Self-Esteem and Depression among Orphan and Non-Orphan Children

Ammara Asif

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Self-Esteem and Depression among Orphan and Non-Orphan Children

Presented by:
Ammara Asif
Department of Psychology,
My Psychologist Community, Dubai-UAE

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Certificate

Certified that Research Paper titled "**Self-Esteem and Depression among Orphan and Non-Orphan Children**" by Dr. Ammara Asif, Registration No. S151DPDCP020 is accepted for submission to the Psychology Department My Psychologist Community, Dubai UAE.

Saim Barnes
Research Supervisor

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Declaration

I, Ammara Asif, Registration No. S151DPDCP020, a Clinical Psychologist of My Psychologist Community. Dubai UAE, hereby solemnly declare that the thesis entitled, “Self esteem & Depression among Orphan and Non-Orphan Children.” Submitted in partial fulfillment of the community monthly research paper program for check the ratio of different areas of countries in base to cure different community individuals for their issues, this is my original work, except where otherwise acknowledged in the text, and has not been submitted or published earlier and shall not, in future, be submitted by me for any job requirement or any other university or institution.

(Ammara Asif)

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Abstract

The aim of this study was to examine the level of depression and self-esteem among orphan and non-orphan children. Participants of this study were 50 orphan children and 50 non-orphan children selected randomly. Totally, 100 orphan and non-orphan children participated in the study. Data about participants were collected through questionnaire. Data were analyzed using both descriptive (percentage, mean and SD) and inferential statistical methods such as independent t-test. The results revealed that there is positive relationship (r = 0.69, *P<0.01)* between depression and self esteem between orphan and non-orphan children. T-test revealed significant depression (t = 3.78, p<0.001), between orphan and non-orphan children. Orphan children obtained higher score on depression scale than non- orphan children. On the other hand, non-orphan children obtained high score on self-esteem (t = 4.85, p<0.001), than their counterparts of orphan children. Finally practical implications of the findings are presented.

Chapter 1

Introduction

Mental health is a level of psychological well-being or an absence of mental disorder (patel, 2006). It is the "psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment" (Mandell, 2014). From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience (Patel, 2006).

According to World Health Organization (WHO) mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others (WHO, 2001). WHO further states that the well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community [1]. However, cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined (Patel, 2006).

The new field of global mental health is "the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide" (Patel V, Prince M 2010). A person struggling with his or her mental/behavioral health may face stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities, mood disorders, or other psychological concerns. Counselors, therapists, life coaches, psychologists, nurse or physicians can help manage behavioral health concerns with treatments such as therapy, counseling, or medication [2].

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in WHO definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [1].

"The emotional and spiritual resilience which enables us to survive pain, disappointment and sadness, It is a fundamental belief in our own and others' dignity and worth". Health Education Authority (1997) Mental Health Promotion: A Quality Framework London: HEA mental health as a state can be found in the English language well before the 20th century, technical references to mental health as a field or discipline are not found before 1946. During that year, the International Health Conference, held in New York, decided to establish the World Health Organization (WHO) and a Mental Health Association was founded in London. Before that date, found are references to the corresponding concept of "mental hygiene", which first appeared in the English literature in 1843, in a book entitled mental hygiene or an examination of the intellect and passions designed to illustrate their influence on health and duration of life (Lewis, 2000). Moreover, in 1849, "healthy mental and physical development of the citizen" had already been included as the first objective of public health in a draft law submitted to the Berlin Society of Physicians and Surgeons (Rosen, 1997).

In 1948, the WHO was created and in the same year the first International Congress on Mental Health took place in London. At the second session of the WHO's Expert Committee on Mental Health (September 11-16, 1950), "mental health" and "mental hygiene" were defined as follows (The World Health Report 2001), "Mental hygiene refers to all the activities and techniques which encourage and maintain mental health. Mental health is a condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment."

However, a clear and widely accepted definition of mental health as a discipline was (and is) still missing. Significantly, the Dorland's Medical Dictionary does not carry an entry on mental health, whereas the Campbell's Dictionary of Psychiatry gives it two meanings: first, as a synonym of mental hygiene and second, as a state of psychological wellbeing. The Oxford English Dictionary defines mental hygiene as a set of measures to preserve mental health, and later refers to mental health as a state. These lexicographic concepts nonetheless, more and more mental health is employed in the sense of a discipline (e.g. sections/ divisions in health ministry's or secretaries, or departments in universities), with an almost perfect replacement of mental hygiene (Oxford, 2003).

History of children depression

Historically, children were not considered candidates for depression. Mostly because of Freudian notions about the unconscious, depression had been viewed as a condition which only affected adults. Today, childhood depression is widely recognized and health professionals see depression as a serious condition effecting both adolescents and young children (Whitley, 1996) [3]. Views on adolescent depression have changed significantly even since the 1970's where childhood depression was thought to be masked by other conditions [4]. The debate continues, even today, as to whether other childhood and adolescent behaviors are simply "masks" for childhood depression.

Fritz [5] writes that depression may often be seen in physical ailments such as digestive problem, sleep disorders or persistent boredom. Lamarine [3] considers that in children, depression may often be mistaken for other conditions such as attention deficit disorder, aggressiveness, physical illness, sleep and eating disorders and hyperactivity. Although depression in children may be confused with attention deficit hyperactivity disorder (ADHD), ADHD must

begin before the age of 7 [6]. Some Researchers prefer to move past the philosophy of masked depression and view adolescent depressive symptoms as similar to those of adults [4,5,7,8].

Along with a reconsideration of depression in children, mania and bipolar disorder (manic-depression) are being added to the acceptable list of childhood and adolescent conditions. The symptoms of mania in children or adolescents consist of euphoria along with extreme anger and rage. Mania or manic-depression may also be misdiagnosed and treated as a masking condition such as and ADHD (Whitley, 1996).

Symptoms of depression and low self-esteem

According to some research [5] about 5% of adolescents suffer from depression symptoms such as persistent sadness, falling academic performance and a lack of interest in previously enjoyable tasks. In order to be considered major depression, symptoms such as suicidal thoughts, lack of appetite and loss of interest in social activities must continue for a period of at least two weeks [9]. Research has also found a correlation between major depression in adolescence and the likelihood of depression in young adulthood [8]. Not only were most depressed adolescents depressed adults, but serious social adjustment problems plagued these individuals as they moved into adulthood. And there is evidence that depression in adolescents is likely to repeat itself within a year or two. In fact, two-thirds of depressed teens will be depressed again during their teenage years [5,7].

One of the chief differences between adult and adolescent depression is that depression in adolescents usually involves more social and interpersonal difficulties which directly leads to self-esteem problems. Adolescents are also more likely to idealize suicide as a solution to feelings of helplessness. Adolescents may also socially isolate themselves when depressed out of feelings of guilt. Dramatic behaviors such as aggression and an obsession or fascination with death often accompany their depression [3].

Adolescent problems that correlate with low self-esteem include depression, unsafe sex. Criminal activity and drug abuse (New model 1995). Educators and schools can be ideal scouts for depression in adolescents. Since depression often results in lower academic performance, behavior problems, and poor socialization, schools are often the best place to observe all these symptoms [3].

