ROLE OF PEER GROUP SUPPORT INTERVENTION IN DEALING WITH INTERNALIZING AND EXTERNALIZING BEHAVIOURAL PROBLEMS OF ORPHAN CHILDREN IN KASHMIR

A Thesis

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in

Psychology

By

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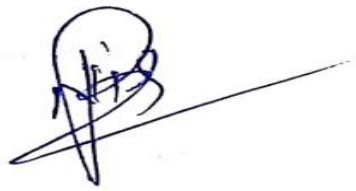
DECLARATION

I, Nisar Ahmad Rather hereby declare that the thesis entitled "*Role of peer group support intervention in dealing with Internalizing and Externalizing Behavioural problems of orphan children in Kashmir"*, submitted to Lovely Professional University for the award of Degree Doctor of Philosophy in Psychology, is my original research work and has been prepared by me in School of Psychology at Lovely Professional University under the supervision of Dr. Manish Kumar Varma, HOD School of Social Sciences and Languages, Lovely Professional University. No part of this thesis has formed the basis for the award of any degree or fellowship previously.



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CERTIFICATE

I certify that **Nisar Ahmad** has prepared his thesis entitled, "**Role of peer group support intervention in dealing with Internalizing and Externalizing Behavioural problems of orphan children in Kashmir"**, for the award of Ph.D. degree of the Lovely Professional University, under my guidance. He has carried out the work at the School of Psychology, Lovely Professional University, Phagwara, Punjab.

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ABSTRACT

Childhood is one important life experience that we share and it plays an important role in the development of human beings. It is a developmental phase of the life and children during this stage of life form the complementary emotional attachment between the child and his/her parents or other caretakers, for healthy social, psychological and physiological developmental, which is known for centuries. Childhood has been regarded as a vital stage from which to proceed into adulthood; it has been observed as the "golden phase" of an individual's life. During childhood mind is free from the disturbance of the world, when fairies are as real as fires, when fables are true, and reality is constantly invented. Childhood is time when seeds are sowed in the children and nourished or watered with loving hands of our parents. Family and parent are the main socializing institution of our society. Parent's helps to learn valuable social norms and values among children and these norms and values helps to develop relations with the other members of the society. Its parents who encourage their children to probe to the world, operate the objects, and explore the physical relationships. However, this delicate garden of childhood gets scathed and fragmented when the undeveloped child unexpectedly is thrown into an eccentric world with no genetic caregiver to look up to due to myriad reasons. The inner self of the young soul weeps intensely and searches frantically for a warm hand, a warm touch, a caress. The children needs much support at that age from their parents and siblings to cope up with physical and emotional development, by losing of their parents make them more disposed to psychological disorders. But unfortunately there are growing numbers of orphan children and also very less attention has been provided to this sensitive and culturally stimulating population.

Children who have lost one or both the parents within the age of 18 years are considered to be orphan. Children who have lost one of the parents are known as single orphan and children who have lost both parents are called double orphan. A child can be said social orphan when neglected by parents and society. Maternal orphan is one who has the bereaved experience of her mother and a child is said to be parental orphan who are dealing with death of his father. Orphan children are one of

the most assailable children in the society; they live in the state of repeated abuse, neglect, fear. Parental loss can exposes a child to long-term psychological disturbances, and it can be much more if the parent is of the same sex. It has been observed the children who have lost their parents become most vulnerable, because they do not have the emotional and physical maturity to deal their psychological trauma associated with parental loss. In the society, orphan children can be considered to be at more risk than average. It has been exposed, that children who lives in orphanages have higher rates of psychiatric symptoms. The death of parents has often serious consequences for the mental health of children. Psychological problems such as symptoms of anxiety, sadness, and feeling of loneliness associated with increased number of changes and disturbances in daily life and with feeling of poor control over ones circumstances may be manifested by children whose parents are dead. Though there are adverse effects on child's health by institutionalization and there may not be the other alternatives to placing children's in institutions in India. Studies have exposed clearly that children and adolescents rose in orphanages or institutional home shown higher level of behavioural and emotional problems as compared to youngsters raised with their family. Thus it clearly signifies the behavioural problems faced in children who are living in orphanages or institutions, but most of these studies are done outside India. Hence it seems that there is requirement for further research on institutionalized children in India, particularly in Kashmir where there is huge residents of this population. So it is imperative that measures should be taken to counteract the negative effect of institutionalization.

A large share of research has been conducted on the orphan children in India. Research done on these neglected section of the society are mostly descriptive in nature. Very less attention has been paid towards these children to resolve the problems faced by these children. However the present research is unique in nature in the Indian context, because the study focuses not only the internalizing (anxiety, depression and stress) and externalizing (aggression, hyperactivity, conduct and peer problems) behavioural problems, but aims to solve these problems through intervention programs. The present study is both descriptive and experimental in nature, which aims to investigate the psychological constructs of internalizing(anxiety, depression and stress) and externalizing (aggression, hyperactivity, conduct and peer problems) behavioral problems and the peer group

support intervention among the orphan children. Along with sample of orphan children, a non- orphan childrens has been taken in the study as to check the level of the behavioural problems on comparative basis.

The objectives of the present study were to examine the differences in internalizing and externalizing behavioral problems of orphan and non-orphan children; to investigate the differences in internalizing and externalizing behavioral problems of single and double orphan children; to examine the gender differences in internalizing and externalizing behavioral problems of orphan children; to investigate the effect of peer group support intervention in dealing with internalizing and externalizing behavioral problems of orphan children. In fact, it is the comprehensive process of testing the hypotheses and examining the obtained data. Although there are a number of research designs, keeping in the view of objectives of the present study, the research design incorporated in present study is descriptive as well as experimental in nature. There are three important components of the research design which are followed by the researcher in the present study as to ensure the validity of results (1) A pre-test and post-test(descriptive) (2) Random assignment of study participants in experimental and control groups (3) Treatment group (Experimental group) and a Control group. After collecting of pre-test data from the orphan and non-orphan children, the orphan children were randomly assigned for six experimental groups and six control groups, with ten children in each group. Each experimental group received six sessions of peer group support intervention on daily basis and at the same control groups did not received any treatment.

The present study was conducted on 240 orphan and non-orphan children selected from five orphanages and six schools of Kashmir valley. Data was collected by employing purposive sampling technique. The data gathering tools used in this study comprised of three separate survey instruments: anxiety, depression and stress scale developed and validated by the Pallavi Bhatnagar, Singh, Pandey, Sandhya and Amitabh comprises 48 items divided into three subscales. The Anxiety subscale comprises the 19 items of the questions, which covers the various symptoms of the anxiety. The depression subscale contains 15 items manifesting the different symptoms of the depression. Stress subscale has 14 items, which covers the state of stress symptoms that people experience during the different situation in their life. The scale can be administered by self as well as the investigator. The scale can be used in

both individual and group setting on the age group of 14-70 years. On the other hand Aggression Scale (AS revised) is developed by the Dr. R.L. Bharadwaj, consists 28 items representing the different samples of behaviours found responsible to foster aggression more objectively. The scale can be performed on self as well as the investigator. It can be administered on the age range 10+ years in individual and group setting. The scale normally takes about 10-15 minutes to fill the responses by the respondents. In addition Strengths and difficulties scale is developed Robert Goodman (1997), contains 25 items in order to measure behavioural disorders of an individual was used for data collection. The scale was designed to know the dimensions of behavioural disorders viz. hyperactivity, conduct and peer problems. The data was analyzed by applying descriptive and inferential statistical techniques such as mean, standard deviation, ANOVA, paired t-test and independent t-test.

The results of the present study were divided into descriptive and experimental parts. Descriptive part defines the pre-test results of orphan and non-orphan children and experimental part explains the results of experimental and control groups of orphan children. Orphan and non-orphan children differ significantly on anxiety, depression and stress dimension of internalizing behavioural problems. The result showed that orphan children possess higher level of anxiety symptoms than the non-orphan children. When compared to depression symptoms again orphan show higher level of depressive symptoms than non-orphan children. Overall the results clearly portrays that the childrens whose parents are expired and are taking shelter in orphanages of Kashmir show maximum amount of internalizing behavioural problems than the childrens who are living under the shadow of parents and family.

The result show significant difference between the two samples of orphan and non-orphan children in the dimensions of aggression and hyperactivity of externalizing behavioural problems. But the finding delineates that there are insignificant differences between orphan and non-orphan children on conduct and peer relationship problem dimensions of externalizing behavioural problems. Moreover when viewing the overall results of childrens whose parents are deceased and are residing in public and private orphanages of Kashmir show higher symptoms of externalizing behavioural problems than the children who are under the care of their parents.

The result delineates that single and double-orphan depicts clear difference in the mean of anxiety dimension of internalizing behavioural problems. Similarly the result portrays those children who have lost both the parents, show higher degree of depressive symptoms than the children who have lost only one of their parents. Further results delineate significant difference between mean scores of single orphan and double-orphan children on the dimension of stress symptoms of internalizing behavioural problems. Generally the results describes that children who have the bereavement experience of both the parents and are living his life in orphanage setting, show higher levels of problems in all the dimensions of internalizing behavioural problems (anxiety, depression and stress) than the children who have the bereavement experience of only one parent and are taking shelter in the orphanage.

Single-orphan and double orphan children on the aggression dimension of externalizing behavioural problems suggests insignificant difference. Similarly, the result suggests that both single-orphan children and double-orphan children have insignificant differences on the hyperactivity dimension of externalizing behavioural problems. The result suggests that mean of the double-orphan children on conduct behavioural problems is higher than mean of single-orphan children, which specifies that double-orphan are dealing with more conduct behavioural problems. Similarly when looking on the result score of peer relationship problems of single and double-orphan children outlines that there is significant difference between these groups. Overall the results describes that children who have the bereavement experience of both the parents and are living his life in orphanages, show significant difference in the total mean score in externalizing behavioural problems, but insignificant difference in aggression and hyperactivity than the children who have the bereavement experience of only one parent and are taking shelter in the orphanage.

Based on the gender difference the orphan children show insignificant difference on internalizing behavioural problems. The results describes that the mean of boys orphan is almost same as the mean of girls orphan on the anxiety dimension of internalizing behavioural problem, thus suggests insignificant difference between boys and girls orphan in anxiety. Similarly on the depression and stress dimensions of internalizing behavioural problems boys and girls orphans show insignificant differences. Over all the result suggests that both the genders are suffering from the

same level of internalizing behavioural problems, when experiencing of parental death and then living in orphanage setting.

The result precisely suggests that in the dimensions of aggression, hyperactivity, conduct problems, both boys and girls orphan possess almost equal mean scores, which specifies that on the basis of gender, orphan children are suffering from same level of these problems. Though the result indicate insignificant differences on the above dimensions of externalizing behavioural problems, but on the peer relationship problems, the outcome delineates significant difference i.e. girls orphan show higher levels of peer relationship problems than boys orphan children. Overall total result score signifies insignificant difference in externalizing behavioural problems among girl's orphan children and boys orphan children residing in orphanages of Kashmir.

The observation of results reveals that experimental and control groups of orphan children showed insignificant differences in internalizing and externalizing behavioural problems on pre-test phase. The result exposes that all the dimensions of internalizing behavioural problems (anxiety, stress and depression) and externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems) suggest insignificant differences between experimental group and control group of orphan children before the peer group support intervention. At pre-test phase both the groups of orphan children are homogeneous in terms of internalizing and externalizing behavioural problems. When compared the mean scores of pre-experimental and post-experimental group of orphan children of internalizing behavioural problems, the result exposes significant difference between the groups. It was clearly found that the mean score of the anxiety, depression and stress dimension of internalizing behavioural problems are lower among the post-experiment group than the pre-experimental group of orphan children. The intervention strategy has proved the decrement of internalizing behavioural problems among the orphan childrens who offered the peer group support intervention. The result clearly indicates statistically insignificant difference of control groups at pre-test and post-test stage of internalizing behavioural problems. The result further suggests that keeping unexposed to peer support group intervention, the pre-control group and post-control group are dealing with equal levels of externalizing behavioural problems. Moreover when used the paired 't' test for the analysis of pre-experimental

and post-experimental group, the result clearly portrays the significant differences in the mean score of pre-experimental and post-experimental group of the orphan children on the dimensions (aggression, hyperactivity and peer relationship problems) of externalizing behavioural problems. The result also illustrates insignificant differences between pre-experimental group and the post-experimental group in the dimension of conduct problems.

Experimental and control group show significant difference on the anxiety, depression and stress dimensions of internalizing behavioural problems. Based on the mean analysis the experimental group, when exposed to peer support group intervention depicts lower degree of mean on anxiety, depression and stress symptoms, compared to control group who did not receive any intervention. Overall peer group support intervention leads lower level of internalizing behavioural problems among the experimental group than the control group of orphan children. On the statistical analysis the result showed that aggression, hyperactivity and peer relationship problems symptoms are lower among the experimental group of orphan children, when exposed to intervention program than the control group of orphan children who received the regular instruction in the orphanages. The result also indicates insignificant difference between experimental group and control group of orphan children on the dimension conduct problem. Thus it can be said that peer group support intervention did not led decrease of conduct behavioural problem in experimental group of orphan children. Generally peer group support intervention leads the decrease of externalizing behavioural problems in experimental group, than the control group who did not receive any intervention program.

This investigation provides insights into nature and frequency of internalizing and externalizing behavioural problem of orphan and non-orphan children Kashmir as well the role of intervention in dealing with these problems. Individual care is required for the children brought up in institutional homes as to enhance wellbeing and quality of life in them. Positive psychological perspective should be commenced in the orphanages as to ensure that children are content, optimistic and happy about his/her future. In a nutshell, family-based care should be introduced and improvised institutional care in orphanages of Kashmir as reduce the burden of behavioral problems in our most precious population. Counselors and child psychologists should be introduced in orphanages to teach health care providers, wardens, teachers and

guardians. All schools and orphanages should have a child guidance counselor in order to help not only the orphans and vulnerable children, but also the teachers, caretakers who are dealing with these children.

Keywords: Internalizing behavioural problems (anxiety, depression and stress symptoms, Externalizing behavioural problems (aggression, hyperactivity, conduct and peer problem), Peer group support, Orphan, Non-orphan

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Dated: 22-01-2021
Nisar Ahmad
Investigator

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ACRONYMSDESCRIPTION

IBP	Internalizing Behavioural Problems
EBP	Externalizing Behavioral Problems
EXT	Externalizing
AS	Aggression Scale
ADSS	Anxiety, Depression and Stress Scale
SADS	Strengths and Difficulties Scale
DF	Degree of Freedom
M	Mean
SD	Standard Deviation
T-Value	Tabulated Value
N	Number of individuals
SD	Standard Deviation
MS	Mean Squares
P-Value	Probability value

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CHAPTER I

INTRODUCTION

Children population shares an important section of our society. The children of today are the future of tomorrow; as they comprise one third of the total population in the country. They are the forerunners of our society (Kumuda, 2014). Every child, on provision of a favorable and an enabling environment, may blossom into an ever fragrant flower, to shine in all spheres of life. This reminds us of the heavy responsibility that we have to shape and mould their current circumstances in the best possible way (Chakraborty, Dasgupta & Sanyal, 2015). The journey in the life of a child involves the critical components of child protection, child survival, and child development. Everyone in our life shares childhood experience. Childhood is one important life experience that we share and it plays an important role in the development of human beings. It is a developmental phase of the life and children during this stage of life form the complementary emotional attachment between the child and his/her parents or other caretakers for healthy social, psychological and physiological development, which is known for centuries (Erol, Simsek & Unir, 2010). Childhood has been regarded as a vital stage from which to proceed into adulthood; it has been observed as the "golden phase" of an individual's life (Chakraborty et al., 2015). According to John Locke (1963) a child is referred as tabula rasa, from which they could learn through experience and develop rationally into the adult world. A child should develop in line with nature and self-discovery and learn through the consequences of their actions (Rousseau,1762). During childhood mind is free from the disturbance of the world, when fairies are as real as fires, when fables are true, and reality is constantly invented. Childhood is time when seeds are sowed in the children and nourished or watered with loving hands of our parents. Family and parent are the main socializing institution of our society. Parent's helps to learn valuable social norms and values among children, in order to develop social affiliation these norms and values are imperative among the children. Its parents who inspire their progeny's to explore the world, operate the objects, and probe the physical associations (Chakraborty et al., 2015). However, this delicate garden of childhood gets scathed and fragmented when the undeveloped child unexpectedly is thrown into an eccentric world with no genetic caregiver to look up to due to myriad reasons. The inner self of the young soul weeps intensely and searches frantically for a warm hand, a warm touch, a caress (Chakraborty et al., 2015). The children needs much support at that age from their siblings

and primary caregivers to cope up with emotional and physical development, by losing of their parents make them more disposed to psychological problems. For a growing child attachment and impact with the siblings is imperative and if children are missing in this relation, because of orphan hood there will be more psychological problems among these children. But unfortunately there are growing numbers of orphan children and also very less attention has been provided to this sensitive and culturally stimulating population.

1.1.Orphan Children

UNICEF and numerous International Organizations adopted the broader definition of orphan in the mid 1990's as the AIDS pandemic began leading to the death of millions of parents worldwide, leaving an ever increasing number of children growing up without one or mere parents. So, the terminology of a single orphan-the loss of one parent and a double orphan-the loss of both parents was born to convey this growing crisis. "A child who is below 18 years of age and who has lost one or both parents may be defined as an orphan" (George, 2011). Maternal orphan is referred to a child who has lost their mother and paternal orphan is referred to a child who has lost their father, while those who have lost both parents are classified as "double orphans. "Social orphans are children who are living without parents because of abandonment or because their parents gave them up as a result of poverty, alcoholism or imprisonment" etc. (Dillon, 2008). The term orphan refers to a child between 0 to 18 years, after the death of his or her primary caregivers, or the death of one and both caregiver and the disappearance of the either of two or both.

Until 2003, the UNAIDS/UNICEF/UNAID's children also used 15 years as the age limit, but only for maternal and double orphans. In contrast the latest (2004) Children on the Brink report pushes the age limit for orphans up to 18, and includes paternal as well as maternal and double orphans. Most accepted definition of orphan is a "child who has lost both parents through death". This definition is extended in most of the groups including the loss of parents through absconding or the parents are unable or unwilling to provide care (Skinner, 2004).

As said before the definition of orphan is the one who when their father and mother passes away a gap develops in his or her life. The terminological meaning of "orphan" in Arabic is that which is alone and unique. The shell which makes pearls in ocean sometimes carries two pearls inside and sometimes there is only one pearl but very precious. Say for example if a person brings one thousand shells from the sea bed; then some would have two

similar pearls inside and some would have one pearl, but much shells when opened will have similar single pearls. But from one of the shell a pearl comes out that is unique and having no match. This is called “orphan” he or she is unique because he has lost his parents who can never come back again (Naqvi, 2014).

When mother and father due to separation or some other reasons are not able to deliver the rights of addressing the feeling of child, a big deficiency gets developed inside the child who remains present throughout life time. If in the age of infancy, a deficiency gets developed in the child due to mother or father then this deficiency remains forever in the life of child. There are very few children who possess the power to eliminate this deficiency when they grow up. And these people are highly sensible, matured who by their willful activities are able to compensate this childhood deficiency, but it is not always the case. Like there are some people who always have ill views about others which means they consider anyone as good. The cause of this problem is the same that some childhood deficiency has remained inside them. These ill views increase the fury of revenge inside them and when they look at anyone else having something good they feel that these people have usurped their rights. This way he gets more revengeful and gradually this incites them to turn into dacoits, criminals and terrorists. In most case children from divorced families become victims of these deficiencies and eventually turn into criminals. Many nations done this, that when criminal cases come to court they do an analysis about the family background of the criminal. The outcome of this analysis in some nations have revealed that majority of these criminals belong to divorced families which implies when they were very young the parents divorced or separated. This divorce or separation affected the child and this child then turned into a professional criminal. It is possible when this child enters in any type of world weather religious, secular, business or any type of society he or she will carry this deficiency with him or her. Some children develop inferiority complex and to hide this inferiority complex they start to do abased and lowly acts (Naqvi, 2014).

These children who developed the deficiency of love and feelings in childhood first develop inferiority complex which means they develop this feelings that I am lower and inferior than other in the society and to suppress this complex he does certain acts to show others that I am superior to others. Love, mercy and kindness are feelings which are present in abundant inside human being which have been thoroughly analyzed by human psychologists. These feelings are present inside every human being and the best

representation of these feelings is between parents and children. The relationship, attachment present between parents and child is an outcome of these innate feelings. Parents are not educated or trained to express these feelings, but it they are present in both parents and child by birth and are not present in others towards the same child. The upbringing of and nurturing of child should start hundred years prior to birth, which means his /her ancestors should be first nurtured and brought up properly. This is because till the time the parents are not well natured and brought up. It is not possible that all what is required by the child can be given to the child by parents or care takers. The child is born with certain rights and this is a very significant point for human beings that the child is not born with responsibilities but born with rights. There are certain rights that come before the responsibilities and then certain responsibilities come up after the deliverance of rights (Naqvi, 2014).

In the era of naturalization when industries were not present such disturbances were not present for human being to this extent. In that era when everything was natural the need of education for human was also limited because in the natural environment everything gets done naturally. If we ponder over natural world there is nothing dependent on education everything gets done in a natural way. Similarly when everything was natural there was no need to make the parents realize responsibilities towards the children because they were naturally doing it. Loving the child, being merciful and kind to children the parents knew it naturally. But the mechanical and industrial world has brought some disturbances in the natural life of human being due to which first damage is suffered by children population of our society. The first generation born to these parents who have distanced themselves from natural criteria of life and are victims of false and deviated mechanical criteria of life suffer a lot. These parents are not able to deliver those rights which they should be doing it due to false standards of life. Hence the mercy and compassion of father and mother is amongst the fundamental need of child. It is possible that physical needs of child that is food; shelter etc. can be fulfilled by others better than the parents. Parents under the poverty might not be having good food to serve their child, no proper cloths, no proper house. This does not mean children should be taken away from their parents and gave all these materialistic goodness in some dormitory or other place. The way it is done in western societies where they adapt children from parents and in some cases the parents give their children to someone else where they get definitely good things but still there is a fundamental missing element which cannot be provided by anyone else other than the parents. Specifically in that age when the child is heavily dependent on mother that is the age of infancy up to 4 to 5 years where the child is

dire need of the feelings of mother and father. If these feelings are not provided to the child in this age then the personality of the child develops a deficiency. When the child matures the same deficiency expresses itself in an unsuitable form such as inferiority complex or some other psychological problems in his personality and it affects his actions as well. In comparison to the child who was brought up in a poor home where all physical things were lacking but the feelings of child was present and parents addressed those feelings; this child grows up without any complexities though there was a poverty of wealth but the poverty of feelings was not present (Naqvi, 2014).

Similarly the artificial and scientific world has increased the expenses and hence the mother who is supposed to give entire time to her child and it is the right of the child that he or she gets hundred percent of her mother's time, but he /she is deprived of it because now she has to go out for work, to fulfill the increased cost of living. Children by birth have these rights to get full time from their mother. The industrial world has taken time away from mother and they are running after earning more and decorating their lives with false ideals. We are not referring to those women and mother who are pursued to work due to social conditions and earn for living but about those who in order to raise their social status and actually are not in need to earn because they have their livings provided by their husband. At times the parents get children after lot of efforts, supplications invocations but what they are expected to give to children they are not able to give and what the children are expected to give them they are also not getting from the child. Industrial world has given impetus to this deficiency in both parent and child. We need organize ourselves to live in an industrial, scientific world and so that there will be no effect on our natural instincts, feelings, relationships, emotions and our rights. But humans did not have time due industrial world to think on these important phenomena of humanity. Now the goodness with others will not yield that benefit which will come out from doing goodness with orphan. It is necessary to make them independent by educating them , taking best care of them and turning them into a respected personality in the society so that he /she does not feel ashamed in the society. This is very important that we need to be enthusiastic about supporting the orphans. One should be enthusiastic and excited for the orphans ant not they are enthusiastic about you coming to help them. When you see an orphan just think that may be tomorrow your children might be the same because there is no information when death can come. It is possible that you will pass away and the same situation might happen to your children so be kind to the orphans so others would be kind to your orphans as well (Naqvi, 2014).

Unfortunately there are growing numbers of orphans in India at alarming rate day by day, particularly in Jammu and Kashmir. Additionally, the tendency of institutionalizing in them is disseminating easily in the society, which had its own traditional mechanism of rehabilitation and care/support (Naqshbandi, Sehgal & Hassan 2012). Orphan exists in every age and in every civilization of the world. In the year 2015, globally, approximately 125 million children have lost a mother or a father and 15.1 million children have lost both parents. More than a third of all orphans live in Africa (52 million) (as cited in Naqshbandi, Sehgal & Hassan 2012). Worldwide, policy makers are battling to find sustentation and upkeep solutions for a probable 125 million children who have lost their one or both parent. Due to high death rate among young adults, because of conditions like HIV/AIDS, malaria, tuberculosis, pregnancy complications, combat wars and natural disasters are responsible for the large and increasing number of orphans (as cited in Kumar, Dandona, Kumar, Ramgopal, &Dandona 2014).

India is a second largest country after china having almost 1.2 billion population and a large section of this population lives below poverty line. This poverty gives impetus to the rise of the destitute population. India assumes large section of children population, one in five children in the world lives in India and among them large number are orphaned or destitute children. India is domicile of 20 million orphan children, a digit probable to increase by 2021, as a study done by the international charity of abandoned and orphaned children. From the data above nearly 18 million of this figure of children live or work on the streets of India and majority of them are involved in crime, prostitution, gang related violence and drug trafficking; however, a large number of these children are orphans (Shrivastava, 2007). Most of these children have been run down by their parents. In reality, only 0.3 per cent of these orphans are children whose parents have actually died. Many of these children are under institutional care. There is no appropriate data on the exact figure of institutionalized children but one estimate by an organization, which has worked across ten states and more than 100 districts of India, places the number at 4.5 million children (Aangan Trust, 2010). These children are placed under institutional care so that their necessities and requirements can be fulfilled and they can bag better health and well-being. However, all the time this may not be the result. Children's are impacted directly by the bereavement experience and the loss of key parenting figures in their crucial developmental years. Loss of the parents can have catastrophic effect on child out comes (Cluver, Gardner, &Operario, 2007; Whetten, Ostermann, Whetten, O'Donnell, &Thielman, 2011; Belsey&Sherr, 2011).

Jammu and Kashmir is the state, which comprises huge residents of orphan population mostly because of the armed conflict since 1990,s. A study done by the Save the Children, an organization of child rights has its roots in UK exposed that Jammu and Kashmir has 2, 14,000 orphans and it also states that 37% of them orphaned due to the armed conflict. The study further revealed that 55 percent of orphans lost one or both parents due to the natural death of parents and remaining eight percent due to other reasons. The study was conducted six districts of Kashmir division, which the percentage of orphaned children in highest in Kupwara district (6.6 per cent), followed by 3.4 % and 2.5 % Ganderbal and Baramulla respectively. As cited in (Bhat, Rahman & Bhat 2015) "Ignored Orphans of Jammu and Kashmir", a report published in Kashmir in its December issue, 2011 under the supervision of Human Rights section delineates that the State is home of 600,000 children who have lost their parents.

1.1.1 Orphanage

Orphanages refer the residential place or institution dedicated to the foster or cares of orphans. Orphanages provides an alternative means to adaption or foster care, by giving orphans community based setting in which they live, flourish and learn. A residential home or institution devoted to care and foster orphans, whose natural parents are deceased or unwilling or otherwise unable to care for them. Sometimes natural parents, and natural grandparents, are legally responsible for supporting children, but in the nonappearance of these or other relatives willing to care for the children, they become a ward of the state, and orphanages are one way of providing for their care, housing and education. We spent money for orphans and even give time for the sake of orphans and possess the feelings as well (Naqvi, 2014).

The gathering of orphans from various families in one particular place, which is known as orphanage and there the children develops feelings of orphans inside or feeling of emotional deprivation in the society. It is similar environment which in past was provided to certain contagiously diseased people like those suffering from leprosy (Naqvi, 2014). People suffering from leprosy are taken out of the town and keep them in some remote place. Religion never says that you should take the orphans out of the society. They should live their lives in the same society in which they are born. Taking these vulnerable children out of the society and then construct a special place for them with a sign board stating that this is an orphanage an then collect donations from society, put donation box in the orphanage and then

various people come to visit them, make the orphans realize that we being fed by the money other people which led to develop psychological problems in them. These orphans will not be able to raise his eyes throughout his life. Everyone will say that you have been brought up with donation money (Naqvi, 2014).

More than 15% of orphan children in Kashmir are taking shelter in these local orphanages. There were traditional way of fostering and rehabilitating the orphans in the State before 1990, like adopted by their families and close relatives. But the tradition has been changed significantly because unstoppable violence conflict, which led the drastic growth of orphans and families are struggling to take care of these children. Furthermore some of these children did not own the other family members, some families are economically unsound to rare and care their relative's children and others concerned about their wellbeing at home. Now the society have changed customary role towards orphans, with various non-Governmental organizations (NGOs) come into existence to look after the destitute population of the society and took over the role extended families and homes got them substituted into new orphanages setting. These orphanages are mostly governed by the NGOs, charities and some are working on the state treasury. Reportedly most of these orphanages are not registered. The community of the State is taking care 85% of these orphans without any outside help from the State Government (Firdosi, 2015). Physiological need like safe shelter, food and clothing are the main purpose of these orphanages, at the same time very less attention are being paid on the psychological well-being and all round personality development on these children. For the long run of life there is no or less evidence that orphanages are helpful and are said to have negative influence on the personal life of an individual. Children living their life under institutional care are dealing poor psychosocial development because of inadequate emotional stimulation. It has been proven beyond doubt that orphanages are an awful place to live in and most developed countries have shut them down during the early parts of last century (Firdosi, 2015). Today we might be able to see a practical solution on reforming our system of orphanages but we can still sow the seed of this reformation. We can at least start to educate the people about the actual concept of honoring the orphans and create a wave of awareness in our society which would pave the way for practical solutions.

1.1.2 Psychological issues of orphan children

Orphan children are one of the most assailable children in the society; they live in the state of repeated abuse, neglect, fear. Hence the safe new home that they can trust is not sufficient itself to repair the damage imposed by early abnormal stress on the developing nervous system (Hughes, 1999). One in every five children experience mental disorder and two requires mental health intervention out of five, but they are struggling to receive the mental health service. Parental loss can exposes a child to long- term psychological disturbances, and it can be much more if the parent is of the same sex (Rutter, 1966). It has been observed the children whose parents are deceased become most susceptible, because during that age, children lacks emotional and physical maturity in order to deal their psychological trauma connected with their parental loss. In the society, orphan children can be considered to be at more risk than average children (Subbarao & Coury, 2004). Research have exposed those children who lives in orphanages have higher frequency of psychiatric symptoms. Some other factors, which research has shown related psychiatric symptoms are time spent by the children in institution, physical structure, and age at the time death of parents or abandonment. For a growing child a family provides clear view of positive social orientation and values of behavior, which acts as safeguard against the development of psychological illness. Institutionalized children are mainly liable to psychological associated problems and long term institutionalization that too in early childhood increases the likelihood that they will grow into psychologically impaired and economically unproductive adults (as cited Rather, & Margoob, 2006). It has also been observed that in an orphanage setting children's emotional and behavioral status worsens and even in well run institutions children develop a range of negative behaviors, including aggression and indiscriminate affection towards adults. Individuals placed in orphanages early in their lives are at greater risk when they reach adulthood of living in poverty, developing psychiatric disorders, having difficulties in interpersonal relationships, and having serious problems parenting their own children. It has been seen also that children who grow up in orphanages or foster care usually have no social connections, and these children are at a disadvantage for completing high school, going to college, or getting job opportunities all of which may be contributing factors in predisposing a child to psychopathology. Institutionalized children who have been handled harshly, inharmoniously and with small consideration may have built up anger from lack of love and nurturing. Also institutionalized children become aggressive because sometimes children do not have the social skills or to manage their behavior. The children become

frustrated when they are not encouraged- to express them-selves. The impact of institutionalization is greater on children who have been living in institutions for long periods of time and from an early age (Van Ijzendoorn, Luijk & Juffer, 2008). In the vast majority of cases, institutional care involves large numbers of children living in an artificial setting which effectively detaches them, not only from their own immediate and extended family and from their community of origin, but also from meaningful interaction with the community in which the institution is located. Research on institutionalized children categorically states the negative effect of institutional care on the physiological, psychological and social health of the children (Nelson, Zeanah, Fox, Marshall, Smyke and Guthrie, 2007; Zeanah, Smyke, Koga, Carlson, & the BEIP core group, 2005; Ford, Vostanis, Meltzer, & Goodman, 2007). Despite the adverse impact of institutionalization, this is a common alternative care option for destitute and orphaned children in India.

There is high frequency of cognitive, emotional, psychological and behavioral problems of institutionalized children than those who live with their parents. (Erol, Simsek, &Munir 2010); Sushma, Padmaja& Agarwal, 2014). Institutionalized children have been found to have lower intelligence, attention deficit, memory difficulties, emotional problems, poor social skills, behavioral issues, inadequate coping skills, mental health problems, etc. (Nelson, Zeanah, Fox, Marshall, Smyke & Guthrie, 2007; Zeanah, Smyke, Koga, Carlson, & the BEIP core group, 2005; Ford, Vostanis, Meltzer, & Goodman, 2007; Mullan, Mcalister, Rollock& Fitzsimons 2007). Though institutional care is aimed at providing protection and care to the children this may not always be the case. Children are dependent upon their parents and secondary care givers, so the relationship of children with these caregiver's are one of the most contributing variables to the occurrence of behavioral problems in both preschool children and the children aged 6-15 years (Children's Behavioral Problem Research group 1993). A trained psycho-analytical psychiatrist John Bowlby stated that the deprivation of maternal parents is the central issue, causing psychological damage to the orphanage children. The psychological issue is greater during the first year of life of children after the death of children and it increases significantly with the duration of living in the orphanage or institution (Goodwin, 1994). Mental health of the children leads harsh consequence due to the parental death. Psychological problems such as symptoms of anxiety, sadness, and loneliness feeling associated with increased number of changes and disturbances in daily life and with feeling of poor control over ones circumstances may be manifested by children whose parents are dead (Foster & Williamson 2000). Though there are adverse

effects on child's health by institutionalization and there may not be the other alternatives to placing children's in institutions in India. So it is imperative that measures should be taken to counteract the negative effect of institutionalization.

1.2 Peer support

Social relationships have utmost importance this new era when seeking treatment is too much expensive for mental health and physical patients. Nowadays social relationship has drawn attention of many social scientists and practitioners of behavioural and health disciplines in the treatment of illnesses and maintenance of health and psychological well-being among the individuals. The developing of interventional programmers on the basis of peer support has led the changes in psychological adjustment, recovery from the traumatic experiences and also helps an individual in extending life dealing possessing with serious chronic disease (Cohen, Underwood, & Gottlieb, 2000).

Peer support is a system of giving and receiving help based on key principles of respect, shared responsibility, and mutual agreement of what is helpful. It is kind of social support where by an individual pass on his/her experimental knowledge, emotional assistance and similar features to the other individuals of the society (Colella & King, 2004). Peer support is a generated source of support, which is other than individual's primary or natural support like family, neighbors and friends. Peer relationship could be helpful in identifying the individual's stressors through directly reactions, such as availability of information about the nature of stress and efforts can be used to diminish it, but an individual can make the comparison it with others. Peer support may deal certainly psychological and health related issues (Cohen, et al., 2000). Numerous ways can be used as the modes of interaction of peer support like individual, one-to-one, self-help or support groups and on-line or through internet. There are many research studies which focus on the group or dyadic setting peer support intervention, though some of them pay the importance on the one-to-one peer support as in the case of population with cardiac surgery. There are vital difference while delivering a peer support, it can be delivered by untrained or by the professionals, paid peers and lay people (Gottlieb, 1983; Ayers, 1989). Peer support can be provided through different sources, it can be provided by the lay people or peers only or can be provided by peers who are working with professionals, facilitator who can facilitate the group of peers.

Many studies suggest that trained peers to assist support, but when people provide peer support each other they can deliver informal support also which can't be delivered by

trained of professional peers. It has been observed that unprofessional peer provide more practical help, mutual and friendship based relationship, altruistic behaviour towards the peers, more experimental knowledge, advice, self-discloser, encouragement, hope, assurance, different analysis, and low importance of problems than professional peer support providers.

Peers can be seen as trustworthy source of information or knowledge, which can act as the role models enhancing the health related or other psychological behaviours (Cohen et al., 2000; Ayers, 1989). It depends on the peer supporter's ability of the strength of peer relationship and strength also depends on who is receiving the help or support and shared life experiences. Peer relationship will be strong enough if provided to similar social, social-economic backgrounds, similar ethnic groups and similar cultural backgrounds. If barriers come during peer support, it can be overcome by peer volunteers compared to peer professionals which may also face problems during working with specialized groups (Brunier, Graydon, Rothman, Sherman, & Liadsky, 2002; Pistrang, Solomons, & Barker, 1999). It has been perceived that lay support from the persons or volunteers, of having parallel features and possesses experimental information helps in lessening social and emotional isolation and also normalize the experience as well as wisdom of validation in the patient (Cohen et al., 2000). Peer support can be delivered through wide range of activities such as listening what people are saying, discussing the ideas, peer sharing, coaching, befriending, mentoring, group activities. Peer support can be delivered by the peers who are paid about how to manage health conditions. Peer support intervention can be delivered in wide variety of setting like in home setting, community sites, in hospital setting, in school setting, in churches etc. Researchers have suggested now innovative peer-led camps for children and houses to deal with long term conditions and support the people dealing with alcohol and substance use (Polcin, Korcha, Bond, & Galloway, 2010). There are the evidences that peer support can be carried out in the community setting or in own homes and can enhance the health related problems (Allicock, Carr, Johnson, Smith, Lawrence, Kaye, ...& Manning, 2014). When to deliver the peer support intervention, there is difference in frequency and duration. Some of the activities of the peer support are given only once or twice during the intervention process and some of them continue for months and years. Some of the peer support are readily available on internet and can be performed daily. Peer support can be delivered on interval bases also such as weekly or monthly.

