english/2009-07/21/content11745889.htm>. 2007