Causes of depression

Causes of depression number almost as high as symptoms of depression. There appears to be a genetic factor to depression. Families with a history of depression often exhibit the symptoms during adolescence [5]. And depressed children frequently come from parents who have been depressed. Besides genetic predispositions to depression, social skills deficits may also contribute. These social skills deficits are harder to determine as it is difficult to find whether the inability to form good social skills causes, or results from the depression [3]. Sexual orientation adjustment problems have also been linked to depression, especially in communities with strong social pressures. A study in currently underway with the Utah Department of Health to study the link between homosexuality and adolescent suicide [10]. Coincidently, the peak age of depression and low self-esteem coincides with the transition from elementary to junior high school. This age may have an inability to deal with the new social demands as well as academic demands of a new school [11,12]. There appears a relationship between latch-key kids and depression. Unsupervised adolescents are more prone to substance abuse, risk-taking, depression, and low self esteem [13]. One of the factors that correlate with recurring depression is a negative relationship between adolescents and their fathers along with an inability of the mothers to monitor behavior [7].

There is a negative correlation between depression and athletic participation. Although adolescents that participate in athletics do not show a decrease in drug use, they do exhibit significantly less depression and suicidal tendencies [14]. Depressed adolescents with a history of sexual abuse have a higher incidence of posttraumatic stress disorder, but no increase in the severity of neither depression symptoms nor tendency for suicide [15].

Another factor associated with adolescent depression and negative behaviors is difficulty in establishing autonomy in the adolescent's relationship with parents. Adolescent depression is seen in higher frequency in families where the children have difficulty establishing their own identity because of negative communication patterns and other dysfunctional family attributes [16].

One topic that permeates the research on depression is the concept of self- esteem. There has been a long standing correlation between low self-esteem and depression. The views on self-esteem are changing more rapidly than even the views on depression. The traditional thinking with self-esteem was if one could improve the way an individual perceived him or herself, then the secondary behaviors that accompany low self-esteem would disappear (New model 1995). This traditional philosophy is taking a new direction.

Relationship of depression and self-esteem

There is a strong correlation between a person's emotional reactions and their involvement in social relationships. Therefore, to increase one's self-esteem, one need to improve one's standing in interpersonal relationships rather than trying to fix some perception about them. Research has shown that it doesn't have to be the actual rejection of a person by a social situation; it can simply be the imagined or anticipated rejection (Rao, 1994). New research indicates that the behaviors are not the result of low self-esteem, but rather the result of social rejection which leads to low

self-esteem. In other words, self-esteem does not cause a person to behave a particular way, it is the result of poor social relationships (New model 1995) [8].

Depression and self-esteem may be viewed as a vicious cycle. The inability to relate positively in social situations may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate with others or be fully accepted in social groups which then adds to the feelings of low self-esteem [18]. This research opens a new area of study into the relationship between depressed people and their environment. Following Bronfenbrenner's [17] notion of the mesosystem model of interactions, the relationships between an individual and the various environments of influence, must be considered just as important as the individual's self.

Since poor interpersonal problem solving skills lead to higher levels of depression, which in turn leads to more interpersonal difficulties, one may argue that teaching problem solving skills is the intervention solution. However, there does not appear to be a relationship between adolescent cognitive problem solving abilities and interpersonal skills. Therefore, one could conclude that it is not that adolescents do not know how to solve problems but they lack the desire or willingness to use those interpersonal skills [18]. Feldman & Elliot [11] report that there is a direct relationship between the perception of social success and self-esteem. This success may include confidence in appearance, academic ability, athletic ability, and social belonging. Self-esteem is then, a barometer of how well one is doing socially. It monitors the acceptance level of the people and groups in the surrounding environment. Similar to Maslow's hierarchy of needs [19], this new theory supports the idea that people seek a certain amount of social acceptance and belonging which will take precedence over other factors such as self-actualization (New Model 1995; At last 1995).

Other factors effect depression and other affective adolescent problems. Parental influences on self-esteem are reported by Feldman & Elliot (1990) who find that parents who model openness and acceptance of new ideas can have a positive effect on their child's self-esteem. Other parental factors include encouragement for children to form their own view points, as well as a secure family relationship to form a basis for exploration. Transition from elementary to junior. High school or from junior high to senior high increases feeling of low self-esteem. Students who do not make such a change in school have a reduced incidence of low self-esteem. Unfortunately, some students, particularly females, do not recover from this low self image in later adolescence [11].

Competition is a popular blame agent for low self-esteem. It is easy for an adolescent to interpret a competitive loss with failure, thereby damaging self-esteem. Not only does competition damage self-esteem, it hinders interpersonal relationships. Instead of being a demonstration of strength and confidence, competition is a show of insecurity [20]. Competition may be viewed as a disservice by educators who should be improving the adolescent's ability to relate well with others. Instead, this spirit of competition held in many school activities serves to block healthy communication. Regarding competition in schools, Kohn writes, "Kids face it all the time in an award assembly, an event usually held in school auditoriums that instantly transforms most people present into losers" (p.1). Competition implies comparisons which should be eliminated from parenting for the sake of self-esteem, according to Evitt [21]. Rather than make comparisons between children, which makes the child feel inferior, parents should acknowledge and encourage the natural differences found in individuals.

Self-esteem has also been linked to problem solving skills. Lochman et al. [22], studied the relationship in aggressive adolescent boys and their social problem solving skills. The study was based on the idea that exhibited behaviors are the result of a person's goals and their expectation that their behavior will lead to that goal. Goals set by socially unpopular adolescents tend to focus on non-social goals involving peer relations. As might be expected, aggressive adolescents value dominance and revenge over affiliation. These adolescents had a higher incidence of depression, which points to lack of self-esteem. Interestingly, while popular students were very clear in their goals of affiliation, non-popular students were unclear in their goals. While unpopular students ranked dominance and revenge higher, they also indicated a significant value for affiliation. This leads researchers to conclude that aggressive or unpopular children have greater internal conflict than popular children. This creates difficulty in social negotiations, leading to low self-esteem, leading to depression. These researchers [22] suggest that intervention should include helping problem adolescents find more socially acceptable strategies for problem solving which will enable them to reach their personal goals. In addition, given this polysemic nature of mental health, its delimitation in relation to psychiatry (understood as the medical specialty concerned with the study, prevention, diagnosis and treatment of mental disorders or diseases) is not always clear. There is a more or less widespread effort to set mental health at least aside from psychiatry and at most as an overarching concept with encompasses psychiatry [23].

Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being [24]. People with depressed mood can feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, ashamed or restless. They may lose interest in activities that were once pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details or making decisions, and may contemplate, attempt or commit suicide. Insomnia, excessive sleeping, fatigue, aches, pains, digestive problems or reduced energy may also be present [24]. Depressed mood is a feature of some psychiatric syndromes such as major but it may also be a normal reaction to life events such as

grief, a symptom of some bodily ailments or a side effect of some drugs and medical treatments [24].

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life (WHO 2012).

Depression is more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide. Depression is the most common mental disorder. Fortunately, depression is treatable. A combination of therapy and antidepressant medication can help ensure recovery (APA 2013).

Childhood is a developmental stage in which the importance of reciprocal emotional bonding between a child and his/her caregivers, for healthy physical, psychological, and social development has been known for centuries [25]. Orphans in group homes or in situations take more risks, have more threats to achievement, and have poorer peer influences [26]. Almost no systematic studies have been carried out during the past five decades about orphanages largely because nearly all orphanages in industrial nations have been replaced by adoption and foster care [27]. This solution, in Third World Countries, is unacceptable either religiously in some countries as Egypt, or has been considered an unrealistic solution in other countries as in Africa [28].

Although orphanages can provide a secure and positive alternative to abusive and unsafe family or community environments, they cannot provide individualized and family nurturing [29]. Research findings indicate that children in institutional care have more behavioral problems, such as aggressive behavior and have higher levels of depression and anxiety, compared to children that are reared in a family environment [30]. Several studies have shown that institutional care has negative effects, especially on young children; however, only a few studies have investigated the prevalence rate of problems among these children, the extent of care service needs, and risk and protective factors by collecting data from multiple informants. Early intervention immediately following institutional care placement is recommended [31].