As cited in (Mead, Hilton, & Curtis, 2001) peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people identify with others who they feel are "like" them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves in conflict. This allows members of the peer community to try out new behaviors with one another and move beyond previously held self-concepts built on disability and diagnosis. Families, individuals and communities can play vital role in dealing and managing of the wellbeing of an individual, because the recognition of these aspects of society have increased day by day and one of the component of this is peer support. Peer support involves mutual interaction between the common experienced people, through which wide range of personal experience, knowledge, emotional assistance and practical help are provided in the beneficial way. Peer support is considered to be different from other types of support, because the source of support is a similar person with relevant experience. An example is people with specific health conditions meeting to share experiences and talk about what works for them. Negative symptoms physical and mental health can be positively managed and coped through the peer support. It is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations. While this belief is well accepted for many conditions, such as addiction, trauma, or cancer, stigma and stereotypes about mental illness have impeded attempts on the part of people in recovery to offer such supports within the mental health system. Peer support is based on the postulate that sharing of similar experiences can help each other in developing informational, emotional, hope and appraisal support. Several studies have indicated that peer support for mental health had yielded promising result in relapse, quality of life, symptoms and social network (Davidson, Chinman, Sells & Rowe, 2006; Dennis, 2003). Peer support is an aspect of a wider recovery program, individual focused outcome like the empowerment, emotional and recovery from the social isolation are given more emphases, fairly than usual clinical outcomes, such as psychiatric symptoms. Through peer support individuals can make their own recovery and the recovery of the other peers and it is possible through emotional and practical support. In order to recovery serious mental problems they face, peers have to

promote hope, empowerment, develop self-efficacy and encourage positive self-discloser and expanding social network (Davidson et al., 2006; Fuhr, Salisbury, De Silva, Atif, van Ginneken, Rahman, & Patel, 2014). The role of peer support workers in the delivery of care can be more accessible, easy affordable and impartial when focusing the people who have living experience of mental health problems will contribute the actively using peer support in developing empowering mental health services. Because they de-stigmatize the mental issues which in the society as mostly regarded as stigma and suggest different views in understanding clients and strengthens the insight of an individual which become vital for the recovery (Ibrahim, Thompson, Nixdorf, Kalha, Mpango, Moran, & Puschner, 2019).

1.3. Behavioral problems

Behavioral problems can occur in the all age groups of children and very often can be initially diagnosed in life of the children. Children suffering from these problems can be vulgar, ill-mannered, rough and having frequent tantrums or outbursts and a higher prone to developing an oppositional defiant disorder/conduct disorder, having difficulties in learning or reading, temperamental instability, hyperactivity and depressive symptoms. Besides with these problems kicking and hitting are found to be common among these children. A large number of children are affected by the behavioural problems. The influence of genes on the behaviours is not predetermined according to the genetic knowledge, but the mediating role of the environment also contributes in the behaviour manifestation of the children. The intermediation of environment provides an opportunity for society as possibly to decrement of incidence of psychological illness like behavioural problems like depression and conduct disorders as well as physical illness like cancer and heart disease (Gullotta, Plant, & Evans, 2014). “Whether or not you agree that it takes a village to raise a child for good or ill the village certainly ends up playing an import role”. The adolescents section of the population mainly gets affected by the outside environment, because the larger community or families outsides act as a role model of thoughts and behaviours which eventually got merged into the teenager’s repertoire. However the role of parents can’t be neglected as vital characteristic development on the adolescents, the influence of peer’s community is also imperative as to gain wider perception of the phenomenon which led the development in adolescents (Gullotta et al., 2014).

An assessment was done on parental reports on behavioural problems indicated that among the five children one faces the behavioural problems in the clinical or borderline range

and are growing significantly (Achenbach, Dumenci, & Rescorla,2003). However the important variability has been found in endurance and outcome of these behavioural problems among the children with the growing age. For example it has been detected that expression of these behavioural problems follow the alteration with time, because the child enters the one stage of developmental to other. Furthermore developmental psychologists led the prominence of individual behaviour according the context of within environment i.e. behaviour of individual should not violate the norms of the society; it should follow the social context or social environment (Ackerman, Brown & Izard, 2004). Behavioral problems are broadly classified into internalizing disorders and externalizing disorders. Behaviour of an individual signifies a key developmental result and it can predict a future adjustment of an individual. The child developmental researchers have classified behavioural problems into externalizing and internalizing manifestations of dysfunction (as cited in Guttmannova, Szanyi & Cali, 2008).

A conceptual background of behavioural problems during the adolescence age has been provided by "problem behaviour theory" and "social cognitive theory". Problem behaviour theory defines "risk behaviours as anything that can interfere with successful psychosocial development and problem behaviour as risk behaviours that elicit either formal or informal social responses designed to control them" (Jessor & Jessor, 1977). Problems behaviours are in constellation form a "risk behaviour syndrome" all of them have shared psychological and social function like showing a strong belief of individuation from parents, to gain the adult eminence, acquisition of acceptance and recognition in the peers. Showing these behaviours in social setting may help an adolescent to cope up from failure, social anxiety, unhappiness or sadness, rejection or neglect, social isolation, restlessness or tedium, lack of self-esteem and low self-esteem. For example an adolescent being downgrading students in his/her follow members or peers make take the drugs in order to achieve the social prominence with their follow mates or peers (Knight, 2009). According to the Social cognitive theory behaviour are the determinants of environment and the individual itself. The theory postulates that behaviour is "triadic reciprocal causation" which means that environment, behaviour and personal factors all integrate together to determine the behaviour of individual. The theory suggests that an individual behaviour is reinforced, imitated and learned through modelling by observing others and seeming to have rewarding outcomes. For example when an individual gets exposure to high-status and efficacious role models who have the habit of using drugs will possibly impact the adolescents. Peers can act as the

models to adolescents for problem behaviours like use of drugs, aggression and sexual behaviour are essential for an individual to become famous, sophisticated tough or macho (Bandura, & Walters, 1977).

1.3.1 Internalizing behavioral problems

Inner directed or covert, over controlled behaviors that cause emotional distress in the self are classified as internalizing disorders. A person who has the internalizing behavioral problems keeps their problems internally and will not let them to come in expressive way. The behaviour that is clear in those with internalizing behavioral problems are anxiety, loneliness, withdrawal and depression. When the person has larger burden of these problems, many issues like withdrawal from society, ideation of suicidal behaviour and sadness and other unexplained physical symptoms come into the life of individual (DiMaria, *2014*). Internalizing behaviour problems were not recognized as frequently as those with externalizing behaviour, because of its hidden and non-intruding nature. Compared to externalizing behaviour, internalizing behaviour problems often went unnoticed (Kauffman, 2001). An internalizing disorder is one type of emotional and behavioral disorder, along with externalizing disorders, and low incidence disorders. Internalizing behavioral problems has the features of over control emotions, like an individual are withdrawing from society, wants attention from the society, the person have the feeling of worthlessness or inferiority feelings and having dependency characteristics (Achenbach, & Edelbrock, 1978). As cited in (Guttmannova, Szanyi, & Cali, 2008) children who are been seen as association with internalizing behavioural problems are predicted to suffer major depression in adolescence, can become the victim of substance abuse in early adolescence. Children did not receive the treatment immediately because due to the silent feature of internalizing symptom compared to externalizing symptoms who are disruptive in nature and girls found to portray more internalizing symptoms than boys. As cited in (Novak & Mihic, 2018) stated that a longitudinal study depicts that internalizing disorders has shown association with academic problems among the children, high parental stress, major health issues and social withdraw or isolation and lasts at the age of early adulthood. Specifically children who have faced three or more negative events like neglect, violence in family, maltreatment or bullying and sexual abuse in their life are prone to develop nine times more internalizing behavioural problems. Conflict among the parents, divorce, peer victimization, rejection and bullying has considerable influence on the development of internalizing behavioural problems. The

important key factors which can lead stable emotional development are a kind of family care or belonging, as well as attachment in school, caring and warm environment should be provided as to enhance well-being among the children. Research has proved that children who have at least close emotional relationship with one peer or friend have very lesser likelihoods of developing internalizing behavioural problems, than the children who did not possess such kind of experiences. Formulation of relationship with other same member in the community are having protective benefits, because they act as the safeguard from negative experience and it has been found low affect among the children who has isolated by friends or by the own choice (Yeung, Thompson,& Leadbeater, 2013).

1.3.1.1 Anxiety symptoms

"Anxiety disorders or symptoms include the disorders characterized by feelings of worry, excessive unrealistic anxiety or excessive fear that are strong enough to interfere with one's daily activities such as work and school activities and are persistent at least six months for adults and four weeks in children and adolescence". The anxiety symptoms or disorders initially occurs in childhood can continue later in the life of an individual if left untreated (DSM-V 2013). The problem is usually self-diagnosable consists behavioural symptoms (restlessness or fidgeting, hypervigilance and irritability), physiological symptoms (excessive fatigue and sweating) and cognitive symptoms (unable to concentrate, unwanted and racing thoughts). The term anxiety is usually defined as a diffuse, muzzy, very displeasing feeling of fear and apprehension. The anxious people are the worriers, particularly about unknown threats. It is the negative psychological state which mostly arises when the conditions are threatening and an individual during these circumstances can suffer with cognitive, affective and physiological changes (Northern, 2010). In addition, the anxious individual shows combinations of the following symptoms: rapid heart rate, shortness of breath, diarrhea, and loss of appetite, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors (Sarason, Sarason, & Selby 1999). Every one among are dealing some sort of anxiety and some people have much enough anxiety at sometimes. If for example examinations are coming for the students and students have prepared enough to cleared the exams, student are still worrying excessively it is an indication of unrealistic anxiety, compared the student who have not studied and portrays excessive or realistic anxiety.

1.3.1.2 Depressive symptoms

Depression is a most commonly found mental disorder that characterizes with mood swings, loss of interest or pleasure, decreasing or increasing weight, decreased energy, feelings of guilt or low self-worth, disturbed sleep (insomnia or hypersomnia) or appetite, poor concentration, recurrent thought of death, suicidal ideation or attempting to suicide. These symptoms should present in an individual since two weeks of time and an individual must possess at least four of the above symptoms. These clinical symptoms should impair the, social, occupational and personal life of an individual of daily life. These symptoms should not attributed by physiological or other medical conditions. "It is a state of low mood and aversion to activity that can affect a person's thoughts behavior feelings and sense of well-being" (DSM-5). Generally depression has become the leading problem in world, due to which 264 million people got affected with this problem. The variations and changes in mood from depression has become challenge in everyday life of an individual, mainly when the problem is moderate or severe, long lasting and it may become the worrying health condition of an individual. Depression has fatal effect on the human mind in which an individual fall victim of suicide, nearly eight lakh people die every year due to suicide and suicide is the second major prominent reason of death in age group 15-29 year. One in fifteen individual adults 6.7% affected by depression in every year and one among the six people will have the exposure of depression at some part of their life. There is no fixed age for in which depression occurs, but usually the late adolescence to mid-twenties depressive symptoms occurs. Women's experience more depression men's and research has showed that one-third of depressed women show the symptoms of major depressive episode in life (APA online site). One who have bereaved experience of closed ones, losses hands from job or quit the relationships are difficult to handle for a person to tolerate end up with depression. Being sad or having grief due to loss of job, death of loved ones or end of relationships are normal feeling of an individual. However of being sad an individual can't be said as depressed and grieving is an innate process in human beings and is distinctive in every individual, but shares some of the symptoms of depression. When these symptoms severe enough that can halt the function of daily life and lasts longer, an individual is said to be have depressive symptoms (APA).

1.3.1.3 Stress symptoms

Hans Selye an endocrinologist coined the term "eustress" and said to be the father of field of research in stress. He defines the stress in 1936 as "the non-specific response of the body to any demand for change". Life of the human being is all about change and every person in the world face some kind of challenge either big or small. It can be challenging for some people what to wear on work, for some school can be challenging, whereas driving can be challenging for someone. Individual had to made decisions and need to require changes that will help to adopt in already made plans (Ciccarelli & Meyer 2010). There are the threats that can affect the psychological well-being such as fight with head, an accident, failed in examination or the job loss. These are all challenges, which need an individual to show the response in any way. "Stress is a term used to describe the physical emotional cognitive and behavioural responses to events that are appraised or judged as the as threatening or challenging". The symptoms of stress can be seen in many ways. People portray the physical symptoms of fatigue, chest pain, nausea, sleeping problems and regular colds while have stress problems. Behavioural symptoms that people depict while suffering the stress are eating excess, crying bouts, pacing, drinking excessively and smoking than usual and hitting or throwing things on others. People in stress can also depict the emotional symptoms like anxiety, depression, irritability, fear and frustration. During stress mental symptoms are also present in the individual like concentration problems, inability formulates proper decisions, memory problems and sense of humor are also absent (Ciccarelli & Meyer, 2010).

The events or things that can cause an individual stress are called stressors and they can be intrinsic that is from the individuals itself or extrinsic which can have the source from the outside and stressor can be very low or very high in intensity. Stressors can be differentiated into two kinds, some can cause "distress" and some of them can cause "eustress" a term coined by the Selye (1936). Distress can be said as an unpleasant experience from the stressors and eustress can results from the positive events like marriage or job promotion both of the stressors demand an individual to adapt or change (Ciccarelli & Meyer, 2010).

1.3.2. Externalizing behavioral problems

"Behavioral disorders that create conflict within the environment or with others are categorized as externalizing disorders" (Achenbach & Rescorla, 2001). Algozzine (1977) categorized externalizing behaviours as "disturbing" to other animated or in animated objects

in the social environment and internalizing behaviours as “disturbing” to the individuals self (Siu, 2007).These are challenging behaviors that are directed towards the external environment. An individual owning these behaviours, instead of expressing their negative emotions or responses to life pressures in a healthy or productive way, people with externalizing behaviors direct their feelings outward to other people or things. For example, a child who's having trouble comprehending schoolwork may choose to bully a classmate who is doing well in school. Externalizing behaviors in childhood and adolescence may be indicative of more serious problems later in life. For example children and adolescents subject to these externalizing behavioral problems have a greater likelihood that they may end up their life in engaging in substance abuse and anti-social behaviour in adulthood. Children who display externalizing problematic behaviour having greater risk of being oppressed and neglected by their group mates than children who do not engage in externalizing behaviour. They are also having academic problems and engage in sexual risk taking behaviors and use drugs as adolescents. As cited in (Guttmannova et al., 2008) externalizing behaviour problems are assemblages of behaviours characterized by non-compliance, aggression, destructiveness, attention problems, impulsivity or hyperactivity. Externalizing behavioral problems has the features of under controlled emotions, like difficulties in interpersonal relationships, an individual are busy in rule breaking, violation of norms, irritability, restlessness and aggressive or hostile nature is the common phenomena of externalizing behavioural problems. The terms “externalizing behavioural problems” and “antisocial” are nearly identical, but there are some differences between these two psychological constructs. For example, according to Shaw and Winslow (1997) that “in most cases we use the term externalizing behaviour rather than antisocial behaviour to discuss the less severe disruption and destructive behaviour of children” (p. 148-158). It is clear that some researcher represent the externalizing behaviour as lower form of antisocial behaviour, particularly found in young children. The hyperactivity dimension includes in externalizing behaviours and found in some children, who can’t be labeled as antisocial, thus demonstrates the clear difference between these two terms “externalizing” and “antisocial”.

1.3.2.1 Aggression

When one person hurts or tries to destroy another person deliberately, either with words or with physical behavior, psychologists call it aggression. It is a form of social interaction. One common cause of aggression is when a person is prevented by from reaching some desired goal. Sigmund Freud (1930) and other early researchers assumed that

aggression was an intrinsic human instinct. Some of the research evidence suggests that human aggression has at least partially a hereditary basis. It was supported by the identical twin studies, which have disclosed that if one identical twin has a violent temper, the identical sibling will most likely also have a same violent temper (Miles & Carey, 1997). Aggression is one of the constituent of conduct disorder, which involves verbal or physical behaviours that can be harmful or threatening to other animated or non-animated property of the society, which include adults, animals and children's (APA, 1994). Aggression is an imperative concept with respect to childhood, because research studies have indicated that aggressive behaviour during the childhood is a strong predisposed factor of offense and violence in adulthood. Additionally aggressive nature of behaviour during the childhood period is the persuading factor of crime and violence later in adulthood (Farrington, 2001). The frequency of aggressive behaviour is widely seen in boys than their counter parts girls and boys mostly employ physical aggression, while girls are usually found in busy in "relational or interpersonal aggression" such as rejection of others in joining their social group (Hadley, 2003). Theoretically aggression includes subtypes, so it is essential to understand the aggression in all of its facets, because different provocations combined with different forms of mental and physiological actions in order to form different forms of aggression. The taxonomies of aggressive behaviour have already been suggested, but there is tendency to overlap, because a slight difference has been emphasized between these subtypes. One leading and remarkable model describes the aggression into two subtype's i.e. instrumental and hostile aggression. Physical and verbal aggressive symptoms fall in the category of hostile aggression, an individual with this type of aggression are emotionally high and uncontrollable and can sustain injury to himself or other in the society by the violence. Form of this aggressive behaviour is called "affective'' "defensive'' "impulsive" or "hot-blooded" aggression. In contrary instrumental aggression is more "predatory" "instrumental" "proactive" "attack" or "coldblooded" in nature. This type of aggression is mainly dominated by decisive and controlled aggression. Emotions in this type of aggression are absent and the purpose of this aggression is usually to achieve the targeted goal, containing the authority and rule on others in the society (Feshbach, 1970; Atkins & Stoff, 1993; Meloy, 1988). Meloy also suggests that aggressive behaviour in humans is primarily sentimental or destructive. Likewise Dodge classifies the aggression in childhood are "proactive or reactive", at the same time confessing that very small aggressive actions are virginally "reactive or proactive". In DSM-V (APA,2013), mentions are made to "intermittent explosive disorder" a form of

clinical aggression in which an individual run with an erratic, losses control for short periods and at the same time becomes extremely aggressive. To understand the effect of biological and environmental factors on aggression, researcher now takes the consideration multi-factorial approaches to measure the role of these two factors. A research study on aggressive and non-aggressive behaviour among the 1500 identical twins of British and Swedish nationalities, it was found that both heredity and environment both effects the aggression and non-aggression among these twins. Social learning or imitation, domestic violence, neglect and child abuse , aggression in schools, watching violence on TV, undernourishment and physiological dysfunction of hormones e.g., testosterone), and abnormal functioning of neurotransmitters led aggressive behaviour among these children (Eley, Lichenstein, & Stevenson, 1999).

1.3.2.2 Hyperactivity problems

The term hyperactivity was first developed by Henshaw (1987) is one the most puzzling term in psychopathology, because the term mentions the two different problems in an individual i.e. one is the excessive fidgeting or motor activity and the other includes the attention deficient or concentration problems. The children mainly display these types of behaviours in the controlled situation such as in the school classroom. Due to the baffling mixture of two underlying problems, DSM-IV makes the use of term "attention-deficit/hyperactivity disorder" (APA, 1994). Being considered a one disorder, children can portray or show the symptoms of either inattention or the symptoms of the hyperactivity. Giving the order of this confusion, DSM-IV has divided the disorder into three subtypes: hyperactive, attention/hyperactive and mainly inattentive type. In the present study the general term of "hyperactivity" will be used in both the forms of attention and hyperactive (Liu, 2004). The prevalence of hyperactivity is 3% to 5% of the children and boy have been found more hyperactivity the girls like aggression and delinquency (APA, 1994; Hinshaw, 1987). The signs of these problems as noticed in toddlers by the parents, but the problem is mostly diagnosed in the elementary school age of the children. The disorder commonly remains constant until the adolescence, but the level of symptoms of the problem gets decreased at the late adolescence and early adulthood. There is high probability that adult who have faced the hyperactivity during childhood have the chances of developing the criminal behaviour in the adulthood phase of the life (Mannuzza, 1989). Hyperactivity concept has become the center of attention among the children, because these problem can

become troublesome for the society if present in the adulthood also. Children can be badly impaired if conduct problems as well as hyperactivity are diagnosed in them, because these children ended up with worst adjustment in the society during adulthood (Barkley, Fischer, Edelbrock & Smallish, 1991). When the children grow up with both conduct problems and hyperactivity, there are concerns that they may develop the antisocial behaviour or psychopathic, which is considered to be guilt and regret free, impulsivity, dampened affect and non-serious behaviour. According to the Lynam (1998) that "children with both conduct problems and problems with hyperactivity, impulsivity, and attention is most likely to be what he terms "fledgling psychopaths." By supporting of this argument, he finds that diagnosed with both of these externalizing behavioural problems thoroughly seems to be the symptoms of psychopathic criminals when assessing the neuropsychological disorders. the externalizing behavioural problems contains the both dimension of hyperactivity, conduct problems and by scoring high on these dimension of externalizing behavioural problems an individual may be at high risk during adulthood of developing psychopathic behaviour.

1.3.2.3 Conduct problems

Children with conduct problems portray reiterative and tenacious type of behaviour through which others basic rights and age appropriate norms of the society are violated. These symptoms should be present in children past 12 months and following are the diagnostic feature in children who are dealing with conduct behavioural problems aggression to the people and animals, destruction to the property, fraudulence or stealing and serious violation of rules. The average prevalence of this problem among the children population is 4% and is found in various countries, in different races and ethnicity. The level of problem increases from childhood to adolescence and boys are found to be higher problems than girls and only little section of these children receive proper treatment (APA, DSM-V 2013). The beginning of the conduct problems usually starts in preschool years, but the full advent of symptoms are in middle childhood and early adolescence. Individuals who are dealing with conduct problems may have the possibility of developing other psychological problems like anxiety, stress, mood disorders, psychotic problems, impulsivity and substance- abuse related problems later in the life (APA, DSM-V 2013).

Environmental factors tend to play an important role in the growth of conduct disorder symptoms among the children. In environmental factors family has foremost importance, children who are facing parental rejection or neglect, lacks better care from

parents, strict discipline, regular changes of caretakers, sexual or physical abuse, deficiency of appropriate supervision, enlarge family, parental criminal record and early institutionalization, all can lead the conduct problem among the children and adolescence. The level of risks present in community setting like peer dismissal, relationship or friendship with the delinquent peer group and exposure of violence in from the neighbors can act as serious role in the growth of conduct problems in the children (APA, DSM-V 2013).

1.3.2.4 Peer Problems

Peer relationship problems can be said that when an individual are unable to form relationship with the other in the society because being bullied, being victimized by others, which are often accompanied by additional psychosocial problems, such as depression, conduct disorders, aggression, hyperactivity and can become a barrier to form relationships with other members of the society. Peer relationship or interaction with peer can serve as vital developmental purpose among the children. Interactions with peers may be more democratic, restriction free, and free from hesitation to express feeling and emotions than the non-peers which may be authoritative and limited to expression of things. Peer relationship can serve an opportunity among the children to develop skills for reasonable play and learn the boundaries of social tolerance. The development of self-image among the children can be attained, because peer offer the levels of quality to compare each other socially (Hetherington, Parke & Locke 1999). The social rules, vital social behaviours and information about the society can be established through peers and they can act as silent reinforcement in attain the crucial social behaviour (LeBlanc, Sautter, & Dore, 2006). Children can enhance or test the capabilities of self-control in peer environment, being multifaceted in nature and experience of peer relationship through group activities, as well as one to one relations with friends (Hartup, 1996). But unluckily all the children don't share or possess the positive relationship with the peer, some of them have negative effect of peer on their developmental process or behaviour and it has been found that 5-10% of children have exposure of difficulties of peer relationships, like rejection and harassment or abuse by the peers (Kupersmidt & Dodge, 2004; Perry, Kusel & Perry, 1988). Peer rejection or peer victimization may be the cause of enormous undesirable outcomes, for example the children may show decreased performance in academics such as drop out, stagnation and poor performance in reading. Peer relationships problems have hazardous influence on the mental health on the children. Children can face internalizing behavioural problems (depression, poor self-concepts and loneliness) and

externalizing behavioural problems like risk behaviours and criminality, aggression and delinquency (McDougall, Hymel, Vaillancourt & Mercer, 2001). In some cases, refusal by peers occurs because of inability or other features which are beyond the control of a child. Nevertheless, important research on peer rejection has focused on the behaviour, which led the cause of peer rejection and can be too easily change.

1.5. SIGNIFICANCE OF THE STUDY

India is the second largest populated country in the world, in every five children one lives in India. Among these children large number have lost their parents or orphaned or destitute. Some of them are living their life in institutional or orphanage care setting. Due to the bereavement experience of parents, abuse, neglect, missing from home, poverty and other variety of reasons has led these children to live a life under institutional care, by providing them care and daily physiological needs like food, shelter and clothing. Children mostly living in these institution or orphanages at the age of eighteen years and after some support are provided to them as to live further life independently (Sushma et al., 2014). In emerging countries, due to the poverty, death of parents, natural and man-made disasters, terrorism, violence civil and armed conflict forcing the children to live institutional or orphanage life (Mariam & Seneviratne, 2006; UNICEF, 2003). Around the world now there is decline of institutionalization of children and adolescents, because of the condemnation faced from the research society. Now the shifting trend of community-based rehabilitation has been introduced for these children by the policy makers (Tobis, 2000). However, in India, especially in Kashmir, institutionalization is still extensively practiced (Naqshbandi et al., 2012). Jammu and Kashmir is the state, which comprises huge residents of orphan population mostly because of the armed conflict since 1990,s. As cited in Bhat et al., (2015) a study done by the UK based child rights organization, Save the Children revealed that Jammu and Kashmir has 2, 14,000 orphans and it also states that 37% of them orphaned due to the armed conflict. The study further revealed that 55% of orphans lost one or both parents due to the natural death of parents and remaining eight percent due to other reasons. The study was conducted six districts of Kashmir division, of which the percentage of orphaned children was the highest in Kupwara (6.6 per cent), Ganderbal (3.4 per cent) and Baramulla (2.5 per cent). According to a report, titled by “Ignored Orphans of Jammu and Kashmir”, published in Kashmir Watch under the Human Rights section in its December, 2011 issue, the number of orphans in the state is around 600,000 children.

It is a well-known fact that orphans lacks something as the normal children have. They lack the parental affection, love, support, and care, which may be the cause to rise of psychological problems of children living in orphanages. Children and adolescence population has become focal point for the researcher in the psychology as to study the mental health problems. Emotional problems such as anxiety, difficulties in social interaction, depression and behavioural problems like hyperactivity and conduct problems has been pinpointed in many research studies (Saleem & Mahmood 2013; Egger & Angold 2006). The risk of developing the psychological problems among these children is higher on some groups. According to the Integrated Child Protection Scheme, India these are the children who are orphans, abandoned by families and being reared and cared by orphanages or institutions (Ministry of Women and Child Development, Integrated Child Protection Scheme GOI, 2017). Research suggests that there higher prevalence of behavioural and emotional problems among the children who are dealing with mourning experience of their parents compared to other vulnerable children (18.3% to 64.53%), but in children whose parents are alive it is reported in between 8.7% to 18.7% (Rahman, Mullick & Pathan, 2012; Doku & Minnis 2016; Erol, Simsek, Oskay & Münir, 2017).

Many research studies exposed high percentage of mental health problems among orphan children sampled from orphanages of Kashmir include depression, stress, anxiety and lack of comprehension. Out of the five orphanages four orphanages depicts stress and all five orphanages delineates depression, anxiety and lack of comprehension. There has been drastic increase in mental health problems of adolescent population due to violence and armed conflict for last more than twenty years in Kashmir valley and it has also seen that there is increase in the orphan population throughout Kashmir valley due to this conflict (Dabla & Ahmad, 2011). As sighted in Bhat (2014) research on this population is vital, because due to the death of the parents there risk of developing psychosocial problems. In fact research has exposed, those children who lost his parents double risk of developing the psychiatric problems as compared the children who are living with their parents. Studies have exposed clearly that children and adolescents rose in orphanages or institutional home shown higher level of behavioural and emotional problems as compared to youngsters raised with their family (Simsek, Erol, Oztop & Munir, 2007). The above studies clearly signify the behavioural problems faced in children who are living in orphanages or institutions, but most of these studies are done outside India. Hence it seems that there is requirement for further research on institutionalized children in India, particularly in Kashmir where there is huge

residents of this population. Keeping in view the above research studies, there is necessity to carry out a research study so that limitations of earlier research can be fulfilled and the author can assess behavioural problems of orphan children being brought up in different public/private institutions. It can be said that there is necessity to detect and measure the mental health problem in these institutionalized children, so that proper intervention program can be formulated as to heal these problems. The present study was led with the purpose of determining the internalizing and externalizing behavioural problems among orphan and non-orphan children, along with the role of peer group support group intervention in dealing the behavioural problems among the orphan children. Recommendations of this research in orphanage setting will provide guide to policy makers, administrators that how to deal with these children and how to help these children to live psychological distress free life in these orphanages.

In India there is dearth of research studies in this regard, so the author conducted the descriptive as well as experimental study to explore the information and knowledge gap about the what extent the internalizing and externalizing behavioural problems are found in these orphan children living in orphanages and non-orphan children living with their parents. The present study will explore the behavioral problems of the orphan and non-orphan children in Kashmir. The study will also attempt to the role of peer group support intervention in dealing with behavioral problems among orphan children. Furthermore the study will attempt to compare the male and female behavioral problems. The present study will be pivotal in making a comprehensive policy for orphan children by developing an interventional model to deal with mental health issues of this neglected population. The current study will highlight the need of different mental health programs of the organizational body to be commenced in these institutions to protect our younger generation from such problems and to improve the quality of life, which indirectly lead prosperous and happy nation as a whole.

1.6. STATEMENT OF THE PROBLEM

Keeping these facts in opinion derived from the significance, the author felt the need for carrying out the study of behavioural problems between orphan children living in institutions and the non-orphan children living with their parents, along the role of peer group support intervention in dealing these behavioural problems among orphan children in Kashmir. Hence the study entitled "ROLE OF PEER GROUP SUPPORT INTERVENTION IN DEALING WITH INTERNALIZING AND EXTERNALIZING BEHAVIOURAL PROBLEMS OF ORPHAN CHILDREN IN KASHMIR".

1.6. OPERATIONAL DEFINITION OF THE TERMS

Internalizing behavioral problems

Inner directed, over controlled behaviors that cause emotional distress in the self are classified as internalizing disorders. A person who has the internalizing behavioral problems keeps their problems internally and will not let them to come in expressive way. The behaviour that is clear in those with internalizing behavioral problems are anxiety, loneliness, withdrawal and depression. When the person has larger burden of these problems, many issues like withdrawal from society, ideation of suicidal behaviour and sadness and other unexplained physical symptoms come into the life of individual (DiMaria, 2014).

Depression symptoms

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 (Marina Marcus et al,). It is a "state of low mood and aversion to activity that can affect a person's thoughts behavior feelings and sense of well-being" (DSM-5).

Anxiety symptoms

"Anxiety disorders or symptoms include the disorders characterized by feelings of worry, excessive anxiety or fear that are strong enough to interfere with one's daily activities such as work and school activities and are persistent at least six months for adults and four weeks in children and adolescence"(DSM-V 2013).

Stress symptoms

"The term stress is used to describe the physical emotional cognitive and behavioural responses to events that are appraised as threatening or challenging" (Ciccarelli & Meyer, 2010)

Externalizing behavioral problems

"Behavioral disorders that create conflict within the environment or with others are categorized as externalizing disorders" (Achenbach & Rescorla, 2001). Algozzine (1977) characterized "externalizing behaviours as disturbing to others in the social environment". For example, a child who's having trouble comprehending schoolwork may choose to bully a classmate who is doing well in school. Externalizing behaviour problems are constellation of behaviours characterized by non-compliance, aggression, destructiveness, attention problems, impulsivity or hyperactivity.

Aggression

"Behavior aimed at harming others physically or psychologically. When such behavior is purposively performed with the primary goal of intentional injury or destruction it is termed *hostile aggression"*.

"*Instrumental aggression* involves an action carried out principally to achieve another goal, such as acquiring a desired resource".

"Affective aggression involves an emotional response that tends to be targeted toward the perceived source of the distress but may be displaced onto other people or objects if the disturbing" (APA Dictionary)

Hyperactivity problems

The term hyperactivity was first developed by Henshaw (1987) is one the most puzzling term in psychopathology, because the term mentions the two different problems in an individual i.e. one is the excessive fidgeting or motor activity and the other includes the attention deficient or concentration problems.

Conduct problems

Conduct problems portray reiterative and tenacious type of behaviour through which others basic rights and age appropriate norms of the society are violated. These symptoms should be present in children past 12 months and following are the diagnostic feature in children who are dealing with conduct behavioural problems aggression to the people and animals, destruction to the property, fraudulence or stealing and serious violation of rules (APA, DSM-V 2013).

Peer problems

Peer relationship problems can be said that when an individual are unable to form relationship with the other in the society because being bullied, being victimized by others, which are often accompanied by additional psychosocial problems, such as depression, conduct disorders, aggression, hyperactivity and can become a barrier to form relationships with other members of the society.

Orphan

"An orphan is defined as a child under the age of 18 who lost one or both parents due to death from any cause" (UNICEF, 2006). The number of orphans generally increase with age, hence older orphans greatly outnumber younger ones (UNICEF, 2004). So, the terminology of a "single orphan-the loss of one parent" and a "double orphan-the loss of both parents" was born to convey this growing crisis.

Peer Support

Dennis developed a comprehensive definition of peer support. According to this definition, peer support within a healthcare context is "the provision of emotional appraisal and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population" (p. 329)."According to this definition, "peer supporters generally offer three types of support emotional appraisal and informational". All three types of support are based on experiential knowledge rather than arising from formalized sources. Expression of emotional support constitutes empathy, caring, reassurance and encouragement and is mostly seen to be boosting the self-esteem (Dennis 2003). Appraisal support includes encouraging persistence and optimism for resolving problems, affirmation of a peer's feelings and behaviours, and reassurance that frustrations can be dealt with (Dennis 2003). Informational

support involves providing advice, suggestions, alternative actions, feedback and factual information relevant to the issue that the peer is dealing with (Dennis 2003).

1.7 Objectives

A large share of research has been conducted on the orphan children in India. Research done on these neglected section of the society are mostly descriptive in nature. Very less attention has been paid towards these children to resolve the problems faced by these children. However the present research is unique in nature in the Indian context, because the study focuses not only the behavioural problems, but aims to solve these problems through intervention programs. The present study is both descriptive and experimental in nature, which aims to investigate the psychological constructs of internalizing and externalizing behavioral problems and the peer group support intervention among the orphan children. Along with sample of orphan children, a non-orphan childrens has been taken in the study as to check the level of the behavioural problems on comparative basis. When reviewing the literature, numerous studies has been conducted on the peer support group intervention and other variable like mental health, psychological well-being etc. on different sample. But in Indian context very little research has been conducted, particularly in Kashmir where the population of orphan children is increasing. There may be positive relationship between these variables to support each other. However these variables may vary among the individual or groups. Bearing in mind gaps and limitations mentioned in the review, the existing research put forward the following major objectives to attain:

1. To examine the differences in internalizing and externalizing behavioral problems of orphan and non-orphan children of Kashmir.
2. To investigate the differences in internalizing and externalizing behavioral problems of single and double orphan children of Kashmir.
3. To examine the gender differences in internalizing and externalizing behavioral problems of orphan children of Kashmir.
4. To investigate the effect of peer group support intervention in dealing with internalizing and externalizing behavioral problems of orphan children of Kashmir.

1.8 Hypotheses

The following are the hypotheses proposed on the basis of above objectives:

1. There exist no significant differences in internalizing behavioural problems among orphan and non-orphan children of Kashmir.
2. There is no significant difference in externalizing behavioural problems among orphan and non-orphan children of Kashmir.
3. There exists no significant difference in internalizing behavioral problems of single and double orphan children of Kashmir.
4. There is no significant difference in externalizing behavioural problems of single and double orphan children of Kashmir.
5. There is no significant difference in internalizing behavioral problems on the basis of gender of orphan children of Kashmir.
6. There exists no significant difference in externalizing behavioral problems on the basis of gender of orphan children of Kashmir.
7. There is no significant difference of peer support group intervention in dealing with internalizing behavioural problems of orphan children of Kashmir.
8. There exist no significant differences of peer group support intervention in dealing with externalizing behavioral problems of orphan children of Kashmir.

1.9 DELIMITATIONS

Every research investigation is limited in numerous ways. It has to be delimited in terms of population covered, sample selected and scope of variables studied. Keeping in mind paucity of time and resources, present study is delimited to five orphanages (two girls and three boys) and six school of the Kashmir valley.

1.10 OUTLINE OF THE THESIS

First chapter of this study introduces the internalizing (anxiety, depression and stress) and externalizing (aggression, hyperactivity, conduct and peer relationship problems) behavioural problems among orphan and the non-orphan children and the effect of peer support to deal these problem and other psychological problems. Conceptual definitions are provided and the objectives and hypotheses are presented. Second chapter reviews related research and the significance of the findings. In this chapter a summary is presented about reviews of the literature on internalizing behavioural problems (anxiety, depression and

stress) and externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems) and the effect of peer group support on these psychological constructs and on the other related variables.

Third chapter includes the methodology to test the hypothetical relationships, differences introduced in this study. Fourth chapter describes the analytical tests of each of the study hypotheses as well as discussion of the findings of the statistical testing of the hypotheses along with implications of these findings. Fifth chapter summarizes conclusions, recommendations directions for future research and limitation of the study.

CHAPTER II

REVIEW OF LITERATURE

The chapter review of literature will summarizes relevant literature that support this study and also it will help us to understand the methodology used by the researchers. The purpose of the literature review was to inform the reader about key topics that are related to the study and to briefly review current understanding the problems of orphan children which they are facing due to the death of their parents. Specifically, this chapter will deliver information about the internalizing (depressive symptoms, anxiety and stress symptoms) and externalizing behavioural problems (aggression, conduct problems, hyperactive problems) among the orphan children. Along with these studies peer group intervention related studies will also be high lightened in this chapter to the research. The review states that much research has been done outside India like South Africa, china, Pakistan, Turkey, Iraq, Egypt, Bangladesh, Britain etc. But very little attention has been paid to do research on the orphan children in India, particularly Kashmir.

It was found necessary to do survey on related literature, so that idea can developed what already has been done and to guide our study under useful lines. It will also advantage the researcher to find the gaps and methodologies by reviewing this related literature. Although very little research has been done on this topic, still researcher manages to find important related studied of the topic.

2.1 Peer Group Support Intervention Review

Kumakech, Cantor-Graae, Maling, and Bajunirwe, (2009) conducted a interventional study on children whose parent are died due to the AIDS and the psychological well-being among these children in Uganda. The researcher employs the peer-group support intervention along with somatic health treatment as an interventional technique in their study. The sample of the study was 326 children whose parents were deceased due to the AIDS epidemics. The researcher uses the multi stage sampling technique and then divides the selected sample into experimental group comprising 159 orphans and control group 167 orphan children with the age range of 10-15 years. The researcher practiced the randomized controlled design as to pick up the participants for experimental group and the control group of the present study. Data were attained by using the Becks self-administered inventory. The intervention process

completed in 10 weeks of time and total sixteen psychosocial activities prescribed during the intervention. The result obtained delineates that the use of peer group support intervention minimizes the symptoms of psychological distress, mainly the symptoms of depression, anger and anxiety. Thus according to the study, peer group support intervention should be incorporated into school health programs and orphanage setting, as enable the children to live happily and productive member of the society.

Puschner et al. (2019) delved a study on rational, methodology and background of using peer support in developing empowering mental health services. It is an international multi-center study in which the researcher desires to find the expansion of peer support in low-income, middle-income and high-income countries among the mental health patients. "Using of peer support in developing empowering mental health services"(UPSIDES) is an international research community, which practice for peer support like peers support workers, mental health workforces in the six different countries of the continent in Asia, Africa and Europe. All the intervention material is existing according the international rules. The conclusion of the study found the "using of peer support in developing empowering mental health services" (UPSIDES) strengths the mental health systems and it has also been seen peer support has made health services more reachable, inexpensive, and impartial.