Globally, one in every five children and adolescents suffers 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 neuropsychiatry disorder will rise to over 50% and will become one of the five most common reasons of morbidity, mortality and disability among children [32]. Despite these alarming figures, mental disorders are often unidentified or diagnosed too late. Behavioral problems can occur in children of all ages and very often start early in life. Children with these problems can be rude, and have tantrums and a higher tendency of developing an oppositional defiant disorder/conduct is order, with difficult temperament, learning or reading difficulties, depression and hyperactivity [33]. In addition, among these children, hitting and kicking other People are common. The importance of early detection of emotional and behavioral problems is recognized worldwide and a number of researches have been con-ducted in developed countries. However, there has been little systematic research into childhood psychiatric disorders in developing countries (Nikaprta, 1991). A cross-sectional survey from Karachi (2007) on 5 to 11-year-old children attending mainstream private and public schools estimated a prevalence of 34% for behavioral problems [34], whereas the burden reported from other developing countries such as Bangladesh and India was 15% [35] and 12% [36], respectively. Many risk factors have been identified for the occurrence of mental disorders, among which social factors are clearly implicated in the genesis and maintenance of these disorders and their extension into adulthood [37]. Other factors include quality of parental relationship, parent's mental health, education, occupation and broader environmental circumstances such as adequacy of housing [38]. Studies have also investigated specific emotional, behavioral, conduct, hyperactivity and peer problems in children. A study from Pakistan has identified a prevalence of 9.3% for emotional and behavioral problems among school children [39]. However, research on specific mental health problems is yet to gain a significant role in developing countries, and researchers are struggling to identify the overall mental health status of children and adolescents [40]. Children living in orphanages are one of the most vulnerable groups of children in a society: many of them live in a state of repeated neglect, abuse or fear. Hence, a safe new home that they can trust is not by itself sufficient to repair the damage imposed by abnormal early stress on the developing nervous system (Huges, 1999). Thus, children in foster care have a disproportionately high prevalence of mental health disorders [41], and studies have indicated that between 50 and 80% of children in foster care suffer from moderate to severe mental health problems [42]. One study on Eritrean orphanages found children with mood disturbances, language delays and disturbed social inter-action with peers, and concluded that orphanages are necessarily the breeding grounds of psychopathological problems [43].

Parents and sometimes grandparents are legally responsible for upbringing children and providing them necessities of life. In some cases when father or both parents of a child are dead and other near relatives are unwilling to take

the responsibility of caring an orphan, the child is usually placed in an orphanage established to provide care and housing to such destitute children (Wikipedia, 2009). The family is both the earliest and the most sustained source of social contact for the child. The first interaction of the child is only with parents. The experience of parental warmth exerts significant influence on personality development of the child. A child who has persistently experienced parental love and affection usually grows up into a well adjusted individual. It is generally recognized that lifelong pattern of behavior, values, goals and attitudes of children are strongly associated with the characteristics of their parents. Although social experiences outside the home have important influence on the developing child, the availability of these experiences and ways in which he/she uses them are strongly affected by what the child has learned at home. Several studies demonstrate that parenting style exert significant influence on behavior, learning sex-role, self concept and interpersonal and intellectual skills (Riaz, 2002, Cherian & Malehase, 2000, Heque, 1998). By and large, the family, especially the parents are the main source of mental and emotional health of children (Khanam 2005). Contrary to that children deprived of a loving family environment experience lasting damage to their intellectual, emotional well being and development. A lack of care and attention may result in stunted growth, lower IQs and a number of behavioral and psychological problems (Louis 2006).

The loss of parents often has serious consequences for the mental health of children. Psychiatric problems such as sadness feeling of loneliness, symptoms of anxiety associated with an increased number of changes and disturbances in daily life and with feelings of poor control over one's circumstances may be manifested by children whose parents are dead (Foster & Williamson, 2000). According to Makame and Mcgregor (2000), orphans show significantly higher number of internalizing problems as compared to non-orphans. Peter, Wolff & Fesseha [43] compared the mental living in two orphanages development of 9-12 years old Eritrean war orphans living in two orphans varying in child care management style. The results reveal that orphans who were encouraged to become self-reliant through personal interactions with staff members, manifested lesser behavioral symptoms of emotional distress than orphans having impersonal interactions with staff members. There is a general consensus among child psychologist that young children living in an institutional setting for a long period are vulnerable to serious psychopathology in later life (Casares & Thombs, 2001).

Rousseau (2009) report that orphan-hood is associated with poor mental health and higher rate of psychological distress in approximate 1 in 6 children namibia. According to world Health Organization (2009), depression is a common mental health disorder characterized by depressed mood, loss of interest or pleasure, feeling of guilt, or low self worth, disturbed sleep, poor appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of every day responsibilities (Wikipedia, 2009). Earlier experts working in the field of childhood psychopathology were reluctant to accept the notion that children can suffer from depressive disorder, but clinician working with children in mental health setting noticed that the symptoms seem indicative of depression. Spitz (1946) described the problem which he called analytic depression, as a behavior pattern, similar to adult depression that occurred infants and children who experienced prolonged separation from their mother/father. This childhood depression may be manifested in such symptomatic behavior as crying, sadness, immobility and apathy (Carson, 2000). Furthermore childhood depression is often disguised by active behavior such as irritability, temper tantrums, violence, risky actions, and/or refusal to go to school. Sometimes behavior as simple as sleep deprivation can mimic depression (Mcintyre, 2004). According to Kaslow and Rahm (1985), childhood depression is similar to adult depression in terms of its emotional, cognitive, behavioral and physical manifestation, but the specific signs and symptoms can vary depending on the age, personality and home environment of the child. Depression and self-esteem may be viewed as a vicious cycle. The inability to relate oneself to others may lead to low self-esteem which leads to depression..The depression then leads to further inability to relate oneself positively in social situations, which adds to the feeling of low self-esteem [18]. Empirical evidence shows that social rejection leads to low self-esteem (New model 1995) [8] which further leads to depression..Social rejection can be a result of poor interpersonal problem solving skills. These skills enhance when they get positive feedback from parents or close relatives which in turn helps to develop the concept of self as the child grows up. In the early stages of development, the self is vague and somewhat poorly integrated phenomenon but becomes increasingly more differentiated as the youngsters mature and interact with significant other in their lived (Ahmad & Bashir 2008).

According to Bee (2000) children feel an overall sense of support from important people around them, particularly parents and peers. Such children are reported to have higher self-esteem than children who report less support from significant others. To test this hypothesis the present study was designed to investigate the effects of isolation and lack of social support experienced by children living in orphanages (Bee, 2000). Adolescence is an important period of physical, social, psychological, and cognitive growth (Stagman, Schwarz, and Powers, 2011). Adolescence is a period of growth and development bridging childhood and adulthood. The physical and emotional changes in this period influence behaviors (Yannakoulia, Karayiannis, Terzidou, Kokkevi, and Sidossis, 2004) in that adolescence is a time of risk taking and experimentation (Dowdell and Santucci, 2003). Also adolescence is a critical period of life in which abilities to express and understand emotions, to assign meaning to emotional experience, and to regulate

feelings may be particularly helpful for psychological and social adjustment (Mavroveli, Petrides, Rieffe, & Bakker, 2007). The family assists the child in establishment of healthy relationships with the environment by showing affection and creating an environment of trust in addition to covering the physical needs of the child. The child develops in social terms by learning the social rules in the family and becomes an individual who is cherished and wanted in the society. Family support is needed in at different levels in each period. Support of the family is very important in the adolescence, which holds an important place in the life of an individual, in terms of development of personality and communication with the environment. Adolescents, who have an emotional tie with their family based on trust, are affected less by the problems created by the adolescence and although the adolescent is oriented towards the exterior in this period, knowing the presence of a family that can support them at all times results in a feeling of security and thus reduces the concerns related with life. However, because of the reasons like being left by parents, lost of parents, family disintegration etc., children live in orphanages (Anonim, Jacobi, 2009). Because of the physical conditions of orphanages, lack of personnel in orphanages, people's views about orphanages, lack of family support on children, orphanages may have negative effects on adolescences (Yildırım 2005). However, when the adolescent is deprived of family environment, they can feel lonely and experience various concerns and fears, and thus, the self concept of the adolescent is affected adversely.