Byrom (2018) conducted an intervention study on the students, who possess the mental health problems. A peer support intervention was faced by these students, who were experiencing the depression and anxiety symptoms for more than one year. A sample of 65 students participated in the peer support intervention process. Most of the sample was females, only 34% completed the given intervention. The result found that students who completed the session show improvement in mental well-being and the student who participated only in one session show lower improvement in mental well-being.

King and Fazel (2019) examined a systematic review on the peer led school based interventions on the mental health of adolescent children. The purpose of the research was to observe the consequence of peer led interventions on mental health of adolescent of the age group of 4-18 years. The authors of the study aggregate the global evidence of outcomes of peer-led intervention on the mental health through the systematic review. The review found that peer support program is valuable for policy maker, health professionals, researchers and those who are involved in providing peer support initiative.

Ibrahim et al. (2019) conducted a systematic review on adults dealing with mental health problems and application of peer support to assess the recovery among these adults. Data sources were gathered through online database, journals, conferences, expert consultation and peer support websites. Among the 5813 publications 53 were selected and were available in many languages including English, German, and French etc. The result of systematic review identified that formal peer support should be implemented in mental health services and it can be implemented in clinical as well as other uses also.

Johnson et al. (2018) delved a study of peer support self-management for the people who were discharged from mental health problems. It was a randomized controlled study in which the researcher screened 3288 mental health service users and from 1848 eligible individuals, selects 221 participants as intervention group and 220 as the control group. Due to the high expenditure of mental health crises, the researcher used the peer support as technique for recovery; prevent relapse and readmission in mental health centers. Participants were randomly selected in the study and were provided ten sessions from peer support workers for the recovery. The result found that intervention group showed significantly lower readmission as compared to the control group who did not received the intervention program within one year and also recovery was found in the intervention group.

Lloyd-Evans et al. (2014) did a research study on peer support for people with severe mental illness. A meta-analytical randomized controlled trail was performed on participants. The intervention were analyzed and categorized separately: peer support services, mutual peer support or peer delivered mental health services. The sample of this study was 5597 participants, who have given eleven trials of peer support services, four trials of mutual support programs and three trials of peer-delivered services. Result show the evidence that peer support was associated with positive effects on measures of recovery, empowerment and hope, although it was not consistent with other different type of peer support.

Naslund, Aschbrenner, Marsch, and Bartels (2016) explored a research study on the peer-to-peer support on the mental health through the social media. It was an online peer support intervention, in which an individual suffers serious mental health problems, decides to take online support from the person who has the experience of such problems. The authors develop the conceptual frame work for an individual who provide the peer support to the individual who are dealing with mental health problems. During this online conversion both individual shares personal stories each other and strategies of coping to deal with mental

health issues. The outcome found that people with mental health issues finds benefits from the online peer-to-peers support and feeling of connectedness and group belonging. The result also found that individual with mental health issues developed insight about their problems, which can help them to encourage mental health care pursuing behaviours.

Carter et al. (2016) performed a research on students of high school with severe disabilities. An effect of peer support on academic and social outcomes was assessed during the study. Randomized controlled experimental designs were used by the researcher in order to draw valid results and control the biases. The responses were collected from 51 high school students dealing with severe disabilities. It was found that children who received the peer support showed more engagement in academic, increased progress on individualized social goals, develop greater number of friendships, more interaction with peers, better participation in social activities, and develop more number of friendship with new students.

Loding, Wold, Skavhaug, and Graue, (2007) examined a problem-solving and peer support group intervention based study among the adolescents suffering from diabetes. The hypothesis formulated by the researcher that intervention will help adolescents to manage their debates. The researcher includes the total 60 adolescents of type-I diabetes in his study, with the age range of 13-18 ears along with their parents. Final 19 individuals agree to take part in the study, selected from the two outpatient clinics in Norway. Responses were collected with the self-report questionnaires at both stages of pre and post-test stage and the follow-up of one year. The result depicts that both problem solving training and peer support group are the appropriate interventions to led the treatment among the adolescents dealing with the type-I diabetes and girls found more improvement than boys in metabolism control.

Brunier, Graydon, Rothman, Sherman, and Liadsky (2002) tried a study on the peer support and its effect on psychological well-being of patients dealing with renal failure. The researcher followed the longitudinal researcher design in the study, in which total 31 peer support volunteers from twelve different ethno-cultural groups completed the full process. Information regarding the psychological well-being was obtained through mental health inventory and open ended questions. The interval time between the interviews was 4, 6 and 12 months. The participants before the peer support intervention were given training in the kidney foundation training Programme Canada. The result found the after exposed to training Programme, the renal peer support volunteers enhanced and maintained their own psychological well-being as well as the other kidney failure patients.

Thompson, Eggert, and Herting (2000) probed a study on youth suicide and depression risk behaviours. The study checks the prevention of these risk behaviours when explored to intervention processes. The intervention which was given is peer group support, teacher social support and mediating effect of personal control. The research was divided into two experimental and one control group with 106 high risk youth. It was seen peer support group and teacher social support has direct/ indirect effect on personal control suicide and depression rick behaviours.

Simpson et al. (2014) explored a pilot study in UK on mental health patients who have been discharged for hospitals. The total 46 participants has been included in the sample for study, who were divided into two groups 23 receives peer support and 23 as usual care. The result found no significant difference between hope, quality of life and hope in mental health patient after the discharge from hospitals.

Mentis et al. (2015) did an intervention study on psychopathological characteristics among the individuals who are caretakers of patients with psychosis i.e. the families of the patients who bears the psychotic patients. Two groups were created from these caregivers one intervention group and other non-intervention group. The result suggest that caregivers who did not received the peer support group intervention show higher level of psychopathological characteristics on many dimensions like depression, anxiety, hostility, interpersonal sensitivity and paranoid ideation.

Rusch et al. (2019) conducted a study on the unemployed people who seek help from the peer led groups. These unemployed people were suffering from the mental health problems. Peer led intervention program were received by these persons. Total samples of 42 participants were selected and randomized controlled groups were formed to these people. Data were collected at baseline (T0), 3 weeks (T1), 6 weeks (T2) and 6 months later (T3). The result finds that the unemployed people show improvement in depressive symptoms and recovery from the mental health problems.

Sledge et al. (2011) conducted a study as to investigate the feasibility and effectiveness of using peer support in reducing the repeated psychiatric hospitalizations admissions. The sample of the research were the patients of the age of 18 years or older with suffering from major mental illness problems. The researcher used randomized controlled design, in which seventy-four patients were selected as the sample of the study, 36 patients as randomly allocated to usual care and 38 patients randomly assigned to peer mentor and usual care,

along with the follow-up at nine months. The findings suggest that regardless the limitations of the study; the use of peer support intervention yields the promising results in reducing repeated psychiatric admissions in hospitals for patients.

Metel and Barnes (2011) explored a research of peer-group support on the children whose parents are departed. The researcher wants to assess the views of children and parents on bereavement experiences and the importance of peer group support interference. Qualitative interview methods were used by the investigator in order to collect the evidence from the respondents. The twenty five children (15 girls and 10 boys) and 17 parents (14 mothers, 3 fathers) were available as sample and the age range of sample were 8-17 years with mean age of 12.5 years. Children and parents were conducted the open ended interviews with no distraction or disturbances. The result showed that the children who have developed the feelings of social isolation from the bereaved experiences can be removed by practicing peer-group support and help them to develop coping strategies.

Pfeiffer, Heisler, Piette, Rogers, and Valenstein (2011) did a research on peer support interventions and its effectiveness on depression. The researcher used the meta-analytical method in the study in which seven randomized controlled trials of peer support vs. usual care for depression involving 869 participants were identified. Pooled standardized mean differences (SMD) in the change in depressive symptoms checked between study conditions. The result delineates those participants who exposed to peer support interventions showed in more improvements from the depressive symptoms than usual care and may have similar efficacy to group cognitive behavioral therapy.

Webel, Okonsky, Trompeta, and Holzemer (2010)conducted a systematic analysis on the effect of peer led intervention on different health related behaviour of adults. The review find that peer based intervention led changes in different health related behaviours, smoking, condom use, and physical related problems among adults.

Dennis et al. (2009) directed a study of peer support on high risk postnatal depressive women. From the screening of 21470 women, 701 were selected for the sample of have high risk of developing postnatal depression. Edinburgh postnatal depression scale and internet based service has been used for the data collection in the research. The 12 weeks to 24 weeks follow-up intervention were given to the participants. The result show that out of 221 women who receive the peer support 80% were satisfied with the intervention and said they would endorse this support to their colleague.

Research suggests that peers sometimes can be risk factors to develop the mental health problem among the adolescents. But school support and parental support can be protective factor for the peer victimization adolescents. It has also been seen that parent support alone can helpful to reduce maladjustment problems among the adolescents (Stadler, Feifel, Rohrmann, Vermeiren, & Poustka 2010).

Sokol and Fisher (2016) did a systematic review on the peer support intervention. The total 47 studies included in the review in which intervention was given child health, diabetes, mental health problems, maternal health and other chronic disease. The review concluded that peer support is broad technique of intervention, where other health facility fails to touch. The review finds that due to the flexibility of the peer support into different contexts had made it successful for health problems.

Ussher, Kirsten, Butow, and Sandoval (2006) executed a study on patients suffering from cancer in Australia. The study was to check the experience of peer support on patients battling from cancer. It was a qualitative study in which questions were asked to the peer support groups and attendant groups regarding the support they giving or providing to these cancer patients which other do not provide. Peer support groups were positioned in such a way so that they will give unconditioned sense of community, recognition and information about cancer and its treatment, in the meantime the other were giving the sense of loneliness, refusal and lack of information about the cancer. Support group were provided help for the family also because they are bearing the burden of these cancer patients. The result find that cancer patients got improvement in confidence , sense of control on self, alive with cancer and contact with others. The result also finds no significant difference between professional and peer led group support and suggests that future study should be done on social support. A systematic review done on substance abuse and co-occurring mental illness, the review find that peer group support is helpful for the people with mental illness and substance abuse, but it is not mostly available for the people suffering these problems (Monica, Nikkel, & Drake 2010).

Hoybye et al. (2010) performed a study on internet based peer support group intervention and its effect on the psychosocial adjustment on the cancer patients. The researcher selects the randomly 58 rehabilitation course weeks and 921 cancer survivals in the study. The intervention was given online through online by internet support groups in lecture form. The result displays that intervention affects the mood disturbance and adjustment in cancer

survival patients 6 months follow-up, but shows reduction after 12 months follow-up. The researcher concludes that further investigation needs be done on Internet-based support groups as to confirm its long-lasting psychological effects.

Albrecht, Payne, Stone, and Reynolds (1998) probed an investigation on effect of the peer support in smoking termination among pregnant adolescents. The researcher develops the three groups' i.e. adolescent group with giving peer support (experimental group), adolescent group without peer support (control group) and adolescent control group with usual care. The sample of the study was 84 subjects selected from the local prenatal clinic and schools and it was that total 46 participants accomplished the post-intervention assessment of smoking status. The result found that intervention group showed significant decrease in smoking in all the dimensions, when compared to the other groups.

Simmons et al. (2015) conducted a research on peers support and patients suffering from type 2 diabetes. A total 1060 were included in the research by grouped them into 100 clusters. The mean cluster size was 10.6 and total clusters were 130. The researcher giving them peer support 8-12 months by trained peer support facilitator. The result find small difference in blood pressure and no significant difference in diabetes stress, quality of life, waist and total cholesterol and weight among these patients. The result also suggests that long term effect should be examined.

Again a pilot research conducted by Dennis (2003) on the intervention of peer support on postpartum depression among women. Forty two women recognized as postpartum depression PPD were taken as sample in the study by the researcher. Edinburgh Postnatal Depression Scale (EPDS) were used to assess the depression among these women and separated into experimental group and control group. Peer based intervention were given through telephone after the 48-72 hours of randomization. Intervention has been given at 4 to 8 weeks after the assessment of PDD. The result found that out of 24 mothers, 16 in the experimental group showed the considerable improvement in the decrease of depressive symptoms and were contented with the peer based intervention.

Vaughan, Foshee, and Ennett (2010) attempted a study on protective effect of peer support and maternal support on depressive symptoms on adolescents. Data was collected in five waves and in wave I complete data were attained from participants, wave II 75% gave complete data, wave III 71% deliver full data and in wave IV and V, 61% and 54% deliver full data respectively. On the inclusive criteria, the final sample of the study was 3444

children, representing many ethnic groups like black, white, Hispanic etc. The researcher used multilevel modeling to assess the effect of peer support and maternal support within and between persons. The result found that peer support predicts depressive symptoms between person levels at the age of 12, but this effect becomes ineffective by the advent of maternal support. The result further indicated that within-person the effects of peer support did not vary on the basis age, gender, or race.

Repper and Carter (2011) conducted a systematic review on peer support in mental health services. The aim of the article was to review literature related to peer support in mental health services. The researcher collected all the studies related to peer support in the development of mental health and summarized them. The result demonstrated that peer can be helpful in the development of mental health. The result suggested that careful training, management and supervision are required for peer support workers.

Kaponda et al. (2009) led a research study on attitudes, HIV related knowledge, personal behaviour and the impacts of a peer-group intervention among the urban hospital workers in Malawi. The intervention was received by the 850 hospital workers. The result found that after the post-intervention health workers shown positive attitude, more knowledge, less stigmatization, more hope, higher knowledge of HIV transfer and prevention, open discussion with partners regarding HIV, more positive attitude towards HIV testing and condom use. But the result indicated that no difference in unsafe sexual behaviours at baseline and post-intervention in health workers.

Rowe et al. (2007) demonstrated a study that group intervention and peer support reduces the criminality and substance abuse among individuals with severe mental health problems. The study compares the effect of two interventions i.e. peer support and group intervention on the sample of 114 adult with severe mental health issues. The researcher used the 2×3 factorial design with randomized controlled trials were given with two levels of intervention (group and peer support). The participants received six to twelve months of intervention and the drug and alcohol use were assessed self- report questionnaire. The result found that experimental group show high reduction of alcohol use than non-experimental group. Further result showed that criminal acts and drug use have decreased in both groups at high level. The study suggests that this intervention program was promising to yield positive outcome of alcohol use of persons with severe mental health problems.

Sells, Black, Davidson, and Rowe (2008) explored a study on peer led and traditional service for the individuals with severe mental illness. The researcher selected 137 adults with severe mental illness as sample in the study and assigned them randomly for traditional or peer based intervention. At 6 to 12 months service was given to them and data were collected through self-report questionnaire on the quality of life, hindrance to recovery and perceived positive regard, unconditional acceptance and empathy with their providers. The outcome of the study revealed that peers who reveal their mental illness experience to their clients, were perceived to be more promising and was favorable at 6 months not at 12 months. A form of invalidation has been sometimes expressed both peers and traditional provider due to the attitude and behaviours of the clients. Researcher further find that early providing of peer support may be effective of fostering progress in clients attitudes behaviours and values.

Boisvert, Martin, Grosek, and Clarie (2008) explored a study on peer support community intervention on the substance addiction recovery in adults. Eighteen adults with the age range 19-16 years were participated, but only ten participants completed the full nine month intervention process. Researcher adopted medical outcomes study support survey (MOS-SSS-Gust,1982), quality of life rating scale (QOLR) developed by Sherbourne and Stewart (1991), and the Volitional Questionnaire 4.0 (VQ) developed by Delas Heras et al., (2003) as an instrument for the data collection in the study. The result of the study found significant effect of peer support community in the recovery from substance abuse addiction, homelessness and significant reduction in relapse in the participants who were included in the intervention.

Travis et al. (2010) probed a telephone based pilot study of mutual peer support intervention for depressive individuals. A total 44 participants with depressive symptoms or functional impairment problem were joined as a sample and among them 32 participants (59.3%) completed the intervention process. The intervention process continues at 12 weeks and at least one call was received by participant in a week, with the mean call length of 26.8 minutes. The result showed that participants found support and meaning of their life when interacted with their partners and telephone based mutual peer support found to be effective in dealing with depression, disability, psychological health and quality of life among the individuals suffering from these problems. The study suggests that longer trails should be provided to assess the effectiveness and efficacy of this promising intervention technique.

Castelein et al. (2008) did a study on patients of psychosis, as to find the effect of peer support group intervention on social network, quality of life, self-esteem and self-efficacy. It was the multi-center randomized controlled study in which the researcher exposes the selected 56 participants for peer support and 50 participants were taken as control group. The data were collected from baseline to eight months of intervention process. The result found that people suffering from psychosis, peer support groups are a useful intervention for by improving their social network.

Verhaeghe, Bracke, and Bruynooghe (2008) explored a research on the role of peer support from the recovery of mental illness. The samples of 595 clients were selected from the rehabilitation centers. Experiencing when peers support, it was found that clients show positive comeback from the stigmatization and minimizes the negative thoughts of stigmatization.

Bryan and Arkowitz (2015) did a meta- analytical study of peer administered interventions effect on the depression symptoms. The researcher selected twenty three eligible studies in his study, random-effects model and mixed effect model were used to compare mean effect sizes, and test for moderation respectively. The result shows noteworthy reduction in pre-test score and post-test score, which indicates lessening depression symptoms. When follow-up data became available for the researcher, the result indicated that peer administered intervention benefits were maintained and warrants further study in the future.

Peterson, Bergstrom, Samuelsson, Asberg, and Nygren (2008) investigated a study on the effect of peer group support intervention on work related stress and burnout among the health care workers. The researcher selects the 151 total participants among 660 individuals as a final sample of the study. The participants include nurses, psychologists, physicians, dentists, occupational therapists, physiotherapists, administrators, teachers, technicians and hygienists. Ten weekly sessions were provided through meeting, each session lasts two hours and follow-up meeting after four weeks among intervention group. The researcher guided them to relax for 10 minutes before the start of all sessions and after the session ends the researcher encourage them to continue meeting. The responses from the participants were gathered with the help of General Nordic Questionnaire for Psychological and Social Factors at Work (QPS Nordic), Hospital Anxiety and Depression Scale (HAD) and Oldenburg Burnout Inventory (OLBI). The result found that peer group support intervention showed useful tool in relieving work-related stress and burnout among the health care workers in Sweden.

Colella and King (2004) probed a theoretical based review study on peer support and recovery from cardiac arrest patients. For the demanding characteristics of the study the researcher finds the current and related literature, which supports the cardiac surgery recovery, transitions, peer support interventions and social support. The conclusion of the study finds that peer support is a feasible and possibly sustainable intervention technique that can be used as tool during changing life events like recovery from cardiac surgery.

Verhaeghe, Bracke, and Bruynooghe (2008) examined a study on the role peer support in developing self-esteem and eradication of stigmatization among the individuals who are dealing with mental health problems. The random sampling technique were used as the selection of the sample, through which 595 participants were chosen from 56 rehabilitation centers, among them 380 were men and 215 were women with the age range of 18-80 years. Self-esteem and stigmatization were measured by self-esteem scale of Rosenberg's and Stigmatization scale of Fife and Wright (2000). The result indicated that stigmatization and self-esteem are negatively correlated to each other. The result also found that peer support reduces the negative relationship between stigmatization and self-esteem and can form the constructive relationship between peers.

2.2 Internalizing and Externalizing Behavioural Problems

El-Slamoni and Hussien (2019) explored a study on depression and aggressive behaviour among the female orphan children living in the orphanages at Tanta city of Egypt. It was the Cross-sectional study in which the researcher picks 94 female children from three orphanages of Tanta city. The age range of the sample was 10-18 years and data were gathered through depression scale constructed by Elbasiony (2006), aggression scale developed by Mounir (1983) and through interview. The result depicted that female orphan children living orphanages showed the higher levels of depression and aggression and needs to be intervened to deal with these behavioural problems.

Shafiq Haider and Ijaz (2020) examined a co-relational study on the orphan and non-orphan adolescents in Pakistan. The aim of the study was to assess the decision making capability among the orphan and non-orphan children, who are dealing with anxiety, depression and stress. The sample of the study comprises 150 orphan and 150 non-orphan children, selected from different orphanages and schools of the Lahore city of Pakistan. The researcher used depression, anxiety & stress scales (DASS) and the adolescent decision making questionnaire (ADMQ) as a tool for the collection of responses from the participants and for the analysis of

data mean, SD, regression and independent 't' test were employed. The result shows the anxiety is more common among the orphan than non-orphan children and further the result concluded that anxiety, depression and stress are positively associated with the decision making.

Thapa (2020) delved a study comparative study on orphan and non-orphan children on self-esteem and depression in Nepal. The investigator employed convenience sampling technique and selects 40 orphan and 40 non-orphan children as a sample of the study. The tools used for data collection are Rosenberg's self-esteem and children's depression Inventory and were analyzed with the help of't' test. The result finds significant difference between orphans and non-orphan children in the levels of depression and self-esteem. It was found that orphans are dealing with high levels of depression and low levels of self-esteem compared to children who are living with their parents.

Kaur, Vinnakota, Panigrahi, and Manasa (2018) conducted a study on the behavioural and emotional problems on orphan and vulnerable children who are staying in institutional homes at Visakhapatnam city Andhra Pradesh. The researcher selected 292 orphan and vulnerable children as sample of the study. The researcher used strengths and difficulties scale and socio demographic scale to collect the behavioural, emotional and personal information respectively. Results was drawn out on the basis of age, sex, years they spending in the institution, age of the admission etc. The study found that orphan children and vulnerable residing in these institutions are prone to behavioural and emotional problems. The study further indicated that several multicenter studies should be done as to get the comprehensive outlook of these problems.

Khurshaid, Mahsood, and Kibriya, (2018) probed a study on adolescents who are taking shelter in orphanages, due to death of their primary caregivers i.e. parents in Peshawar, Pakistan. In the current study the researchers take in consideration frequency and causes of behavioural problems among orphans living in orphanages. The study comprises the sample of 360 adolescent orphans; among them 334 were boys and 26 were girls with the range of 10-19 years. The data regarding the behavioural problems were collected through strengths and difficulties questionnaire. The result found that the rate of behavioural problems among these children were 33.9%, with highest prevalence of conduct problems 24.4%, peer problems 18.8% and hyperactivity 8.3%. The result further delineates that the determinants of these behavioural problems were status of parents before death, gender, age and type of

orphanage among these children, but the duration time of initialization and age of parents did find any significant effect on behavioural problems.

Bano, Fatima, and Naz (2019) delved a research study on orphan children residing in orphanages of Gujarat, Pakistan on the psychological problems and stigma as its predicting factor. It was the correctional research study in which the researcher takes 200 children as sample with the age range of 12-17 years. The researcher practices the purposive sampling technique and data were collected by orphan stigma scale, revised children's manifest anxiety scale, conduct disorder scale and depression scale for children. The result found that being an orphan perceived as a stigma is a significant predictor of depression and anxiety, but the stigma was not predicting factor of conduct disorder among the orphan children. It can be said that orphan children living in orphanages have depression and anxiety, but there is absence of conduct disorder.

Nsabimana, Rutembesa, Wilhelm, and Martin-Soelch (2019) examine a comparative study on children living with their parents and children who are dealing with bereaved experiences, as to assess the effects of institutionalization on the well-being and psychological adjustment among these children. The total of 178 children were included in the sample, among them 94 children are living in institutions and 84 children living with their families, among the children who lived in institutions 34 children were lost both of the parents, 14 children were lost one of the parent and 46 children are those whose parents are alive. The children who are living with their family among them 16 children were lost both of the parents, 9 children lost one of their parents and remaining are non-orphans. The responses were collected with child behaviour checklist and Cooper Smith self-esteem inventory. The result found that children living in institutions showed more levels of externalizing behavioural problems than children who are living with their family. Additionally non-orphan showed more externalizing behavioural problems than orphan. The result found no difference in levels of internalizing behavioural problems among the children living in institution and children living in with their family.

Bhat et al. (2015) probed a research on mental health issues on adolescent orphan children who are residing under the institutionalized setting in Kashmir. The study revealed extremely shocking results i.e. eleven participants (13.75%) are suffering DSM 1V criteria for MD, 6.5% children reported of having suicidal tendencies, 11.25% portrayed dysthymic symptoms, 10% revealed panic disorder, 20% are suffering from agoraphobia, 7.5% are

dealing with separation anxiety disorder, 16.25 % with social phobia, 15% specific phobia, 6.25% of having PTSD symptoms, 1.25% substance dependence (Non -alcoholic), 3.75% depicted ADHD, 1.25% showed conduct disorder, 3.75% ODD, 8.75% GAD and nineteen participants i.e. 23.75% showed co-morbid conditions.

Vinnakota and Kaur (2018) investigated a study on adolescent children who are living in institutional setting in Vishakhapatnam city Andhra Pradesh. It was the cross sectional study in which the researcher measures the externalizing, internalizing behavioural problems and depression among the adolescent children of institutional care. The researcher includes 150 children as a sample of the study and screening for depression patient health of questionnaire was used and to assess the internalizing and externalizing behavioural problems strengths and difficulties questionnaire were used. The result found that 12.75 % and 19.3% children showed severe and mild depression respectively. It was also found that on the basis of gender girls depicts higher level of depression than boys and children who were academically weak portray higher rate of depression that those children who were academically better. The result further showed the internalizing and externalizing behavioural problems among these children and was found positively correlated with depression, but there were negative correlation with pro-social behaviour.

Shiferaw, Bacha, and Tsegaye (2018) investigated a study of orphan children in Ilu Abba Bor Zone of South West Ethiopia. It was an institutional based cross-sectional study in which Depression and its associative feature assed by the researcher, with taking the sample of 220 orphans from two orphanages of Ilu Abba zone. The researcher used the semi-structured questionnaire as a tool for interviewing as to collect the data from participants data. The result depicts the high pervasiveness of depression among the orphan children. Psychological and mental health intervention should be incorporated for these children in orphanages.

Safdar (2018) delved a comparative study of orphan girls and orphan boy on the depression and self-esteem in Rawalpindi Pakistan. The researcher adopted the random sampling technique, through which 150 girls and 150 boys with the age range 10-15 years were selected as the sample of the study. Self-esteem scale (Rifai, 1999) and childhood depression scale constructed by Musarrat Jabeen (2005) were administered to obtain the responses from the participants of the study. The result finds that girls who had bereavement experiences show higher levels of depression, than boy orphan children.

Sahad, Mohamad, and Mohamad (2018) carried out a comparative study in between orphan and non-orphan adolescent children in Malaysia. The researcher has taken a total sample of 480 adolescents, in which 240 are the children of having bereavement experiences living under institutional care and 240 children living under the parental care. The multi-stage sampling was used in the selection of sample and the age range of the sample 13-17 years. The validated Malay version of depression, anxiety, stress scale 21 item (DASS21) were used to collect the responses from the orphan and non-orphan children. The result clearly delineates difference in mental health problems between the groups, in which higher levels of depression, stress and anxiety showed in orphan childrens than their counterparts non-orphan children. The result further revealed that all orphanages including Government funded and NGO funded need to implement intervention programs as to ensure better mental health among orphan children in Malaysia.

Musisi, Kinyanda, Nakasujja, and Nakigudde (2007) delved a comparative study on the primary school-going orphans and non-orphans of the behavioral and emotional disorders in Uganda. To compare the behavioural and emotional problems, a cross-sectional unmatched case control design was employed by the researcher during the research. The study bears 210 primary school-going orphans and equal number of non-orphans as the sample of the study, by using random method of sampling. Both qualitative and quantitative methods were used for data collection, by employing standardized questionnaire, informant interview and focus group discussion. The study revealed that orphan has more emotional and behavioural problems compared to non-orphans. The study further reveled that orphans were more prone to be emotionally dependent, feeling insecure, poor, exploited, being abused, or being neglected than non-orphans.

Bhat (2014) investigated emotional stability and depression among orphan and non-orphan children of secondary school students in Kashmir. The researcher uses the purposive sampling technique in the present study, which consist 210 secondary school students of them 131 are orphans and 79 are non-orphans with age range 13-17 years, taken from different schools and orphanages. The result of the present study discovers significant difference between these groups in emotional stability and depressive levels. The outcome result indicated that orphans have more levels of depression and low levels emotional stability as compared to their counterpart's non-orphan secondary school students.

Naqshbandi et al. (2012) did a qualitative study among the orphans taking shelter in orphanages of Kashmir. The data were collected by using interview schedule from the respondents. The study highlighted out the result that most of the orphans residing in the orphanages of Kashmir are suffering from psychological problems and it was also found that they face difficulties in adjustment among the societies after discharging from the orphanages. The study also shows that increasing number of orphans in the valley is because the rising of army conflict.

Lassi, Mahmud, Syed, and Janjua (2010) conducted a study on behavioural problems of children living conventional orphanages and SOS Village in Karachi Pakistan. It was cross-sectional study in which 330 children with the age range of 4-16 years were taken as the representative of the study, residing in an SOS or other traditional orphanages of Karachi. When compared to overall behavioural, the study revealed the prevalence of behavioral problems was 33% among the groups. The study further indicated insignificant difference among the groups in the overall behavioural problems.

Hermenau, Eggert, Landolt, and Hecker (2015) explored a comparative study among orphan and non-orphans in Tanzania. The researchers want to assess the psychological distress in context neglect and perceived stigmatization among orphan and non-orphan children. The objective of this study was to thoroughly probe orphans' who are experiencing maltreatment, stigmatization and to detect causes which led them psychological distress. The sample of this research was 178 Tanzanian children, who were divided into two groups i.e. (89 orphan children and 89 non orphan children) with 51% boys. The study observed that orphans share high levels of PTSD symptoms, depressive symptoms, and aggressive behavior thane living with their primary caregivers.

Chakraborty et al. (2015) probe a research on orphan and non-orphan on psychosocial study of aggression, attachment styles and personality among orphans and normal children. The representative of this study comprises 120 children, with equal number orphan and non-orphans i.e. 60 children. The tools used in this study was specially designed information schedule, State-Trait Anger Expression Inventory - 2 TM Child and Adolescent (STAXI-2 TMC/A) by Brunner and Spielberger (2009) etc. to assess anger as a precursor to aggression. The result revealed that orphans showed anger- expression out aggression were as non-orphan children shows anger-expression in aggression.

Rather and Margoob (2006) carry out a study of girl's orphanages in Kashmir by using DSM-IV guidelines. Two trained psychiatrist were selected for the examination of these children in the orphanage setting. To identify the children dealing with psychological problems, researcher used the mini-kid screening technique. Through this technique, from the 76 childrens 32 children was identified of being psychologically ill. The Results of the study found that PTSD is most commonly found psychiatric disorders among these children (40.62%), the next common psychological problem were diagnosed were major depression disorder (25%), followed by conversion disorder (12.5%). The researcher mainly attributed these causes in the state, due to the prevailing mass trauma almost last two decades.

Hermenau, Hecker, Ruf, Schauer, Elbert, and Schauer (2011) investigated pretest and post test results on childhood adversity, mental ill-health and aggressive behavior in an African orphanage. The findings showed that due to ongoing violence experienced by the orphan childrens residing in theses orphanages are indicating the positive correlation with the aggressive behavior of the children. The study further discovered that with the implementation of psychotherapeutic treatment and new instructional system, there is massive decline in the severity of PTSD-symptoms and violence exposure. The study further revealed that there is little decline in internalizing and externalizing problems and depressive symptoms among these childrens.

SG, G, SP, V, and Dandona (2016) performed a research on AIDS orphan and other orphan children in southern India. The sample of this study was 400 orphaned children (200 from AIDS orphan and 200 from other orphan children) with the age range 12–16 years residing in orphanages in and around Hyderabad city in southern India. The center for "epidemiologic studies-depression scale (CES-DC)" was used to assess depression and other related risk factors. The difference in the strength of depression was assessed using multiple classification analysis (MCA). The result showed that there is depression among both of them, but the AIDS orphaned children share higher depressive symptoms than the orphaned children of other causes. It was also revealed children orphaned by AIDS were being frightened by friends or relatives (50.3%) and are facing discrimination (12.6%) than those orphaned due to other reasons.

Sushma et al. (2014) carry out an explorative research among children under institutional care. The objectives of this study were to determine the level of internalizing problems, emotional symptoms, externalizing problems and to explore the level of depression among

institutionalized children. The sample of the study was 40 children (22 boys and 18 girls) between the age group of 12-15 years were included through purposive sampling. Strengths and Difficulties Questionnaire and Adolescent Well-being scale were used to collect the responses from the representative sample. The result shows that among internalizing problems, level of emotional symptoms and level of hyperactivity were in the normal range. But among externalizing problems, conduct problems were above the normal range and peer problems were in the normal range.

Merz and McCall (2010) did a research on behavior problems in children adopted from psychosocially depriving institutions. The sample of this study was 342 children with the age range 6-18 years, selected from Russian institutions, which help them to provide suitable physical resources, but not reliable as responsive care giving. The result indicated that children adapted by these institutions portray commonly attention and externalizing problems as a whole. The result further indicate that frequency of behavioral problems are increased with age at adoption, such as children adopted at the age of 18 months or older had higher rates than children who have not been institutionalized, but younger adopted children did not.

Koul and Shaker (2014) conducted a study on orphanhood, mental health and difficulty in emotion regulation of children in Jammu and Kashmir with 100 sample size, of which 50 were orphan and 50 participants were non orphan. After the analysis of data the result showed that orphans face more psychological problems, which effecting their mental health. The result also indicated that orphan children have emotional problems compared to their counterpart's non orphans.

Salifu Yendork and Somhlaba (2014) did a research on orphan and non-orphan children in orphanage of Ghana Africa. It was an exploratory study on quality of life, stress, symptoms of anxiety and depression and coping among orphan and non-orphan children. The sample of the study was 200 children, grouped into two parts 100 orphans (experimental group) taken from four orphanage and 100 non orphan (control group) taken from public schools. The age group of the sample was 7-17 years. The result showed that orphan children have anxiety symptoms compared to their counter parts non-orphans. The data further exposed that no depressive symptoms were found in orphan compared to non-orphan on overall quality of life.

Doku (2009) investigate a study on AIDS orphaned children, children whose parents are suffering from HIV/AIDS, children whose parents died due to the other causes and non-

orphaned children, whose parents are free from AIDS disease. It was actually cross sectional study with the sample 200 children divided into four groups. The age group of the sample was 10-19 years by strengths and difficult questionnaire. The study found that both the children orphaned by AIDS or other cause show high conduct problems and low hyperactive problems. The study further revealed that all the groups have high emotional problems except non-orphan group.

Atwine, Cantor-Graae, and Bajunirwe (2005) performed a research on AIDS orphans and non-orphans of one or both parents died in Uganda's rural area with the sample of 233 of which 123 was orphans and 130 non orphans. The age of the sample was 11-15 years. Becks youth inventory were used to assess the anxiety, anger and depression. The multivariate analysis showed that orphans had higher risk of depression, anger and anxiety than non-orphans. The result further indicated that orphans are sensitive to depressive symptoms, suicidal ideation, and feeling of hopelessness. Furthermore it showed that material support not enough for these children. Another study has been done on AIDS orphans by oxford university UK. The study was actually done in Cape Town South Africa. The researcher takes 1025 participants in this research with the age group of 10-19 years from different urban population of South Africa. The outcome revealed higher risk of developing mental health problem like depression, PTSD and behavioral problems among both orphans due to other causes and orphans due to AIDS with the association of stigma. The result further revealed that AIDS orphan children have higher level of delinquency and internalizing behavioural problems, but conduct problems has been seen low (Cluver, Gardner, & Operario, 2007).

Kirkpatrick, Rojjanasrirat, South, Sindt, and Williams (2012) have done a study on emotional status assessment of Zambian orphan children. The sample of the research was 306 orphan children (156 boys and 150 girls) of the age group 6-12 years and 158 primary care givers. The conclusion of the finding shows most of the children show the signs of emotional distress like having terrifying dreams, angry, prefer to be alone, unhappy, neglect to eat something.

Colderbank (2009) completed a research on orphan children in Haiti on social support and behavioural outcomes. It was actually a co-relational study between social support and behavioural outcomes among orphans. The sample of the study was 52 orphans dived into two groups male and female. The result showed that females have more problems like anxiety, depression, withdraw problems, thought problems somatic problems, aggression,

internalizing and externalizing problems compared their counterparts. In contrary male have been seen more social problems compared to females.

Thurman, Kidman, Nice and Ikamari, (2014) performed a study on orphan and vulnerable children in Kenya. The sample was of the study 2487 caregivers and 3423 orphan and vulnerable children from central Kenya. The analysis was done on the basis of loss of parents or illness in association with externalizing behaviours and family functioning. The result found that significant difference between parental illness and externalizing behavioural problems in both male and females. The result further indicated that orphan children have behavioural problems but mostly among girls**.**

Chi and Li (2012) did a systematic review on HIV/AIDS orphan children and orphans of other causes. In this review data from 30 studied were obtained. The of the these findings suggest that children who become orphans due to AIDS and vulnerable children show low psychological well-being compared to the children who had become orphan due to other causes. The review also finds that psychological well-being is also stimulated due to persistent long HIV infection in parents of children and such effects remains after death. The review further recommends that suitable interventions should be given in order to develop psychological well-being among these children. Effected

Erol, Simsek, and Munir (2010) probed a research in Turkey on mental health and hope of adolescents reared and cared in institutions. It was actually cross sectional study with the sample of with the sample of 360 of which 163 males and 180 females of the age group 11-18 years. The findings show that children reared in institutions have higher rates of internalizing, externalizing and social problems. Again problem of delinquency, aggression, thought problems, and attention problems were reported from these children. The research further revealed that many factors like smoking, alcohol and fatalistic views enhance these problems significantly.

Salifu Yendork, and Somhlaba (2015) conducted an explorative study on orphan and non-orphan children in Ghana. The sample of the study consists of 100 orphan children and 100 non orphan children of the age group of 7-17 years selected from different orphanages and public schools. The result revealed that 41% of orphans show depression of which 32% orphans show mild depression and 9 % show severe depression. The result further indicated that non orphan also have depressive symptoms. In this research significant difference of anxiety symptoms have also been found in orphans and non-orphans. The important thing

that researcher revealed in the research was that orphans mostly perceive there support from their friends and non-orphan perceive from their family.

Bazezew (2014) did a study on orphans caring management in Ethiopian capital Addis Ababa. The researcher used both qualitative and quantitative method in the study. The findings revealed that orphan children headed by household show the deficiency of emotion and material needs and things that spring the sense of social and cultural life in the children.

Fawzy and Fouad (2010) probe a research in Egypt on developmental and psychosocial status among orphans of orphanage. The participants of the research were 294 orphan children selected from four different orphanages with the age group 6-12 years. Data has been obtained from the child depression inventory CDI, Rosenberg self-esteem scale and children manifest anxiety scale. The study find high rate of depression, anxiety, self-esteem and developmental disorders of orphans in orphanages.

Hawk and McCall (2010) conducted a study on the children who has been adapted after the institutionalized. It was a review based study which attempt to focus on 18 studies. The findings suggest that behavioural problems caused by the age of adaption, children who are adapted 6/18 months after institutionalization early age show more behavioural problems, especially attention problems, internalizing and externalizing problems. The study further revealed that most problems exposes during adolescence.

Iqbal (2012) conducted a study on street children in Pakistan. The study was done in three districts with the sample of 75 male children 25 children from each district. The result find that street children are suffering high level of externalizing behavioural problems (aggression, impulsivity) and internalizing behavioural problems (helplessness, depression, withdrawal, immaturity problems and inadequacy.

Degefa (2015) examined a case study on orphan children in Addis Ababa capital Ethiopia. The purposive sampling technique has been used in this study with the sample of 10 female orphans. Data has been collected through depth interview and discussion. The findings suggest that due to the death of the parent's, children has been admitted in the orphanages, which led them problems like the feeling of isolation and stranger in the society. The study further showed that by leaving from orphanage the orphan children lacks the skill to flourish and live effectively in the society.

Kodero (2000) performed a study on psychological status and education of AIDS orphan children in orphanages of Kenya. The sample of the study was 450 children of the age group of 6 to 15 years. The finding suggests that orphan children have good psychological and educational status in the orphanage, compared to caretakers, and families. The findings also revealed that how we deal these children can affect their psychological well-being, it means that attitude towards the orphan is important. One of the important suggestions given by this research is that peer support can be the best way to deal the psychological problems among the orphan children or to develop psychological well-being among the AIDS orphan children.

Ramagopal, Narasimhan Uma, and Devi (2016) did a descriptive study on children living in orphanage in Tamil Nadu and depression among these children. It was the cross-sectional study in which author selects 180 children as the sample of the study, with age range of 12-18 years. Data were obtained from the participants by using the Hamilton depression scale. The result describes that among the age group of 12-14 years 53% showed depressed features and among the age group of 15-17 years 46% displayed depression. Girl's shows high depression 52% than boys 48% and with growing there is decrease of depression. When examining the levels of depression 52% shows mild, 23% moderate, 14% severe, 9% with very severe and 38% children showed suicidal tendencies.

Nyamukapa et al. (2010) accomplished a research on reasons behind the psychological distress among the orphan children's in eastern Zimbabwe. A sample of 1469 children was taken as sample in the study. The sample was equally divided into material orphan, parental orphan, orphans whose both parents has died and non-orphan. Together qualitative and quantitative data collection technique were used in the study. The results found that orphans are suffering more psychological distress compared the non-orphan. The findings further suggest that psychological distress can be reduce if provided proper support like care giving , community based support and skill.

A research on children orphaned by Ebola conducted in Sierra Leone, West Africa, with the sample of 24 children selected from the Ebola affected families. The data were collected the thematic approach presenting drawing and captions and participants responses were collected. These responses then collected from the thematic approach to develop well-structured interview. The result found that Ebola is dangerous disease that developed stigma and fear among the people. This fear and stigma restrained the society or community to help

these Ebola orphaned children and has developed serious psychological consequences for these children (Denis-Ramirez, Sorensen & Skovdal, 2017).

Sengendo and Nambi (1997) conducted a study done in Rakai district of Uganda, as to assess the effect of orphan hood on the psychological health of orphan children. Case studies of total 193 children were taken as the sample in the study by the researcher. The result found that children who were adapted after the death of parents feel angry and depressed. The result further found that children living with their widowed fathers and those who are living with their own are more depressed. It was also found due to the death of parents early, orphans become the vulnerable or predisposed to many psychological and physical problems

Ruiz-Casares, Thombs, and Rousseau (2009) probed a study on orphan and non-orphan children in Namibia. Researcher was to assess the depressive symptoms among single and double orphan in comparison with the non-orphans. The researcher took 157 children as a sample with the age group of 7-21 years. Becks translated version of children depression scale were used to collect the data. The study found the proof that there are high rate of depression and mental health problems among the orphan children. It was also found that double orphans scores high on depressive symptoms as compared to single and non-orphans.

Kolayiş, Sarı, Soyer, and Gurhan (2010) did study of effect on anxiety and self-esteem of physical activities on orphans in Turkey. The sample of 25 orphans was taken in the study with the average age of 11 years. The research was pretest and posttest based, in which after the pretest 8 weeks of physical activities were practiced to the orphans. Data were collected through general anxiety scale and self-concept scale of Piers-Harris children's. The result found significant improvement in anxiety after the physical activities were practiced to these children.

MacKenzie et al. (2014) investigated a research on orphans in Jordanian orphanages. The researchers want to assess the effect of orphanage on behaviour and mental health of orphan children. The sample of the study was 134 children with the age of 18 months to 12 years. Internalizing and externalizing behaviour were assessed by using child behaviour checklist and DSM-IV oriented sub scales. The result found negative effect of orphanages on children with high level of affective disorder, conduct problems, social problems and pervasive developmental disorder. The result also found decrease of internalizing behavioural problems with the increase of age, but increase of externalizing behavioural problems with the changing age of the orphan children.

Gearing, MacKenzie, Schwalbe, Brewer, and Ibrahim (2013) probed a research done in Jordan, to assess the behavioural problems among adolescents cared in institutions. The participants of the study was 70 youths selected from four Jordanian care institutions with the mean age 14 years and date has been collected with the case history of children and child behaviour checklist. Entry in the institution was mainly because of orphaned or abandoned by parents. The result found that 53% of adolescents are suffering mental health problems. The result further find that 43% have high internalizing and 46% have high externalizing behavioural problems and females show high anxiety as compared to males, were male show high conduct problems compared to females.

Onuoha, Munakata, Serumaga-Zake, Nyonyintono, and Bogere (2009) examined a comparative study on AIDS orphans, orphans of other causes and non-orphans Uganda. Total 948 participants were included in the sample, divided into three groups i.e. 373 AIDS orphans (167 males and 206 females), 285 orphans of other causes (130 males and 155 females) and 290 non-orphans (113 males and 177 females). The age group of majority of the children was 10-17 years. The result revealed that AIDS orphaned children had highest indication of depression, child abuse, anxiety, social discrimination and negative mental health and it was also find that AIDS orphaned children has low self-esteem compared to other groups in the study. The result further revealed that children monitored by their parents show less negative and high positive mental health.

Bachman et al. (2012) conducted a research on orphan and non-orphan children in KwaZulu-Natal, South Africa. In this study 157 school going orphans and 480 non-orphans with the age group 9-15 years were taken as sample. The result finds low anxiety, depression, and self-esteem, oppositional behaviour in both orphans and non-orphans. The result further find that food insecurity, as an indicating factor higher depression, anxiety and perceived social support as helpful to reduce anxiety and depressive symptoms.

Makame, Ani, and Grantham-McGregor (2002) directed a comparative study on the population of orphan and non-orphan children with the construct of psychological well-being in Dar El-Salaam, Tanzania. A total 82 children were participated in the sample of which 41 are orphans and 41 taken as non-orphans, of the age range 10-14 years. Data were collected through internalizing problem scale in which most items were taken from Becks depression inventory and Rand Mental Health Inventory. The study found that orphans has higher

internalizing behavioural problem as compared to non-orphans and reported ideation of suicide attempts.

Kaggwa and Hindin (2010) carried out study on the psychological effect of orphanhood in Mukono, Uganda. The researcher takes 1500 children in the sample, which then reduced to 1309 (665 male and 644 female) children. The result that found orphanhood leads to many psychological problems in these children. High depressive symptoms have been found in male double and male maternal orphan. It was also found that between orphaned female and non-orphaned female show no significant difference in depressive symptoms and psychological effect of orphanhood very according to the gender and the type of outcome.

Pelton and Forehand (2005) examined a study of AIDS orphans on problem behaviours. The sample of the study was 105 children whose mothers were suffering HIV, children whose mothers are not infected and children who were orphans, equally divided into groups i.e. 35, with the age range 6-11years. Child behaviour checklist was used to assess the behavioural problems. The result found that orphans children have more internalizing and externalizing behavioural problems.

Simsek, Erol, Oztop, and Munir (2007) did a study on behavioural and emotional problems of children living or cared by orphanages. In this study 674 children were selected as sample by using stratified sampling technique, with the age group of 6-18 years nurtured or cared in orphanages. The researcher compared the two groups of children, one nurtured in orphanages and one in family setting. Youth self-report child behaviour checklist, teacher report and demographic sheet were used to collect the data. The result revealed that children under institutional care have prevalence externalizing and internalizing behavioural problems, but externalizing behavioural problems are higher. Again the result found that children under family care show low attention problems, thought problems and social problems compared to children cared in orphanages. The result further exposed that recurrent physical illness, fatalistic beliefs, feeling of stigma, abuse neglect etc. are reasons behind these psychological problems.

Onuoha and Munakata (2010) probed a study on psychosocial health of AIDS orphan, orphan of other causes and non-orphans. There researcher select total 952 children in the sample, by dividing them into three groups AIDS orphans(185), orphans of other causes (475) and non-orphans (292) with the mean age 13.59 years. The result showed that AIDS

orphans boys have highest psychosocial distress, same as in girls. However no significant differences were found within group on the basis of gender.

Collishaw, Gardner, Aber, and Cluver (2016) investigated a study on children with bereaved experience. It was a longitudinal study and the sample of study was 655 children, separated in three groups AIDS orphans, other causes orphans and children whose parents are alive with the age range of 10-19 years. The result showed little variation of mental health within gender, orphan and non-orphan groups. The result further discovered that better relationship with peers, of being less bullying, less exposure to community violence, able physical health and care giving facility develop resilience among children and sustain better mental health.

Nyamukapa et al. (2008) examine a survey based research to assess the psychological distress among orphan and vulnerable children in Zimbabwe. The survey was done on 5321 children between the age group 12-17 years. The result exposes that orphans experience more psychosocial distress compared to non-orphans. On the basis of gender, maternal orphans, parental orphans and double orphans have highest distress then non orphans.

He and Ji (2007) did a study on AIDS orphans children in china with the construct of psychological well-being, quality of life and nutritional status in Henan area. A total 186 children (93 AIDS orphans and 93 non orphans) were taken as the sample in the study of the age group of 8 to 15 years. By using regression analysis the result found that orphanhood is the cause of low self-esteem and high depression, which adds lower quality of life among orphan children. The result also found no significant difference among maternal, parental and double orphans.

Ahmad and Mohamad (1996) investigated a study on the orphans in Iraqi Kurdistan. The researcher exposes the Scio-emotional development of orphans cared in orphanages and traditional foster care after one year of their entry in these settings. In this study child behaviour checklist of Achenbach and other scales of PTSD were utilized by the researcher to collect the data among the respondents. The results find higher frequency of PTSD of orphans living in orphanage and children living in foster care.

Elegbeleye (2014) conducted a study on mental health of orphan children in southwest Nigeria. Researcher selected a sample of 400 children in which 200 were orphans and 200 were non-orphans with the age of 13 to 18 years. General health questionnaire (GHQ28) was

selected as tool to assemble the data among the participants. The study finds significant difference in mental health of orphans and non-orphan children.

Elebiary, Behilak, and Kabbash (2010) performed a study on institutionalized children's behavioural and emotional problems. A descriptive research design was employed and the sample of study was 114 children, separated from their parents living in institutions. An observational checklist and child depression inventory were used to gather the responses from the representative sample. The result showed that most of children have problems like difficult to form relationships or friendships with children, telling lie, shouting, stealing etc. The result also revealed that hyperactivity, withdrawal, aggressiveness, and disobedience problems among the institutionalized children.

Brand and Brinich (1999) attempted a study on the mental health and behavioural problems among children under foster care, adapted and non-adapted in United States. The sample of the study was 47485 households containing, 122310 individuals, which was then reduced to 11840 children with 5 to17 years of age. The sample was divided into three group's children adapted by non-relatives 188, children in foster care 37, and children living with at least one biological parent 10766. The result found that adopted and foster care children have more behavioural problems and mental health issues compared to children that are non-adopted.

Zhao et al. (2010) conducted a study on parental and maternal AIDS orphans in china on the variable of psychosocial well-being. A total 459 children who have lost single parent and are under family care were selected as the sample of the study. Many factors like depression, posttraumatic stress, social support, isolation, self-report health status were used to assess during the research. It was found that children have better health of his/her surviving parent have less or no depression, post-traumatic stress and loneliness than children having sick surviving parent. It was also found no differences in psycho-social health in terms of parental and maternal orphan.

Hong et al. (2009) attempted a comparative study on psychological distress and perceived social support among AIDS orphaned children, vulnerable children and children who are independent from HIV related illness and death of parents. A total 1625 children was selected as sample, separated into four groups double orphans 296,single orphans 459,vulnerable children (children living with HIV-contaminated parents) and normal children. The result found that perceived social support was the determining factor of the

psychological well-being among the groups and it was found that vulnerable children find less perceived support compared to other groups and are prone to psychological problems.

Wolff and Fesseha (1998) probed a study on orphans living in orphanages of Eritrea. In this study the researcher compared the mental health and cognitive development of orphan children living in two orphanage of Eritrea on the basis of care management and staff interaction. The total 80 participants, 40 from each orphanage were taken in the sample. The researcher used the staff organization questionnaire, behavioural symptoms questionnaire and child management inventory to gather the data from the sample. The result found that children who were inspired to become independent through personal interaction of staff members display lower behavioural symptoms of emotional distress, compared to orphans whose life decision were directly influenced by the rules, norms and schedules made by staff members of orphanages.

Attar-Schwartz (2008) investigated a meta-analytical study on emotional, behavioural and social problems among the children of residential care. The study is based on the data stated by the social workers of all children (4420) living in residential care setting headed by the welfare minster. Child behaviour checklist and measure were used to collect the data among the participants. The result shows that boys had more levels of aggression and low in depression/anxiety compared their counter parts girls. The result further indicated that children from two parent family and better contact with the family members show lower psychosocial problems.

Ptacek, Kuzelova, and Celedova (2011) conducted a research on children living in foster care, institutional care and children living with their biological parents. The researcher want assess the social and emotional loneliness among these children, which led to the problems in cognitive and emotional development. The sample of the study was (360) children divided into three groups i.e. foster care (120), institutional care (120) and biological parenting (120). The result of study finds that children under foster care and institutional care show serious problem in emotional and social development compared to children living with their parents. The outcome further suggested that these children need extensive psychosocial support for the proper development of emotional and social well-being.

Sushma, Padmaja, and Agarwal (2016) performed a study on well-being and psychosocial problems among children living in institutions and with their parents. Researcher used the sample of 40 institutionalized children and 70 children cared by their parents, by using

strength and difficult questionnaire and adolescent well-being scale to collect the data. The result found that children living under institutional care had more internalizing, externalizing and poor well-being than children living with their parents

Getachew, Ambaw, Abebe, and Kasahun (2011) examined a study on psychological distress among AIDs orphans and non AIDS orphans adolescents. It was a comparative research in which researcher used both qualitative and methods of research. The sample of 966 adolescent were selected and divided into two equal groups i.e. AIDS orphan (438) and non- AIDS orphans (438) adolescents. Rosenberg's self-esteem, hospital anxiety and depression scale, multidimensional scale of perceived social support and structured interview were used as measures of data collection on depression, anxiety, self-esteem and perceived social support. The result found that large section of AIDS orphan and non AIDS orphan adolescent show depressive and anxiety. The result additionally indicated that perceived social support and self-esteem are the factors which led depression and anxiety among these children and some other factors were also identified as predictors of depression and anxiety like discrimination, abuse child labor and school enrolment.

Caman and Ozcebe (2011) investigated a study in Ankara, Turkey on adolescent's psychological symptoms living in orphanages. The sample of the study comprises 166 adolescents of the age range 13-16 years with 65.7% males living in orphanages. For the data collection brief symptom inventory and Kiddo-Kindl Health-Related quality of life questionnaire were used and to analyses the data descriptive statistics were used. The result found adolescents who were busy physically show minor depressive symptoms and greater quality of life than adolescents who were less active. Overall children living in orphanages show high prevalence of psychological symptoms compared to general adolescent population. Children who are encouraged to take active part in sports and other physical activities as an intervention can promote mental health among these children living in orphanages.

Mack (2001) did a study on adult well-being, childhood family disruptions, parental death and divorce in United States. The researcher took 4341 as sample and made comparison between adults who experience divorce, parental death and rose in disruptive families. The result found that adult who experienced parental divorce and adult who experience disruptive families show lower level of depression, higher level of confidence and lower level of parent child relationship than children who experience parental death during the childhood. Thus it

can be said that early death of parents of children may face problems later in their life, if proper care not provided.

Luecken (2000) investigated a study on early parental loss in association with depression, social support and adult hostility. Total 30 university students who experience parental death before the age of 16 and 31 other participants were taken as sample. The result revealed that early parental loss, along with low social support show higher depression during later of their adulthood.

Ahad, Ara, and Shah (2016) probed a study on the adolescent orphan children of Kashmir, as to assess the aggression and self-concept. The sample of the study was the 88 orphan childrens (47 male and41 females) selected from the different orphanages of the Kashmir with the age range of 15-17 years. The researcher adopted the purposive sampling technique with Aggression Scale (A-Scale) by Pal and Naqvi (1983) and Self-concept Questionnaire (SCQ) by Raj Kumar Saraswat (1984) as a tool to collect the data. The result exposed the moderate to higher levels of aggression among the orphan children. The result further revealed that both the genders share same levels of aggression.

Rahman et al. (2012) examined a research study in Dhaka city on orphan children and the authors assessed the emotional and behavioural disorders among these children. It was a cross sectional study done between conventional orphanages "Sarkari Shishu Paribar" and privileged orphanage namely "SOS Children's Village" with the sample of 342 children of the age group 6-18 years. The researcher used the convenient sampling technique in the study. The result found that both emotional and behavioural disorders are highly predominant among these orphan children and the research further concluded that initial diagnosis and mediation will improve the quality of life among these children.

Cerel, Fristad, Verducci, Weller, and Weller (2006) conducted a study on children who had bereavement experience after two years of post-parental death on psychopathology. The researcher selects 360 bereavement experienced children with the age range of 6-17 years and interviewed them four times (at 2, 6, 13, and 25 months) after the death of their parents during the first two years, the surviving parent also interviewed. The researcher compared the psychiatric symptoms of 122 bereaved children, 128 community control children and 110 clinical depressed children. The result suggests that during the first two years after death of parents, children showed increased rate of psychiatric problems. The result further found that

children who had depression, along with parental loss are at more risk of developing psychopathology and depression overall.

Koumi et al. (2012) delved a cross-sectional research study on institutionalized children in three private orphanages of Cairo. The two hundred sixty five orphan children were included in the sample of the study. The researcher used the Child Behaviour Checklist (CBCL) and clinical interview method as the tool of data collection. The result of the study found children living in these orphanages showed the prevalence of behavioural disturbances like attention deficient hyperactivity disorder (ADHD), oppositional defiant disorder and nighttime enuresis. The result further delineates that age of admission, causes of residing in orphanage and moving from one institution to other more than two times have increased risk of suffering emotional and behavioural problem.

Wild, Flisher, and Robertson (2011) examined a study on adolescent orphans who are living in AIDS affected community in South Africa. A self- report questionnaire was verbally directed on the sample of 159 parentally bereaved adolescent of the age group of 10-19 years. The questionnaire consist the dimensions of depression, anxiety and self-esteem. The result found cumulative stress experience and growing risk of internalizing problems because of the two causes, one is the bereavement experience of parents and other is care taken by the non-relative. The result further found that peer connection, family regulation, individuality and community connected with the emotional resilience.

Saraswat and Unisa (2017) investigated a qualitative study on coping mechanism and psychological distress among orphan and other vulnerable children living under institutional care in New Delhi. It was the qualitative based study, so the researcher selects the 15 children (male=9 and female=7, age 10-17 years) as a sample from three randomly selected orphanages and purposive sampling technique were used. The researcher used in-depth interviews as an instrument to draw out the information from the respondents of the study. The result proclaimed that children enjoy all the basic facilities in these institutions, but still they feel distressed, stigmatized and socially excluded. It was also found that they used praying to God; avoid crowing places and shifting focus as coping strategies. As coping strategies they also used substance abuse, discrimination and delinquency to avoid psychological distress. Intervention programs need to be required to gain access of psychological problems, cultivate social skills and enhance coping strategies and resilience among these childrens.

Doku and Minnis (2016) preformed a research investigation among orphan, vulnerable children and non-orphan children in Ghana in context with HIV/AIDS. It was the multi-informative study in which the researcher tries assess the psychological distress among the orphan children, vulnerable and non-orphan children. The researcher selects 291 children and their caregivers as a sample of the study and verbal autopsy and strengths and difficulties scale were used to collect the responses from the respondents. The result depicts those children whose parents expired due to the AIDS and are living with HIV/AIDS infected caregiver show higher levels of mental health difficulties than the both other children orphaned and non-orphan. The result further delved significant portion of orphan children by AIDS and orphan children by other caused showed depressive symptoms and other psychiatrist issues than non-orphan children group. It was also found that caregivers gave higher rating of externalizing behavioural problems and lower levels of internalizing problems, but the vice-versa results were found when children self-reports were analyzed.

Thabet, Elheloub, and Vostanis (2017) explored a study on the occurrence depression, PTSD and anxiety among the orphan children in Gaza Strip. The sample of the study includes 81 orphan children with minimum age of 9 years and maximum age of 18 years from Al-Amal Institute of Orphans. For the data collection from the respondents socio-demographic sheet, revised child manifest scale, revised PTSD index, and Birleson depression self-rating scale for children (BDSRS). The result shows that girls are suffering more PTSD, arousal and avoidance symptoms then their counterpart's boys. The result further indicated 67.9% of depression and was higher in the northern Gaza children than the other four area of Gaza Strip. It was also found that 55.6% revealed moderate type of PTSD, 34.6% showed severe PTSD and 30.9% of orphan children portrayed anxiety related cases. Younger and the older aged children delineated lower rate of anxiety compared to the age range of 13-15 years children. The study recommended that governmental and non-governmental organization should provide the therapeutic programs to these childrens to enable them functional and productive member of the society.

Morgan et al. (2007) examined a case study on psychosis in different ethnic groups on the children who has lost his their parents or separation from the parents. The final sample of the study was the 390 participants and the data were gathered relating to death or separation from the participants through medical research council (MRC), socio-demographic schedule and the symptoms of psychosis were collected through schedules for clinical assessment in

neuropsychiatry (SCAN) ICD-10 diagnoses. The result portrays that loss of parents or separation from parents before the age of sixteen years has three times more risk of developing psychosis in white British and black Caribbean than the black African participants.

Dowdney et al. (1999) delved a research study on the children ware parentally bereaved. The target of the study was to assess the psychological disturbance they face after the death of their parents. There researcher selects the 45 children coming from the bereaved families as a sample of the study. Child behavior checklist and general health questionnaire were used for response collection from the participants. The result found the high level of psychological morbidity (internalizing and externalizing behavioural problems) among the children who have lost their parents and boys have been seen more affected than girls. It has also been seen that bereaved mothers displayed higher levels of mental health issues than bereaved fathers. The result also described that children indicate higher levels of psychological disturbance, when their living parents showed psychological disturbances.

Asif (2017) did a work on the self-esteem and depression between orphan and non-orphan children of Rawalpindi Pakistan. The sample of the study was 50 orphan and 50 non-orphan children with the age range 13-17 years and purposive sampling technique were used to select the participants. Demographic questionnaire, child depression inventory (CDI) and Rosenberg self-esteem scale were used to collect the information from the respondents. The result found higher level of depression among orphan children than non-orphan children and self-esteem in the orphan children are lower than the non-orphan children.

Masoodi (2012) a social activist led a study on orphan children residing in various orphanages in Kashmir. The author included the 140 children who dealing with bereaved of their parents and the responses from the respondents were collected with Mini-International Neuro-psychiatric interview. The result of the study indicated that children living in these orphanages have high frequency of separation anxiety, conduct disorder, social phobia, post-traumatic stress disorder and panic disorder. It was also found that children living in these orphanages are dealing with generalized anxiety disorder and dysthymia. Additionally the result portrayed that children living in these orphanages showed higher rate of mental health problems, mainly emotionally unstable.

Sujatha and Jacob (2014) delved a research study on orphan children living in orphanages of Mangalore, India and the researchers wants to assess the behavioural and emotional

problems faced by these adolescent's orphans. The researchers investigated the study on forty orphan children taken from two orphanages of Mangalore, of having the age range of 12-17 years. The result of the study found that 7.5% of children are battling with hyperactivity problems, along with 37% children are at the risk of peer problems and among then 12% are at high ratio of peer problems. The result further found that no children are at risk of developing the conduct problems, regarding the pro-social behaviour 22.5% are at risk; among them 5% are having severe problem in pro-social behaviour. The conclusion of the study suggested that positive emotions should be promoted among these orphan children, so as to enhance the health and wellbeing.

Kazim and Mohamed (2016) performed a study on orphan children and their psychological status living in orphanages of Bagdad city. A purposive sampling technique was employed by the researchers as sample selection tool, through which 50 orphan children were chosen as the participants of the study. To measure the psychological status the researcher conducted the interview and distributed the adapted questionnaire among the orphan children based on Tyelor Anxiety and Beck Depression scale. The result of the study found that most of the orphan children have moderate and severe type of anxiety. The findings also indicate that 48% of the children are dealing with mild depression, 30% of the orphan children are suffering with severe depression and 22% of the children are leaden with moderated level of depression and significant correlation of depression and anxiety has been with age, education level and loss of parents.

Hailegiorgis et al. (2018) examined a comparative research study among the orphan and non-orphan children on the variable of psychological well-being in Jimma town, Ethiopia. It was the cross sectional research study, in which 370 childrens (185 orphans and 185 non-orphans) were selected randomly as the sample of the study with the age group of 10-18 years. In order to measure the psychological well-being among these children, the researcher collected the responses with Ryff Psychological Wellbeing Scale. The result of the study finds that orphan childrens are dealing with lower levels of psychological well-being than non-orphan children who score higher on psychological well-being.

Overall the review states that much research has been done outside India like Africa, china, Pakistan, Turkey, Iraq, Egypt, Bangladesh, Britain etc. But very little attention has been paid to do research on the orphan children in India, particularly Kashmir and there is dearth of interventional research in India on this sample. It has been found that peer group

support intervention minimizes the symptoms of psychological distress, mainly the symptoms of depression, anger and anxiety (Kumakech et al., 2009). Peer support group intervention shows improvement in mental well-being and has made health services more reachable, inexpensive, and impartial (Byrom 2018; Puschner et al., 2019). Depression, anxiety, hostility, interpersonal sensitivity and paranoid ideation were found less among the families of the patients who bears the psychotic patients (Mentis et al. 2015). Unemployed people show improvement in depressive symptoms and recovery from the mental health problems when led by peer support interventions (Rusch et al., 2019). Experiencing when peer support, it was found that clients show positive comeback from the stigmatization and minimizes the negative thoughts of stigmatization (Verhaeghe et al., 2008). Peer support found to be effective in dealing with depression, disability, psychological health and quality of life among the individuals suffering from these problems. The study suggests that longer trails should be provided to assess the effectiveness and efficacy of this promising intervention technique (Castelein et al., 2008). Overall, it can be said large body of work has been done on peer group support intervention in multidimensional way, with many psychological and other non-psychological constructs.

Anxiety, high levels of depression and low levels of self-esteem is more common among the orphan than non-orphan children (Shafiq et al.,2020; Thapa, 2020). Orphan perceived as a stigma is a significant predictor of depression and anxiety and orphan children living in orphanages have depression and anxiety, but there is absence of conduct disorder (Bano et al., 2019). Orphan children living in orphanage setting are dealing with major depression, panic disorder, separation anxiety disorder, substance dependence, ADHA, generalized anxiety disorder, social phobia , agoraphobia, conduct disorder and co-morbid conditions(Bhat et al,. 2015). Internalizing and externalizing behavioural problems among both orphan boys and girls were found (Vinnakota & Kaur, 2018). Children living under institutional care had more internalizing, externalizing and poor well-being than children living with their parents and these children need extensive psychosocial support for the proper development of emotional and social well-being (Sushma et al.,2016; Ptacek et al.,2011). AIDS orphan and non-AIDS orphan adolescent show depressive and anxiety. Discrimination, abuse, child labor and school enrolment were identified as predictors of depression and anxiety among these children (Getachew et al., 2011). Early parental loss, along with low social support show higher depression during later of their adulthood (Luecken, 2000). Orphan children by AIDS and orphan children by other caused showed

depressive symptoms and other psychiatrist issues than non-orphan children group. Boys had more levels of aggression and low in depression/anxiety compared their counter parts girls (Doku & Minnis, 2016; Attar-Schwartz, 2008). Psychological morbidity are high (internalizing and externalizing behavioural problems) among the children who have lost their parents and boys have been seen more affected than girls (Dowdney et al,. 1999). Children living in the orphanages showed the high prevalence of behavioural disturbances like attention deficient hyperactivity disorder (ADHD), oppositional defiant disorder and nighttime enuresis, high frequency of separation anxiety, conduct disorder, social phobia, post-traumatic stress disorder, generalized anxiety disorder, dysthymia and panic disorder. Further it was found that age of admission, causes of residing in orphanage and moving from one institution to other more than two times have increased risk of suffering emotional and behavioural problem (Koumi et al,. 2012; Masoodi, 2012).The above literature suggests that large part of research has been done on orphan and non-orphan children, but most of these finding has been done in foreign setting. It can be concludes that children from the above literature review that children who are living their life in orphanages setting are dealing with psychological and mental health problems such as anxiety, difficulties in social interaction, depression, anxiety and behavioural problems like hyperactivity, conduct problems etc.

CHAPTER III

METHODOLOGY

This section of the present research gives us the detailed description of the research methods used for the investigation. Methodology provides the detailed depiction of the research design of the study, the sampling technique, details of the intervention program, a description of research tools, the method of data collection and use statistical techniques in the study. "Methodology is the broad term used to refer to the research design methods, approaches and procedures used in an investigation that is well planned to find out something"(Keeves,1997). For example, data assembling, sample, tools used and data analysis, are all parts of the broad field of methodology. In sum, methodology articulates the logic and flow of the systematic processes followed in conducting research project, so as to gain knowledge about a research problem.

The methodology portion of any research has its utmost importance, because it is a way for the researcher to which he can attain his goal of the research. It is a systematic way for the researcher which begins from the identification of the problem and to the final conclusion of the research. A valid and reliable research study depends on the well adapted methodology of the research study. The comprehensive review of literature highlights various studies carried out on orphan and non-orphan childrens behavioural problems and the peer support intervention on the different samples and variables. Further, it also brought to light many unresolved research problems and its mode of resolving those problems among the orphan children living in institutional setting. It is important to view an orphan children behavior with reference to the children whose parents are alive.

The chapter comprises the comparative research design, the experimental research design; the nature of interventions exposed to the sample in the research, the sample design, research instruments, method of data collection and discusses the types of statistical techniques adopted to test the hypotheses. The present study aims of evaluate the behavioural problems among the orphan and non-orphan children and the effect of peer support group intervention on behavioural problems of orphan children residing in the orphanages of Kashmir. Based on the review of literature, several hypotheses were framed and the research design was confirmed to find the vital objectives of the study. The following parts deal with the key aspects of research design and methods of data collection.

Part I: presents the research design and detailed administration of the intervention program targeted to the orphan children

Part II: covers the sample technique.

Part III: introduces the research tool, used to assess the variables before and the after intervention.

Part IV: presents the method of data collection.

Part V: discuss the types of statistical techniques used to analysis of the data and testing of the hypotheses.

3.1 Part I: Research design and detailed administration of the intervention program

The present study is experimental and as well as descriptive in nature. In this study the researcher first focuses on the behavioural problems among the orphan and non-orphan children, then orphan children were exposed to intervention program. A Pre-test, Post-test Experimental Group Research Design was followed to assess the effects of the peer support group intervention on the internalizing and externalizing behavioural problems among the orphan children. To ensure the validity of the research design a due care of great extent were set. However the levels of maturation among the group mates and other outside exposure during the intervention process may create the problems in internal validity. There are three important components of a pre-test, post-test randomized experimental and control research design as to ensure the improvement in behavioural problems among the orphan childrens from peer support group intervention (1) A pre-test and post-test (2) Random assignment of study participants (3) Treatment group (Experimental group) and a Control group. All these three components were systematically followed by the researcher.

1. **Pre-test and Post-test**: A pre-posttest design ensures that the relevant criterion factors such as internalizing and externalizing behavioural problems from the orphan and non-orphan children participants of the study before the intervention takes place (Pre-test), and the researcher used the same process from the same orphan participants of collecting the data using the same measures once again after the intervention took place (Post-test). This design is the best way to find out that the intervention had a causal effect.
2. **Random assignment of participants:** It is vital to confirm that both the experimental group and the control group should be homogenous in nature in all possible ways

except the nature of exposure to intervention given. While no two groups will ever be exactly alike, the best way to make sure that they are as close as possible by having a random assignment of the study participants into the experimental group and control group. The sample of 120 orphan children is randomly allocated to both experimental group and control group. When following this procedure, it was assured that any difference between the experimental group and control group is due to chance alone, and not by a selection bias.

3. **Treatment group (Experimental group) and Control group:** For the true conclusion of the peer support group intervention, the researcher divides the proposed sample of 120 orphan children into 12 groups, in which six groups were taken as experimental groups and the six groups were kept as control groups, followed by ten orphans in each of these groups. The researcher develops the equal number of male and female groups i.e. 3 each groups, as same are with the control groups. The experimental groups distinctively exposed to intervention, whereas the control groups are free from such exposure. The researcher here adapted the separate sample post-test design, which means repetition of intervention on daily basis, that will enable the researcher develop controlled situations for intervention programs. The experimental groups undergo the six session of peer support group intervention on daily basis and one hour of time is allotted in each session. The peer support group intervention effect will reveal in the differences between the pre-test and post-test results of the experimental groups only. Over same period of time the control groups receives the regular instruction in the orphanages.

Figure 3.1 Schematic Representation of Descriptive Research Design

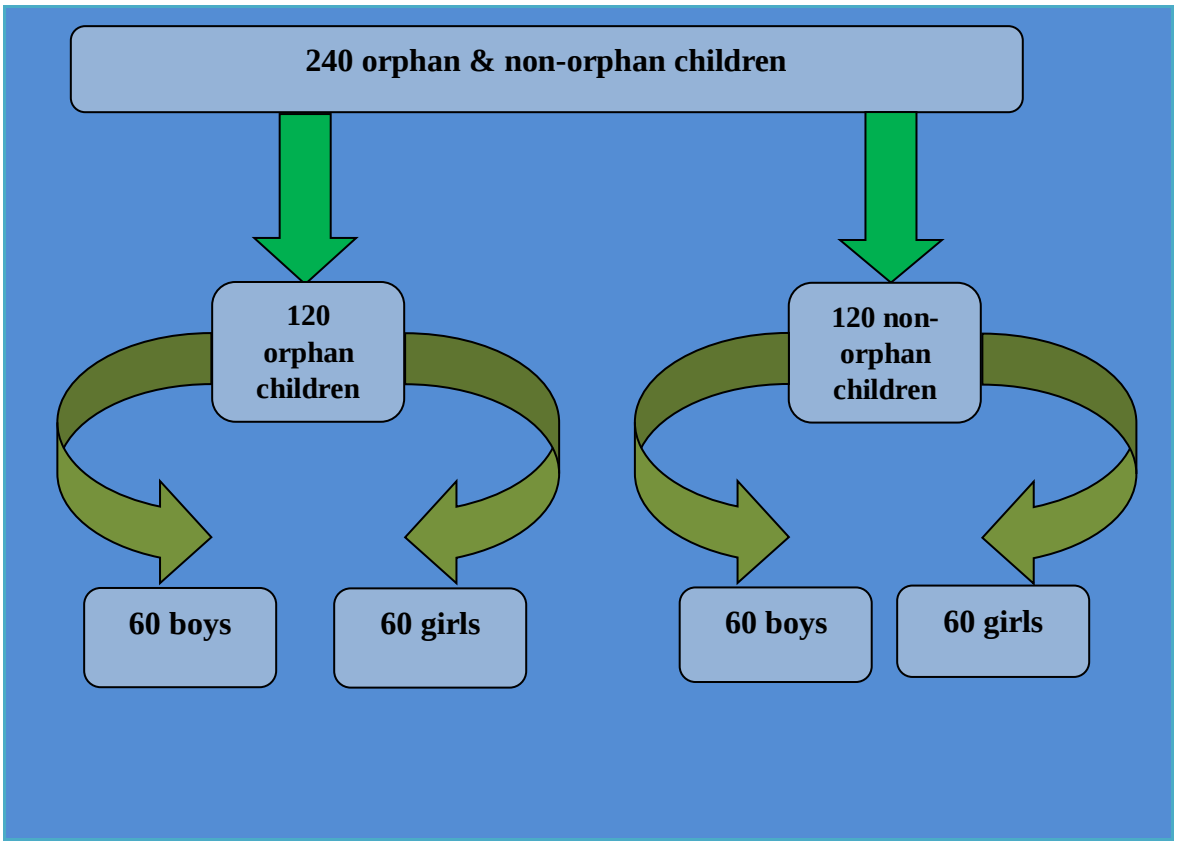
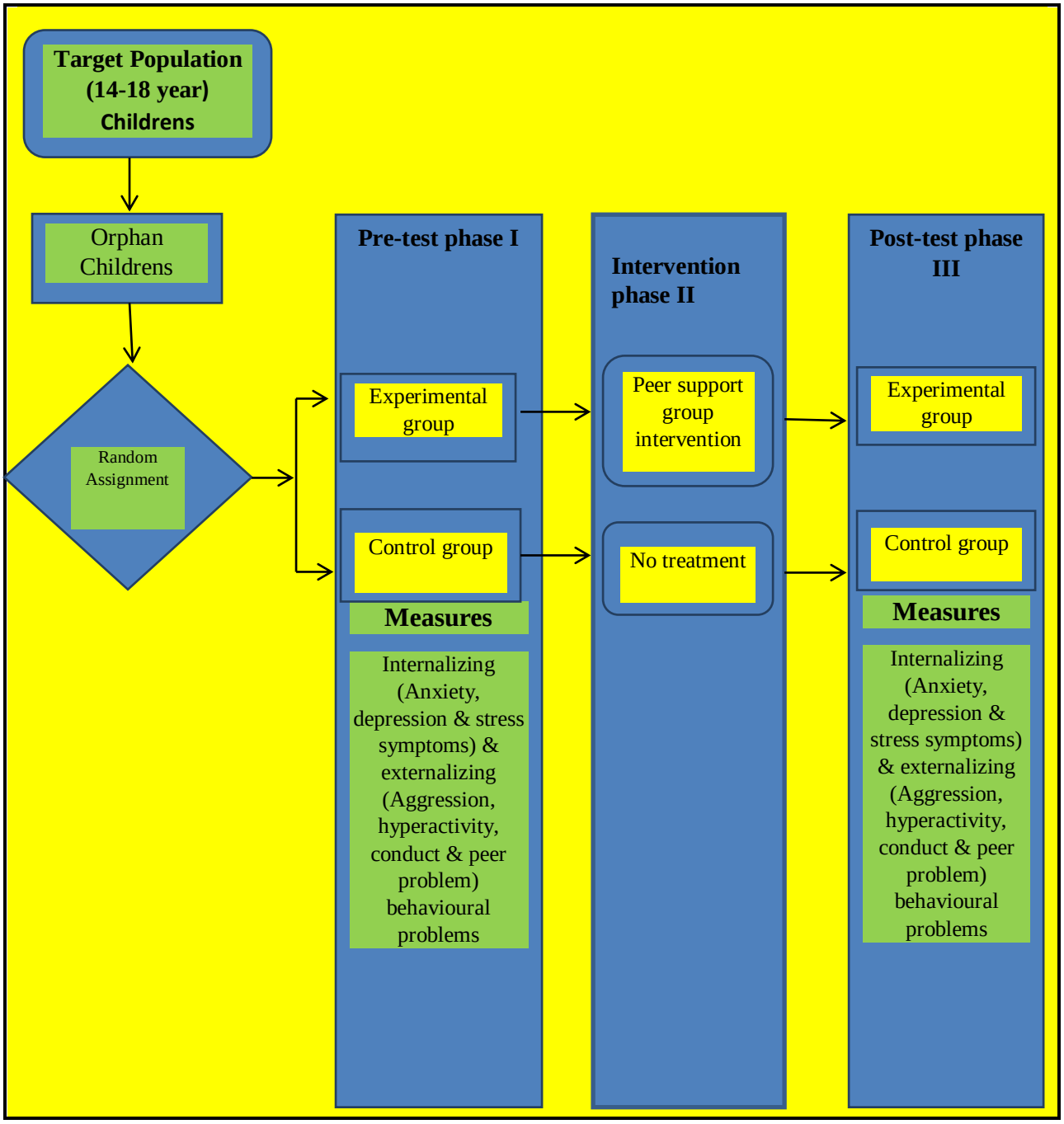


Figure 3.2

Schematic Representation of Experimental Research Design



3.1.1 ADMINISTRATION OF THE INTERVENTION PROGRAM

The intervention program was provided to the participants, who were selected for experimental group after collecting the baseline data of the variables from experimental group and control group. The intervention was administered by the investigator to the experimental group in six weeks. The experimental group was divided into six subgroups, each sub group received six sessions in a week. The duration of the session was one hour time. The participants of intervention group were collected in a separate room of orphanage and participants were exposed to peer support group intervention. Those children that found by the researcher are not fully cooperating or feeling shy or insecure, the researcher met them separately after the group intervention session. The following tasks and exercises were recommended in each session.