Self concept which means acceptance of the self, valuing self, self-confidence, and self-esteem has an important place in a person's life especially in adolescence. Starting with babyhood attachments during the period until adolescence including childhood, individual develops a sense of identity and self-esteem in parallel with the sense of identity (Cebe 2005). During this period, there are various factors having effect on the self. Among these factors, socio-economic conditions (Bilgin, 2001), working in the streets (Arnas, 2004), disability (Ersek, 1992), adolescents' physical appearance (Phillips & Hill, 1998), health situation, their perception of their parents as work-focused (Chamberlin and Naijian, 2009), physiology (Song et al. 2007), friend relationships (Büyükşahin Çevik, 2007) and orphanage (Avdeeva, 2009) can be counted. Among these factors living in an orphanage may have negative effects on self-concept and self-concept of adolescences through affecting all developmental areas of adolescents (Cebe 2005) Being brought up by an institution can affect children's development in a negative way (Sloutsky, 1997; Garland, Hough, McCabe, Yeh, Wood and Aarons, 2001; Üstüner, Erol, Şimşek, 2005; Jacobi, 2009). According to the studies, institution care have negative effects on children's psychological health (Şimşek and Erol, 2004), social development (Tharp-Taylor, 2003; Pantıukhına, 2009; Shakhmanova, 2010), cognitive development (McCall, 1996; Sloutsky, 1997; MacLean, 2003), level of loneliness (Aral et al. 2006) and anxiety level (Gürsoy and Yıldız Bıçakçı, 2005). Studies also show that adolescences living in orphanages have low self-concept level. Aral, Gürsoy and Yıldız Bıçakçı, (2005) have determined that adolescents living in orphanage have less self-design level. Individuals with adversely affected self concept may be estranged from the society and the social relationships may be weakened. In time, said adolescents start to see themselves differently from the society and the process of social acceptance becomes difficult. In this study, it is aimed to investigate level of self-concept of adolescences that live in orphanages and those who do not live in orphanages and giving suggestions according to the results of the study Marina Intezar (2007-2009) Supervisor: Prof. Dr. Yasmin N. Farooqi The current research investigated differences in self-esteem between orphan children and children living with their parents. The sample was composed of 150 children. Non- probability purposive sampling was used. Children living with both portents were drawn from different schools of Lahore that were Aizhar school system, The Lahore lyceum school, and The Educators. Jonathan Berent's Self-esteem Scale (1988) was individually administered to all the research participants. Orphan children reported have less self-esteem than children living with their parents. The result showed that there is a significant difference in self-esteem between orphan child's and children living with their parents. The findings of this research promoting understanding about the personality in children as a result of self-esteem and relationship between Attachment to Parents and Level of Anxiety.

Childhood orphan-hood is considered a major risk factor for poverty in adulthood, through, among other channels, shortfalls in human capital investments in children. This paper provides unique evidence on the long-term impact of orphan-hood in a region of Tanzania near Lake Victoria, an area ravaged by HIV/AIDS. The underlying data set is a 13-year panel data set in which individuals interviewed at baseline were traced irrespective of their current residence. This allows us to focus on non-orphaned children experiencing the loss of one or both parents during the survey period, controlling for their characteristics before becoming an orphan. Furthermore, we can focus on the permanent impact in terms of height and educational attainment once these children reach adulthood and recovery is hardly possible anymore. Using within-sample estimates of the returns to height and education, we can also estimate the resulting life-time welfare loss.

We find significant permanent education and health effects. Adults who had been maternally orphaned between the ages of 7 and 15 experience a loss of, on average, nearly 2 cm of final attained height and one year of schooling. In contrast, paternal orphans have significantly lower height and years of schooling but our analysis shows that a causal link does not seem to exist. Our projections suggest that maternal orphan hood creates a lifelong deficit in consumption expenditure of roughly 8.5 percent. In Sub-Saharan Africa,

the prevalence of orphan hood among children has been greatly exacerbated by the HIV/AIDS pandemic. While there are other, more prevalent diseases in Africa, the characteristics of HIV/AIDS suggest that its economic and demographic impact will be profound. Because HIV in Africa is transmitted primarily through heterosexual contact, the epidemic is having a major effect on the mortality of men and women in their prime childbearing and earning years. With rising mortality rates and decrease easing adult life expectancies, orphan-hood rates in Africa continue to increase, placing increasing numbers of children at risk.

Orphan-hood is expected to influence health outcomes and schooling although there are multiple potential pathways of this effect. Obviously, income effects are a strong candidate, especially when 2parental deaths are associated with costs and income losses due to chronic illnesses. If households are credit constrained, then reduced incomes can result in lower investments in education. Aside from these direct wealth effects, orphan-hood can be associated with an increased value of the child time in home production (as a substitute for adult labor) which results in less schooling. There may be discrimination against orphans and favoritism towards biological children for double orphans or among single orphans who do not reside with their surviving parent (i.e. are fostered out). Beyond the financial consequences of adult deaths and the implications of a loss of parental involvement, children who become orphans may suffer trauma which, in turn, affects schooling and health outcomes. Children who lose a parent due to AIDS specifically may be additionally stigmatized relative to other causes of death. The available evidence of the impact of orphan hood, some of which is discussed in the next section, typically relates to the impact of orphan hood from HIV/AIDS and other causes in the short-run, often by examining a sample of school-age children in cross-sectional survey data. A small number of studies use longitudinal data over short-run (perhaps 1-2 years) periods in which household coping strategies may successfully mitigate the impact. Studies of long-run impacts and outcomes are rare. Understanding short-run outcomes is important, but short-run effects may not ultimately translate into worse welfare outcomes in the long-run (that is, in adulthood). For instance, the socio-economic consequences of a parent's death may affect outcomes around the time of illness or during a period of Funeral/ mourning. However, as extended families foster in orphans, these outcomes may recover over time.1The next section reviews some of the existing empirical analysis. Section 3 discusses the data used in this study. Sections 4 and 5 present the empirical specifications and results. The final section concludes.

Background

The studies cited in Golden (1994) regarding catch-up growth among stunted malnourished children. The existing literature on the consequences of orphan hood tends to focus on education outcomes and use cross-sectional data, which may limit the robustness of the outcomes. The findings of these studies are mixed 2as are the findings of the few studies looking at other outcomes such as health. Few studies have also used panel data, which allows for extensive control of initial conditions. Among the studies using large cross-sectional household survey data, several control for concurrent household characteristics to identify the impact of the loss of a parent on schooling. To the extent that orphans are found in relatively better-off households that also have higher demand for schooling, simple cross-sectional comparisons of enrollment rates between orphans and non-orphans may underestimate the true impact (for example, Hargreaves & Glynn, 2002, Ksoll, 2007). On the other hand, depending on mortality patterns, in some settings, an orphans household may be poorer prior to death, thus over-estimating the impact of orphan-hood. Ainsworth and Filmer (2006) find considerable diversity in the orphan/non-orphan differential across countries and conclude that it is difficult to draw generalizations about the extent to which orphans are disadvantaged.

Case et al. (2004) use cross-section data; using household fixed effects, they find that orphans are disadvantaged relative to other children within the same household. However, it is not clear that a household fixed-effects approach is satisfactory. If orphans are strategically placed in better-off households within the extended family, then the orphans in a household fixed-effects framework are compared to a non-random sample of non-orphan co-residents. It is then not shown that orphan hood reduces schooling, but rather that orphans are placed with better-off relatives. 4 For instance, in their study of orphan hood in Zimbabwe. Nyamukapa and Gregson (2005) describe the system of childcare 2 Even estimates of the number of orphans is debated, with some research showing that the commonly-cited statistics from the UN may be seriously over-estimating the number of orphans (Bennell, 2005). Even conclusions from the same data sets can differ depending on how data from countries are combined. Bicego et al. (2003) combine Demographic and Health Survey household data across countries for West Africa and East Africa whereas Ainsworth and Filmer (2006) do not merge data sets across countries. In West Africa, Bicego et al. find evidence of a significant impact of among paternal orphans (6-14 years) and two-parent orphans (6-10 years).

For East Africa, the findings are significant among maternal and two-parent orphan's ages 11-14 years. 4 Gertler et al. (2004) address problems of nonrandom selection into orphan hood (i.e. the death of a parent being correlated with other disadvantages but not caused by the event of losing a parent) using propensity score matching techniques. However, this matching is done between orphans and non-orphans based on characteristics of current 4arrangements as traditionally based in part on both relatives' relationships with the orphan and their ability to assist. They further note that orphan care arrangements are increasingly being influenced by financial considerations. Evidence of other outcomes for orphans beyond schooling is much more scant but here, too, the evidence is mixed (Chatterji

et al. 2005). In one of the few studies which is able to identify actual cause of death of parents, Crampin et al. (2003) examine health of children in Malawi on linked with information on the HIV/AIDS status of parents measured 10 years prior.5They conclude that surviving children are not discriminated against as a result of parents having been ill or having died from HIV/AIDS. Another study of cross-sectional data finds that the health status of surviving orphans younger than 6 years is similar to their non-orphan counterparts in western Kenya (Lindblade et al. 2003). The studies cited above use cross-sectional datasets which are limited to examining correlates of outcomes after a parental death, without controls for initial conditions, prior to the death of the parent(s). These studies only identify who is an orphan and not how recently a parent died or the status of the child prior to being orphaned. Depending on mortality patterns of adults, there could be omitted variables which bias results. Several recent studies utilize panel data available to address these concerns.

Ainsworth et al. (2005) find that adult deaths are associated with delayed enrollment among younger children (7-10 years). Among orphans, younger maternal orphans are held back whereas other orphans are not found to be disadvantaged. Case and Ardington (2006) study schooling outcomes using a 2-3 year panel survey from South Africa. They find evidence of a causal effect of mothers deaths on children education outcomes. Father's death, on the other hand, does not result in lower education, residence which may itself be endogenous. Information on residence prior to orphan hood may be more appropriate but is not available to them.5Of the 2,250 offspring identified from the 593 individuals for whom the HIV/AIDS status at baseline is known; Crampin et al. were able to trace 1,141. Of these, 761 offspring were alive and interviewed, 167 were alive but left the district and not traced, and 213 were deceased. It is unclear what the implications of this sample selection are on the measured impacts. 5which instead is found to be indicative of the socio-economic conditions of the household prior to the death.

Ainsworth and Semali (2000) use the KHDS 1991-94 data (the baseline for this study) to present random and fixed child effects model estimates of adult death on children's height-for-age and weight-for-height. While random effects results show lower height for all maternal orphans and reduced height among paternal orphans in poor households, the fixed effects results are not significant possibly due to the small number of children who have any change in their orphan status in between the survey rounds (about 21 months from first to last interview). They find no association between the loss of a parent (regardless of being co-resident at the time) or recent adult death in the households and subsequent child weight-for-height. Overall, the authors conclude that policy interventions should target poor households in general, among which the households hardest hit by adult mortality are likely to be found. They identify population-wide policy interventions, like universal availability of oral rehydration salts at health facilities, measles vaccination and improved physical access to medical care as being most appropriate. Using unique panel data from Kenya, Evans and Miguel (2007) study a large sample of no orphans enrolled in grades 1-7 in 1998 and re-interviewed in 2002. They evaluate the impact of orphan hood transitions on schooling participation (measured as the fraction of visits in the school year in which the child was in school on the day of an unannounced check). Maternal deaths lead to lower participation after the death, as well as in the 1-2 years before the death. Paternal orphans did not have lower school participation. It is unclear how the measure of school participation translates into completed school years, but, presumably, it implies lower overall attainment. They also examine the direction of omitted variable bias and conclude that unobservable characteristics of orphans lead to under estimates of impact.

Yamano and Jayne (2005) study the impact of prime-age adult deaths on schooling for 7-14 year olds using panel data from 2000 and 2002 which is similar, although not equivalent, to assessing the impact of orphan hood. They find much larger effects among children from poorer households. Girls suffer reduced schooling prior to the adult death while boys experience lower schooling after deaths. 6While existing studies are varied in their methods and conclusions, several themes emerge. Panel data analyses show that omitted variable (pre-orphan characteristics) can bias results. Further, there may be considerable heterogeneity across different types of orphans, or in effects depending on the circumstances of different orphans, such as gender. For example, there is a higher likelihood that orphans who are fostered from a young age may be treated more like the children of the head, if foster children when fostered at young ages display similar bonding with foster parents as biological children. Likewise, conditional on age, outcomes may differ depending on whether a child was already enrolled when s/he become orphaned. Bhargava (2005) analyzes a sample of orphans and finds a positive relationship between enrollment prior to becoming an orphan and subsequent enrollment rates among orphans.

Lastly, since these studies focus on samples of children, their findings may not reflect the consequences in adulthood of the loss of a parent as a child. This paper contributes to the existing set of studies by presenting unique evidence of the extent to which orphan hood matters in the long-run for health and education outcomes.6The data are from a region of Northwestern Tanzania deeply affected by the HIV/AIDS epidemic. We use a sample of non-orphaned children aged 6-15 surveyed in 1991-94, who were traced and re-interviewed as adults in 2004.7A large proportion, 19 percent, lost one or both parents before the age of 15 in this period, allowing us to identify the permanent impact of orphan-hood shocks. In the analysis, we can control for a wide range of child, parental, and household characteristics before the loss of the parent, as well as community fixed effects.

Globally, one in every five children and adolescents suffers 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 neuropsychiatry disorder will rise to over 50% and will become one of the five most common reasons of morbidity, mortality and disability among children. Despite these alarming figures, mental disorders are often unidentified or diagnosed too late. Behavioral problems can occur in children of all ages and very often start early in life. Children with these problems can be rude, and have tantrums and a higher tendency of developing an oppositional defiant disorder/conduct disorder, with difficult temperament, learning or reading difficulties, depression and hyperactivity [44]. In addition, among these children, hitting and kicking other people are common. The importance of early detection of emotional and behavioral problems is recognized worldwide and a number of researches have been con-ducted in developed countries. However, there has been little systematic research into childhood psychiatric disorders in developing countries [45].