As Newton and Wilson (1996) explain, "we have underestimated the therapeutic power of acceptance and over emphasized the negative influence of the peer group". The reality is that there are enormous benefits to all if the strengths of the natural peer group can be realized to support the vulnerable individual.'

Activity I: Peer shearing (co-listening)

Peer shearing usually involves the sharing of ideas and resources about sensitive life issues by individuals who have 'credibility' within the peer group, and who are perceived to have understanding of, empathy for and the concerns of that group. Their style of presenting information is likely to be informal and tolerant. Because there is a more balanced educator/participant relationship, it is likely that there will be more open discussion about important concerns. This is the two-part activity that provides orphans first an opportunity to relieve stress by talking about what they are thinking or feeling in the moment, while being intentionally listened to and second talk about opportunities and help them to move beyond current feelings of stress and tension. The activity involves one orphan talking while his/her partners listens without comment. The proposal is to be set with orphan children by establishing rules for safe sharing. For example, be respectful, no teasing, and information shared is not talked about once activity ends, respect all feelings, ideas, opinions. Before beginning of activity the researcher clearly demonstrate the activity. This activity is based on two parts they are as under.

Part One

1. Orphans are arranged in pairs, they find a partner (e.g. the researcher numbers the students 1, 2, 1, 2…).

2. Orphan child first talks, while orphan second simply listens (e.g. the researcher ask orphan #1 to share how they are feeling today and why? Or how they are feeling at the moment or about any concerns or worries they are experiencing).

3. After 1-3 minutes the childrens switch roles and orphan children second talks but this time children first will listens for another 1-3 minutes (children second now talks about the same question, e.g. how they are feeling today and why?).

Part Two

4. After the pairs are done sharing, group children are being in triads now (groups of three; again the investigator number the students 1, 2, 3, 1, 2, 3 …).

5. Children first talks and orphan children second and third will listen (e.g. the experimenter ask children first to talk about opportunities and solutions related to current issue or stressors he/she is experiencing or concerned about).

6. Every 1-3 minutes switch until each participant in the group has a turn to talk.

8. Check in with orphans to see if they feel any sense of relief, calmness, focus or less stressed as a result of the activity.

Outcome

Childrens will have the opportunities to practice peer sharing at other moments. This kind of activity will encourage them to practice on their own amongst themselves for mutual support.

Activity II: Circle Time

We turn now to a particular technique "Circle Time" that has grown out of the co-operative group work approach (Mosley, 1996). This is a method for enhancing effective communication amongst members of a class group, for affirming the strengths of each member of the group, and for creating a safe space in which to explore issues of concern and difficulty experienced by members of that group. Circle Time usually lasts for about 20–30 minutes, and provides a useful forum for the discussion of important issues, including peer relationships, democratic principles, friendship, justice and individual freedom. Circle Time gives children the opportunity to discuss matters of personal concern; explore relationships

with peers, develop a sense of being members of a community, learn about the experience of reflection and silence. The Circle encourages children to think about and reflect on issues. They learn to listen and take turns. The technique has been done in five step process.

1. **Meeting up**

The researcher starts meeting up process with to help the children relax, release tension, feel comfortable, enjoy being together and ask the orphan children to create a supportive atmosphere. Like the researcher asks the orphan children to curl up with their knees. The childrens uncurl when the researcher well come them into circle with words:

Investigator: Where is Bisma?

Bisma: Here I am.

Investigator: Great to see you.

Everyone: Great to see you, Bisma

2. **Warming up**

The researcher warm up the orphan children as to prepare them for further process of the activity. Warm up can be done by the investigator by giving the orphan children turns to complete the sentence started by the researcher for example child sitting next to investigator asked to complete the following sentence: 'My name is ….. And I like to …… Continue this around the group.

3. **Opening up**

This is an important section of the circle time as now the children have to express the personal feeling. The 'Open Forum' is an opportunity for children to work together, explore problems, concerns, hopes and fears. The researcher facilitates the group to open up their individual problem, feelings, isolation due to the death of the parents, difficulties facing without the parents. They investigate what it means to be part of a community and think about social and moral responsibilities. They learn to offer peer support in respectful and compassionate ways, practice problem-solving skills and rehearse behaviours to strengthen confidence and self-esteem. Childrens learn to express opinions and join in discussions to develop their ability to reason. Sessions should never end on 'opening up' activity as this stage can open up participants' feelings of vulnerability.

4. **Cheering up**

The researcher did not allow the orphan children to go after the opening up process. It can be difficult for troubled children to 'switch off' from issues of concern so it is important to provide two closing activities to help participant's leaves the meeting feeling calm and refreshed. The 'cheering up' step celebrates individual successes and strengths.

5. **Calming down**

Each meeting ends with a closing ritual designed to calm and ensure feelings of emotional safety and closure. At last the researcher involves the visualizations; sensory work and breathing techniques until everyone is in a happy frame of mind.

Important rules need to be following during the performing of this activity. Rules frequently fall into these categories:

- Physical safety (e.g. 'we are gentle')
- Emotional safety ('we are kind')
- Respect for each other ('we listen')
- Respect for work ('we do our best')
- Respect for the truth ('we are honest')

Activity III: Visual Imagery

Investigators lead students through the process of visual imagery as a relaxation technique

1. In this activity the researcher led the orphan children to sit comfortably.

2. After that the researcher used the clam, slow and low voice and provides the enough time for the orphan children to ease for vision and to get each step.

3. Creating a visual scenario appropriate to orphans childrens age, experience and interest. Example: let your eyes closed and concentrate your mind on a beautiful place like river bank. With the bright and warm sunshine, a slow breeze is coming from the river, trees are overhead and river birds are circling around. Imagine that you have put your feet into the river, walk barefoot into the river water and let the water roll over on your feet, which is refreshing. Come out of the water, walk on the edge of the river lay down and relax. Take a rest for some time and feel the natural beauty that is around you. Make an Imagine that how it sounds, scents and views. Then take a deep breath with warm fresh river air and stay as long

as you like. After doing all these things get ready to go back, before you leave the place go to the edge of the river water and take the problems out who are disturbing in life, like feeling sad, angry and worry about anything (e.g. problems at your home, bullies, loved ones death and problems with your peers) and through them into deep into the water. Imagine that it was big rock hanging on your shoulders and see how it is sinking deep into the river and taken by the waves to far away. When all these things had done, be thankful that your burden is released, then go back calmly on the bank of the river and take a rest for some time, the problem and worry is over now.

4. This imagery can be practiced 10-20 minutes, depending upon the level of the group.

5. Time has been allowed for the orphan children to interrogate and share about the process of visualization and how they felt about the experience of this technique.

- During the visualization where did you take yourself?

- Did you feel relaxed after performing this activity?

- How did you feel when you left your problems into the water?

- How you are feeling now again into your class room?

- will you continue this activity in your future to let calm down, relax and decrease your stress.

Along with the above group activities, some other sessions were provided to these participants of experimental group like cooperative group work, conflict resolution mediation, befriending and brief session of Islamic counselling.

3.2 Part II: SAMPLING TECHNIQUE

The quality a research falls or stands not only by the suitability of instrumentation and methodology, but also by the appropriateness of the sampling approach that has been employed (Cohen, Manion, & Morrison, 2007). Generally in behavioral sciences, to study the entire population is somewhat difficult. Investigators must take decisions early regarding sampling in the total planning of a piece of research. Factors such as expenditure, time, and availability frequently prevent investigators from gaining evidence from the whole population. Consequently, they often need to be able to get data from a smaller group or subset of the population in such a way that the information gained is representative of the total population under study (Cohen et al., 2007).

3.2.1 Population

For this study, all orphan children who are living in public and private orphanage of Kashmir and non-orphan school going children with the age group of 14-18 years would make up the population of the study.

3.2.2 Size of the Sample

Within this target population, investigator chose a sample for present study. A sample is a subgroup of the target population that the investigator plans to study for generalizing about the target population (Creswell, 2002). As this study is experimental as well as descriptive in nature, the researcher selects the total 120 orphan and 120 non-orphan childrens. The orphan children are then divided into experimental and control group. A total 60 orphan children are selected for experimental groups and other 60 orphan children were kept as control groups. The researcher generates the 12 equal sized groups, in which 10 children are allocated. In experimental groups three female groups and three male groups are formed. The age range of the both the orphan children living in orphanages and non-orphan school going children are 14-18 years.

TABLE 3.1

THE LIST OF ORPHANAGES AND SCHOOLS ALONG WITH NUMBER OF CHILDRENS OF DIFFERENT REGIONS

S.No	Name of Orphanage or school	Region	No. of childrens
1	Gulshan-E-Banat Girls Hostel	Gopolpora	40
2.	Gulshan-E-Banat Girls Hostel	Handwara, Kupwara	20
3.	Gulshan Mahal Boys Hostel	Makhdoom, Sahib	20
4.	Baitul Falah Boys Hostel	Singpora, Pattan	20
5.	Al-Masoomeen Boys Hostel	Hawal, Srinagar	20
Total			120
1	Govt. Boys & girls H.Sec school	Mujgund, Bandipura	20
2	Govt. Boys & girls H.Sec school	Chadora, Budgam	20
3.	Govt. Boys H.Sec school	Budgam	15
4.	Govt. Girls H.Sec school	Budgam	20
5.	Govt. Boys H.Sec school	Nawa Kadal, Sgr	20
6.	SRS coaching center	HMT, Srinagar	25
Total			120

3.2.3 Sampling

For an effective research study it is imperative to select the well-designed sampling technique and the representative of the study. To select a large sample from the population, a general rule of thumb has been recommended by the Creswell (2008). A convenience

sampling technique should be introduced in the study, because due to the non-cooperation of participants, some refuse to answer and some of the participants and give back the questionnaires or return an incomplete questionnaire (Panneerselvam, 2011). Whereas, Ahuja (2014) said in research situations where appropriate list of the respondents is not available probability sampling will be difficult and inappropriate. As the focus of the present study is on children who have lost their one or both parents living in orphanages and the school going children who are living with their parents, it was decided to follow the Purposive Sampling technique to pick only those students who happened to fall into this category.

3.2.4 Criteria for Sample Selection

INCLUSIVE CRITERIA

- The orphans living in public and private orphanages of Kashmir taken up as the sample.
- The orphans selected as sample of the age group of 14-18 years living in different public and private orphanages.
- The orphans who had lost one or both of the parents living in different orphanages.
- The non-orphans school going children with the age group of 14-18 taken as sample.
- The orphan and non-orphan children who are willing to participate.
- The orphan and non-orphan who have the ability to read.

EXCUSIVE CRITERIA

- The orphans who are not residing in the orphanages of Kashmir.
- The orphans and non-orphans whose age range is above 18 years or below the 14 years.

3.3 TOOLS USED

For quantitative data collection and analyses, there are numerous methods and research instruments/measurements available for collecting information from the respondents on designated constructs. Keeping the age group and constructs in view, the researcher used three separate survey instruments for ascertain the data from the respondents. The following section discusses about the measurement instruments for each construct of the psychological criterion variables such as internalizing behavioural problems(anxiety, depression and stress symptoms.) and externalizing behavioural problems (aggression, hyperactivity, conduct and peer problem).

3.3.1 DESCRIPTION OF ANXIETY, DEPRESSION AND STRESS SCALE (ADSS)

This scale is developed by Bhatnagar, Singh, Pandey, Sandhya and Amitabh. The scale includes 48 items divided into three subscales. 1. Anxiety scale, 2. Depression scale and 3. Stress scale. The Anxiety subscale comprises the 19 items of the questions, which covers the various symptoms of the anxiety. The depression subscale contains 15 items manifesting the different symptoms of the depression. Stress subscale has 14 items, which covers the state of stress symptoms that people experience during the different situation in their life. The scale can be administered by self as well as the investigator. The scale can be used in both individual and group setting on the age group of 14-70 years. Usually there is no time limit in the completion of the scale, but the respondent may complete it within 15-20 minutes. Responses of the items are in the form of "YES'' or ''NO'' option. One of the features of the scale is that during the development of the scale both clinical and non-clinical samples were taken into consideration, which increases the generalizability and applicability of the scale. The table 3.2 displays the number of items in the subscales.

Table 3.2

Number of items in the subscales

Subscales	No. of Items	Total
Anxiety	1,2,7,11,14,15,18,20,21,24,25,28,32,34,35,39,41,45,47.	19
Depression	3,6,9,10,13,22,26,27,31,33,37,38,42,44,48	15
Stress	4,5,8,12,16,17,19,23,29,30,36,40,43,46.	14

SCORING PATTERN OF SCALE

The scale comprises the 'Yes' and 'No' options. Each item of the scale is scored 1 if yes responses are given by the respondents and 0 for the no response. For the anxiety subscale the range of the score is 0-19, the range of depression subscale score is 0-15 and for the stress subscale the range of score is 0-14. The higher scores indicate the higher anxiety, depression, stress and vice-versa.

Table: 3.3

NORMS TABLE FOR INTERPRETATION OF THE LEVEL OF ANXIETY, DEPRESSION AND STRESS

S.No	Range of Raw Scores			Range of z-Score	Grade	Level
	Anxiety	Depression	Stress			
1	17& above	__	__	+2.01 & above	A	Extremely High
2	13-16	13-15	12-14	+1.26 to+2.00	B	High
3	10-12	09-12	09-11	+0.51 to +1.25	C	Above Average
4	04-09	03-08	05-08	-0.50 to +0.50	D	Average
5	01-03	00-02	03-04	-1.25 to-0.51	E	Below Average
6	00	__	00-02	-2.01 to -1.26	F	Low
7	__	__	__	+2.01 & above	G	Extremely Low

RELIABILITY OF THE SCALE

Reliability of the total scale in terms of internal consistency as measured by Cronbach's Alpha and Spearman-Browan coefficient is 0.81 and 0.89. The obtained reliability for anxiety, depression and stress subscales as measured by Cronbach's Alpha is 0.76, 0.75 and 0.61 and when measured by Spearman-Brown coefficient is 0.86, 0.86 and 0.76 respectively.

Table 3.4

TABLE OF RELIABILITY STATISTICS OF ANXIETY, DEPRESSION AND STRESS SUBSCALES

S. No.	Subscales	Reliability forms	
		Cronbach's Alpha	Spearman Brown Coefficient
01	Anxiety	.76	.86
02	Depression	.75	.86
03	Stress	.61	.76

3.3.2 DESCRIPTION OF AGGRESSION SCALE (AS)

The Aggression Scale (AS revised) is developed by the Dr. R.L. Bharadwaj. It consists 28 items representing the different samples of behaviours found responsible to foster aggression more objectively. The scale can be performed on self as well as the investigator. It can be administered on the age range 10+ years in individual and group setting. The scale normally takes about 10-15 minutes to fill the responses by the respondents.

SCORING PATTERN OF SCALE

The scoring of this scale is quantitative in nature and can be done easily. The scale can be scored easily with reference to the scores obtained for each item separately. Each item has five different alternatives and subject has to choose the option according to his/her will from anyone of these five alternatives. The scoring of these alternatives follow a system of 5,4,3,2, and 1 from upper to lower end of the scale. Aggression score of the subject are the addition of all the scores obtained on each item.

RELIABILITY OF THE SCALE

The co-efficient of reliability has been found to be .79 acquired by product moment method, is determined by test-retest method on a sample of 100 subjects. In addition the reliability coefficient of the scale was also determined by split-half method and it has been found to be .86 by Gutmon Formula.

VALIDITY OF THE SCALE

The theoretical validity of the scale has been found to be .83. Along with the theoretical validity, the construct validity of the given scale has been determined with one of the mode Frustration Scale (Aggression) constructed and standardized by Chauhan and Tiwari, (1972) on a sample of 64 subjects. The validity has been found to be .78. Again the construct validity of this scale is also determined with Manifest Aggression Scale developed and standardized by Dr. R.A.Singh (1986) found the coefficient of correlation to be .81.

Table 3.5

Norm Table of Aggression Scale

S. No	Percentiles	Categories
1	70 and above	Very high or Saturated
2	60-69	High
3	40-59	Average
4	30-39	Low
5	5-29	Very low

3.3.3 DESCRIPTION OF STRENGTHS AND DIFFICULTIES SCALE (SADS)

The Strengths and Difficulties scale is developed Robert Goodman (1997), in order to measure behavioural disorders of an individual. The scale was designed to know the dimensions of behavioural disorders viz. hyperactivity, conduct, pro-social behaviour, emotionality and peer problems. This scale is widely used in all over the world as well as in India. In India, Sushma (2014); Kaur (2018); Kumar (2016); used this instrument as well as established its validity and reliability. The Reliability of this scale in terms of internal consistency as measured by Cronbach's Alpha is 0.73.

This scale is based on three-point rating i.e. not true, somewhat true and certainly true. This scale has 25 statements measuring hyperactivity, conduct behaviour, emotionality, prosocial behaviour and peer problems of an individual. So, it is based on five dimensions

pertaining 5 items each for hyperactivity, conduct, emotionality, pro-social behaviour and peer problem. For each dimension the range of score is 0-10. Higher the score in hyperactivity conduct and peer problem scale indicates higher the problems in these dimensions. The table 3.6 displays the description of total 15 statements of the measure into its three components.

Table 3.6

DISTRIBUTION OF THE ITEMS OF STRENGTHS AND DIFFICULTIES SCALE

Conduct problem	Hyperactivity problem	Peer problem scale
I get very angry often lose my temper.	I am restless I it find hard to sit down for long.	I would rather be alone than with other people.
I am generally willing to do what other people want.	I am constantly fidgeting or squirming.	I have at least one good friend.
I fight a lot. I can .make other people do what I want	I am constantly fidgeting or squirming.	Other people generally like me.
I am often accused of lying or cheating.	I am easily distracted; I find it difficult to concentrate.	Other people pick me or bully me.
I take things that are not mine from home, work or elsewhere	I think before I do things	I get along better with older people

SCORING PATTERN OF STRENGTHS AND DIFFICULTIES SCALE

The scoring of all subscales is easy, as each item has three options to choose. The alternatives which the subjects have to choose are Not True, Somewhat True and Certainly True. Somewhat true has always scored as 1, but the scoring of "Not True" and "Certainly True" varies with the item. The range of the score of all of the subscales is 0-10 if all 5 items were completed by the subject. Scale score can be calculated if at least 3 items were completed by the respondents.

Table 3.7

NORM PATTERN OF STRENGTHS AND DIFFICULTIES SCALE

Subscales scores	Normal	Borderline	Abnormal
Conduct problem score	0-3	4	5-10
Hyperactivity score	0-5	6	7-10
Peer problem score	0-3	4-5	6-7

3.4 PROCEDURE OF DATA COLLECTION

A demographic profile sheet was prepared to gather general information about the participants which include name, class, age, gender and type of children. Then all the participants were contacted personally after taking permission from the higher officials in each orphanages and schools. Investigator introduced himself as a research scholar and told them about the purpose and application of the present study. They were requested to answer frankly and honestly as the information were to be kept confidential and to be used for research purposes only. Demographic profile was used to establish a good rapport, and then, all the questionnaires were given to the subjects, one at a time and they were requested to read the directions given on the top of each scale or questionnaire. Researcher has described concisely but clearly the purpose of the research study and requested the participants to fill up general information given in a separate performa. If they did not understand anything, it was made clear by the investigator. It was made clear that there were no "right" or "wrong" responses and if they had any queries, they could ask the investigator. The investigator tried to complete all tests to each subject in a single day. The procedure of test administration was uniform for all the subjects. The participants were assured that their answers would be kept confidential. Due care was taken that the participants did not leave any statement unmarked. So, scoring was done according to directions given in the respective manuals. Same procedure has been followed by the investigator after experimental groups were exposed to intervention process and control groups with no intervention.

Pilot Study

A pilot research study was conducted on the sample of 35 orphan children residing in two orphanages of Srinagar and Budgam districts of Kashmir. These are the objectives and aims of the pilot study:

- In this pilot study pre-test were done to validate research tools
- To find the reliability and validity of the instruments adopted for the current research study
- To confirm whether instruments are clearly comprehensible for the sample and are satisfying the theoretical contexts. and the procedures used are effective
- To find procedures are effective and followed to be systematically
- To check the probable prejudices and biases that may occur by the researcher during the study
- To ensure the researcher of minimizing errors and help them to develop proper skills for intervention and for the administration of questionnaires

3.5 STATISTICAL TECHNIQUES

In order to examine the collected data with appropriate statistical methods, the following statistical techniques were used in present study:

1. In order to find out the levels of internalizing behavioural problems (anxiety, depression, stress symptoms) and externalizing behavioural problems(aggression, hyperactivity, conduct problems, and peer problems) among the orphan and non-orphan children descriptive statistics was used i.e. Mean, ANOVA test were employed.
2. In order to find out the levels of differences in internalizing and externalizing behavioural problems on the basis of gender and in between single orphan and double orphan ANOVA test and Mean, were used.
3. To study the differences in internalizing behavioural problems and externalizing behavioural problems among the pre-experimental and pre-control groups of orphan children, Mean Independent t-test was employed.

4. To find out the difference between pre-control and post control groups mean, paired 't' test were employed.
5. In order to find out the difference in internalizing and externalizing behavioural problems among pre-experimental and post experimental groups of orphan children Mean, Paired t-test were used.
6. To find out the difference in internalizing and externalizing behavioural problems among post experimental and post control groups Mean and Independent't' test were employed.

CHAPTER IV

RESULTS AND DISCUSSION

The fundamental stage in the practice of psychological research, after the collection of data, is the analysis and discussion of the data and arriving at the conclusions and generalizations to get a noteworthy representation of the raw evidences thus collected. Present chapter highlights the use of various statistical tools for analysis of the data. Data is a meaningless heap of information unless a researcher does not classify it systematically, analyze scientifically, interpret intelligently and conclude rationally. The data analysis was carried by suitable quantitative statistical analysis techniques by applying inferential statistics (ANOVA test, Independent't' test and Paired't').

As the study is descriptive and experimental in nature, the researcher first investigated the internalizing and externalizing behaviour among orphan and non-orphan children. In order to explore to what extent comprehensive peer support group intervention program can lead to decrease of internalizing and externalizing behavioural problems among orphan children living in orphanage settings. Before the peer support group intervention program, ANOVA test was used to assess the mean differences among the orphan and non-orphan children. After that researcher divides the orphan children into experimental and control groups for further process in his study. The data obtained from the respondents before and after the administration of the peer support group intervention program were analyzed using appropriate statistical analysis to draw meaningful inferences on the dimensions of internalizing (anxiety, depression and stress) and externalizing (aggression, hyperactivity, conduct and peer relationship) behavioural problems among orphan childrens.

The demographic profiles of the sample were drawn based on the personal information furnished by the respondents. Further, an independent sample t-test was used to compare the means of the criterion variables between experimental and control groups before the administration of peer support group intervention program. A paired sample t-test was used to assess the mean difference between pre-test and post-test scores of all the criterion variables for both the experimental and control group of orphan children. Subsequently, an independent sample t-test was used to compare gains score on all the criterion variables for the experimental and control group only after the administration of peer support group intervention program. The obtained results and interpretation are presented into two parts i.e.

Part: I and Part: II. The Part I comprises the comparative results of the study and the Part II includes the experimental results of the study that are presented in the forthcoming sessions.

4.1 COMPARATIVE RESULTS OF ORPHAN AND NON-ORPHAN CHILDREN

4.1.1 SAMPLE CHARACTERISTICS OF ORPHAN AND NON-ORPHAN CHILDREN

4.1.2 COMPARISON ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) BETWEEN ORPHAN AND NON-ORPHAN CHILDREN OF KASHMIR

4.1.3 COMPARISON ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY PROBLEMS, CONDUCT PROBLEMS AND PEER RELATIONSHIP PROBLEMS) BETWEEN ORPHAN AND NON-ORPHAN CHILDREN OF KASHMIR

4.1.4 COMPARISON ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) OF SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN OF KASHMIR

4.1.5 COMPARISON ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER RELATIONSHIP PROBLEMS) OF SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN OF KASHMIR.

4.1.6 COMPARISONS ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) AMONG ORPHAN CHILDREN ON THE BASIS OF GENDER

4.1.7 COMPARISONS ON EXTERNALIZING BEHAVIOUR PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER RELATIONSHIP PROBLEM) AMONG ORPHAN CHILDREN ON THE BASIS OF GENDER

4.2 PRE-TEST AND POST-TEST RESULTS OF EXPERIMENTAL GROUP AND CONTROL GROUP OF THE STUDY.

4.2.1 SAMPLECARACTERISTICS OF EXPERIMENTAL GROUP AND CONTROL GROUP OF ORPHAN CHILDREN

4.2.2 COMPARISON OF EXPERIMENTAL GROUP AND CONTROL GROUP ON ANXIETY, DEPRESSION AND STRESS SYMPTOMSOFINTERNALIZING BEHAVIOURAL PROBLEMSAT THE PRETEST PHASE

4.2.3 COMPARISON OF EXPERIMENTAL GROUP AND CONTROL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM) AT PRETEST PHASE

4.2.4 COMPARISONS OF PRE-CONTROL GROUP AND POST-CONTROL GROUP ON ANXIETY, DEPRESSION AND STRESS DIMENSIONS OF INTERNALIZING BEHAVIOURAL PROBLEMS

4.2.5 COMPARISONS OF PRE-CONTROL GROUP AND POST-CONTROL GROUP ON AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM DIMENSIONS OF EXTERNALIZING BEHAVIOURAL PROBLEMS

4.2.6 COMPARISONS OF PRE-EXPERIMENTAL GROUP AND POST-EXPERIMENTAL GROUP ON ANXIETY, DEPRESSION AND STRESS DIMENSIONS OF INTERNALIZING BEHAVIOURAL PROBLEMS

4.2.7 COMPARISONS OF PRE-EXPERIMENTAL GROUP AND POST-EXPERIMENTAL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM) WHEN EXPOSED TO PEER SUPPORT GROUP INTERVENTION

4.2.8 COMPARISON OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS DIMENSIONS) OF ORPHAN CHILDREN

4.2.9 COMPARISONS OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER RELATIONSHIP PROBLEM) OF ORPHAN CHILDREN

PART I

In part 1 comparative result of orphan and non-orphan children are presented which are given below. In this analysis first three objectives i.e. (1) "to examine the differences in internalizing and externalizing behavioural problems of orphan and non-orphan children of Kashmir" (2) "to investigate the differences in internalizing and externalizing behavioural problems of single and double orphan children of Kashmir" and (3) "to examine the gender difference in internalizing and externalizing behavioural problems of orphan children of Kashmir" have been achieved and same have been presented in the following breakups:

4.1 COMPARATIVE RESULTS OF ORPHAN AND NON-ORPHAN CHILDREN

In order to examine the significant differences in mean scores of orphan and non-orphan children ANOVA-test has been applied for analysis of data. The ANOVA-test has been done using three categorical variables viz: type of children i.e., orphan and non-orphan, gender, type of orphan and two independent variable i.e., internalizing and externalizing behavioural problems were applied. The following analysis portrays sample distribution, differential analysis based on groups of variables in this study.

4.1.1 SAMPLE CHARACTERISTICS OF ORPHAN AND NON-ORPHAN CHILDREN

In order to explore the differences among groups, one hundred orphan children whose one or both parents are expired and are residing in orphanages of Kashmir and one hundred twenty non-orphan children living with their parents. Comparison between the two group samples were ascertained on the basis of internalizing and externalizing behavioural problems. During the comparative phase of this study, a demographic data sheet was collected from the sample of 240 orphan and non-orphan children as to collect some fundamental information regarding age, type of children and gender. Table 4.1 and figure 4.1 displays the demographic profile of the sample such as age and gender.

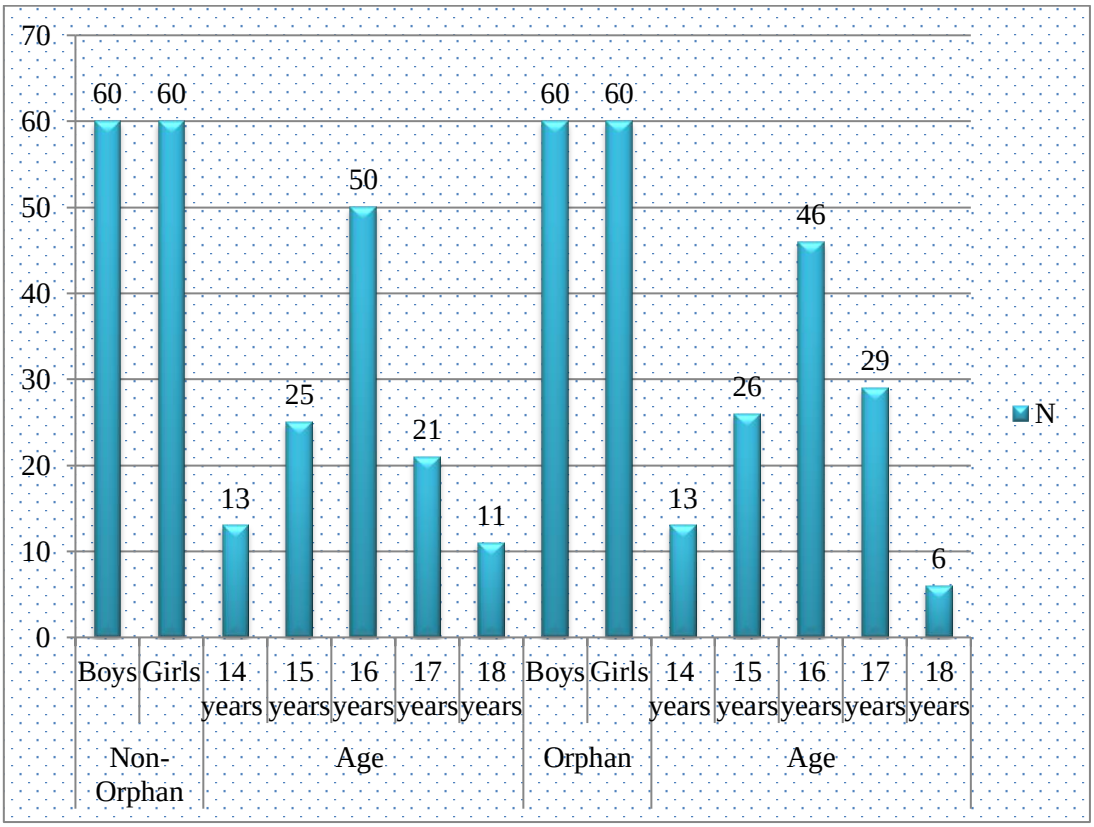
TABLE 4.I

DEMOGRAPHIC PROFILE OF THE SAMPLE

Type	Gender	N	Percentage
Non-Orphan	Boys	60	50%
	Girls	60	50%
Age	14 years	13	10.833%
	15 years	25	20.833%
	16 years	50	41.667%
	17 years	21	17.5%
	18 years	11	9.167%
Orphan	Boys	60	50%
	Girls	60	50%
Age	14 years	13	10.833%
	15 years	26	21.667%
	16 years	46	38.333%
	17 years	29	25.167%
	18 years	6	5%

FIGURE 4.1

GRAPHICAL REPRESENTATION OF DEMOGRAPHIC PROFILE OF THE SAMPLE



4.1.2 COMPARISON ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) BETWEEN ORPHAN AND NON-ORPHAN CHILDREN OF KASHMIR

The first objective of the study is "to examine the differences in internalizing and externalizing behavioural problems of orphan and non-orphan children of Kashmir". The analysis between Orphan and Non-Orphan Children on Internalizing Behavioural Problems(anxiety, depression and stress symptoms) has been presented below. Table 4.2 shows the means, mean squares; F-value's and number of orphan and non-orphan children.

TABLE 4.2

SUMMARY OF 'F'-VALUES FOR THE ORPHAN AND NON-ORPHAN CHILDREN ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS)

Constructs	Group	N	Mean	MS	df	F	Sig.
Anxiety	Orphan	120	4.80				
				1233.067	238	185.521	.000
	Non-orphan	120	9.33				
Depression	Orphan	120	3.53				
				874.07	238	110.829	.000
	Non-orphan	120	7.34				
Stress	Orphan	120	5.08				
				640.267	238	107.820	.000
	Non-orphan	120	8.34				
Total(IBP)	Orphan	120	13.30				
				7958.017	238	298.026	.000
	Non-orphan	120	24.82				

Note: IBP = Internalizing behaviour problem

**/* Significant at 0.01 & 0.05 level of confidence

The above table 4.2 displays the result of ANOVA test, which indicates that there are significant differences between orphans and non-orphans on Anxiety with F=(185.521) p<.01, Depression F=(110.829) p<.01, Stress F= (107.820) p<.01 and total internalizing behavioural problems F=(298.026) p<.01. The results suggest that orphans and non-orphans differ significantly with regard to internalizing behavioural problems (anxiety, depression and stress symptoms) with t=298.026,p<.005.

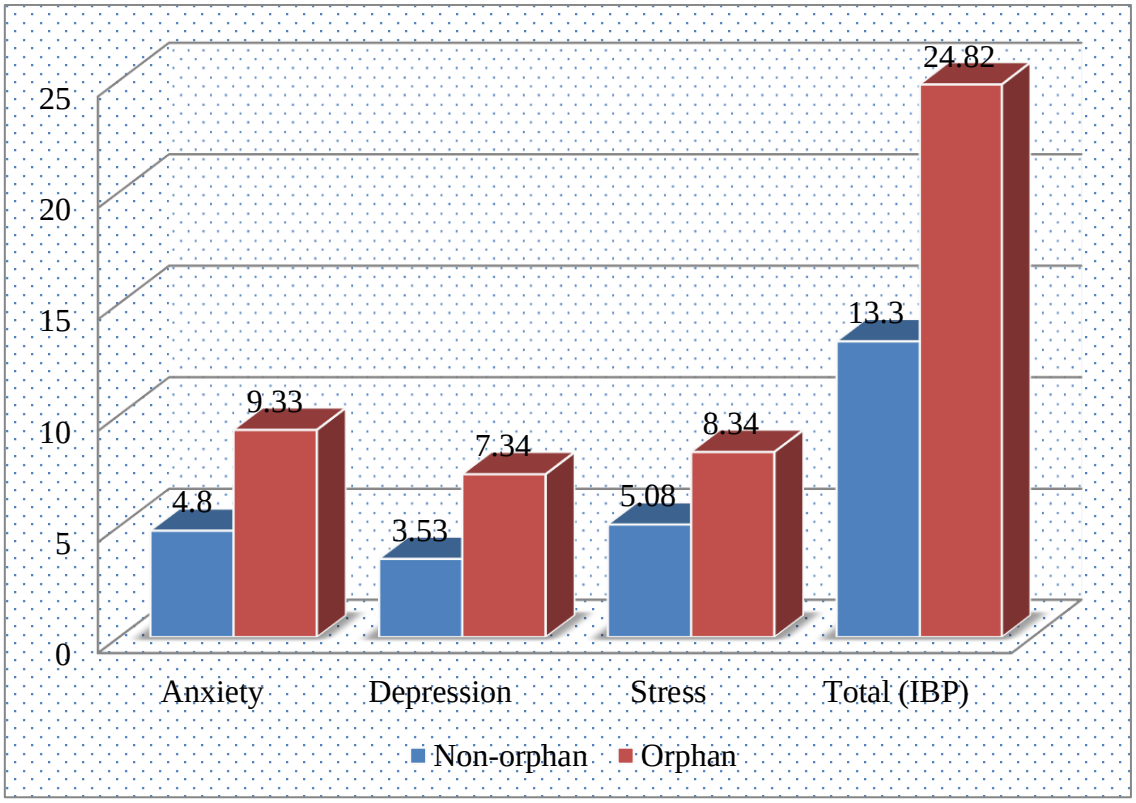
Further from the table 4.2 it was found that non-orphan children score low mean (Mean = 4.80) than orphan children (Mean=9.33) on anxiety dimension, which describes the significant difference on the basis of mean between orphan and non-orphan children. Again the orphan score more mean (Mean=7.34) as compared the non-orphan (Mean=3.53) on the

dimension of depression, which portrays the significant difference between orphan and non-orphan children.

The table further indicates that orphan children score higher mean (Mean = 8.34) than non-orphan children (Mean = 5.08) on the dimension of stress, clearly suggests significant difference on the basis of mean between orphan and non-orphan children. At the end of table the total mean of orphan children on internalizing behavioural problems (Mean=24.82) is higher than the total mean of non-orphan children (Mean = 13.30), which shows that among the two groups orphans share higher levels of internalizing behavioural problems. Therefore, the first proposed hypothesis of the study which is stated that "there is no significant difference in internalizing behavioural problems among orphan and non-orphan children of Kashmir" stands rejected. Further, figure 4.2 depicts graphical representation in internalizing behavioural problems of orphan and non-orphan children in Kashmir.