A cross-sectional survey from Karachi on 5- to 11-year-old children attending mainstream private and public schools estimated a prevalence of 34% for behavioral problems [45], whereas the burden reported from other developing countries such as Bangladesh and India was 15% [35] and 12% [36], respectively. Many risk factors have been identified for the occurrence of mental disorders, among which social factors are clearly implicated in the genesis and maintenance of these disorders and their extension into adulthood [46]. Other factors include quality of parental relationship, parent's mental health, education, occupation and broader environmental circumstances such as adequacy of housing [35,38,47]. Studies have also investigated specific emotional, behavioral, conduct, hyperactivity and peer problems in children. A study from Pakistan has identified a prevalence of 9.3% for emotional and behavioral problems among school children [39]. However, research on specific mental health problems is yet to gain a significant role in developing countries, and researchers are struggling to identify the overall mental health status of children and adolescents [48-51]. Children living in orphanages are one of the mostvul-nerable groups of children in a society: many of them live in a state of repeated neglect, abuse or fear. Hence, a safe new home that they can trust is not by itself sufficient to repair the damage imposed by abnormal early stress on the developing nervous system [52]. Thus, children in foster care have a disproportionately high prevalence of mental health disorders [41], and studies have indicated that between 50 and 80% of children in foster care suffer from moderate to severe mental health problems [42,53].

One study on Eritrean orphanages found children with mood disturbances, language delays and disturbed social inter-action with peers, and concluded that orphanages are necessarily the breeding grounds of psychopathological problems [54]. The situation clearly signifies that the mental health of orphaned children is vulnerable, and in a country like Pakistan they further face the problem of inadequacy in the number of orphanages and the quality of care provided. Notwithstanding that Karachi is the largest and the most populated city of Pakistan (with a population of 14.5 million), it has only five registered orphanages (the list of facilities was provided by the City Police Liaison Committee). These include one operated by the government and four by non-governmental organizations. Among these, SOS and Edhi homes are the only ones that have outreach activities and children of both sexes from multiple catchments areas. SOS is an international movement that aims to provide housing and care to orphaned children. It was started in Ist, Austria, in 1949 after World War II by Herman Gmeiner from SOS children village Pakistan (Gmeiner, 2000).

Gmeiner believed that all children needed a mother, a home, siblings and a family. It then became the mission of the SOS organization to meet these needs and to ensure that every child raised in an SOS Village was equipped for transition into a successful and productive adulthood. This survey was aimed not only to obtain credible baseline data for estimating the prevalence of behavioral problems among children living in orphanage facilities in Karachi, but also intended to compare the behavioral problems of children in an SOS facility with that in conventional orphanages. The latter objective is important because unlike an SOS facility, the conventional orphanages have segregated facilities for male and female children and the concept of family is not really built in. Our study hypothesizes that children living in the SOS facility have a better mental health status, as SOS provides a family setup for its children. If this hypothesis is validated, SOS can be recommended as a role model for the care of orphaned children (Gmeiner, 2000).

Concept and Theory of Self-Esteem

Self-esteem is a personal judgment of worthiness that's expressed in the attitudes the individual holds towards himself (Cooper smith, 1967). It expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy. According to(Pope, 1988 cited in cooper smith,1967), self-esteem is an evaluation of the information contained in the self concept, and derived from the individual's feeling about the entire thing one is. The definition proposed by psychologist Cohen (1968) is the degree of correspondence between an individual ideal and actual concept of himself. For Rentsuch and Heffner (1992), cited in Gonzalez-Mena (1993), self-esteem is an evaluation of oneself as person, and for Derlga and Janda (1986) it is how we think of ourselves, whether in a positive or negative fashion. Jacobson in Campall (1984) defined it as an expression of the harmony or discrepancy between the self representations and the wishful concept of the self. As to Gonzalez-Mena (1993), self-esteem is how we feel about how we define ourselves. Self-esteem has also been defined in a number of other ways. The common theme refers to an individual's perception of himself in a number of physical, intellectual and social activities and depends up

on the evaluation conveyed to the individual by significant others, by the standard of his reference groups and by his perceived effectiveness in achieving goals (Douvan and Gold, 1966 cited in Heatherton, 1991).

Many stressful situations have both positive and negative aspects. Whether a person tends to focus on the positive or negative aspects of a stressful life events may be an important determinant of the person's psychological adjustment. High self-esteem is considered to be a "healthy" of the self-one that realistically encompasses shortcomings but is not harshly critical of them. According to pope (1988 cited in Heatherton, 1991) a person who has a high self-esteem evaluates himself in a positive way and feels good about his strong points. Feeling satisfied with the major portion of the self does not mean that the individual has no desire to be different in any way. A person with high self-esteem evaluates himself in a positive way and feels good about his strong points. High self-esteem according to campball (1984) is the basis for a good personality and effective social functioning he further stated that a high self-esteem enables to influence people. Coopersmiths (1967) stated high self-esteem as: Youngsters with a high degree of self-esteem are active, expressive. Individuals who tends to be successful both academically and socially. They are eager to express opinions, do not side-step disagreements are highly interested in public affairs. They appear to trust their own perfections and reactions and have confidence that they will be well received (p.20) Cooper smith (1967) describes low self-esteem individuals as individuals with a picture of discouragement and depression. They feel isolated, unlovable, incapable of expressing or defending themselves and too weak to confront or overcome their deficiencies. In the presence of a social group, at school or elsewhere, they remained in the shadows, listening rather than participating, sensitive to criticism, self-conscious, pre occupied with inner problem.

Self-esteem individuals are more likely to be unhappy, weak academically, discouraged, quick tempered, etc. which means a person lacks a global sense of self-worth (Gonzalez-Mena, 1993).Different studies reveal that persons who seek psychological help frequently acknowledge that they suffer from feelings of inadequacy and unworthiness. These people see themselves as helpless and inferior-incapable of improving their situations and lacking the inner resources to tolerate or reduce the anxiety readily around by every day events and stress (Rogers, 1978 cited in Gonzalez-Mena, 1993).

Self esteem theory

Many of the most popular theories of self-esteem are based on Cooley's (1902 cited in cooper smith, 1967) notion of the looking-glass self, in which self-appraisals are viewed as inseparable from social milieu. (Mead's 1934, cited in cooper smith, 1967) symbolic interactionism outlined a process by which people internalize ideas and attitudes expressed by significant figures in their lives. In effect, individuals come to respond to themselves in a manner consistent with the ways of those around him. Low self-esteem is likely to result when key figures reject, ignore, demean, or devalue the person. Subsequent thinking by Cooper smith (1967) and Rosenberg, as well as most contemporary self-esteem research, is well in accord with the basic tenets of symbolic interactionism. According to this perspective, it is important to assess how people perceive themselves to be viewed by significant others, such as friends, classmates, family members, and so on. According to the socio meter theory, self-esteem functions as a monitor of the likelihood of social exclusion. When people behave in ways that increase the likelihood they will be rejected, they experience a reduction in state self-esteem. Thus, self-esteem serves as a monitor, or socio meter, of social acceptance-rejection. At the trait level, those with high self-esteem have socio meters that indicate a low probability of rejection, and therefore such individuals do not worry about how they are being perceived by others. By contrast, those with low self-esteem have socio meters that indicate the imminent possibility of rejection, and therefore they are highly motivated to manage their public impressions. There is an abundance of evidence that supports the socio meter theory, including the finding that low self-esteem is highly correlated with social anxiety. Although the socio meter links self esteem to an evolved need to belong rather than to symbolic interactions, it shares with the earlier theories the idea that social situations need to be examined to assess self-esteem (Heatherton, 1991).

Concepts and theory of depression

Depression is an extremely complex disease. It occurs for a variety of reasons. Some people experience Depression during a serious medical illness. Others may have depression with life changes such as a move or the death of a loved one. Still others have a family history of depression. Those who do may experience depression and feel overwhelmed with sadness and Loneliness for no known reason. Depression is a state of low Mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. People with depressed mood can feel sad, anxious, empty, hopeless, helpless, worthles, guilty, irritable, ashamed or restless (Lindert, 2014)

Cognitive theories of depression

Cognitive theories of depression hypothesize that particular negative ways of thinking increase individuals' likelihood of developing and maintaining depression when they experience stressful life events. According to these theories, individuals who possess specific maladaptive cognitive patterns are vulnerable to depression because they tend to engage in negative information processing about themselves and their experiences. Beck hypothesized that depression-prone individuals possess negative self-schemata (beliefs), which he labeled the "cognitive triad." Specifically, depressed patients have a negative view of themselves (seeing themselves as worthless, inadequate,

unlovable, deficient), their environment (seeing it as overwhelming, filled with obstacles and failure), and their future (seeing it as hopeless, no effort will change the course of their lives). This negative way of thinking guides one's perception, interpretation, and memory of personally relevant experiences, thereby resulting in a negatively biased construal of one's personal world, and ultimately, the development of depressive symptoms. For example, the depression prone individuals are more likely to notice and remember situations in which they have failed or did not live up to some personal standard and discount or ignore successful situations. As a result, they maintain their negative sense of self, leading to depression (Lata, 2000). A second cognitive model, the hopelessness theory of depression, proposed by Abramson, Metalsky & Alloy is based on Seligman's work on learned helplessness and attribution styles The hopelessness theory of depression posits that when confronted with a negative event, people who exhibit a depressogenic inferential (thinking) style, defined as the tendency to attribute negative life events to stable (enduring) and global (widespread) causes, are vulnerable to developing depression because they will infer that: a) negative consequences will follow from the current negative event, and b) that the occurrence of a negative event in their lives means that they are fundamentally flawed or worthless. For example, consider a woman whose fiance breaks off their engagement. If she attributes the cause of the break-up to her personality flaws, a stable-global cause that will lead to many other bad outcomes for her, or if she infers that a consequence of the break-up is that she will never marry or have children, or if she infers that without a lover, she is worthless, she is likely to become hopeless and develop the symptoms of depression. Thus, according to hopelessness theory, a specific cognitive vulnerability operates to increase the risk for depression through its effects on processing or appraisals of personally relevant life experiences (Lata, 2000).

Rationale of the study

This study was conducted In Rawalpindi at the institution named Aghosh. The rationale behind researcher's focus on orphaned children is that since the researcher is working with orphaned children it may enable researchers to secure relevant data from participants. The study population comprises of the 50 orphan children and 50 non-orphan children. In general population of the study is 100 children As previous research indicates orphan children faces several challenges such as lack of important psychological services such as less showing unconditional love to the orphan children by their significant other children in non-orphan which in turn leads to low self esteem and depression in orphan children. Non-orphan children living in the community achieve higher in their self esteem than living in orphan children. Levels of self esteem and depression, controversial findings were observed. These controversial findings may be because of cultural and ethnic group difference or other methodological problems related with the studies.

Chapter 2

Method

Statement of the problems

The magnitude and prevalence rate of orphaned children has been increasing in every part of the world. It is estimated that there are between 143 million and210 million orphans worldwide (UNICEF, 2003). Regarding the number of orphan children 43.4 million of them are found in sub-Saharan Africa, of which 5 million of them are found in Ethiopia (UNICEF et al. 2004). All humans have a need to be respected and to have self-esteem and self-respect. Esteem presents the normal human desire to be accepted and valued by others. People need to engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued, be it in a profession or hobby. Imbalances at this level can result in low self-esteem or an inferiority complex. Institutionally raised children have still have problems interacting with peers and adults outside the institutions. Additionally, children with high self-esteem have a much closer relationship with their parents and peers than do children with low self-esteem [28,55]. Though the problem is devastating, depression and low self-esteem symptoms of institutional orphan children related researches are not done amply by Ethiopian researchers. Therefore, by taking these problems in to consideration, the researcher has tried to study the case as a research topic, and this will help to open a chance to other researchers to study further in the area. Thus, the researcher investigates the level of depression and self -esteem symptoms difference between IOC and NIOC in the case of kolfe, and kechene institution and Tsehay chora Elementary school in Addis Ababa. Thus, the study was intended to give answers for the following research questions.

1. Is there a statistically significant difference in the level of depression between institutionalized orphan children and non-institutionalized orphan children?
2. Is there statistically significant difference in the level of self-esteem between institutionalized orphan children and non-institutionalized orphan children?

Objectives of the study

The present study will be undertaken to examine the self-esteem and depression among orphan and non-orphan children. The present study is carried out to achieve the following objectives:

1. To find out the relationship between Self esteem and CDI among children living with parents and children in orphans.
2. Children living in orphan homes will have higher Depression as compared to those living with their parents/families.
3. Orphans will score lower on Rosenberg Self-esteem as compared to children living in their homes with parents.

Hypotheses

a) Children living in orphan homes will score significantly higher on children Depression Inventory as compared to those living with their parents/families.

b) Orphans will score significantly lower on Rosenberg Self-esteem scale as compared to children living in their homes with parents.

c) There will significant relationship between Self esteem and CDI among children living with parents and children in orphans.

Sample

The specific age group 13 to 17 was selected because there is indication that self-esteem is most common during the first three years of secondary school (Karatzias et al. 2002). Convenient purposive sampling technique is used to draw the sample of the present study which comprise of (*N* = 100) children from 9th to 11th grade from Fouji Foundation college and orphan homes (50 from each grade). The age of sample is ranged between 13 to 17 years. Sample is further categorized as (n = 100).

Operational Definitions of Variables

A) **Self esteem:** Gail McEachron (1993) defines self-esteem as the "judgment one makes about their self-concept. "Self-concept" refers to the attributes one has. McEachron (1993, p. 67) supports this definition with the work of Dr. Morris Rosenberg whom defines self-esteem as the "attitude one holds toward themselves as an object (McEachron, 1993, pg. 8-9)."

B) **Depression:** Depression is a state of low mood and aversion to activity. It may be a normal reaction to occurring life events or circumstances, a symptom of a medical condition, a side effect of drugs or medical treatments, or a symptom of certain psychiatric syndromes, such as the mood disorders major depressive disorder and dysthymia (Nelson, 1996). Depression in childhood and adolescence is similar to adult major depressive disorder, although young sufferers may exhibit increased irritability or aggressive and self-destructive behavior, rather than the all-encompassing sadness associated with adult forms of depression. Children who are under stress, experience loss, or have attention, learning, behavioral, or anxiety disorders are at a higher risk for depression (Eapen & Valsamma, 2012).

Instruments

Demographic information sheet: Demographic information about each respondent including name, age, sex education and socioeconomic status was obtained through a self devised structured questionnaire.

Children Depression Inventory (CDI): The CDI is a 27 items self rated symptoms oriented scale or designed to

assess the severity of depressive symptoms in children from age 7 to 17.This scale require the lowest reading level of any measure of depression for children (Schwartz & Kaiser,1983; Kazdin & Petti, 1982). The CDI has been translated into many languages (other than English) and as such has proved useful for assessment of depression among children from various cultural backgrounds .For the present study CDI was translated by researchers in to Urdu language using back-translation method.

Rosenberg Self-Esteem Scale (RSS): The Rosenberg Self-Esteem Scale (1965) is a 10 item self report measure of global self-esteem. It consists of 10 statements related to overall of self worth or self acceptance. It is a six-point rating scale ranging from strongly agree to strongly disagree and the scores range from 4 to 1.