FIGURE 4.2

MEAN SCORES IN 'INTERNALIZING BEHAVIOURAL PROBLEMS' OF ORPHAN AND NON-ORPHAN CHILDREN IN KASHMIR



4.1.3 COMPARISON ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY PROBLEMS, CONDUCT PROBLEMS AND PEER RELATIONSHIP PROBLEMS) BETWEEN ORPHAN AND NON-ORPHAN CHILDREN OF KASHMIR

The analysis between orphan and non-orphan children on externalizing behavioural problems **(**aggression, hyperactivity problems, conduct problems and peer relationship problems) has been presented below. The table 4.3 shows the means, mean squares, F-values and number of orphan and non-orphan children.

TABLE 4.3

SUMMARY OF 'F'-VALUES FOR THE ORPHAN AND NON-ORPHAN CHILDREN ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY PROBLEMS, CONDUCT PROBLEMS AND PEER RELATIONSHIP PROBLEMS)

Constructs	Group	N	Mean	MS	df	F	Sig.
	Orphan	120	76.92				
Aggression				640.267	238	5.048	.025
	Non-orphan	120	80.18				
	Orphan	120	3.14				
Hyperactivity				14.504	238	4.700	.031
	Non-orphan	120	3.63				
	Orphan	120	2.96				
Conduct Problem				7.004	238	2.806	.095
	Non-orphan	120	3.30				
	Orphan	120	3.41				
Peer Problem				4.534	238	1.581	.210
	Non-orphan	120	3.68				
	Orphan	120	86.43				
Total(EXT)				1148.438	238	8.044	.005
	Non-orphan	120	90.80				

Note: (EXT) Externalizing behavioural problems

The analysis from above table 4.3 portrays that there is significant difference between orphans and non-orphans on dimensions of Aggression with F= (5.048) p<.05, Hyperactivity F = (4.700) p<.05. On the other hand, insignificant differences was found between orphan and non-orphan children on the dimensions of conduct behavioural problem F= (2.806) p>.05 and Peer Relationship problem F= (1.581) p>.05.However, total score of externalizing

behavioural problems in the above table indicates that there is significant difference between orphan and non-orphan children F=(8.044) p<.05.

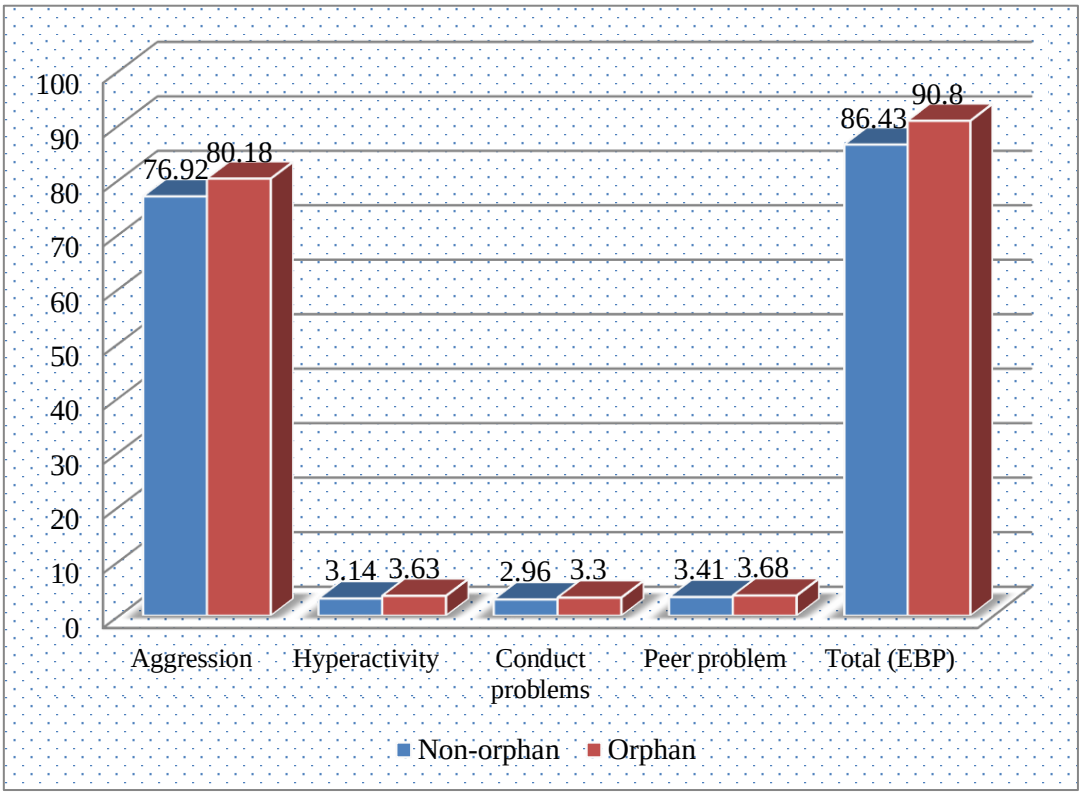
The table 4.3 portrays that the mean=(76.92) on the dimension of aggression of non-orphan children is less, compared to the mean=(80.18) of orphan children is higher than non-orphan, thus depicts the significant differences on the basis of mean. Additionally, the table displays that the mean=(3.14) of non-orphan children on the dimension of hyperactivity is lower than the mean=(3.63) of orphan children on the dimension of hyperactivity, which suggests that there is significant differences on hyperactivity between orphan and non-orphan children.

Furthermore the mean=(2.96) on the dimension of conduct behavioural problems of non- orphan children and the mean=(3.30) on the same dimension of orphan children is almost nearer to equal, thus describes insignificant differences between two samples. Again the mean=(3.41) of peer relationship of non-orphan and the mean=(3.68) on similar dimension of orphan children are almost same which suggests insignificant differences.

Overall the total mean=(86.43) of non-orphan children is lower than the total mean =(90.86) orphan children on externalizing behavioural problems describes significant differences between orphan and non-orphan children. But the two dimensions of externalizing behavioural problems i.e. conduct and peers relationship problems have insignificant difference. Therefore, the second proposed hypothesis which was stated that "there is no significant difference in externalizing behavioural problems among orphan and non-orphan children Kashmir" stands partially rejected on the basis of total mean of externalizing behavioural problems. Further, means are also presented through figure 4.3 in externalizing behavioural problems' of orphan and non-orphan children in Kashmir.

FIGURE 4.3

MEAN SCORES IN 'EXTERNALIZING BEHAVIOURAL PROBLEMS' OF ORPHAN AND NON-ORPHAN CHILDREN IN KASHMIR



4.1.4 COMPARISON ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) OF SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN OF KASHMIR

The second objective of the study is "to investigate the differences in internalizing and externalizing behavioural problems of single and double orphan children of Kashmir". In order to analyze the significant difference between single-orphan and double-orphan children on internalizing behavioural problems (anxiety, depression and stress symptoms) has been presented below. The table 4.4 shows the means, MS, F-value's and number of single-orphan and double-orphan children.

TABLE 4.4

SUMMARY OF 'F'-VALUES FOR THE SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN ON ANXIETY, DEPRESSION AND STRESS SYMPTOMS

Variables	Type	N	Mean	MS	df	F	df	Sig.
Anxiety	single-orphan	93	8.96	4.899	118	7.737	118	.003
	double-orphan	27	10.63					
depression	single-orphan	93	6.88	26.786	118	6.449	118	.004
	double-orphan	27	8.93					
Stress	single-orphan	93	8.10	14.179	118	5.932	118	.037
	double-orphan	27	9.19					
Total (IBP)	single-orphan	93	23.66	139.091	118	5.333	118	.000
	double-orphan	27	28.81					

Table 4.4 portrays that the F-value of single-orphan and double-orphan is F= (7.737) p<.05 on the dimension of anxiety with (Mean=8.96) and (Mean=10.63) respectively, suggesting that there is significant differences on anxiety between single-orphan and double-orphan children of Kashmir. Again on the dimension of Depression F = (6.449) p<.05 with (Mean=6.88) of single-orphan children and with (Mean=8.93) of double-orphan children depicts that there is significant difference between single and double orphan children on the dimension of depression.

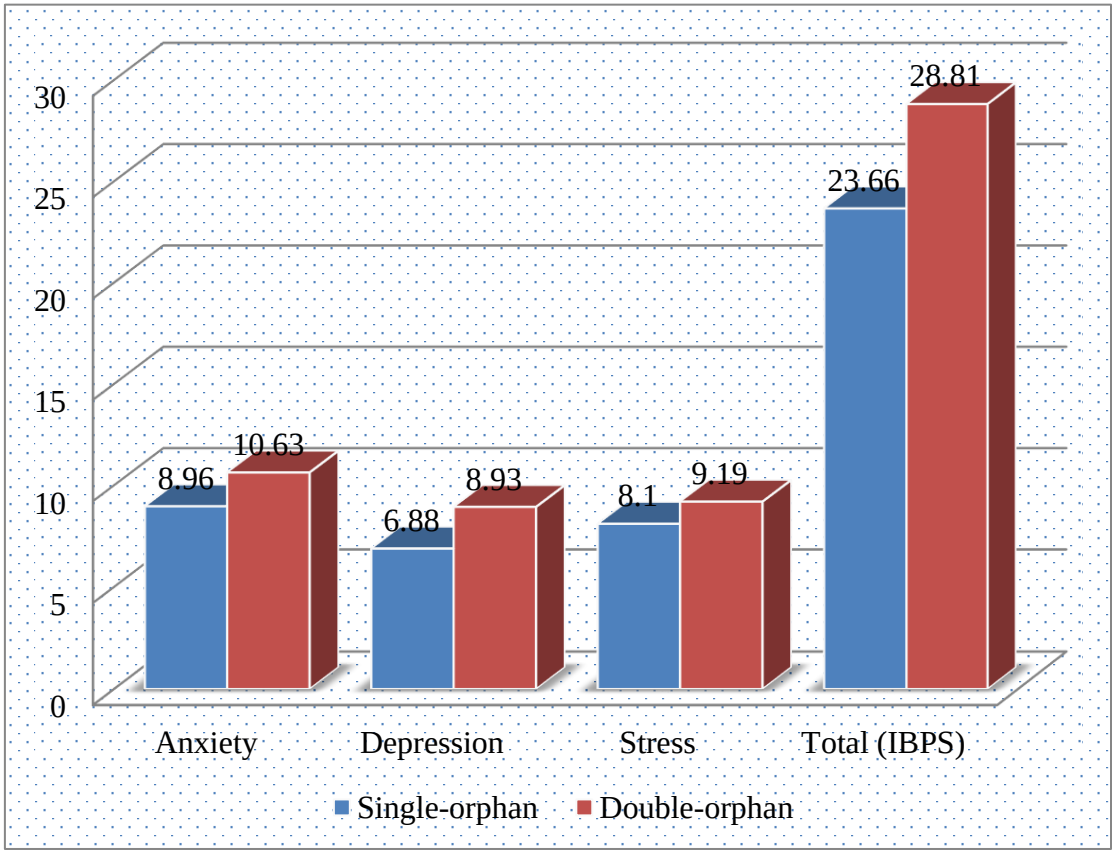
Further the table delineate that the value of F = (5.932) p<.05 with Mean = 8.10 of single orphan children and Mean=9.19 double orphan children on stress dimension of internalizing behavioural problems, thus it clearly signify the significant differences on the aspect of stress between single-orphan and double orphan children.

Moreover from the above table, the total internalizing behavioural problem score of single-orphan children (Mean=23.66) and (Mean=28.81) of double-orphan children with F= (5.333) p<.01 shows significant difference on the internalizing behavioural problems between single-orphan and double-orphan children. The result suggests that double-orphan children are dealing with higher levels of internalizing behavioural problems than single orphan

children. Therefore, the third proposed hypothesis which was stated that, "there exists no significant difference in internalizing behavioural problems of single and double orphan children of Kashmir" is rejected. Further, means are also presented through figure 4.3 in internalizing behavioural problems' of single-orphan and double-orphan children in Kashmir.

FIGURE 4.4

MEAN SCORES IN 'INTERNALIZING BEHAVIOURAL PROBLEMS' OF SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN OF KASHMIR



4.1.5 COMPARISON ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER RELATIONSHIP PROBLEMS) OF SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN OF KASHMIR.

The analysis between single-orphan and double-orphan children on externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems) has

been presented below. The table 4.5 shows the means, MS, F-value's and number of single-orphan and double-orphan children of Kashmir.

TABLE 4.5

SUMMARY OF 'F'-VALUES FOR THE SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN ON AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER RELATIONSHIP PROBLEMS

Variable	Type of orphan	N	Mean	MS	F	df	Sig.
Aggression	single-orphan	93	79.22	15.312	1.699	118	.092
	double-orphan	27	83.52				
Hyperactivity	single-orphan	93	3.60	.119	.383	118	.702
	double-orphan	27	3.74				
Conduct problems	single-orphan	93	3.11	9.400	3.514	118	.013
	double-orphan	27	3.96				
Peer problem	single-orphan	93	3.51	2.242	2.174	118	.032
	double-orphan	27	4.30				
Total (EBP)	single-orphan	93	89.43	77.808	2.283	118	.024
	double-orphan	27	95.52				

Table 4.5 illustrates that F=(1.699) p>.05 with mean = 79.22 of single-orphan and mean=83.52 of double-orphan on the dimension of aggression. It is clear that both the groups have insignificant differences of aggression dimension of externalizing behavioural problems.

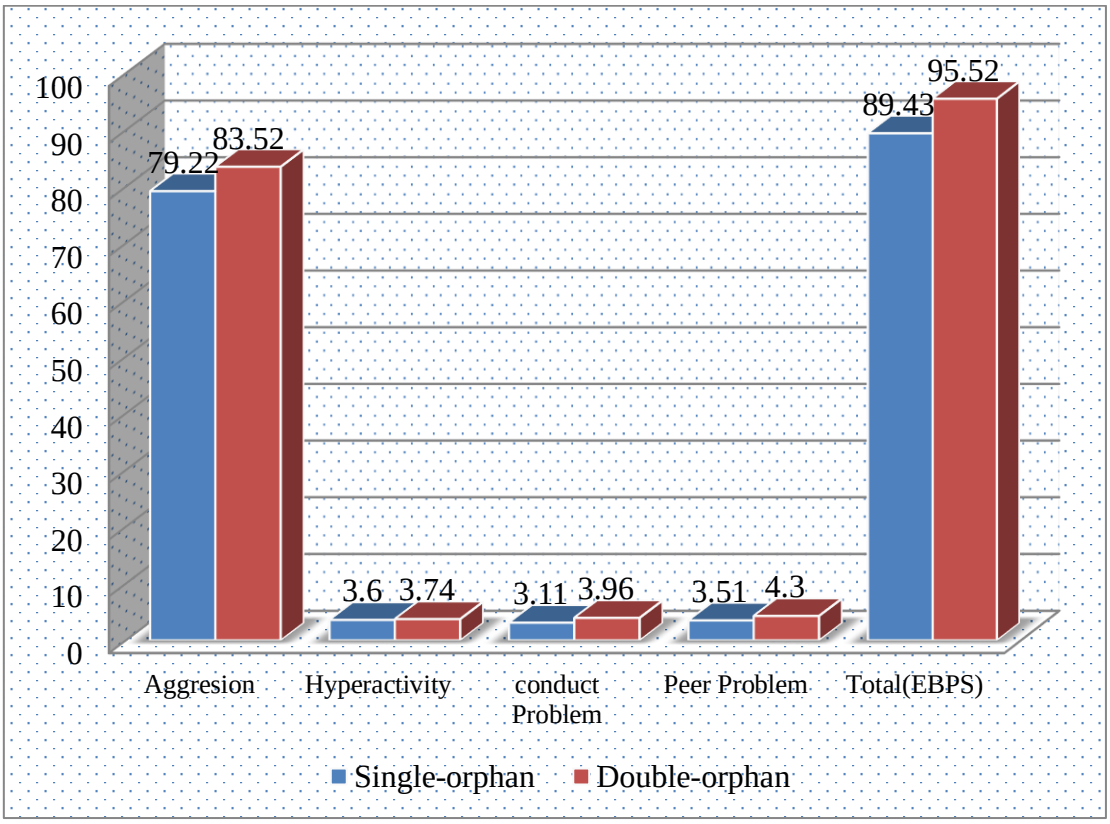
Furthermore from the above table that F= (.387) p>.05 with mean = 3.60 of single-orphan and mean=3.74 of double-orphan children, describes that there are insignificant difference between single and double-orphan children on the dimension of hyperactivity.

Again from the above table 4.5 indicates that F= (3.514) p<.05 with (mean = 3.11) of single- orphan children and the mean=3.96 of double-orphan children indicate that there is significant difference on conduct problem dimension of externalizing behavioural problems. Similarly, when looking on the result score of peer relationship problems of single and double-orphan children outlines that there is significant difference between these groups at F= (2.174) p<.05 with (mean=3.51) of single-orphan and (mean=4.30) of double-orphan.

At the end of table 4.5 when paying attention on the total score F=(2.283) p<.05 depicts the significant difference between single and double-orphan children in externalizing behavioural problems. Based on the mean analysis, double-orphan children possess higher mean=95.52, than the single-orphan children with mean = 89.43 describes that there are significant difference between single-orphan and double orphan in externalizing behavioural problems, but the aggression and hyperactivity dimensions shows insignificant difference. Therefore, the fourth hypothesis of the study which was stated that "there is no significant difference in externalizing behavioural problems of single orphan and double orphan children of Kashmir" stands partially rejected. Further, means are also presented through figure 4.5 in externalizing behavioural problems' of orphan and non-orphan children in Kashmir.

FIGURE 4.5

MEAN SCORES IN 'EXTERNALIZING BEHAVIOURAL PROBLEMS' OF SINGLE-ORPHAN AND DOUBLE-ORPHAN CHILDREN OF KASHMIR



4.1.6 COMPARISONS ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS) AMONG ORPHAN CHILDREN ON THE BASIS OF GENDER

The third objective of the study was "to examine the gender differences in internalizing and externalizing behavioural problemsof orphan children of Kashmir". So, in order to analyze gender difference ANOVA test has been applied and the results are presented below. The table 4.6 shows the means, MS, F-value's and number of boys and girls orphan children.

TABLE 4.6

SUMMARY OF 'F'-VALUES FOR THE BOYS AND GIRLS ORPHAN CHILDREN ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS)

Constructs	Group	N	Mean	MS	Df	F	Sig.
	Boys	60	9.20				
Anxiety				.075	118	.011	.915
	Girls	60	9.25				
	Boys	60	7.30				
Depression				12.675	118	1.336	.250
	Girls	60	7.95				
	Boys	60	8.35				
Stress				.033	118	.006	.939
	Girls	60	8.32				
	Boys	60	24.83				
Total(IBP)				11.408	118	.489	.486
	Girls	60	25.45				

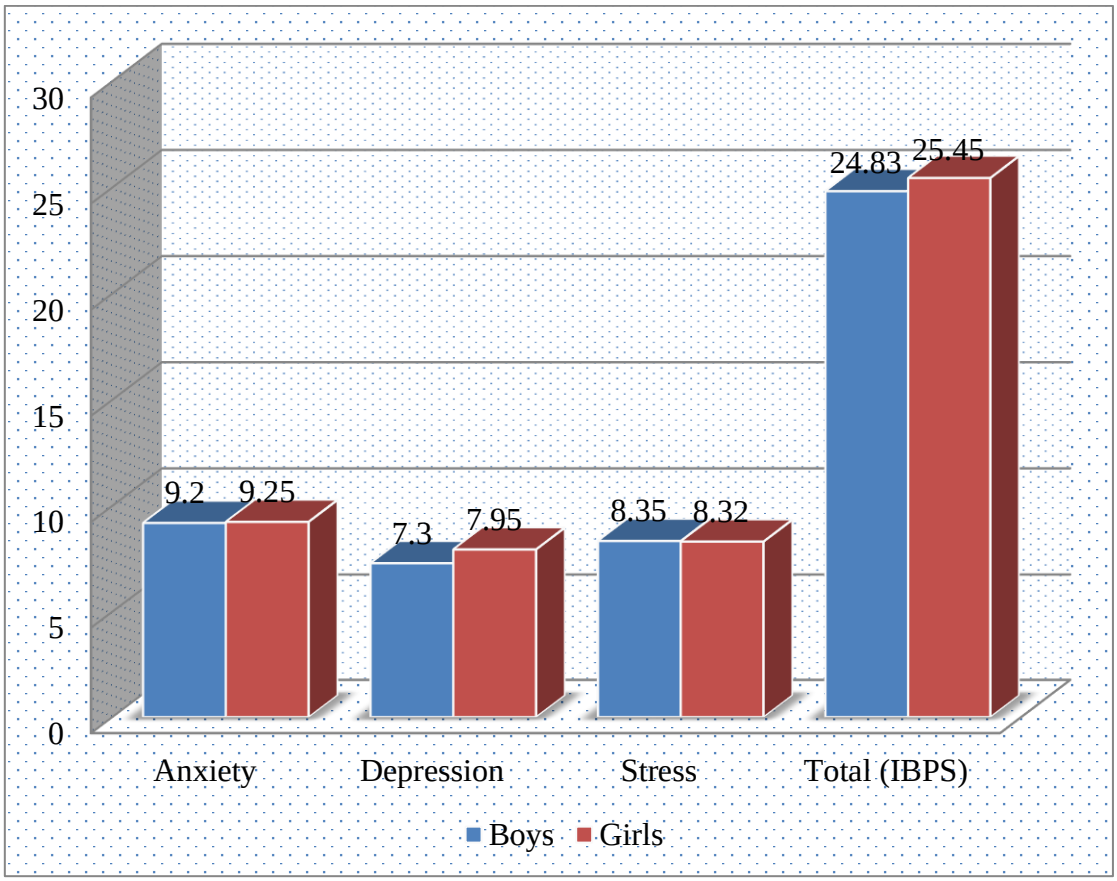
Table 4.6 delineates that the F=(.011) p>.05 of anxiety dimension among the orphan children on the basis of gender found to be insignificant with mean=9.20 of boys orphan children and mean=9.25 of girls orphan children. Similarly F=(1.336), p>.05 on depression found insignificant on the basis of gender with mean=7.30 of boys and mean=7.95 of girls.

Again between both the genders the stress dimension of internalizing behavioural problems with mean=8.35 in boys and in girls with mean=8.32 of F= (.006), p>.05 depicts the insignificant difference between the groups. When inspecting overall scores of internalizing behavioural problems (anxiety, depression and stress symptoms) with mean=24.83 of orphan boys and mean=25.45 of orphan girls at F=(.489) found to be insignificant at .05 level of significance. This clearly shows that there are insignificant difference in both boys orphan and girls orphan with regard to internalizing behavioural problems. Thus it can be said that bereavement experiences effects boys and girls orphans

equally on internalizing behavioural problems. Therefore, the fifth hypothesis of the study which states that, "there is no significant difference in internalizing behavioural problems on the basis of gender of orphan children of Kashmir" is accepted. Further, means are also presented through figure 4.6 in internalizing behavioural problems of boys and girls children of Kashmir.

FIGURE 4.6

MEAN SCORES IN 'INTERNALIZING BEHAVIOURAL PROBLEMS' OF BOYS AND GIRLS ORPHAN CHILDREN OF KASHMIR



4.1.7 COMPARISONS ON EXTERNALIZING BEHAVIOUR PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM) AMONG ORPHAN CHILDREN ON THE BASIS OF GENDER

The analysis of externalizing behaviour problems **(**aggression, hyperactivity, conduct and peer relationship problems) among orphan children on the basis of gender has been presented below. The table 4.7 shows the means, MS, F-value's and number of boys and girls orphan children.

TABLE 4.7

SUMMARY OF 'F'-VALUES FOR THE BOYS AND GIRLS ORPHAN CHILDREN ON EXTERNALIZING BEHAVIOUR PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM)

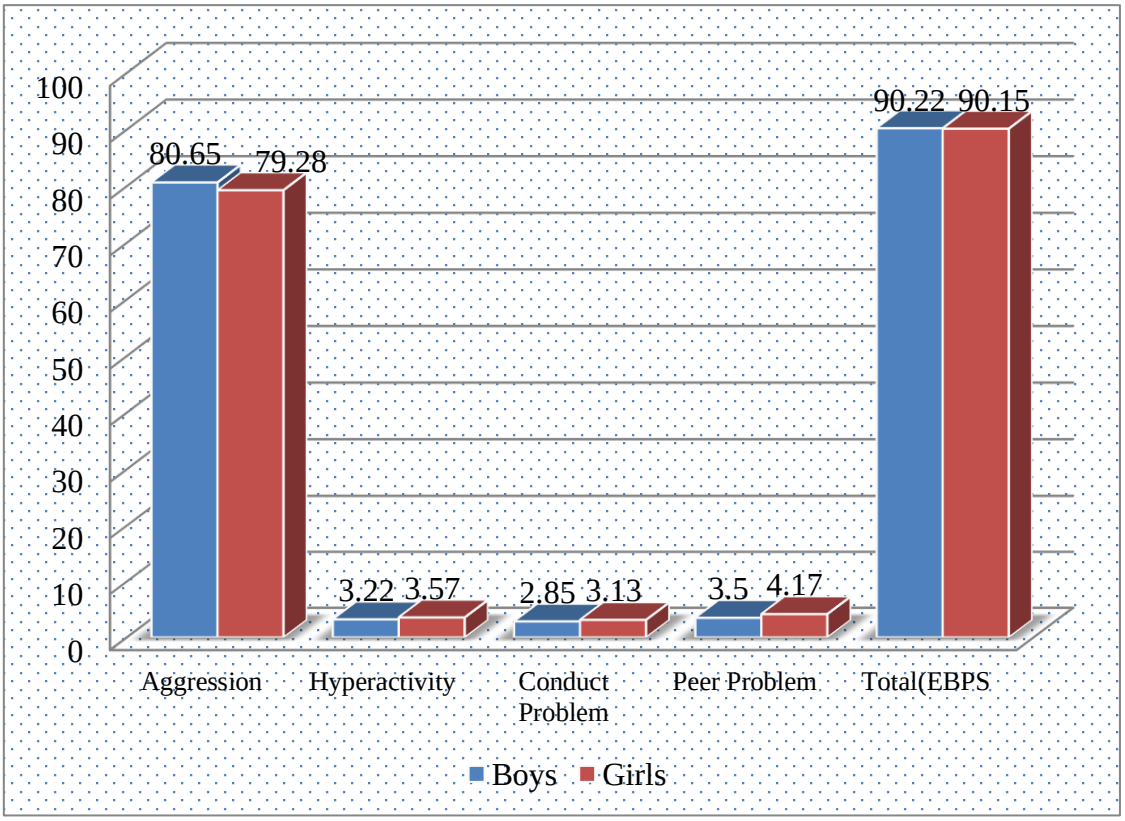
Constructs	Group	N	Mean	MS	df	F	Sig.
	Boys	60	80.65				
Aggression				56.033	118	.418	.519
	Girls	60	79.28				
	Boys	60	3.22				
Hyperactivity				3.675	118	1.625	.205
	Girls	60	3.57				
	Boys	60	2.85				
Conduct Problem				2.408	118	1.277	.261
	Girls	60	3.13				
	Boys	60	3.50				
Peer Problem				13.333	118	6.067	.015
	Girls	60	4.17				
	Boys	60	90.22				
Total EXP				.133		.001	.976
	Girls	60	90.15				

Table 4.7 precisely exposes the insignificant difference at F=(.418) p>.05 on the dimension of aggressive behavior on the basis of gender with mean=80.65 of boys and mean=79.28 of girls orphan. Similarly hyperactivity dimension of externalizing behavioural shows insignificant differences with F=(1.625) p>.05 of mean=3.57(girls), mean=3.22(boys). Additionally the table depicts insignificant difference on conduct problem of externalizing behavioural problems with F=(1.277) p>.05 with mean=2.85(boys), mean=3.13(girls) on the basis of gender.

Furthermore the above table explicitly specifies significant differences F= (6.067) p<.05 with Mean=3.50 of boys orphans and mean=4.17 of girls orphans on the dimension of peer problems, which shows that girls orphan are dealing with higher levels of peer relationship problems. At the end of the table the total score of externalizing behavioural problems shows insignificant difference between orphan boys and orphan girls with Mean=90.22 of boys and mean=90.15 of girls at .05 level of significance with F=(.001), but significant difference between both the genders are found on peer relationship problem. Therefore, the sixth proposed hypothesis states that, "there exists no significant difference in externalizing behavioural problems on the basis of gender of orphan children of Kashmir" is partially accepted. Further, means are also presented through figure 4.7 in externalizing behavioural problems' of boys and girls children in Kashmir.

FIGURE 4.7

MEAN SCORES IN 'EXTERNALIZING BEHAVIOURAL PROBLEMS' OF BOYS AND GIRLS ORPHAN CHILDREN IN KASHMIR



DISSCUSSION ON RESULTS

The result of the present study exposed that orphan and non-orphan children have significant differences in anxiety, depression and stress dimensions of internalizing behavioural problems. It was found that non-orphan children are less laden with anxiety, depression and stress symptoms as compared to the children who are dealing with the one or both parental bereavement experience and are living in orphanages. The results clearly depicts that orphan and non-orphan are significantly different in terms of externalizing behavioural problems (aggression and hyperactivity). The results suggest that orphan children are more engaged in aggressive and hyperactive behaviours than the non-orphan children. The result also portrays insignificant relationships in the dimensions of conduct and peer relationships of externalizing behavioural problems. It was found that both the groups have almost same levels of conduct and peer relationship problems. Examination of findings suggests a number of diverse explanations. For example, it may be because those children are dependent upon their elders and Parents. So the relationship of children with their parents is one of the most contributing variables to the occurrence of behavioral problems in both preschool children and the children aged 6-15 years (Children's Behavioral Problem Research group 1993). A trained psycho-analytical psychiatrist (Bowlby, 1951) reported that the deprivation of maternal parents is the central issue, causing psychological damage to the orphanage children. The psychological issue is greatest during the first year of life and it increases significantly with the length of stay in the orphanage or institution (Goodwin, 1994). A research study conducted on the orphan and vulnerable children, results of the study delineates that orphan children residing in orphanages are prone to develop behavioural and emotional problems (Vinnakota & Kaur, 2018). The result is consistent with the present study which states that orphans are dealing with high levels of depression and low levels of self-esteem compared to children who are living with their parents (Thapa 2020). Anxiety is more common among the orphan than non-orphan children and further anxiety, depression and stress are positively associated with the decision making (Shafiq Haider & Ijaz 2020).

Another study which supports our study conducted between orphan and non-orphan children in Ghana reveals that 41% of orphan children show depression of which 32% possess mild depression and 9% show severe depression. The result also revealed more anxiety symptoms in orphans as compared to non-orphans and orphans mostly perceive their support from their friends and non-orphans from their family. The study thus suggests that

parents or family care have utmost importance for children to resist psychological problems among themselves (Salifu-Yendork & Somhlaba, 2015). Orphan children have high level of depression living in orphanages of Kashmir, then the children who are living with their parents (Bhat, 2014). The Psychological problems such as symptoms of anxiety, sadness, and feeling of loneliness may be because increased number of changes and disturbances in daily life and with feeling of poor control over ones circumstances may be manifested by children whose parents are dead (Foster & Williamson, 2000). It has been observed the children who have lost their parents become most vulnerable, because they do not have the emotional and physical maturity to deal their psychological trauma associated with parental loss. In the society, orphan children can be considered to be at more risk than average children (Subbarao & Coury, 2004). A more supportive study which suggests that orphan adolescent girls staying in the orphanages more than 12 years found to be suffering depressive symptoms and aggressive behaviour and children who are living with the surrogate or unknown parent found to be less aggressive, internalizing their aggressive behaviour (El-Slamoni & Hussien, 2019).

Orphan children have higher rate of depression and mental health problems that non-orphan children and among the orphan childrens double-orphan children shares more depressive symptoms compared to single and non-orphan children (Thombs & Rousseau, 2008). Children who are residing in orphanage have negative effect on them with high levels of affective disorder, conduct problems, social problems and pervasive developmental disorders and with increasing age, externalizing behavioural problems increase in them (Michael et al., 2014). Orphan children have higher rates of internalizing and externalizing behavioural problems than the non-orphans (Makame et al., 2002; Pelton & Forehan, 2005). Children living under institutional care had more internalizing, externalizing and poor well-being than children living with their parents (Padmaja et al., 2014; Bachman et al., 2012). Orphans has more emotional, behavioural problems than non-orphans and are more likely to be emotionally needy, insecure, poor, exploited, abused or neglected(Musisi et al., 2007). Orphans experience more psychosocial distress compared to non-orphans and on the basis of gender, maternal orphans, parental orphans and double orphans has highest distress then non-orphans (Nyamukapa et al., 2008).Again problem of delinquency, aggression, thought problems, and attention problems were reported from these children, higher rates of internalizing, externalizing and social problems were also found and factors like smoking, alcohol and fatalistic views enhance these problems significantly (Erol et al., 2010;Shafiq et al.,2020; Thapa, 2020).

This result is also consistent with (Hermenau et al., 2015; Chakraborty et al., 2015) observed that orphan children have more depressive symptoms, posttraumatic stress symptoms and aggressive behaviour than non- orphan children. This finding has been supported by a large body of studies (Sahad et al.,2018;Thurman, 2014;Khurshaid et al., 2018; Merz and McCall,2010; Atwine et al., 2005; Cluver et al.,2007; Colderbank, 2009; Erol et al., 2008; Fawzy & Fouad, 2010; Hawk & McCall, 2010; Iqbal, 2012; Sengendo & Nambi,1997; Gearing et al.,2013; Sujatha & Jacob 2014). Apart from the above results of orphan and non-orphan children, insignificant difference has been found on the basis of gender among the orphan childrens in internalizing and externalizing behavioural problems, but significant difference has been found on the dimension of conduct behavioural problems among orphan children on the basis of gender. To conclude bereavement experience and living in orphanage setting, without the care and affection of parents directly led the children to develop internalizing and externalizing behavioural problems. Due to loss of parents and at the same time shifting the children to orphanage, are the breeding ground of psychopathology among the orphan children (Rather & Margoob, 2006).

PART II

4.2 PRE-TEST AND POST-TEST RESULTS OF EXPERIMENTAL GROUP AND CONTROL GROUP OF THE STUDY.

This section deals with the results of the pre-test scores of the sample of orphan students exploring whether any such significant differences exist between the experimental and control groups on various criterion variables like internalizing behavioural problems (anxiety, depression and stress symptoms) and externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems). These tests were carried out to ensure whether the two comparable groups were homogenous in nature before the administration of the peer support group intervention. The results of the independent sample t-test (pre-test scores) between the experimental group and the control group are presented below.

This experimental results also deals with the results of the pre-test and post-test results of orphan children exploring whether any such significant differences exist between the pre-experimental and post-experimental groups and control groups on various criterion variables like internalizing behavioural problems (anxiety, depression and stress symptoms) and externalizing behavioural problems (aggression, hyperactivity, conduct and peer

problems). These tests were carried out to ensure whether the post-experimental group have gained the improvement than pre-experimental and post-control group from internalizing behavioural problems (anxiety, depression and stress symptoms) and externalizing behavioural problems (aggression, hyperactivity, conduct and peer problems) after the administration of the peer support group intervention. The results of the Paired‘t’ test of pre-post experimental and pre-post control groups are also presented in following part. Further, the results of the Independent‘t’ test of post-test experimental and post-test control Groups are presented in following section.

4.2.1 SAMPLE CHARACTERISTICS OF EXPERIMENTAL GROUP AND CONTROL GROUP OF ORPHAN CHILDREN

In order to explore the differences between experimental group and control group of orphan children of Kashmir, the sample of 120 orphan children were divided into experimental and control group with 60 orphan children in each group. Table 4.8 and figure 4.8 displays the demographic profile of the sample such as age, type and gender.

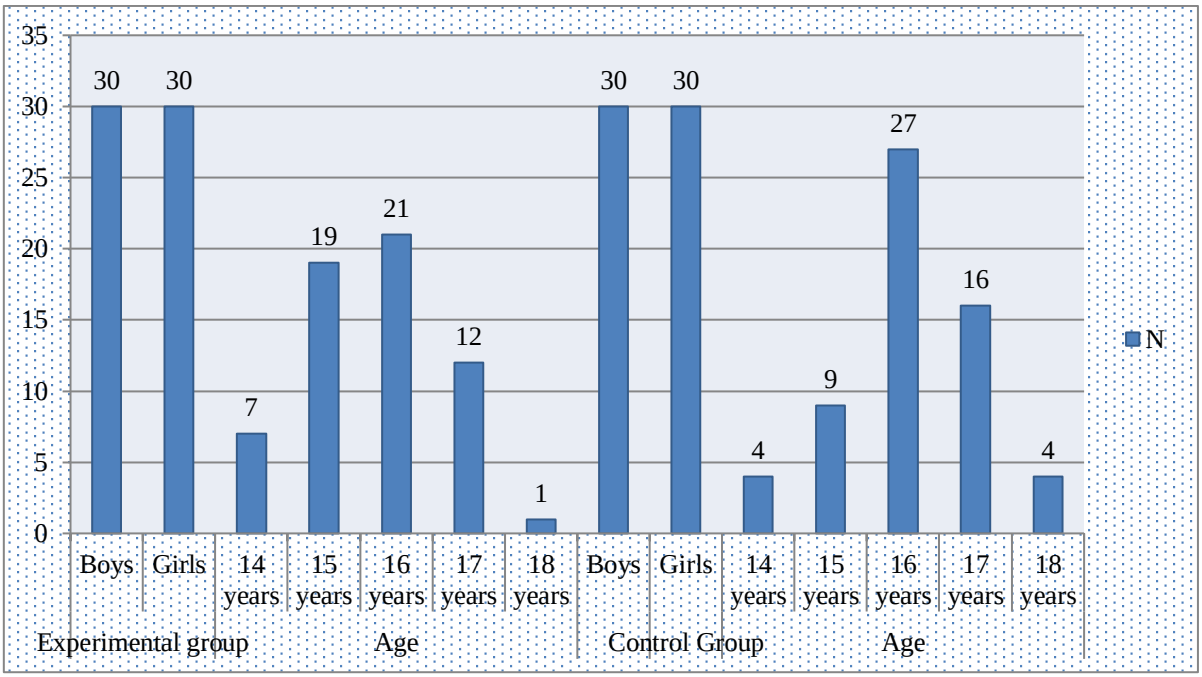
TABLE 4.8

DEMOGRAPHIC PROFILE OF THE SAMPLE OF EXPERIMENTAL GROUP AND CONTROL GROUP OF ORPHAN CHILDREN

Type	Gender	Number	Percentage
Experimental group	Boys	30	25%
	Girls	30	25%
Age	14 years	7	5.833%
	15 years	19	15.833%
	16 years	21	17.5%
	17 years	12	10%
	18 years	1	0.833%
Control Group	Boys	30	25%
	Girls	30	25%
Age	14 years	4	3.33%
	15 years	9	7.5%
	16 years	27	22.5%
	17 years	16	13.33%
	18 years	4	3.33%
	Girls	30	25%
	Boys	30	25%

FIGURE 4.8

GRAPHICAL REPRESENTATION OF DEMOGRAPHIC PROFILE OF EXPERIMENTAL GROUP AND CONTROL GROUP OF ORPHAN CHILDREN



4.2.1 COMPARISON OF EXPERIMENTAL GROUP AND CONTROL GROUP ON ANXIETY, DEPRESSION AND STRESS SYMPTOMSOFINTERNALIZING BEHAVIOURAL PROBLEMSAT THE PRETEST PHASE

The fourth objective of the study is "to investigate the effect of peer group support intervention in dealing with internalizing and externalizing behavioural problems of orphan children of Kashmir". This analysis is related to experimental group and control group on anxiety, depression and stress symptoms of internalizing behavioural problems at the pretest phase and has been presented below. The table 4.9 shows the means, standard deviations, standard error of mean, and t-values of experimental group and control group at the pretest phase.

TABLE 4.9

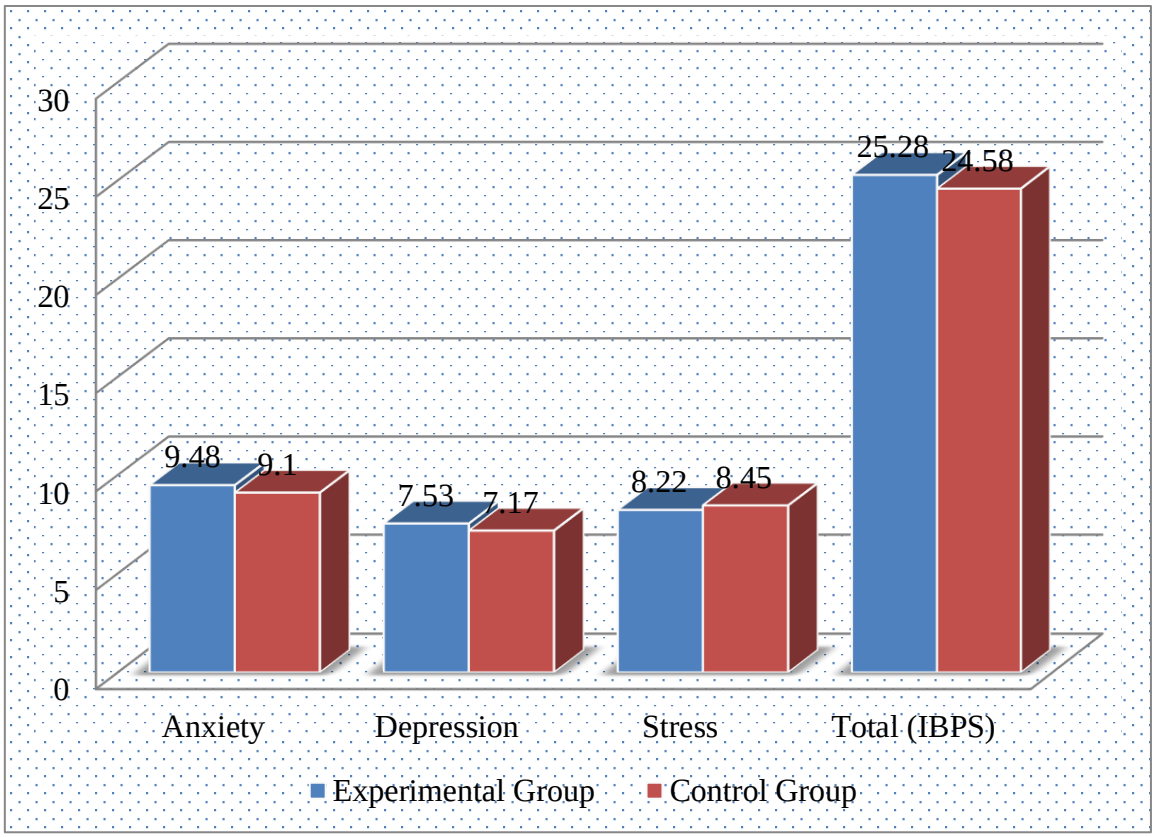
'T'-VALUES OF EXPERIMENTAL GROUP AND CONTROL GROUP ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) AT THE PRETEST PHASE

Constructs	Group	N	Mean	SD	SEM	t-value	df	Sig
Anxiety	Experimental	60	9.48	2.528	.326	.814	118	.417
	Control		9.10	2.628	.339			
Depression	Experimental	60	7.53	3.471	.448	.605	118	.546
	Control		7.17	3.163	.408			
Stress	Experimental	60	8.22	2.464	.318	.536	118	.539
	Control		8.45	2.303	.297			
Total (IBP)	Experimental	60	25.28	4.794	.619	.756	118	.415
	Control		24.58	5.334	.689			

The results of independent 't' test in table 4.9 precisely portrays that there are insignificant differences between experimental group and control group at the pre-test phase on anxiety with mean=9.48 of experimental group and mean=9.10 of control group t = (.824) p>.05, depression with mean=7.53 of experimental group and mean = 7.17 of control group t = (.605) p>.05, stress with mean=8.22 of experimental group and mean=8.45 of control group t= (.536) p>.05. Overall in table 4.9 the internalizing behavioural problems of experimental and control group show clearly insignificant difference with mean=25.28 of experimental group and control group of mean=24.58 at t= (.756) p>.05. The outcome revealed that both the groups are identical in nature with regard to dimensions of internalizing behavioural problems (anxiety, depression and stress symptoms) at pre-test phase. Further, means are also presented through figure 4.9 in internalizing behavioural problems of experimental and control group of orphan children.

FIGURE 4.9

MEAN SCORES IN 'INTERNALIZING BEHAVIOURAL PROBLEMS' OF EXPERIMENTAL GROUP AND CONTROL GROUP AT THE PRETEST PHASE



4.2.3 COMPARISON OF EXPERIMENTAL GROUP AND CONTROL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEMS) AT PRETEST PHASE

The analysis is related to experimental group and control group on externalizing behavioural problems (aggression, hyperactivity, conduct and peer problem)at the pretest phase and has been presented below. The table 4.10 shows the means, standard deviations, standard error of mean, and t-values of experimental group and control group at the pretest phase.

TABLE 4.10

T-VALUES OF EXPERIMENTAL GROUP AND CONTROL GROUP ON AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER RELATIONSHIP PROBLEM DIMENSIONS OF EXTERNALIZING BEHAVIOURAL PROBLEMS AT PRETEST PHASE

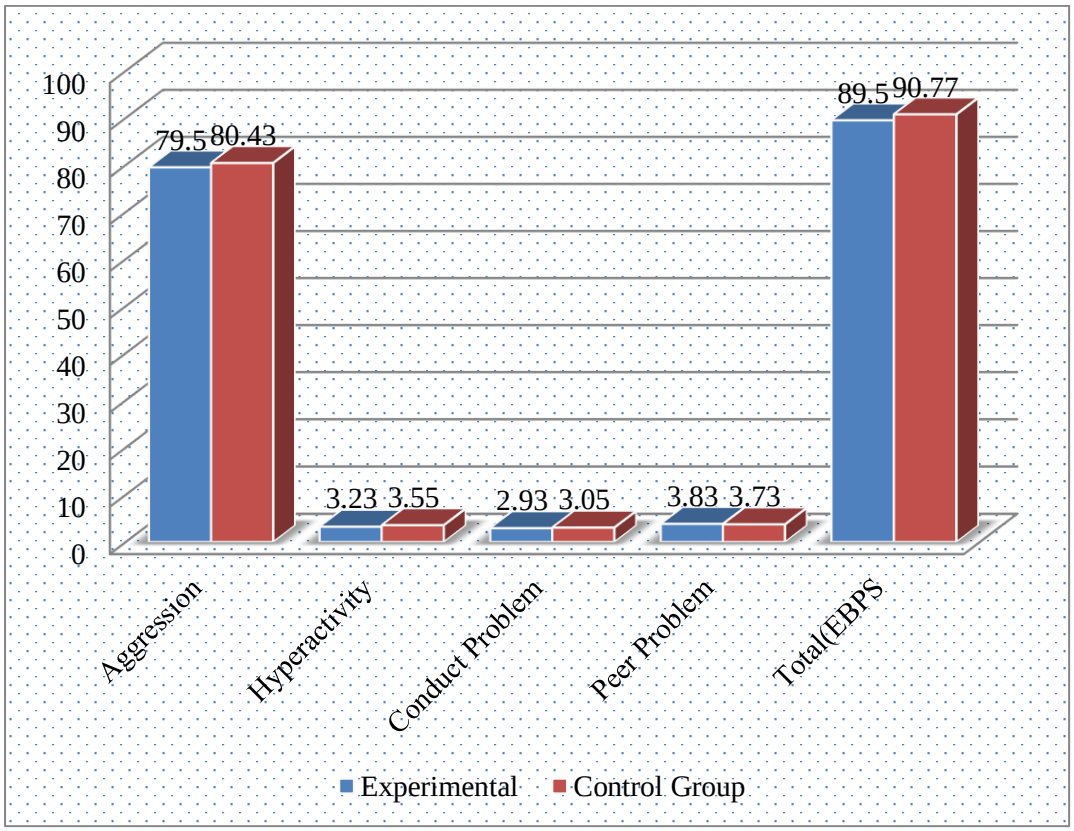
Constructs	Group	N	Mean	SD	SEM	t	df	Sig.
Aggression	Experimental	60	79.50	10.946	1.413	.441	118	.660
	Control	60	80.43	12.211	1.576			
Hyperactivity	Experimental	60	3.23	1.332	.172	1.152	118	.252
	Control	60	3.55	1.661	.214			
Conduct	Experimental	60	2.93	1.528	.197	.463	118	.644
	Control	60	3.05	1.213	.157			
Peer problem	Experimental	60	3.83	1.787	.231	.345	118	.731
	Control	60	3.73	1.364	.176			
Total	Experimental	60	89.50	11.632	1.502	.570	118	.570
	Control	60	90.77	12.694	1.639			

The results in the table 4.10 clearly depicts the insignificant difference between experimental and control groups at pre-test stage on the dimensions of aggression, hyperactivity, conduct and peer problems of externalizing behavioural problems. The result indicate insignificant difference on the aggression t= (.441), p>.05 with mean=79.50 of experimental group, mean=80.43 of control group, hyperactivity t=(1.152), p>.05 with mean = 3.23 of experimental group, mean=3.55 of control group, conduct problem t = (.463) p>.05 with mean=2.93 of experimental group, mean=3.05 of control group and peer problem t=(.345) p>.05 with mean=3.83 of experimental group, mean=3.73 of control group. Further

the total score in the table 4.10 delineates insignificant difference between experimental and control groups t= (.570) p>.05 with mean=89.50 of experimental group and mean=90.77 of control group. Thus the result exposed that both the groups are homogeneous in nature with regard to externalizing behavioural problems (aggression, hyperactivity, conduct and peer problems) at pre-test phase.

FIGURE 4.10

MEAN SCORES IN 'EXTERNALIZING BEHAVIOURAL PROBLEMS' OF EXPERIMENTAL GROUP AND CONTROL GROUP AT PRE-TEST PHASE



4.2.4 COMPARISONS OF PRE-CONTROL GROUP AND POST-CONTROL GROUP ON ANXIETY, DEPRESSION AND STRESS DIMENSIONS OF INTERNALIZING BEHAVIOURAL PROBLEMS

The analysis is related to pre-control and post-control group on internalizing behavioural problems (anxiety, depression and stress symptoms)has been presented below. The table 4.11 shows the means, standard deviations, standard error of mean, and t-values of Pre-control group and Post-control group.

TABLE 4.11

T-VALUES OF PRE AND POST CONTROL GROUP ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSIVE AND STRESS SYMPTOMS)

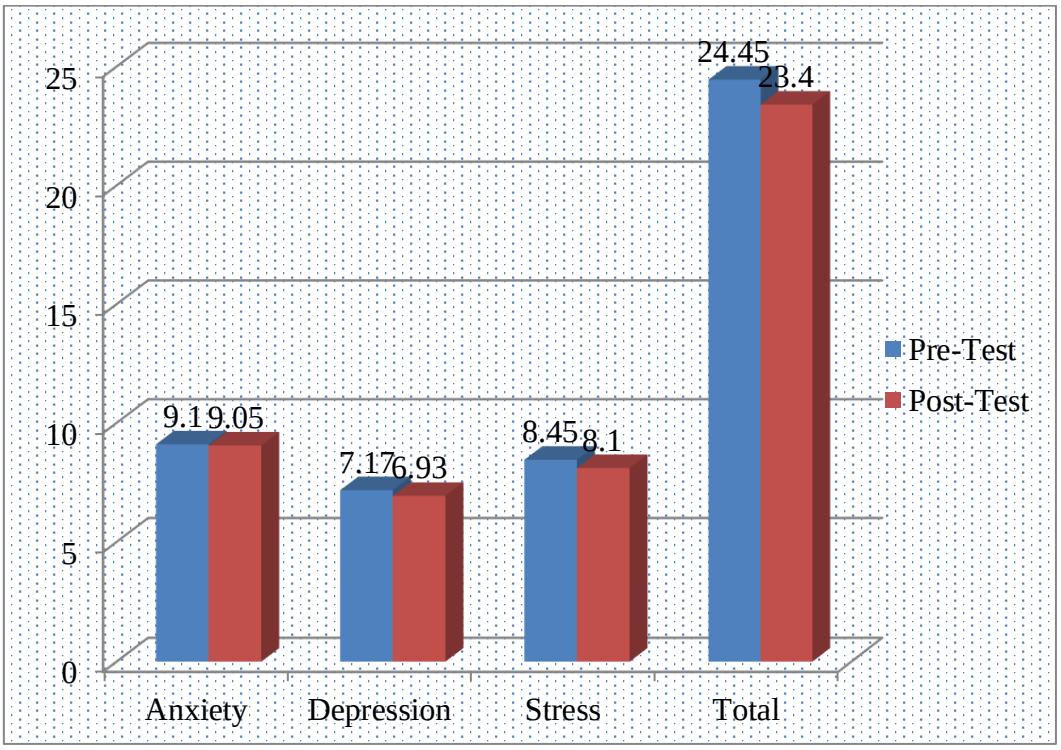
Group	Constructs	Mean	N	SD	SEM	t-value	df	Sig.
Pre-test	Anxiety	9.10	60	2.628	.339			
						.104	59	.918
Post-test	Anxiety	9.05	60	2.639	.341			
Pre-test	Depression	7.17	60	3.163	.408			
						.204	59	.839
Post-test	Depression	6.93	60	3.012	.406			
Pre-test	Stress	8.45	60	2.303	.297			
						.042	59	.967
Post-test	Stress	8.10	60	2.301	.281			
Pre-test	Total IBP	24.45	60	5.334	.689			
						.182	59	.856
Post-test	Total IBP	23.40	60	5.401	.645			

The results of the Paired‘t’ test of control groups at pre-test and post-test stage shows statistically insignificant difference of the dimensions anxiety at t=.104,p>.05, depression at t=.204,p>.05 and stress at t=.042, p>.05 of internalizing behavioural problems.

At the end of table when viewing the total internalizing behavioural problem score, it indicates insignificant difference between the pre-control and post-control group of orphan children with mean=24.45of pre-control group and mean=23.40 of post-control group at t= (22.395), p>.0. Thus result suggests that pre-control and post-control group of orphan did not led any change in the internalizing behavioural problems, who were given regular instruction and at the same time experimental group were exposed to peer support group intervention.

FIGURE 4.11

MEAN SCORES OF PRE-CONTROL GROUP AND POST CONTROL GROUS ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION ANDSTRESS SYMPTOMS)



4.2.5 COMPARISONS OF PRE-CONTROL GROUP AND POST-CONTROL GROUP ON AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM DIMENSIONS OF EXTERNALIZING BEHAVIOURAL PROBLEMS

The analysis is related to pre-control and post-control group on externalizing behavioural problems (aggression, hyperactivity, conduct and peer problems) has been presented below. The table 4.11 shows the means, standard deviations, standard error of mean, and t-values of Pre-control group and Post-control group.

TABLE 4.12

T-VALUES OF PRE AND POST CONTROL GROUPS ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEMS)

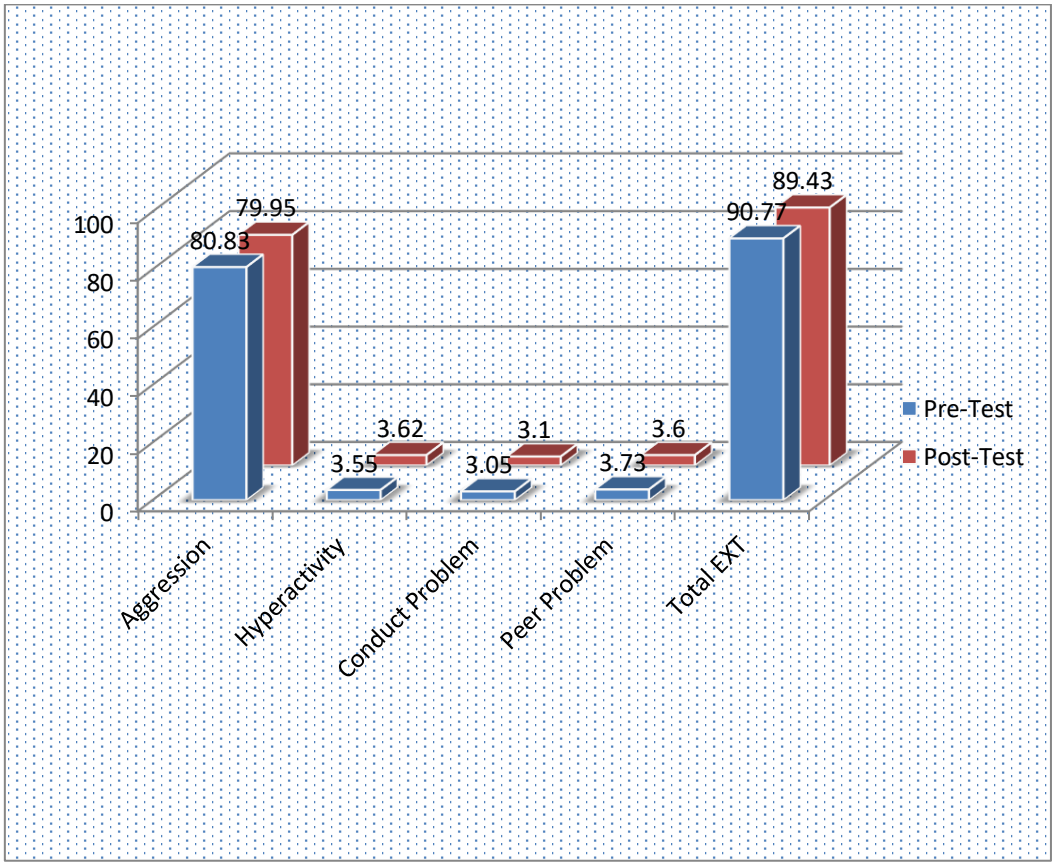
Group	Constructs	Mean	N	SD	SEM	t-value	df	Sig.
Pre-test	Aggression	80.43	60	12.211	1.576			
						.237	59	.814
Post-test	Aggression	79.95	60	12.158	1.570			
Pre-test	Hyperactivity	3.55	60	1.661	.214			
						.242	59	.809
Post-test	Hyperactivity	3.62	60	1.519	.196			
Pre-test	Conduct problem	3.05	60	1.213	.157			
						.228	59	.812
Post-test	Conduct Problem	3.10	60	1.258	.162			
Pre-test	Peer Problem	3.73	60	1.364	.176			
						.000	59	1.00
Post-test	Peer problem	3.60	60	1.284	.170			
Pre-test	Total Ext	90.77	60	12.694	1.639			
						.372	59	.813
Post-test	Total Ext	89.43	60	12.304	1.594			

The above table indicates insignificant difference between the pre-control and the post-control group on the dimensions of Aggrsssion at t=.237,p>.05, Hyperactivity with t=.242,p>05, conduct problem of having t=.228,p>.05 and peer problem with t=.000,p>.05 of externalizing behavioural problems. The overall mean of externalizing behaviouarl problems of pre-control group is 90.77 and post-control group is 89.43 which indicates insignificant difference at t=.372,p>.05. Thus the result suggests that keeping unexposed to peer support

group intervention, the pre-control group and post-control group are dealing with equal levels of externalizing behavioural problems.

FIGURE 4.12

MEAN SCORES OF PRE-CONTROL AND POST-CONTROL GROUPS ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT PROBLEM AND PEER PROBLEM)



4.2.6 COMPARISONS OF PRE-EXPERIMENTAL GROUP AND POST-EXPERIMENTAL GROUP ON ANXIETY, DEPRESSION AND STRESS DIMENSIONS OF INTERNALIZING BEHAVIOURAL PROBLEMS

The analysis is related to pre-experimental and post experimental group on internalizing behavioural problems (anxiety, depression and stress Symptoms).The table 4.11 shows the means, standard deviations, standard error of mean, and t-values of experimental group at the pretest and post-test phase.

TABLE 4.13

T-VALUES OF PRE AND POST EXPERIMENTAL GROUP ON ANXIETY, DEPRESSION AND STRESS DIMENSIONS OF INTERNALIZING BEHAVIOURAL PROBLEMS

Group	Constructs	Mean	N	SD	SEM	t-value	df	Sig.
Pre-test	Anxiety	9.48	60	2.528	.326	13.603	59	.000
Post-test	Anxiety	7.13	60	1.995	.258			
Pre-test	Depression	7.53	60	3.471	.448	9.176	59	.000
Post-test	Depression	6.13	60	2.734	.353			
Pre-test	Stress	8.22	60	2.464	.318	14.070	59	.000
Post-test	Stress	6.18	60	1.891	.244			
Pre-test	Total (IBP)	25.28	60	4.794	.619	22.395	59	.000
Post-test	Post (IBP)	19.42	60	3.761	.486			

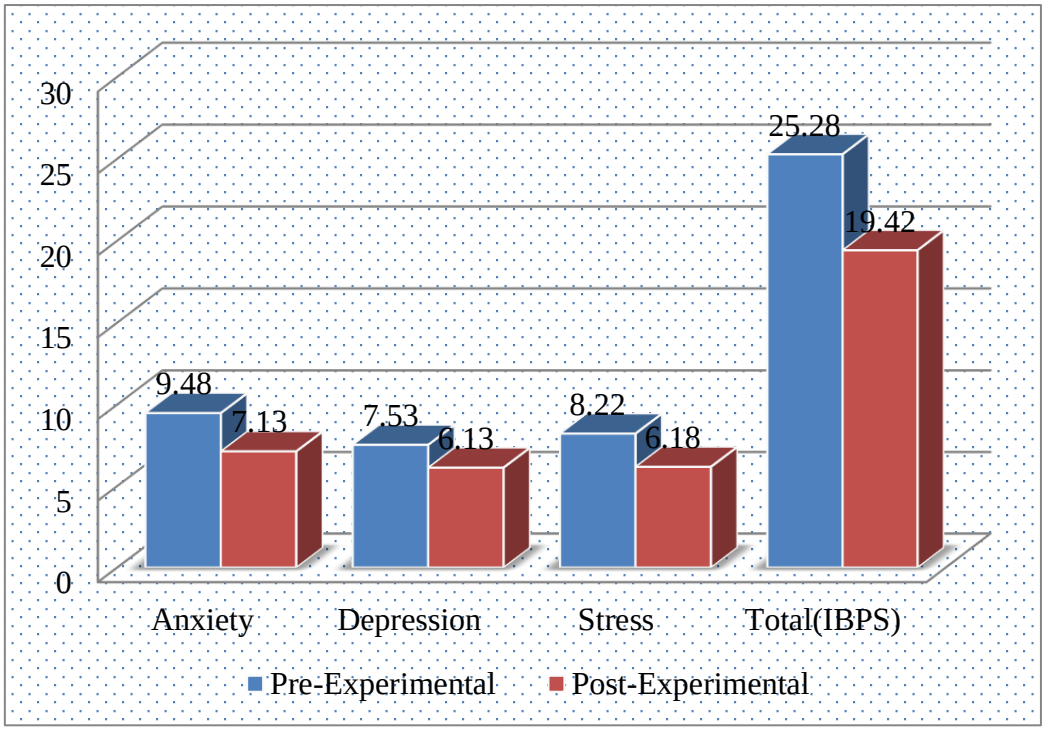
The results of the Paired‘t’ test at the post-test stage after experimental group were exposed to the peer support group intervention program show statistically significant decrease of internalizing behavioural problems. The table clearly displays the significant difference on anxiety dimension t=(13.603) p<.01 with mean=9.48 of pre-experimental group and mean=7.13 of post-experimental group of orphan children.

Further the table depicts that significant difference on the dimension of depression at t= (9.176) p<.01 with mean=7.53 of pre-experimental and mean=6.13 of post-experimental group after the administration of peer support group intervention. Similarly, stress of pre-experimental and post-experimental group of orphan children delineate significant difference when exposed to peer support group intervention t= (14.070) p<.01 with mean=8.22 of pre-

experimental group and mean=6.18 of post-experimental group. At the end of table when viewing the total internalizing behavioural problem score, indicates the significant difference between the pre and post-experiment group of orphan children with mean=25.28 of pre-experimental group and mean=19.42 of post-experimental group at t= (22.395) with .01 level of significance.

FIGURE 4.13

MEAN SCORES OF PRE-EXPERIMENTAL GROUP AND POST EXPERIMENTAL ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS)



4.2.7 COMPARISONS OF PRE-EXPERIMENTAL GROUP AND POST-EXPERIMENTAL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM) WHEN EXPOSED TO PEER SUPPORT GROUP INTERVENTION

The analysis is related to pre-experimental and post experimental group on externalizing behavioural problems (aggression, hyperactivity, conduct and peer problem) at the pre and post test phase and has been presented below. The table 4.14 shows the means, standard deviations, standard error of mean, and t-values of experimental group at the pretest and post-test phase.

TABLE 4.14

T-VALUES OF PRE-EXPERIMENTAL GROUP AND POST-EXPERIMENTAL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS WHEN EXPOSED TO PEER SUPPORT GROUP INTERVENTION

Group	Constructs	Mean	N	SD	SEM	t-value	df	Sig.
Pre-test	Aggression	79.50	60	10.946	1.413			
Post-test	Aggression	69.53	60	11.224	1.449	6.609	59	.000
Pre-test	Hyperactivity	3.40	60	1.532	.198			
Post-test	Hyperactivity	2.77	60	1.155	.149	3.306	59	.002
Pre-test	conduct problem	2.93	60	1.528	.197			
Post-test	conduct problem	2.62	60	1.195	.154	1.634	59	.108
Pre-test	peer problem	3.83	60	1.787	.231			
Post-test	peer problem	2.48	60	1.097	.142	5.574	59	.000
Pre-test	Total (EBP)	77.10	60	13.604	1.756			
Post-test	Total (EBP)	71.68	60	12.145	1.568	4.206	59	.000

Note: EBP means externalizing behavioural problems

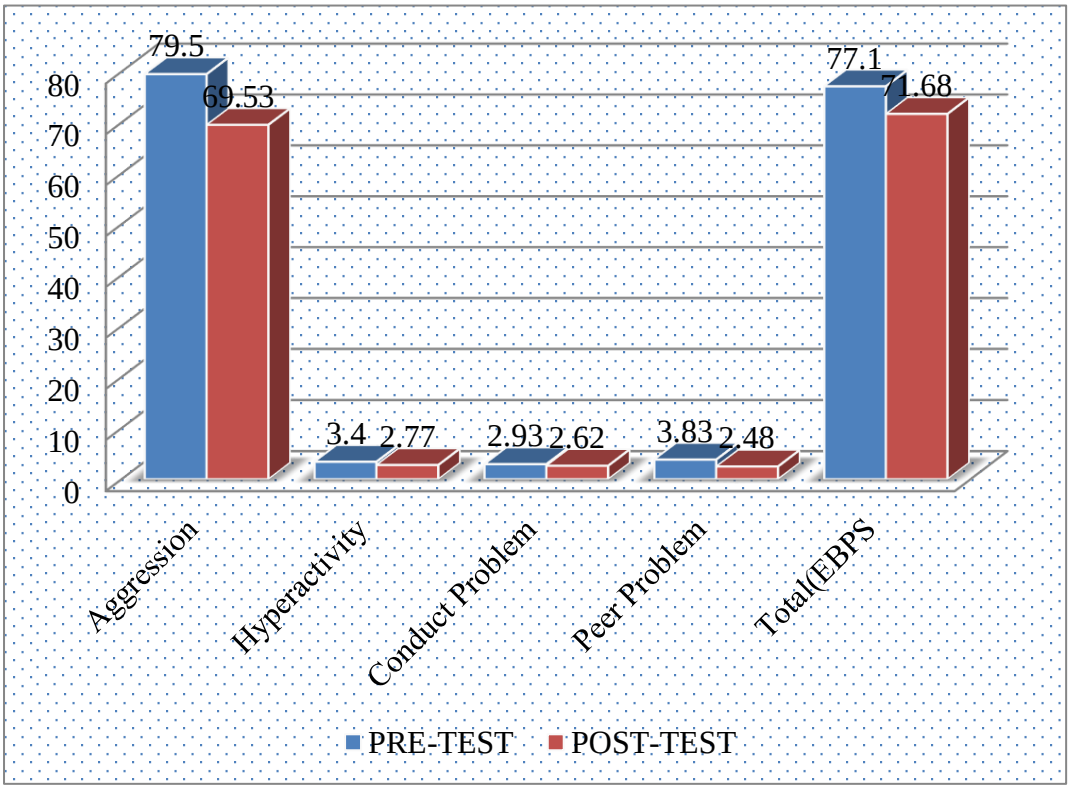
The table portrays significant difference on aggression dimension of externalizing behavioural problems between pre-experimental group and the post-experimental group t= (6.609) p<.05 with mean=79.50 of pre-experimental group and mean=9.53 of post-experimental group.

Similarly the table further delineates significant differences on hyperactivity t= (3.306) p<.05, mean=3.40 of pre-experimental group and mean=2.7) of post-experimental group. Moreover the result indicates significant difference on peer problem t=(5.574) p<.05 with mean=3.83 of pre-experimental group, mean=2.48 of post-experimental group of externalizing behavioural. But the table indicates insignificant difference between pre-experimental group and post-experimental group on the dimension of conduct behavioural problems at t= (1.634) p>.05 with mean=2.93 of pre-experimental group and mean=2.63 of post-experimental group. Overall externalizing behavioural problem show significant

difference between pre-experimental and post-experimental groups of orphan children living in orphanages at t=(4.206) p<.01 with mean=77.10 of pre-experimental group and mean=71.68 of post-experimental. Thus, it can be said that peer support group intervention has led the significant decrease of externalizing behavioural problems in the post experimental group. Further, figure 4.12 displays the mean scores of pre and post experimental groups of orphan children.

FIGURE 4.14

MEAN SCORES OF PRE-EXPERIMENTALAND POST-EXPERIMENTAL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT PROBLEM AND PEER PROBLEM)



4.2.8 COMPARISON OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS SYMPTOMS) OF ORPHAN CHILDREN

The analysis is related to post-experimental and post control group on internalizing behavioural problems (anxiety, depression and stress symptoms) has been presented below.

The table 4.15 shows the means, standard deviations, standard error of mean, and t-values of post-experimental and post-control.

TABLE 4.15

T-VALUES OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP ON INTERNALIZING BEHAVIOURAL PROBLEMS (ANXIETY, DEPRESSION AND STRESS) OF ORPHAN CHILDREN

Group	Constructs	N	Mean	SD	SEM	t-value	df	Sig.
Experimental	Anxiety	60	7.13	1.995	.258	4.16	118	.000
Control		60	9.10	2.628	.339			
Experimental	Depression	60	5.90	2.413	.311	2.466	118	0.015
Control		60	7.17	3.163	.408			
Experimental	Stress	60	6.18	1.891	.244	5.892	118	.000
Control		60	8.45	2.303	.297			
Experimental	Total (IBP)	60	19.18	3.587	.463	6.508	118	.000
Control		60	24.58	5.334	.689			

An examination of table 4.15 depicts that there is significant difference on the dimension of anxiety between experimental and control group at t=(4.16) p<.05 after the peer group support intervention. Based on the mean analysis the experimental group when exposed to peer support group intervention score low mean=7.13 as compared to the control group who did not receive any treatment, score high mean=9.10, suggests significant difference on anxiety symptoms between experimental and control groups.

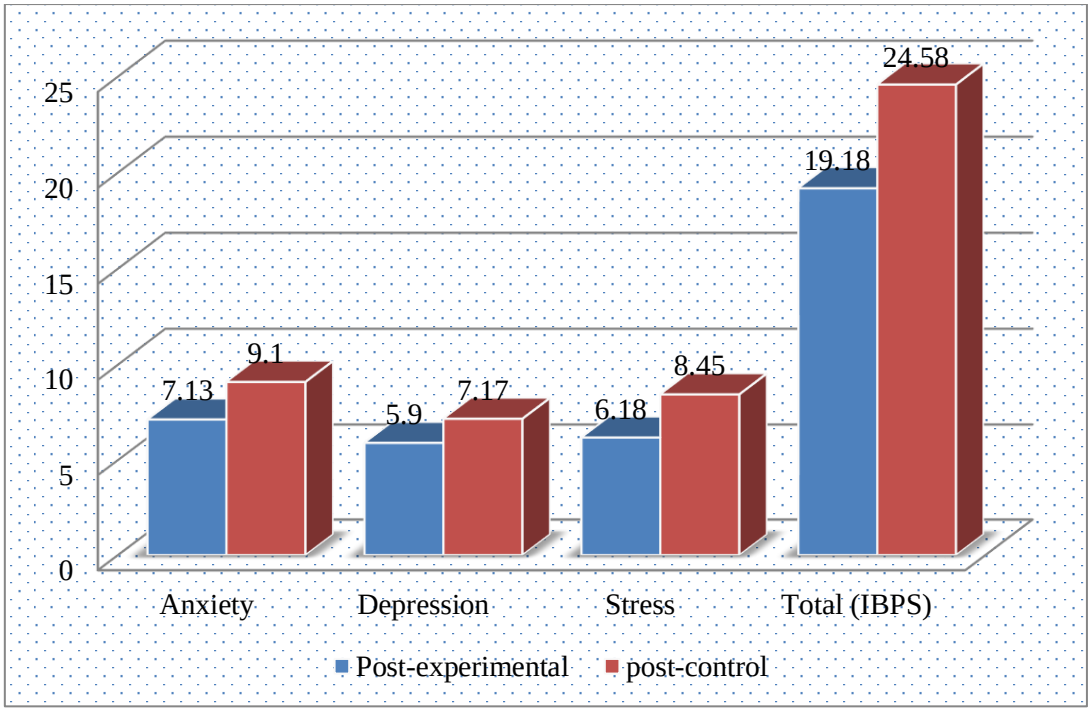
The result further delineates significant difference between experimental and control group on the dimension of depression of internalizing behavioural problems at t= (2.466) p<.05. Inspecting on the mean analysis of table above, the experimental group show less mean= (5.90) after the peer support group intervention compared to control group who did score high mean =7.17, again indicate the significant difference between experimental group and control on the dimension of depressive symptoms.

Table 4.15 further reveals significant between experimental group and control group on the stress dimension of internalizing behaviour problems at t= (5.892) p<.05.Observing the mean analysis from the above table, the control group of orphan children show more mean=8.45 than the experimental group of orphan children, which show low mean = 6.18 on the stress dimension of internalizing behavioural problems, thus again indicate significant difference between the groups.

Overall when looking at the total score of the internalizing behavioural problems from the above table which clearly specifies the significant difference between experimental and control group of orphan children at t=(6.508) p<.05. Based on the mean analysis of the table 4.15, experimental group possess the least mean=19.18 after the exposition to peer support group intervention, than control group of orphan children who are having high mean=24.58 also depicts the significant differences. Therefore, the proposed hypothesis no. 07, which was stated that "there is no significant difference of peer support group intervention in dealing with internalizing behavioural problems of orphan children of Kashmir", stands rejected. Further, figure 4.15 displays the mean scores of internalizing behavioural problems (anxiety, depression and stress symptoms) of post-experimental and post-control group of orphan children.

FIGURE 4.15

MEAN SCORES IN 'INTERNALIZING BEHAVIOURAL PROBLEMS' OF POST-EXPERIMENTAL AND POST-CONTROL GROUP OF ORPHAN CHILDREN



4.2.9 COMPARISONS OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM) OF ORPHAN CHILDREN

This analysis is related to post-experimental and post-control group on externalizing behavioural problems (aggression, hyperactivity, conduct and peer problem) and the results has been presented below. The table 4.16 shows the means, standard deviations, standard error of mean, and t-values of post-experimental group and post-control group.

TABLE 4.16

T-VALUES OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP ON EXTERNALIZING BEHAVIOURAL PROBLEMS (AGGRESSION, HYPERACTIVITY, CONDUCT AND PEER PROBLEM) OF ORPHAN CHILDREN

Type of Group	Constructs	N	Mean	SD	SEM	t-value	df	Sig.
Experimental	Aggression	60	69.53	11.224	1.449	5.091	118	.000
Control		60	80.43	12.211	1.576			
Experimental	Hyperactivity	60	3.02	1.282	.166	2.414	118	.017
Control		60	3.63	1.507	.195			

Experimental	Conduct	60	2.77	1.267	.164	1.531	118	.128
Control		60	3.12	1.236	.160			
Experimental	Peer problem	60	2.48	1.097	.142	5.532	118	.000
Control		60	3.73	1.364	.176			
Experimental	Total (EBP)	60	72.00	11.975	1.546	8.425	118	.000
Control		60	90.92	12.613	1.628			

An examination of table 4.16 portrays that aggression dimension of externalizing behavioural problems between experimental and control group is found to be significant at t= (5.091) P<.01. Based on the mean analysis the experimental group when exposed to peer support group intervention score low mean=69.53, than the control group who did not receive any treatment score higher mean=80.83, thus illustrates significant difference on aggression dimension of externalizing behavioural problems between experimental and control groups of orphan children.