Procedure

For the present study participants were selected from the different orphans home (for orphans children) and regular schools (for control group) of Rawalpindi Pakistan. Convenience sampling technique had been used to select the participants. Before initiating the study, approval of the superintendent of orphanage was obtained. All the participants were informed about the purpose of this research and confidentiality of obtained data. After taking demographic information the CDI and RSS were administered individually to each child. Following the administration of CDI, RSI Scale was administered to each child, in accordance with the standard instructions.

Data analyses

After completion of the data collection, from 100 childrens (orphan and non-orphan) the gathered data is analyzed using Statistical Package for Social Sciences 21 version (SPSS). Keeping in views the objectives of the study various statistical analyses were used such as Pearson correlation to find out the relationship among study variables, *t*-test to find out the orphan and non-orphan differences. Results are displayed in subsequent chapter

Chapter 3

Result

The current study was aimed to find out the relationship between Self-Esteem and Depression among children and comparison of these variables on orphans and non-orphans. Pearson correlation was used to find out the relationship and *t*-test to find out the differences, on study variables, which indicate the following results:

a) Table 1 shows frequency and percentage of all demographics used in the present study.

b) Table 2 shows the descriptive statistics, alpha reliabilities, of scales. Alpha coefficients were found to be satisfactory and ranged between. 68 for Self esteem and, 66 for depression scale.

c) Table 3 yields the results of t-test that was computed to explore the children differences on study variables.

Table 1: *Frequency and percentage of participants (N = 100).*

Demographic Variables	F	%
Gender		
Male	100	50
Female	100	50
Class		
9th Class	49	24.5
10th Class	51	25.5
11th Class	50	25
12th Class	50	25

Table 2: *Descriptive Statistics and Alpha Reliabilities for all study variables coefficient and pearson correlation among study variable (N = 100).*

Variables	N	M	SD	A	1	2
Self-Esteem	100	3.05	0.520	0.68	-	0.69
	100	0.53	0.674	0.66	-	-

P<.01

Table 3: *Mean, Standard Deviation and t-values for children living with parents and orphans on study variables (N = 100).*

Variables	Children Of Orphan Homes (N = 100)		Children With Parents (N = 100)				95% CI		Cohen's D
	M	SD	M	SD	t (98)	p	UL	LL	
Self esteem	3.04	0.445	3.06	0.592	4.85	0.834	-0.185	0.229	0.0381
SDI	0.63	0.72	0.043	0.612	3.78	0.141	-0.465	0.67	0.29931

Chapter 4

Discussion

In this section, the results presented in the previous section are discussed. Possible explanations and potential reasons for obtained results are forwarded. Also the results are compared with similar previous research findings.

Level of depression in orphan and non- orphan children

As can be indicated in the result section of the study there is statistically significant difference between orphan and non-orphan children in their depression was observed. This shows that institutionalized children are more depressed than their counter parts of orphan non institutionalized children. This may be because institutionalized children may face several problems such as care giver may not provide what is all important for children in the institution, as children of living with their parents or relatives. Which may in turn leads children to feel depressed. In line with this findings Browne and Hamilton-Giachritis (2005) reported that, institutions are considered to be the last resort for the care of parentless children; they have a role to play in short-term, emergency placements for sibling groups. Consistent with this findings study conducted by Berger, (2003) shows that some of the problems encountered by children who are living in a certain institution including psychological stress ,negative impact of education, loss of inheritance and physical as the result of these and other burdens children are exposed to depression, low self-esteem and alienation are common.

Self-esteem level in orphan and non - orphan children

As can be depicted in the result section of the present study statistically significant difference between orphan and non-orphan children in their level of self-esteem was observed. This shows that non orphan children are better in their level of self-esteem than their counter parts of orphan institutionalized children. Consistent with the result found the study conducted by Juffer, Marinus and Ijzendoorna (2007) found that adopted children show lower self-esteem than their non-adopted peers. Adopted children are hypothesized to be at risk of low self-esteem. They may endure from the consequences of neglect, abuse and underfeeding in institutions before adoption. They have to cope with their adoptive status which often includes difficulties associated with the lack of similarity to their adoptive parents. In addition, in line with the present finding, study conducted by Berger (2003) shows that's one of the problems encountered by children who are living in a certain institution including psychological stress, negative impact of education, loss of inheritance and physical as the result of these and other burdens children are exposed to depression, low self-esteem and alienation are common.

Conclusion

The findings of this research suggest that there is a significant difference in self-esteem and depression of the orphan children and the children living with their parents. The orphan children reported lower self-esteem and higher in depression than the children living with their parents. The findings of this research have implications for understanding the emotional state of mind and personality development of the children living in orphanages as compared to those who are living with their parents.

Limitations of the Study

The present study has certain limitations with respect to such issues as sampling, measurement and instruments that can influence the generalization of the results.

1. The research was limited to representative sample of 100 individuals but it was taken from only one division which was not sufficient to be generalized to the population.
2. In the present study cultural background number of siblings family back ground parents' education was not controlled.
3. Furthermore, certain demographic variables like birth order, socio economic status, birth order have not been controlled in the present study which might have been relevant to the constructs of the present study

Recommendations

1. In future research, to obtain more externally valid results can be replicated on a large and diverse sample of the participants in different School and colleges.
2. The sampling technique in the present was convenience sampling that was not fully representative of the population; therefore a method of probability sampling should be used.
3. Finally, demographic variables such as socio economic status, birth order, family system, cultural background, number of siblings ,parents education, school and life style of participants should also be explored in relation to bullying and behavior problems among adolescents and academic performance.
4. A higher depression and a lower self -esteem symptom have been seen in many children as the research findings revealed. Thus the institution has to work on providing appropriate psychosocial support, education and developmentally appropriate care and providing support and skills training specially at summer season, when school programs are off.
5. To let children minimize their depression and low self-esteem symptoms the institution has to think over in advance manner on the communication and interaction of children with the community, the method that is being used like attending educational schooling and follow up religious congregations with the community has to be continued and strengthen.

6. NOG has also advised to play their role in supporting orphanage children especially, in terms of psychosocial support through giving counseling services on how to increase self esteem of these children and on how to overcome factors that lead them to feel depression.

Implications

These research findings will benefit teachers, society and child counselors in the way for the development of intervention programs to boost the self-esteem and to reduce the depression in orphanages children, which will then lead them to achieve high self-esteem and to reduce depression. Moreover, present findings may also be the interest of parents in order to have an insight in problems related to their children.

Chapter 5

Annexure A

Demographic Sheet

I am Clinical Psychologist of My Psychologist Community Dubai, UAE. I came here for my research purpose. In my research I am examining the "*Mental Health of Children Living In Orphans Homes"*. Your voluntarily participation is needed and I assure you the confidentially of information, you will provide to me. You have the right to refuse to participate in this research. If you feel uncomfortable you may also withdraw you data at my stage of research.

Your cooperation is highly valuable and will assist to advance scientific knowledge.

Thanks

Signature of researcher_____ **Signature of participant**_____

Date_____ **Date**_____

Demographic information

Name _____

Age _____

Gender _____

Education _____

Living with parents _____

Living In orphans homes _____

Annexure B

SELF-ESTEEM SCALE

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

No.	Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
1.	On the whole, I am satisfied with my self	1	2	3	4
2.	I never think that I am not good at all.	1	2	3	4
3.	I feel that I have a number of good qualities.	1	2	3	4
4.	I am able to do things as well as most other people.	1	2	3	4
5.	I feel I have much to be proud of.	1	2	3	4
6.	I never feel useless at times	1	2	3	4
7.	I feel I am a person of worth at least an equal plane with other	1	2	3	4
8.	I have sufficient respect of my self	1	2	3	4
9.	All I all I am inclined to feel that I am a success.	1	2	3	4
10	I take positive attitude toward my-self.	1	2	3	4

Chapter 6

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