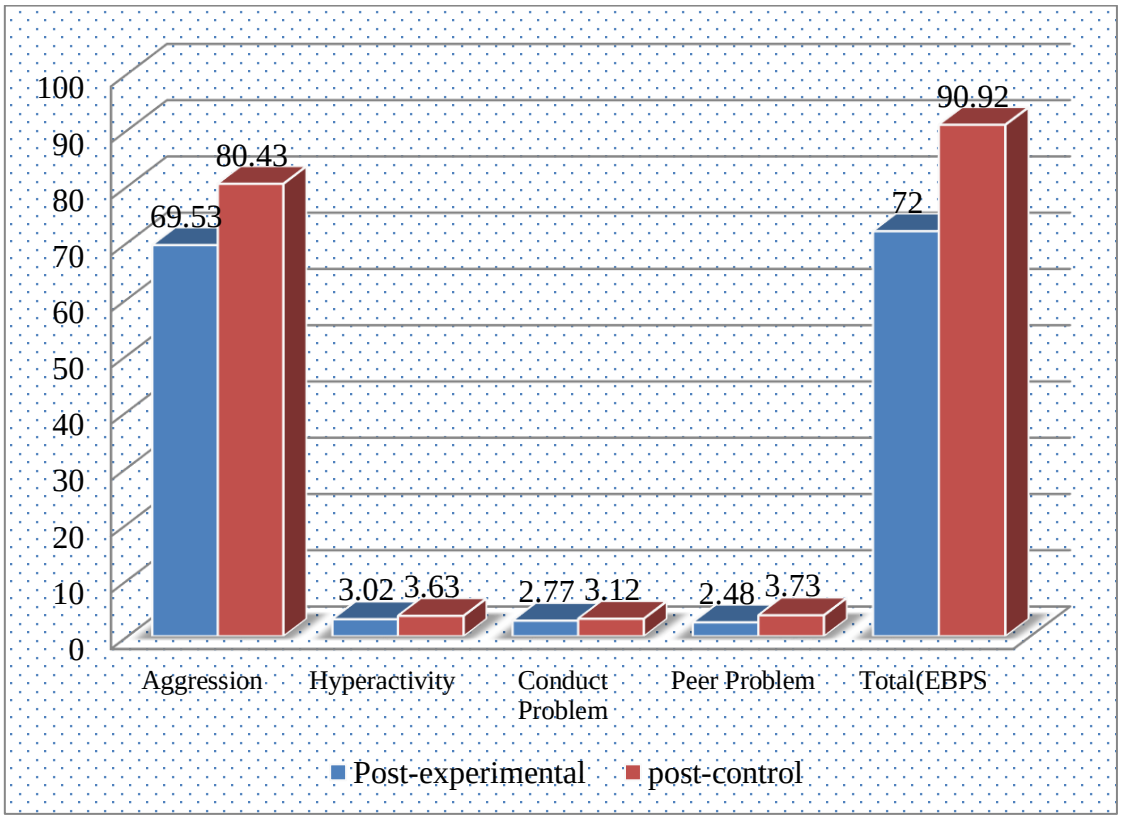
Additionally the table 4.16 delineates significant difference between experimental and control group on the hyperactivity dimension of externalizing behavioural problems at t= (2.414) p<.05. Inspecting on the mean analysis of the above table, experimental group show less mean= 3.02 after the peer support group intervention, compared to control group who did receive any treatment, score higher mean=3.63, again indicate the significant difference between experimental group and control of orphan children.

The results of table 4.16 reveals insignificant difference between experimental group and control group on the conduct problem dimension of externalizing behaviour problems with t= (1.531), p>.05.Observing the means from the above table, control and experimental group of orphan children show almost equal mean i.e. mean=2.77 of experimental group and mean= 2.77 of control group on the conduct problem dimension of internalizing behavioural problems, which clearly shows the insignificant difference. The result from the above table 4.16 clearly shows higher mean of control group mean=3.73, than experiment group mean=2.8, hence indicates significant difference in peer problems between the experimental and control group at t=(5.532), p<.05.

Overall when looking at the total score of the externalizing behavioural problems from the above table clearly specifies the significant difference between experimental and control group of orphan children at t= (8.425) p<.05. Based on the mean analysis of the above table, experimental group possess the least mean=72.00 after the exposition with peer support group intervention than control group of orphan children who are scores high mean=90.92, therefore describes the significant difference on externalizing behavioural problems. Thus, it can be said that orphan children who were exposed to peer support group intervention showed significant decrease in externalizing behavioural problems, except conduct problem dimension. Therefore the proposed hypothesis number eight, stated that "there is no significant difference of peer support group intervention in dealing with externalizing behavioural problems of orphan children of Kashmir" stands partially rejected.

FIGURE 4.16

MEAN SCORES IN 'EXTERNALIZING BEHAVIOURAL PROBLEMS' OF POST-EXPERIMENTAL GROUP AND POST-CONTROL GROUP OF ORPHAN CHILDREN



DISSCUSSION ON RESULTS

As in this experimental part of the research, the experimental group of orphan children show significant decrease of internalizing behavioural problems (anxiety, depression and stress symptoms) when becoming the part of peer group support intervention in comparison with control group of orphan children who were kept away from the intervention program. It was found that experimental group of orphan children depict clearly decreases of the aggression, hyperactivity and peer relationship problem dimensions of externalizing behavioural problems. But the result shows insignificant differences between experimental and control groups in conduct problems of externalizing behavioural problems. When the results of experimental group were assessed before and after the peer group support intervention, it shows significant depletion of internalizing behavioural and externalizing behavioural problems, but did not show any decrease of conduct behavioural problems among the orphan children.

A more related study has been done which supports this study suggests that peer group support group intervention decreases the psychological distress particularly symptoms of depression, anxiety and anger among AIDS orphans children in Uganda (Kumakech et al.,2009). Thus, the use of peer-group support interventions should be incorporated into existing school health programs (Kumakech, et al.,2009). Peer Group Support intervention show improvement in mental well-being among the students. A structured peer support helps to reduce the depression and improves the student well-being (Byrom, 2018). Peer support can be the best way to deal the psychological problems among the orphan children or to develop psychological well-being among the AIDS orphan children (Kodero, 2000). This result is consistent with (Rusch et al., 2019; Bryan & Arkowitz, 2015) that peer administered interventions can lessen the depressive symptoms and recovery from the mental health problems and its benefits can be maintained and warrants further study in future. Peer-group support has the potential to improve bereaved children experiencing feelings of social isolation and help them develop coping strategies (Metel & Barnes, 2011). Peer support intervention results in greater progress in depressive symptoms and may have parallel efficacy as the cognitive behavioural therapy (Pfeiffer et al., 2011). Peer support show increased academic engagement, more progress on individualized social goals, develop greater number of friendships, more interaction with peers, increased social participation, and

develop greater number of friendship with new students among the children who are dealing with severe disabilities (Carter et al., 2016).

A favorable study with this research suggests that peer support helps the women who are suffering with postpartum depression. The experimental groups showed the considerable improvement in the decrease of depressive symptoms and were contented with the peer based intervention (Dennis, 2003). A study done by the Mentis et al. (2015) among the individuals who are caretakers of patient with psychosis suggests that caregivers groups who received the peer support group intervention show lower level of psychopathological characteristics on many dimensions like depression, anxiety, hostility, interpersonal sensitivity and paranoid ideation compared to group who did not receive the peer group support intervention. Criminality and substance abuse show significant decrease among the individuals with severe mental health problems when exposed to peer group support intervention and the study further suggests that this intervention program was promising to yield positive outcome of alcohol use of persons with severe mental health problems (Rowe et al., 2007). Exposed to peer support it was found that clients show positive comeback from the stigmatization and minimizes the negative thoughts of stigmatization (Verhaeghe, 2008). Peer support is associated with positive effects on measures of recovery, empowerment and hope among the people with severe mental illness (Lloyd-Evans et al., 2014). A more supportive study which suggests that peer support found to be effective in dealing with depression, disability, psychological health and quality of life among the individuals suffering from these problems. The study suggests that longer trails should be provided to assess the effectiveness and efficacy of this promising intervention technique (Castelein et al., 2008).

Peer support group and teacher's social support has direct indirect effect on personal control suicide and depression rick behaviours among the youth (Thompson et al., 2000). A systematic review done on the peer support intervention on child health, diabetes, mental health problems, maternal health and other chronic disease, the conclusion of review found that peer support is broad technique of intervention, where other health facility fails to touch. The review finds that due to the flexibility of the peer support into different contexts had made it successful for health problems (Sokol & Fisher 2016). Large body of work has been done on the efficacy of peer support group intervention on psychological and other non-psychological paradigms (Webel et al.,2010; Sledge et al.,2011; Simpson et al.,2014; Dennis et al.,2009;Stadler et al.,2010; Ussher et al.,2006; Monica et al.,2010; Simmons et al.,2015; Vaughan et al.,2010; Repper & Carter, 2011; Albrecht et al., 1998; Kaponda et al. 2009).

Overall, it can be said that peer group support intervention can be used in multidimensional way with many psychological and other non-psychological constructs.

CHAPTER V

CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

The present study had its prime focus on the internalizing and externalizing behavioural problems among orphan and non-orphan as well as the role of peer support group intervention in dealing these internalizing and externalizing behavioural problems among children who had been experiencing parental bereavement and are residing in orphanages of Kashmir. Childhood is one important life experience that we share and it plays an important role in the development of human beings. But unfortunately there are growing numbers of orphan children and also very less attention has been provided to this sensitive and culturally stimulating population. Childhood has been regarded as a vital stage from which to proceed into adulthood; it has been observed as the "golden phase" of an individual's life. According to Locke, (1963) "a child is referred as tabula rasa from which they could learn through experience and develop rationally into the adult world". As mentioned earlier that children who lost or rejected by their parents may lead to the development of an unhealthy life structure. It has been observed the children who have lost their parents become most vulnerable, because they do not have the emotional and physical maturity to deal their psychological trauma associated with parental loss. In the society, orphan children can be considered to be at more risk than average children (Subbarao & Coury, 2004). There is high prevalence of emotional, cognitive, psychological, behavioral problems of institutionalized children than those who live with their parents. (Erol, et al.,2010; Sushma et al., 2014). A new study done by the international charity of orphaned and abandoned children found that India is domicile of 20 million orphan children, a digit probable to increase by 2021. Approximately 18 million of this number of children live or work on the streets of India and majority of them are involved in crime, prostitution, gang related violence and drug trafficking; however, a large number of these children are orphans (Shrivastava, 2007). Jammu and Kashmir is the state of India, which comprises huge residents of orphan population mostly because of the armed conflict since 1990,s. As cited in Bhat, et al. (2015) a study done by the UK based child rights organization, Save the Children revealed that Jammu and Kashmir has 2, 14,000 orphans and it also states that 37% of them orphaned due to the armed conflict. Though several comparative studies has been done between the orphan and non-orphan on different psychological constructs and almost all the studies suggest that

orphan children show higher levels of psychological problems than the children who are receiving the primary care from their parents. But the limited research has been done in India, especially in Kashmir, where the rate of this neglected section of the society is high. Although little research has been done on this deserted population of our society, but very less attention has been paid on the intervention process so that problems faced by these children can be eradicated. As these children are living in group setting in orphanages, it seems then that there exists research gap to understand the role of peer group support intervention in dealing with internalizing and externalizing behavioural problems among the orphan childrens.

Present chapter deals with three aspects i.e. conclusions, recommendations and suggestions for future research have been provided comprehensively.

5.1 CONCLUSIONS

This section reflects an attempt to portray brief summary of the findings drawn on the basis of descriptive and inferential statistics.

5.1.1 Comparative Analysis of orphan and non-orphan children

Objective 1: **To examine the differences in internalizing and externalizing behavioral problems of orphan and non-orphan children of Kashmir.**

Orphan and non-orphan children differ significantly on anxiety, depression and stress dimension of internalizing behavioural problems. The result showed that orphan children possess higher level of anxiety symptoms than the non- orphan children. When compared to depression symptoms, orphan children are dealing with higher level of depressive symptoms than non-orphan children. The results further reveled that there are significant differences in stress dimension of internalizing behavioural problems among the children whose parents have expired and the children who are under the care of their parents. Overall the results clearly portrays that the childrens whose parents are expired and are taking shelter in orphanages of Kashmir show maximum levels of internalizing behavioural problems than the childrens who are living under the shadow of parents and family.

The result show significant difference between the two samples of orphan and non-orphan children in the dimensions of aggression and hyperactivity of externalizing behavioural problems. Children who are far away from home and are living in orphanage setting show higher levels of aggressive symptoms and hyperactivity behavioural problems

than the children who are living with their parents and secondary care givers. But the finding delineates that there are insignificant differences between orphan and non-orphan children on conduct and peer relationship problem dimensions of externalizing behavioural problems. Moreover when viewing the overall results of childrens whose parents are deceased and are residing in public and private orphanages of Kashmir show higher symptoms of externalizing behavioural problems than the children who are under the care of their parents.

5.1.2 Comparative Analysis of Single orphan and Double orphan children

Objective 2: To investigate the differences in internalizing and externalizing behavioral problems of single and double orphan children of Kashmir.

Single and double-orphan depicts clear difference in the mean on anxiety dimension of internalizing behavioural problems. The result finds that, those children who have lost one of the parents leads lower level of anxiety symptoms than those children who have lost both of their parents. Similarly the result portrays those children who have lost both the parents, show higher degree of depressive symptoms than those children who have lost only one of their parents. Further results delineate significant difference between mean scores of single orphan and double-orphan children on the dimension of stress symptoms of internalizing behavioural problems. Double orphan children are dealing with higher levels of stress symptoms than the single-orphan children. Generally the results describes that children who are having the bereavement experience of both the parents and are living his life in orphanage setting, show higher levels of problems in all the dimensions of internalizing behavioural problems (anxiety, depression and stress symptoms) than the children who are having the bereavement experience of only one of the parent and are taking shelter in the orphanage of Kashmir.

Based on the mean analysis, single-orphan and double orphan children on the aggression dimension of externalizing behavioural problems suggests insignificant difference. The result displays almost same score of mean between the children who possess only one parent and the children had deprived from the both of the parents, which indicates that both the childrens have same levels of aggressive symptoms. Similarly the result suggests that both single-orphan children and double-orphan children have insignificant differences on the hyperactivity dimension of externalizing behavioural problems. Both the groups have almost the same mean in hyperactivity problem dimension, which specifies same degree of hyperactivity behavioural problems between single-orphan and double-orphan

children. Furthermore keeping on the view of the results of mean scores of single-orphan and double orphan children, it gives us the indication of significant difference on the conduct behavioural problems. The result suggests that mean of the double-orphan children on conduct behavioural problems is higher than mean of 140 single-orphan children, which specifies that double-orphan are dealing with more conduct behavioural problems. Similarly when looking on the result score of peer relationship problems of single and double-orphan children outlines that there is significant difference between these groups. It clearly suggests that double-orphan have higher degree of peer relationship problems than the single-orphan children on the basis of mean. Overall the results describes that children who are having the bereavement experience of both the parents and are living his/her life in orphanages of Kashmir, showing the higher levels of externalizing behavioural problems, but same levels of aggressive behaviour and hyperactivity than the children who have the bereavement experience of only one parent and are taking shelter in the orphanage.

5.1.3 Comparative Analysis of Boys and girls orphan children

Objective 3: To examine the gender differences in internalizing and externalizing behavioral problems of orphan children of Kashmir.

On the gender, the orphan children show insignificant difference on internalizing behavioural problems. The results describe that boys and girls orphans are dealing with same levels of anxiety problem. Similarly depression and stress dimensions of internalizing behavioural problems, boys and girls orphans show insignificant differences i.e. both the boys orphan and the girl's orphans have almost nearer to equal mean, which indicates that both gender are suffering from same level of depression and stress symptoms. Over all the result suggests that both the genders are suffering from the same level of internalizing behavioural problems, when experiencing of parental death and then living in orphanage setting in Kashmir.

Externalizing behavioural problems on the basis of gender show insignificant difference among the orphan children. The result shows that due to the bereavement experiences of parent's children living in orphanages of Kashmir, clearly portrays insignificant difference. The result precisely suggests that in the dimensions of aggression, hyperactivity, conduct problems, both boys and girls orphan possess almost equal mean scores, which specifies that on the basis of gender, orphan children are suffering from same level of these problems. Though the result indicate insignificant differences on the above

dimensions of externalizing behavioural problems, but on the peer relationship problems, the outcome delineates significant difference i.e. girls orphan show higher levels of peer relationship problems than boys orphan children. Overall total result score signifies insignificant difference in externalizing behavioural problems among girl's orphan children and boys orphan children residing in orphanages of Kashmir.

5.1.3 Comparative Analysis of Experimental and Control groups

Objective 4: To investigate the effect of peer group support intervention in dealing with internalizing and externalizing behavioral problems of orphan children of Kashmir.

5.1.4 Comparative Analysis of Experimental and Control groups at Pre-Test Phase.

The statistical processing reveals that experimental and control groups of orphan children showed insignificant differences in internalizing behavioural problems on pre-test phase. The result exposes that all the dimensions of internalizing behavioural problems (anxiety, stress and depressive symptoms) suggest insignificant differences between experimental group and control group of orphan children before the peer group support intervention. At pre-test phase both the groups of orphan children are homogeneous in terms of internalizing behavioural problems.

In context with the externalizing behavioural problems, the experimental group and control group of orphan children clearly exposes insignificant differences. Thus in all the dimensions of externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems) both the groups have insignificant difference at the pre-test phase or before the offer of peer support group intervention. Thus the result exposed that both the groups are homogeneous in nature with regard to externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems) at pre-test phase.

5.1.5 Comparative analysis of Pre-control and Post control group

Based on the mean scores pre-control group and post control groups of orphan children on internalizing behavioural problems shows insignificant difference. The result exposes that all the dimensions of internalizing behavioural problems (anxiety, stress and depressive symptoms) suggest insignificant differences between pre-control and post control group of orphan children. Thus the result indicates that pre-control group and post control group are homogeneous in terms of internalizing behavioural problems, which suggests that changes in the experimental group are due to intervention program.

Externalizing behavioural problems of the pre-control group and post control group of orphan children clearly exposes insignificant differences. Thus in all the dimensions of externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems) in both the groups have insignificant difference. The result exposed that both the groups are homogeneous in nature with regard to externalizing behavioural problems (aggression, hyperactivity, conduct and peer relationship problems), which indicates that decrease in externalizing behavioural problems in post experimental group are not due to chance, but due to exposition of peer support group intervention.

5.1.7 Comparative Analysis of Pre-Experimental group and Post Experimental group

When compared the mean scores of pre-experimental and post-experimental group of orphan children of internalizing behavioural problems, the result exposes significant difference between the groups. It was clearly found that the mean score of the anxiety, depression and stress dimensions of internalizing behavioural problems are lower among the post-experiment group than the pre-experimental group of orphan children. The peer group support intervention thus proved the decrement of internalizing behavioural problems among the orphan childrens residing in the orphanages of Kashmir.

Moreover when used the paired 't' test for the analysis of pre-experimental and post-experimental group, the result clearly portrays the significant differences on the mean score of pre-experimental and post-experimental group on the dimensions (aggression, hyperactivity and peer relationship problems) of externalizing behavioural problems. But the result further illustrates insignificant differences between pre-experimental group and the post-experimental group in the dimension of conduct problems. Thus it can be said no change of conduct behavioural problems between pre-experimental and post-experimental group, when exposed to the peer support group intervention. Overall the result showed lower levels of externalizing behavioural problems in post-experimental group when peer support group intervention was delivered.

5.1.8 Comparative Analysis of Experimental and Control group groups at Post-Test Phase.

Experimental and control group show significant difference on the anxiety dimension of internalizing behavioural problems. Based on the mean analysis the experimental group, when exposed to peer support group intervention depicts lower degree of mean on anxiety

symptoms, compared to control group who did not receive any intervention. Similarly on depression dimension of internalizing behavioural problems, experimental group and control group show significant difference. Experimental Group of orphan children show lower levels of depressive symptoms than control group of orphan children after receiving the peer group support intervention. Further the result delineates that both the groups showed significant difference on Stress dimension of internalizing behavioural problems i.e. experimental group exposed to peer group support intervention displayed lower levels of stress symptoms than the control group of orphan children who did received any treatment in the orphanages. Overall the result found that peer group support intervention leads the decrease of internalizing behavioural problems among the experimental group than the control group of orphan children.

On the statistical analysis of externalizing behavioural problems between experimental and control group of orphan children, it signifies significant differences when experimental group led to peer group support intervention. It was found experimental group and control group show significant difference in the dimensions of aggression, hyperactivity and peer relationship problems of externalizing behavioural problems. The result showed that aggression, hyperactivity and peer relationship problems symptoms are lower among the experimental group of orphan children, when exposed to intervention program than the control group of orphan children who received the regular instruction in the orphanages. The result also indicates insignificant difference between experimental group and control group of orphan children on the dimension conduct problem. Thus it can be said that peer group support intervention did not led decrease of conduct behavioural problem in experimental group of orphan children. Generally peer group support intervention leads the decrease of externalizing behavioural problems in experimental group, than the control group who did not receive any intervention program.

5.2 RECOMMENDATIONS

The aim of the present study is to find out the internalizing and externalizing behavioural problems among the Orphan and Non-orphan children and the effect of peer group support intervention on these behavioural problems among the orphan children living in orphanage of Kashmir. The result of present study found that orphan children are suffering higher behavioural problems than the children whose parents are alive. The intervention

strategies reduce the level of behavioural problems among the orphan children residing in the orphanages of Kashmir. Keeping in view the conclusions and the importance of the study, the following recommendation are driven out for different stakeholders i.e. governing body of orphanages, government officials, policy makers and society as means to reduce the psychological problems facing by these orphans in orphanages, so that these vulnerable children can live happy and prosperous life and become the productive member of the society and did not let them feel isolation from the society.

1. The present study revealed that orphan children living in different public and private orphanages of Kashmir are having higher levels of behavioural problems than the children who are living with their parents at their own home setting, which indicate that due to bereavement experience of their parents, children living in these orphanages develop such kind of psychological problems. As Datta, Ganguly, & Roy, (2018) proclaimed that, behavioral problems are found higher among children who did not have parental care, because due to the absence of parental care they become prone to exploitation, abuse, and neglect in the society. Children living out from the parental and family care likely to become emotionally needy, poor and insecure. So individual care is required for the children brought up in institutional homes as to enhance wellbeing and quality of life in them. Positive psychological perspective should be commenced in the orphanages as to ensure that children are content, optimistic and happy about his/her future. In a nutshell, family-based care should be introduced and improvised institutional care in orphanages of Kashmir as reduce the burden of behavioral problems in our most precious population.
2. The present study describes that children living in orphanage of Kashmir are dealing with higher levels of internalizing behavioural problems (anxiety, depression and stress symptoms) as well as externalizing behavioural problem (aggression, hyperactivity, conduct and peer relationship problems). As (Sameena, D. et al 2016) asserted that children living in the orphanages of Kashmir are suffering high occurrence of psychiatric morbidities and to eradicate its lethal consequence on the community, recommendation of appropriate observation of the orphanages by the supervising authorities and for the caregivers regular training courses should be introduced to help improving their children caring skills. Early discovering and treatment of psychiatric problems for the children living in orphanages should be available continuously. Additionally larger studies should be done on the larger

sample, with longer period of time, so as to get full coverage of childrens living in orphanage of Kashmir.

3. In present study peer group support intervention were used to enhance peer relationship among the orphan children living in orphanage, so that they can share their feeling, concerns, problems, emotions etc. each other, in order to overcome from the internalizing and externalizing behavioural problems they are facing in orphanages. As (Kumakech. et al., 2008) asserted that psychological interventions such as peer-group support should be introduced in institutional setting, which may improve adjustment among orphan children and decrease the psychological distress, particularly anger, and depression related with AIDS orphan and other orphan children. The effectiveness of the peer group intervention shown here provides evidence for the success of psychosocial support and care for orphans. As (Metel & Barnes 2011) proclaimed that peer-group support may have the potential to improve bereaved children experiencing feelings of social isolation and help them develop coping strategies. Thus the sessions of peer group support intervention should be given regularly as they are living in group setting, with common bereavement experiences of all the children so that they can share feeling, emotions, information, problems etc., with this children would not develop the feeling of loneness. The care giver and administrators of the orphanages should be made aware about the peer support group intervention.
4. Counselors and Child Psychologists should be introduced in orphanages to teach health care providers, wardens, teachers and guardians. All schools and orphanages should have a child guidance counselor in order to help not only the orphans and vulnerable children, but also the teachers, caretakers who are dealing with these children. Families who possess the orphan children should be provided help in terms of physiological needs and counseling about the information on the Rights of the Child, so that they may look after in healthier way of their orphans.
5. Government can play vital role to regulate and supervise the conditions of orphanage care to children and ensure well-being, the safety, and proper development of the orphan children who are taking shelter in these orphanage. Government can appoint psychologists, counselors and other health professions for early recognition of mental health problems among the children of orphanages. For the better rehabilitation and social development of orphan children, early detection of mental

health problems in orphanages would be an important guide for policy makers. Therefore the current study gives clue for the responsible body to supervise the application of the services for the children in the orphanage.

6. Caretakers in these orphanages should be officially trained and specialization should be given preferences to work in these orphanages. The training that should be given to these caretakers includes the importance of relationship with the orphans, how to identify the different mental and behavioural problems and how to judge suicidal tendencies among the orphan children. A clear recommendation system should be introduced for a more formal service to be established.
7. Orphanage authorities should work on the inherited tendencies of these orphan children, so that their aptitudes and potentialities can grow up at peak and they may become independent and productive member of the society. For those co-curricular activities, like role plays, debates, discussions, writing competitions, mock trails, talent shows, games etc. should be introduced in these orphanages. Involvement in these co-curricular activities helps orphan children to develop strengths and talents, management, organizational skills, confidence and self-esteem. The activities can channelize the energies of orphan children in healthy ways, rather than towards the behavioural problems, drug abuse and crime. It will also help orphan children to develop healthy relationship with their peers, they will not feel isolation and confined in orphanages, when providing the facilities of co-curricular activities in orphanage of Kashmir.
8. In institutional setting children should be involved in regular recreational activities, involvement in these activities may be beneficial for the children and they can display their talents, creativity and help them to develop self-esteem. Second, participation in these activities can help the children to improve their interaction and communication skills. Social settings with positive role models and peer groups can provide opportunities to the children to learn healthy communication and social skills.
9. Social aspects provide the children with adequate social support that would buffer them from hardships. Create peer support networks that would simultaneously provide much needed emotional support to the children, give opportunities for positive social interactions and act as a setting for learning new social behavior.

5.3 Limitations of the Study

The limitations of the present study would be worth listing as it will enable the reader to interpret the results in the backdrop of these limitations.

1. The present study was restricted to some selected orphanages and schools because of prevailing situations in Kashmir. Further in the present study, there were absence of funding by any Government and Non-governmental agency. Consequently, there issue of generalizability, therefore the results will only be applicable to similar institutions in similar settings.
2. Due to the descriptive as well as experimental nature of the study, the sample of the study was limited to only five orphanage and five schools of Kashmir.
3. Due to the demanding criteria of the present study, the age group of (14-18 years) orphan and non-orphan children were selected as sample, the orphan and non-orphan children below the age of 14 years were neglected. They may be suffering more psychological problems compared to the age group taken as sample in this study.
4. The present study did not take the maternal orphan, paternal and social orphan into consideration, instead single, double orphan and non-orphan children were taken into the sample. Furthermore orphan children who are not residing in the orphanages and are living with their family members should have been included in the sample of present study.
5. The present study was conducted on only three variables on the population orphan children who are living in orphanages and non-orphan who are living with their parents. More broad study can done on larger sample and other variables like causes of death of parents, resilience, socio-economic status, personality traits, subjective well-being and emotional intelligence.
6. Instead of using random sampling, which can yield valid results, the researcher make the use of purposive sampling technique in the present study, so the prudence needs to be taken as to generalize the result on the whole population.
7. One of the major limitations was that the study could not represent of orphan and non-orphan children from socio-economic background and further from how much time they are living in orphanages.
8. The improvements that led in behavioural problems of experimental group of orphan children was only because of peer group support intervention, to know fully additional support may should have been introduced through the somatic treatment on

the third group of orphan children, but it was it beyond the range of present study to develop the third group of orphan children.

9. There is absence of follow up data collection in the present study; follow-up data would have added the efficacy of peer group support intervention.
10. Religious practices have not been included in the study which might contribute in a special way in the formation of the characteristics features of the individual.
11. Participant-predisposition effects such as co-operative of uncooperative participant effect and evaluation apprehension as well as experimenter expectancy effects could also have been impacted the intervention.
12. In present study only three main activities of peer support activities were utilized during intervention process, due to political turmoil in Kashmir since 2019. Other interventions like mindfulness, meditation, along with peer group support intervention should have been introduced in the study, so as to assess the interaction effect on psychological distress among the orphan children living in orphanages. Furthermore length of the interventions should be bigger to get the preferred changes among the orphan children.
13. Another limitation of the present study is that age of admission and length of staying in an orphanage by the children was not taken into consideration.
14. Orphan children living with their family members should also have been provided peer group support intervention as to measure the residential effect on behavioural problems of orphan children.

5.4 DIRECTIONS FOR FUTURE RESEARCH

The understanding and insights gained during the course of the present study, it is possible to come out with some specific suggestions regarding future research that may be taken up on this segment of the population. This study is just a beginning, for such issues that can only be addressed further by scientific researchers. Some of them are listed below.

1. The research was restricted to some selected orphanage and schools Kashmir; it can be further expanded on many orphanages and schools, as to gain more insight on orphan childrens, living in these orphanages.
2. Descriptive study can be done on the children living in public and the private orphanages of Kashmir on other psychological constructs.

3. The study can expanded on the orphan and non-orphan children below the age of 14 years.
4. A well-organized and controlled experimental study can performed on this vulnerable population in Kashmir as well as in whole India.
5. A comparative study can be done between the orphan children living in the orphanages of Kashmir and orphan children living with their family.
6. The present study give the hint to the adjustment problems of orphan children living in orphanages of Kashmir, so the future research can be done on the adjustment behavioural problems of these children and it will be a genuine appeal to the rehabilitation council and government to organize the facilities for these needy population.
7. A further research can be done on the maternal orphan, paternal and social orphan on the larger sample with other psychological variables.
8. More broad study can done on larger sample and other variables like causes of death of parents, resilience, socio-economic status, personality traits, subjective well-being emotional intelligence etc.
9. The effects of the peer group support intervention on other psychological constructs such as social intelligence, self-esteem; coping and emotional intelligence can be investigated in future research.
10. An effect of integrated intervention program can be investigated on the internalizing and externalizing behavioural problems on orphan children residing in orphanages of Kashmir.
11. More in-depth insight can be gained by using the mixed model approach of both quantitative and qualitative design in the future research on this sample.
12. A cross-sectional study can be done by the future researcher between the age group of 10-14 years and 14-18 years of orphan childrens, by doing this, it can be assumed that the difference are happened due to the age group rather than something that happened over a time.
13. Due to the longer stay in these orphanages, a longitudinal research investigation can be introduced on this population and the role of moderating characteristics (e.g. sex, age, social network, religiosity and stigma) may also be investigated by the future researcher. Other areas of future research include longitudinal designs investigating the casual relationship.

14. A comparative study of maternal orphans, paternal orphans, and social orphan can be done on internalizing and externalizing behavioural problems, along with peer support group intervention and psychological intervention.

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Scale I

Anxiety, Depression and Scale (ADSS)

Pallavi Bhatnagar, Megha Singh, Manoj Pandey, Sandhya and Amitabh

Please fill the following entries: - Date: _____

Name_____ Fathers Name_____

DOB_____ Gender: Male/Female

Class: _____ Area: Urban/Rural

Are you under treatment of Anxiety/Depression/Phobia_____?

S.N	Statements	Yes	No
1	I am aware of the dryness of my mouth.		
2	I feel difficulty while breathing (e.g. excessively rapid breathing, breathlessness in the absences of physical exertion).		
3	I am not able to feel good**.**		
4	I find it difficult to relax.		
5	I feel that I get upset easily.		
6	I often feel that I am not able to do anything.		
7	I often have a feel of numbness/shakiness in my hands and legs (e.g. legs going to give away).		
8	I find myself getting restless if delayed in anyway.		
9	I feel that I have nothing to look forward to.		
10	I often feel downhearted and sad.		
11	I often get the feeling of faintness.		
12	I feel that I am rather touchy.		
13	I am not able to be enthusiastic about anything.		
14	I perspire heavily even in the absence of exertion and high temperature (e.g. hand sweaty).		
15	I get sacred without any reason.		
16	I find as if I am getting more irritable.		
17	I find it hard to calm down after getting upset.		
18	I have difficult in swallowing.		
19	I find that it is difficult for me tolerate any interruptions in whatever I am doing.		
20	I am worried about those things in which I might panic and make a fool of myself.		
21	I feel more nervous and anxious than usual.		
22	I have difficult in taking the initiative for any new task.		

23	I find myself getting agitated in everything.		
24	I am bothered about headaches, neck and back pains.		
25	I feel weak and get tried easily.		
26	I feel sad and depressed.		
27	I feel that I am losing interest in almost everything.		
28	I can feel my heart beating fast.		
29	I am slow to respond.		
30	I feel extremely upset if exposed to events that remind me of similar stressful event.		
31	I feel I am not worth as a person.		
32	I get feeling of numbness and tingling in my fingers, toes.		
33	I have no expectations/hope from the future.		
34	I am bothered by stomachs and indigestion.		
35	I have to empty my bladder often.		
36	I have repeated unwanted memories of the stressful event.		
37	I feel that my life is meaningless.		
38	I am not able to handle/control my feelings.		
39	I have nightmares.		
40	Often my mind goes blank.		
41	I have heavy pressure in the chest.		
42	I often have crying bouts without any good reason.		
43	The stressful events cause problems in my relationships with other people.		
44	Often I want to be alone.		
45	Sometimes my vision is blurred.		
46	I have difficult in concentrating.		
47	Often I have feeling of nausea.		

48	I feel unwell.		

Scale II

Aggression Scale (AGS)

Dr. Rajeev Lochan Bhardwaj

Please give information about yourself:

Name:_____ Fathers Name:_____

Gender: M/F Age: _____ Education: _____ Area: Urban/Rural

Instructions: Please read carefully as every statement is related to your expressed behaviour and answer each and everything with utmost honest. All the information given by you shell remain confidential.

S. N	Statements	Responses
1	Whether your friend or relative…. in meeting you.	( ) avoid in excess ( ) avoid much ( ) avoid generally ( ) generally do not avoid ( ) never avoid
2	I take…… in debating with others even without need.	( ) excessive pleasure ( ) much pleasure ( ) pleasure normally ( ) no pleasure ( ) not at least pleasure
3	To hear and read the story of revolutionary heroes, I…….	( ) like very much ( ) like much ( ) like normally ( ) like less ( ) like the least
4	To obey the rules of the society, I……	( ) do not consider necessary always. ( ) do not consider necessary. ( ) do not consider necessary off and on. ( ) consider necessary. ( ) consider necessaryalways.
5	To drive fast or to sit in the fast driven car without much need of the occasion, I ……..	( ) like very much. ( ) like much. ( ) like normally. ( ) like less. ( ) like the least.

6	To retort the other's provoking answer, I……..	( ) like very much. ( ) like much. ( ) like normally. ( ) like less. ( ) like the least.
7	To return a blow in lieu of slap, I……	( ) consider very much appropriate. ( ) considermuch appropriate. ( ) consider appropriate normally. ( ) consider less appropriate. ( ) consider least appropriate.
8	In the event of a work against my wishes, I……..	( ) lose my temper in excess. ( ) lose my temper very often. ( ) lose my temper occasionally. ( ) do not lose my temper normally. ( ) never lose my temper.
9	Actions of violence in the programmes of TV, I……..	( ) like very much. ( ) like much. ( ) like normally. ( ) like less. ( ) do not like at all.
10	During the sleep the dreams of strife and violence, I…….	( ) have in excess. ( ) have very often. ( ) have occasionally. ( ) do not have generally. ( ) do not have at all.
11	How to improve the present social system around us? This point…….	( ) is the most important for me. ( ) is the most important for me. ( ) is most important for me. ( ) is the most important normally for me. ( ) is not at all most important for me.

12	In order to achieve my goal (right or wrong), I……	( ) remain always eager. ( ) remain eager. ( ) occasionally remain eager. ( ) hardly remain eager. ( ) never remain eager.
13	To have a meeting with the battle warriors and horrible fighters, I…….	( ) like very much. ( ) like much. ( ) like normally. ( ) like less. ( ) do not like at all.
14	For the selfish interests of others, I…….	( ) become a tool always. ( ) become a tool generally. ( ) become a tool occasionally. ( ) do not become a tool normally. ( ) never becomes a tool.
15	Finding that my things are not properly placed, I…….	( ) become angry in excess. ( ) become much angry. ( ) become angry occasionally. ( ) do not become angry normally. ( ) do not become angry at all.
16	To break or to throw away the inanimate objects, I……	( ) like very much. ( ) like much. ( ) like generally. ( ) do not like generally. ( ) do not like at all.
17	To hunt the animals and birds without much cause, I…….	( ) like very much. ( ) like much. ( ) like normally. ( ) like less. ( ) do not like at all.
18	In teasing and torturing others, I…….	( ) find delight in excess. ( ) find delight. ( ) find delight normally. ( ) do not find much delight. ( ) find no delight.

19	While being confronted with partiality, I…….	( ) become very much angry. ( ) become angry. ( ) become angry normally. ( ) do not become angry generally. ( ) do not become angry at all.
20	How the opponent should be tortured? This thought, is ….	( ) always present in my mind. ( ) generally present in my mind. ( ) occasionally present in my mind. ( ) not present in my mind normally. ( ) never present in my mind.
21	To obey the elders, I……	( ) do not like at all. ( ) generally do not like. ( ) occasionally do not like. ( ) like normally. ( ) like much.
22	To hear others in loud tone, I…….	( ) do not like at all. ( ) do not like normally. ( ) tolerate some times. ( ) tolerate very often. ( ) tolerate always.
23	To tell the faults of elders while they are at faults, I…….	( ) consider very much necessary. ( ) consider necessary. ( ) consider necessary normally. ( ) consider less necessary. ( ) do not consider necessary at all.
24	While failing to take revenge with the opponent, I……	( ) shout and murmur for a long time. ( ) shout and murmur for quite some time. ( ) shout and murmur normally. ( ) shout and murmur a little. ( ) hardly shout and murmur.

25	In the interest of the nation, even the deeds going against public interest, I……..	( ) accept very easily. ( ) accept easily. ( ) accept normally. ( ) hardly accept. ( ) do not accept at all.
26	If a small event of tussel appears on the road, I…..	( ) begin to irritate in excess. ( ) begin to irritate. ( ) begin to irritate normally. ( ) hardly irritate. ( ) never irritate.
27	If I get angry on others, I …… for my own loss.	( ) never care ( ) don't never care normally ( ) don't never care occasionally ( ) careless ( ) least care
28	In the unnecessary disputes of the society, I……..	( ) participate very often. ( ) participate often. ( ) participate occasionally. ( ) hardly participate. ( ) do not participate at all.

Scale III

Strengths and Difficulties Questionnaire

For each item, please mark the box for not true, somewhat true or certainly true. It would help us if you answered all items as best you can even if you are absolutely certain. Please give your answers on the basis of how things have been for you over last six months.

Name: _____ Gender: Male/female

DOB: _____ Area: Rural/Urban

Statements	Not true	Somewhat true	Certainly true
I try to be nice to other people. I care about their feelings			
I am restless, I find it hard to sit down for long			
I get a lot of headaches, stomachs or sickness			
I usually share with others, for example food or drink			
I get very angry and often loss my temper			

I would rather be alone than with other people			
I am generally willing to do what other people want			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have at least one good friend			
I fight a lot. I can make other people do what I want			
I am often unhappy, depressed or tearful			
Other people generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily loss confidence			
I am kind to children			
I am often accused of lying or cheating			
Other people pick on me or bully me			
I often offer to help others (family members, friends, colleagues).			
I think before I do things			
I take things that are not mine from home, work or elsewhere			
I get along better with old people than with of my own age			
I have many fears, I am easily scared			
I finish “I am” doing. My attention is good			